

Governing Board Meeting Agenda

1:00 PM – 3:30 PM November 6, 2017

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>
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<u>Time:</u>	<u>Agenda Item:</u>	<u>Proposed Action:</u>	<u>Attachments</u>
1:00 PM	Introductions – Barry Kling <ul style="list-style-type: none"> Board Roll Call Review of Agenda & Declaration of Conflicts Public Comment 	Discussion	Agenda
1:10 PM	Approval of October Minutes – Barry Kling	Motion to Approve: Minutes	Minutes
1:15 PM	Treasurer’s Report – Sheila Chilson	Motion to Approve: Financial Report	Financial Report
1:25 PM	Executive Director’s Update – Senator Parlette <ul style="list-style-type: none"> Update on open position Approach to Annual Meeting and Board Terms, Open Business Seat 	Information Possible action on Board terms.	Newsletter
1:40 PM	BHO Update – Tamara Burns	Information	
1:45 PM	FIMC Update – Christal Eshelman	Information	
1:50 PM	Board Nomination – Barry Kling <ul style="list-style-type: none"> Education Sector – Michelle Price NCESD 	Motion to Approve: Michelle Price to fill the vacated education seat	Bio
1:55 PM	Program Manager Update – John Schapman <ul style="list-style-type: none"> Nov 16 Proposal Update on Tribal Resolutions – Molly Morris 	Information	<ul style="list-style-type: none"> Project Plan Budget Resolution Packet
2:10 PM	Whole Person Care Collaborative – Peter Morgan <ul style="list-style-type: none"> CCMI Upcoming WPCC Activities 	Information	
2:20 PM	Pathways Community HUB – Barry Kling <ul style="list-style-type: none"> Contract/proposal 	Motion to Approve: Cost for initial HUB development contract	Proposals (Burgoyne and Harnach)
2:30 PM	Other Workgroup Updates <ul style="list-style-type: none"> Transitions & Diversions – John Schapman Opioid – Christal Eshelman HIT/HIE Workgroup Charter – Caroline Tillier Focus group(s) – role of social service orgs in the Demonstration – Barry Kling 	Information Motion to Approve: HIT/HIE Charter	Draft Charter
2:50 PM	Governing Board Round Table – All Members	Discussion	
3:00 PM	Governing Board Executive Session on Personnel and Related Issues	Board Members Only	
3:30 PM	Adjourn		

10/2/17 NCACH Governing Board Meeting Minutes 12:30–3:00

Confluence Technology Center, Wenatchee WA

Board Member Attendance: Tim Hoekstra, Rick Hourigan, Kevin Abel, Sheila Chilson, Winnie Adams, Barry Kling, Bruce Buckles, Kayla Down, Jesus Hernandez, Brooklyn Holton **Phone:** Doug Wilson, Nancy Nash-Mendez, Molly Morris, Ray Eickmeyer, Mike Beaver **Absent:** Theresa Sullivan, Senator Warnick, Tyler Paris

Public Attendance: Jolyn Hull, Kaitlin Quirk, Roseann Martinez, Laurel Lee, Rosa Guerrero, Shirley Wilber, David Olson, Ken Sterner, Ann Crain, Whitney Howard, Blake Edwards, Christine Mickelson

NCACH Staff Attendance: Linda Parlette, Peter Morgan, John Schapman, Christal Eshelman, Caroline Tillier, **Minutes:** Teresa Davis

Agenda Change: Add discussion on HUB after WPCC Update

Conflicts of Interest: None

Public Comment: MCO Provider symposium – please sign up.

Minutes: *Sheila Chilson moved to approve the September minutes as written, Tim Hoekstra seconded the motion, no further discussion, motion passed*

Treasurers Report-Sheila Chilson: Sheila and Kandis Boersema from the Chelan-Douglas Health District have worked to make the financial report easier to read. Sheila went over the two pots of funding, SIM Funds and Demonstration Funds noting that we have received \$6 Million to date in the demonstration funds, but it is not reflected on this sheet. Sheila has no concerns with the financial report.

- ❖ *Tim Hoekstra moved to approve the financial report as submitted by Sheila Chilson, Brooklyn Holton seconded the motion.*

Comment RE: Page 2 demonstration funds-missing info prior to July because we were not spending any money out of that budget until the funds were received in July.

- ❖ *No further discussion, motion passed*

Executive Directors Report: Linda Parlette thanked all for the support during her husband's illness and passing. See October newsletter for updates.

Program Manager Update-John Schapman:

- NPIP Insurance Resolution – full packet was emailed to board members.
Question: Did we get competitive bids? Yes. No other concerns with the resolution that was passed on September 11th.
- Phase 2 Certification Feedback – score 97.5 out of 100%. Improvement opportunities...
 - Data and Analytic Capacity – Will be solved with the addition of Caroline to the NCACH Team.
 - Inclusion of Community Base Organizations and Social Determinants of Health – we will be working hard to show our engagement.

WPCC Update -Peter Morgan:

We are moving down the road to get more specificity to what the collaborative will look like. We have made progress in approving documents. We have agreed on the parameters on the first round of funding. Ran out of time on the discussion for the consulting proposal. There are some questions from the group about the role of the consultant that we need to resolve before moving ahead. Consultant contract will be around \$40-50K for the design phase.

- ❖ *Bruce Buckles moved to approve the document that has been accepted by the Whole Person Care Collaborative, Tim Hoekstra seconded the motion.*

Question: Was the entire document approved by the Collaborative? Yes, with the assumption that scoring may change and timeline may also be modified. The framework and concept are what we are approving.

Jesus:

- Do we agree the healthcare sector deserves only 10% of the credit for the health of the community?
- Who is dominating this conversation around the transformation process?
- Are the things we are measuring things that can be controlled and influenced by the healthcare sector?
- Where are the transformation dollars being targeted?
- What are we doing that is compelling other sectors to contribute and share the responsibility?
- Measuring tool – Will change plans reflect how we are going to engage existing community base organizations?
 - Barry: The point of the WPCC is to address things that can be addressed by the clinical organizations. There are other things going on to address the Social Determinants of Health through other projects.
 - Doug: This is the gap of knowledge that we have discussed in the WPCC Meeting. Agrees with what Jesus said. When we discuss what it means to transform care, it absolutely means working hand and hand with these organizations.
 - Tim: What are we really approving? He understands that even if we approve, there is room to make adjustments in the scoring.
 - Bruce: We are approving the catalyst to the transformation project that is going to involve the non-medical social determinants of health with the recognition of the clinical determinants and that there needs to be that inclusion and move forward.
 - Peter explained that this is designed to work from the inside out by changing the behavioral health and primary care practices and enable them to engage with the social determinants of health to deal with population health and care coordination. The next phase would be transforming this into the application template that would need to be approved by the board.
 - Sheila: In primary care we can only influence 10% of a patient's life. Would like to flush out social determinants of health in section 3, 5, 7 -- how are organizations going to engage? We need to clearly ask the question in the application process.
 - Can organizations choose not to answer a question? Procedures have not been worked out. This can all be taken into account in the template. We are really just doing a check in with the board to make sure that we are heading in the right direction.

❖ ***No other discussion, motion approved, Jesus Hernandez - opposed***

HUB Update-Barry Kling: Last meeting we spoke of delays in getting the HUB in a box. Expecting an outline and more information in the next couple of days. Initial cost is about \$20,000 for a 6 month engagement and we will be able to join this first cohort. We will be convening the board sub-committee together to create an RFP for the Care Coordination HUB and also to put together a care coordination inventory. Looking to get approval for the Executive Director or the Executive Committee to be able to engage in these contracts up to a certain amount. We would initially pay for this out of the design funds and pay back once demonstration funds are received and the ACH will not be charged the 15% overhead fee.

❖ ***Kevin Abel moved to authorize the Executive Director to establish a contract with Care Coordination Systems costing up to \$25,000 for assistance over the next six months in HUB business development and the development of a business plan for a Pathways Hub. The 15% CDHD administration fee would not be applied to this expenditure because it would be refunded later with demonstration funds. Bruce Buckles seconded the motion.***

- Kayla: Other ACH's have been quoted ten times higher than this. Would like clarification of what this includes.
- Barry: This is limited to the business side to develop a business plan.

- Sheila: In favor of allocating funds for the sake of forward progress, but would like to bring the board committee together. Would like to make some funds available for staff to move forward in the short-term, but then together with the board committee, really try to hammer this out.
- Bruce: We will benefit from the experience of others. It would cost a lot more to establish from the beginning.
- Tim: Likes this approach because the business plan will give us the nuts and bolts. If we move forward with the business plan, we are not obligated to move forward with other phases.
- ❖ **Motion approved, Kayla Abstained on behalf of the Managed Care Sector**

CCMI Contract:

- David Olson has heard from other ACH's that we are looking at up to \$250,000 to facilitate the collaborative in the future.
- Tim would like to know what design phase is: Business plan? We need to understand how it will effect social determinants of health, what are their resources? How can we all come together and collaborate?
- ❖ **Sheila moved to authorize up to \$55,000 to direct the Executive Director to research and contract with an organization to help us develop an effective learning collaborative including a business plan. 15% CDHD overhead fee would not apply. Rick Hourigan seconded the motion.**
- Tim Hoekstra: Wants to be sure that the entity builds on the grassroots effort that we have established.

Estimated Costs from the CCMI proposal:

Design phase \$15,000 – \$66,000
Pre Work Phase \$45,000 – \$75,000
Transformation Phase \$150,000 - \$225,000 per year

- Peter said that the design phase would have stand-alone value just in setting up and understanding what a learning collaborative does.
- ❖ **Motion passed**

Workgroup updates-John Schapman & Christal Eshelman:

- Transitional Care and Diversion Workgroup Charter: Under composition, it states that the Executive Director will appoint members. Change that wording to Executive Committee.
- ❖ **Jesus Hernandez moved to approve the Transitional Care and Diversion Charter changing the wording under composition to read "The NCACH Executive Committee will recommend to the Governing Board workgroup members", Sheila Chilson seconded the motion, no further discussion, motion passed**
- Opioid Workgroup Charter: Under composition, it states that the Executive Director will appoint members. Change to Executive Director to Executive Committee
- ❖ **Tim Hoekstra moved to approve Opioid Charter changing the wording under composition to read "The NCACH Executive Committee will recommend to the Governing Board workgroup members", Nancy Nash Mendez seconded the motion.**

Rick: Clarification, what is the strength and how well formed are the other county Opioid groups? Okanogan has an active group. Grant has been attending the Chelan-Douglas meetings and are forming a group. Will include three members from each county Opioid group and then have the Executive Committee fill in the gaps.

- ❖ **Motion passed.**

We need two board members on each workgroup. John will send an email to the board asking them to sign up for a workgroup if their schedule allows. Expect to see something this week.

Data Update-Caroline Tillier:

- Summary of measures included in the packet for the Demonstration; CORE helped put this together for the region. Includes information only for the six projects that have been chosen.
- Plan to continue this summary information as the data matures – need to eventually figure out a data workgroup not only to validate the information (from a provider end), but also sort through the analysis HIT/HIE implications for the Demonstration projects.

BHO Update-Christine Mickelson:

- Qualis came for external review of the BHO last week; draft report expected early November.
- Working with Archives for document retention and appropriate shifts to electronic. Have created a database for reconciliation on billing and discharge planning as well.
- Currently sorting through inventory of county/Medicaid-funded equipment.
- Contract amendments just received from the state, will need to sort through amendment applicability to sub-contracts as well, plus lease agreements and terminations.
- Parkside crisis triage demo currently underway – Forte will be at the BHO governing board meeting this afternoon to discuss. Still aiming for construction to be done by February.

FIMC Update-Christal Eshelman:

- Advisory committee will not have a meeting in October – will likely have two more before the end of the year.
- Consumer Engagement waiting on updated documents from HCA, then meeting will be scheduled.
- Sept 29-Oct 2 HCA expected to send information out about BHO closure
- November HCA expected to send information to enrollees about plan changes
- Christal will send information out about IMC changes to North Central organizations as they are developed/finalized to the Board.
- IT workgroup scheduled for October 17.
- Early Warning System Presentation to approve indicators to be sent to HCA
 - Bruce/Ombudsmen to have a discussion about tracking complaints in early warning system.
 - Sheila: How will providers report issues that are general issues, what are the means for reporting? Isabel said that there will be daily calls, then they will move to less and less as the time goes on.
- ❖ ***Jesus Hernandez moved to approve the Early Warning System Indicators as presented, Sheila Chilson seconded the motion, no further discussion, motion passed.***

Project plan update-John Schapman: Due November 16th - HCA is looking at revisions to the template. We will need to show a process for governance funding. Presented a preliminary funds flow document, can be discuss further on the mid-month call.

Governing Board Round Table

- Rescheduling – may need to consider adjusting the timing of meetings: 11a-1p for WPCC meeting and adjusting the Board meeting from 1-3:30p.
- Barry said that the staff is and will continue to work on ways to address the social determinants of health.

Meeting adjourned at 3:00 PM by Barry Kling

Next Meeting: November 6th 1:00-3:00 Confluence Technology Center, Wenatchee

SIM Funds Report on NCACH Expenditures to Date

Fiscal Year: Feb 1, 2017 - Jan 31, 2018

	Budgeted Allocation	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Totals YTD	% Expended YTD to Budget	Comments
Salary & Benefits	\$ 407,378.36	40,958.85					\$ 236,700.50	58.1%	
Office Supplies	\$ 13,337.48	318.78					\$ 4,174.83	31.3%	
Computer Hardware	\$ 10,119.12						\$ 9,949.80	98.3%	
Legal Services	\$ 5,880.40	152.75					\$ 6,526.15	111.0%	
Travel/Lodging/Meals	\$ 7,000.00	846.18					\$ 4,075.26	58.2%	
Website Redesign	\$ 5,000.00	150.00					\$ 3,821.59	76.4%	
Advertising	\$ -	286.36					\$ 1,268.10		Job ads.
Meeting Expense	\$ 4,000.00	428.99					\$ 4,240.01	106.0%	Mainly meeting room rental costs.
Other Expenditures	\$ -						\$ 20,310.24		WPC speaker expense, stationary printing, office furniture
Misc. Contracts (CORE)	\$ 23,650.00						\$ -	0.0%	
Misc. Contracts (CHIs)	\$ 36,000.00						\$ 12,000.00	33.3%	
Subtotal	\$ 512,365.36	\$43,141.91	\$ -	\$ -	\$ -	\$ -	\$ 303,066.48	59.2%	
15% Hosting fee to CDHD	\$ 76,854.80	6,471.29	0.00	0.00	0.00	0.00	\$ 45,459.97	59.2%	Includes space, computer network & support, fiscal, etc.
Meal Expenses - not charged a hosting fee							\$ 412.20		
Grand total	\$ 589,220.16	\$49,613.20	\$ -	\$ -	\$ -	\$ -	\$ 348,938.65	59.2%	

Total Funds Received	\$ 480,296	% of Fiscal Year	67%
Amendment 6 - funds available up to \$55k	\$ 27,405		
Amendment 5 - amount TBD (up to \$392k)	\$ 392,000		
Total SIM Funds	\$ 899,702		
Budgeted Amount	\$ 589,220.16		
Total Uncommitted Funds	\$ 310,481.69		

Demonstration Funds Report on NCACH Expenditures to Date

Fiscal Year: Jan 1, 2017 - Dec 31, 2017

	Budgeted Allocation	Sep-17	Oct-17	Nov-17	Dec-17	Totals YTD	% Expended YTD to Budget	Comments
Salary & Benefits	\$ 27,464.00					9,141.02	33.3%	
Legal Services	\$ 4,000.00					-	0.0%	
Travel/Lodging/Meals	\$ 5,000.00	289.69				289.69	5.8%	
Website	\$ 1,500.00					-	0.0%	
Admin (HR/Recruiting)	\$ 1,500.00					-	0.0%	
Advertising/Community Outreach	\$ 5,000.00	71.53				418.15	8.4%	
Insurance	\$ 3,000.00					3,892.39	129.7%	
Meeting Expense	\$ 5,000.00					-	0.0%	
Other Expenditures	\$ 15,000.00					378.11	2.5%	B&O Tax
Misc. Contracts (CHIs)	\$ 30,000.00					-	0.0%	
Subtotal	\$ 97,464.00	\$ 361.22	\$ -	\$ -	\$ -	\$ 14,119.36	14.5%	
15% Hosting fee to CDHD	\$ 14,619.60	54.18	-	-	-	2,117.90	14.5%	Includes space, computer network & support, fiscal, etc.
Grand total	\$ 112,083.60	\$ 415.40	\$ -	\$ -	\$ -	\$ 16,237.26	14.5%	

Total Funds Received (Starting July 2017)	\$ 6,000,000.00
Budgeted Amount (July - December 2017)	\$ 112,083.60
Total Uncommitted Dollars	\$ 5,887,916.40

% of Fiscal Year 75%

NC ACH Funding & Expense Summary Sheet

	Contract/Amendment Date	Funds Received	Funds to be Received	Expended to Date	Funds Remaining
Original Grant Contract K1437		\$ 99,831.63		\$ 99,831.63	\$ -
Amendment #1		\$ 150,000.00		\$ 150,000.00	\$ -
Amendment #2		\$ 330,000.00		\$ 206,899.17	\$ 123,100.83
Amendment #3 (\$50k Special Allocation)		\$ 15,243.25		\$ 15,243.25	\$ -
Workshop Registration Fees/Misc Revenue		\$ 19,155.00		\$ 19,155.00	\$ -
Amendment #4 (FIMC Advisory Comm. Spcl Allocation 2016)		\$ 15,040.00		\$ 6,783.41	\$ 8,256.59
Amendment #5*			TBD		\$ -
Amendment #6** (FIMC Adv Comm Spcl Alloc 2017)		\$ 27,594.60	\$ 27,405.40	\$ 27,594.60	\$ 27,405.40
Original Contract K2296 - Demonstration Phase 1		\$ 1,000,000.00		\$ 16,237.26	\$ 983,762.74
Original Contract K2296 - Demonstration Phase 2		\$ 5,000,000.00			\$ 5,000,000.00
Totals		\$ 6,656,864.48	\$ 27,405.40	\$ 541,744.32	\$ 6,142,525.56

* Amendment 5 will provide additional funds when needed for a total of \$872K through 1/31/2019.

** Revenue outstanding. Funding is monthly cost reimbursement.

2015-16 Report	99,831.63	2015-16 Expenses	\$ 99,832.00
2016-17 Report	480,000.00	2016-17 Expenses	\$ 76,736.40
SIM Report	\$ 77,032.85	SIM YTD	\$ 348,938.65
DEMO Report	\$ 6,000,000.00	DEMO YTD	\$ 16,237.26
	<u>\$ 6,656,864.48</u>		<u>\$ 541,744.31</u>
Variance	\$ -		\$ 0.01

Michelle Price, Ed.D. moved to East Wenatchee from Moses Lake. She is the new superintendent of North Central Educational Service District 171. Michelle is married to Rich Price. Together they have four adult children and three grandchildren. Michelle is a lifelong learner holding three degrees - a Bachelor of Arts degree in education, a Master's degree in School Administration, both from Central Washington University and a Doctorate degree in School Administration from Washington State University. She has a passion for children and public education, serving as a teacher, principal, assistant superintendent for teaching and learning and superintendent over the last 30 years in Tacoma, Soap Lake, and Moses Lake. Michelle is committed to community service. She is a past president of the Moses Lake Chamber of Commerce, served on the Columbia Basin Boys and Girls Club Board of Directors, and is a Rotarian. Her state and national advocacy for rural Washington has led her to be the past president of the Washington Association of School Administrators (WASA) and to serve on the Executive Committee for the American Association of School Superintendents (AASA).

ACH Project Plan Supplemental Data Workbook Template:
 Funds Distribution



* All funding estimates are considered preliminary and subject to change when NCACH understands the changes to DSRYP funding that could come to our region and the costs associated with full project implementation plans

Planned Use of Project Incentive Funds - Distribution by Use Category

Using this tab of the Supplemental Data Workbook, fill out the section below to indicate anticipated high-level distribution of Project Incentive funds by use category over the course of the demonstration (DY1 through DY 5 combined).
 The following reflects fixed, required use categories that should not be changed. In the additional rows, ACHs may enter in additional use categories but are encouraged to use the standard use categories to the extent possible. The intent is to standardize the broader use categories to the extent possible, with the category definitions allowing each ACH to use additional detail.
 For all use categories (required and optional), ACHs must provide definitions of the use categories.

SECTION 1: Planned Use of Project Incentive Funds - Distribution by Use Category			
Use Category	Description	Use Category Definition	Est. Percent of Total
Project Management and Administration	Central management of DSRIP Projects (e.g. Central services provided by an ACH, Conveneing, etc.)	Direct NCACH project management will be paid by design funds. This funding will cover contractors that work with partnering providers in the region to address specific needs that related to every partner in a project (e.g. Center for Collaboration, Motivation and Innovation helping NCACH establish a learning collaborative for behavioral health and primary car providers)	2%
Provider Engagement, Participation and Implementation	Project Incentive funds distributed to providers to support or incentivize engagement in Project planning or to fund specific implementation activities	Funding that will be used to help with initial capacity building for partnering providers and than be distributed based on partnering providers reporting process measures that will help NCACH achieve the "pay-for-reporting" metrics outlined in the Toolkit	60%
Provider Performance and Quality Incentive Payments	Project Incentive funds distributed to providers based on quality or other performance metrics	NCACH will be allocating "pay-for-performance" funding based on how partners assist NCACH in moving the metrics. Therefore, any P4P funding falls under this use category. The exact methodology of funds allocation to partnering providers will be developed in Q1 of 2018	23%
Health Systems and Community Capacity Building	Project Incentive funds distributed to support the required health systems and community capacity (Domain 1) focus areas including value-based payment, workforce development, and population health management. ACHs will be required to put a prescribed percentage of funds in this category to support statewide Domain 1 efforts in addition to the percentage to be distributed for their own activities.	Funding for Health Systems and Community Capacity buidling allocates funds to assist in a regional HIT/HIE system,to support potential contractors to assist regional partners to move towards Value Based Purchasing, and potential work of NCACH around Workforce Development	15%
Additional Use Category			0%
Additional Use Category			0%
Additional Use Category			0%
Additional Use Category			0%
Additional Use Category			0%
Additional Use Category			0%
Additional Use Category			0%
Additional Use Category			0%
Total Percent:			100%

Internal Use Only:	
Overall Project Pool Fund Dollars available:	\$29.5M in Project Pool Funding (30% reduction in Project Pool Funds)
Project Management and Administration	Estimated \$800,000 for CCMI over the course of the demonstration.
Provider Engagement, Participation and Implementation	Estimated that we spend \$17.7M on partners in the implimentation of project plans
Provider Performance and Quality Incentive Payments	Estimated that \$8.28M be earned and paid for by Provider performance and Quality Incentive payments (100% of P4P funds)
Health Systems and Community Capacity Building	Estimated that \$5.4M be dedicated to Value Based Purchasing and EHR workgroup (Dollars would be allocated for regional EMR and VBP workgroup contractor)

*This does not include the \$6M in Design funds or the \$5.5M in Mid-adopter funds since the chart asks specifically about project pool funds



Planned Use of Project Incentive Funds - Distribution by Organization Type

* All funding estimates are considered preliminary and subject to change when NCACH understands the changes to DSRYP funding that could come to our region and the costs associated with full project implementation plans

Using this tab of the Supplemental Data Workbook, fill out the section below, projecting how the ACH will distribute its Project Incentive funds by organization type for DY 1.

Section 1: Planned Use of Project Incentive Funds - Distribution by Organization Type					
Organization Type	DY 1	DY 2	DY 3	DY 4	DY 5
ACH Organization / Sub-contractors	7%	0%	0%	0%	0%
Partnering Provider Organizations	93%	0%	0%	0%	0%
Providers traditionally reimbursed by Medicaid (e.g., primary care providers, oral health providers, mental health providers, oral health providers, hospitals and health systems, nursing facilities)	54%	0%	0%	0%	0%
Providers not traditionally reimbursed by Medicaid (e.g., community-based and social organizations, corrections facilities, Area Agencies on Aging)	15%	0%	0%	0%	0%
Tribes/ITUs	2%	0%	0%	0%	0%
Other	22%	0%	0%	0%	0%
Total Percent:	100%	0%	0%	0%	0%

NOTE: Distribution percentages should be estimated to include both direct recipients of funds AND indirect beneficiaries of centralized investments.

Define types of organizations included in "Other," if any:

Funding Percentages: The above percentages are based on NCACH receiving \$4.416M in project incentive funds through the project plan application. This take into consideration the reduction in funding that has been discussed with HCA (~36%)

ACH Organization /Subcontractors: This funding would go directly to the subcontractors of NCACH to work with partnering providers including the Center for Collaboration Motivation and Innovation and Providence CORE

Other: This would include funding that would be utilized to help improve EMR/HIE functions and creating a regional approach to address Value Based Purchasing. This could go to provider groups, but uncertain the exact details on how spending will be accomplished. Therefore funding is going under the "Other" category. This category includes funds that will be held by the Fianicial Executor in DY1 to be allocated to partners at a later date.

Preliminary Recommended Approaches and Target Populations (Project Plan Application)

Project	Evidence Based Approach	Target Population
2A – Bi-Directional Integration	<div><div>1. Behavioral Health into Primary Care:<div><div>1. Bree Collaborative (Primary)</div><div>2. Incorporate elements of Collaborative Care Model</div></div></div><div>2. Primary Care into Behavioral Health (Clinics can choose one of the following):<div><div>1. Off-site, Enhanced Collaboration</div><div>2. Co-located, Enhanced Collaboration</div><div>3. Co-located, Integrated</div></div></div></div>	<div><div>1. All Medicaid beneficiaries (children & Adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD)</div><div>* Each Individual clinic will take these approaches and tailor them to their more specific subpopulation</div></div>
2B - Community Based Care Coordination	<div><div>1. Pathways Community Hub</div></div>	<div><div>1. Medicaid beneficiaries with one or more chronic disease or condition that that synchronizes with Transitional Care and Diversion Interventions populations – re-entry from intensive settings (Jail, ER, hospital) in particularly high ER utilizers.</div></div>
2C - Transitional Care	<div><div>1. Care Transitions Intervention</div><div>2. Care Transitions Interventions in Mental Health</div><div>3. Evidence-Informed approaches to Transitional care for people with health and behavioral health needs leaving Incarceration</div></div>	<div><div>1. Medicaid beneficiaries in transition from intensive setting of care or institutional settings, including beneficiaries discharged from acute care to home or supportive housing, and beneficiaries with SMI discharged from inpatient care, or client returning to the community from prison or jail.</div></div>
2D - Diversion Intervention	<div><div>1. Emergency Department (ED) Diversion</div><div>2. Community Paramedicine Model</div></div>	<div><div>1. Medicaid beneficiaries presenting with ED for non-acute conditions</div><div>2. Medicaid beneficiaries who access EMS services for non-acute issues</div></div>
3A - Addressing the Opioid Crisis	<div><div>1. 2016 Washington State Interagency Opioid Working Plan.</div><div>*Implementation plan includes the following: Prevention, Treatment, Overdose Prevention, and Recovery</div></div>	<div><div>1. Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.</div></div>
3D – Chronic Disease Prevention and Control	<div><div>1. Chronic Care Model</div></div>	<div><div>Medicaid beneficiaries (adults & children) with:<div><div>1. Diabetes</div><div>2. Heart Disease</div></div></div><div>*Medicaid beneficiaries with behavioral health issues is not an target population option however, we will likely address this with in combination with 2A</div></div>

Colville Confederated Tribes Resolutions:

Brief Description:

- These resolutions describe the Colville Confederated Tribes program updates, projects, and directives for the Health Programs
- The below resolutions NCACH staff identified as those resolutions that align with the projects that we are completing under the Medicaid Demonstration Project.
- This information is to give the Governing Board members an awareness of the major issues that our tribal partners are working on

Resolutions:

Affiliated Tribes of Northwest Indians (ATNI):

A regional organization comprised of American Indians/Alaska Natives (AI/AN) and tribes in the states of Washington, Idaho, Oregon, Montana, Nevada, Northern California, and Alaska.

2017 Annual Convention Resolutions (Spokane, WA):

- **Resolution #17 – 59:** Support for Adoption of “Center for Disease Control Guideline for Prescribing Opioids for Chronic Pain” by Indian Health Service Facilities and Tribal Health Organizations
- **Resolution #17-60:** Support for Legislation Amending Title XIX of the Social Security Act for Adult Inpatient Treatment and grant funding for AI/AN Youth Addiction Treatment Facilities’ Infrastructure
- **Resolution #17-62:** Support for Recommendations to Congress to Obtain Additional data on Indian Health Services (HIS) Health Care Facilities Construction Funding and Distribution Methodologies

The National Congress of American Indians:

Established in 1944 and is the oldest and largest national organization of American Indian and Alaska Native tribal government.

- **Resolution #MOH-17-013:** Funding for Correctional Health Care in Tribal and BIA Facilities
- **Resolution #MOH-17-038:** Support for the Reauthorization of the Special Diabetes Program for Indians



2017 Annual Conference Spokane, WA

RESOLUTION #17 – 59

“SUPPORT FOR ADOPTION OF “CENTER FOR DISEASE CONTROL GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN” BY INDIAN HEALTH SERVICE FACILITIES AND TRIBAL HEALTH ORGANIZATIONS”

PREAMBLE

We, the members of the Affiliated Tribes of Northwest Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants rights secured under Indian Treaties, Executive Orders and benefits to which we are entitled under the laws and constitution of the United States and several states, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the welfare of the Indian people, do hereby establish and submit the following resolution:

WHEREAS, the Affiliated Tribes of Northwest Indians (ATNI) are representatives of and advocates for national, regional, and specific tribal concerns; and

WHEREAS, ATNI is a regional organization comprised of American Indians/Alaska Natives (AI/AN) and tribes in the states of Washington, Idaho, Oregon, Montana, Nevada, Northern California, and Alaska; and

WHEREAS, the health, safety, welfare, education, economic and employment opportunity, and preservation of cultural and natural resources are primary goals and objectives of ATNI; and

WHEREAS, opioid prescriptions have risen dramatically over the past 15 to 20 years and the annual incidence of opioid overdoses and deaths have also risen nationally; and

WHEREAS, people in rural counties are nearly twice as likely to overdose on prescription painkillers as people in big cities and many Tribal communities are located in rural areas; and

WHEREAS, AI/AN people are more likely to overdose on prescription painkillers; and

WHEREAS, AI/AN people in the Northwest (Oregon, Idaho, and Washington) are two times more likely to fatally overdose on prescription painkillers compared to non-Hispanic Whites in the region; and

WHEREAS, the California Public Health Department has identified that some of the highest rates of opioid overdose in the United States are in Northern California, with some counties' opioid prescription death rates 2 - 3 times higher than the national average; and

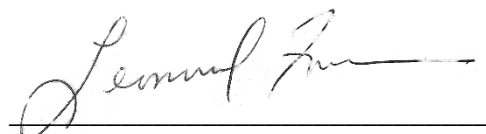
WHEREAS, the Centers for Disease Control and Prevention (CDC) developed and published the CDC Guideline for Prescribing Opioids for Chronic Pain, available at <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>, to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings; and

WHEREAS, adoption of the CDC Guideline for Prescribing Opioids for Chronic Pain by Indian Health Service (IHS) and Tribal Health Organizations in Washington, Idaho, Oregon, Montana, Nevada, Northern California, and Alaska would improve how opioids are prescribed to AI/AN patients; and ensure that AI/AN patients have access to safer, more effective chronic pain treatment, while reducing the number of AI/AN people who abuse or overdose from these drugs; now

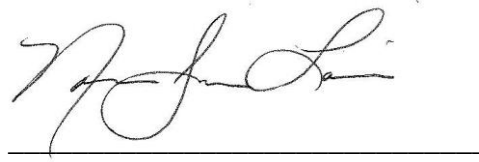
THEREFORE BE IT RESOLVED, that in the absence of any tribal-specific policy to reduce opioid addiction, overdose and death of AI/AN people, the ATNI supports adoption of the CDC Guideline for Prescribing Opioids for Chronic Pain, *available at* <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>, by Indian Health Service and Tribal Health Organizations to reduce opioid addiction, overdose and death of AI/AN people.

CERTIFICATION

The foregoing resolution was adopted at the 2017 Annual Convention of the Affiliated Tribes of Northwest Indians, held at the Davenport Grand Hotel, Spokane, Washington on September 18-21, 2017, with a quorum present.



Leonard Forsman, President



Norma Jean Louie, Secretary



2017 Annual Convention Spokane, WA

RESOLUTION #17 – 60

“SUPPORT FOR LEGISLATION AMENDING TITLE XIX OF THE SOCIAL SECURITY ACT FOR ADULT INPATIENT TREATMENT AND GRANT FUNDING FOR AI/AN YOUTH ADDICTION TREATMENT FACILITIES’ INFRASTRUCTURE”

PREAMBLE

We, the members of the Affiliated Tribes of Northwest Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants rights secured under Indian Treaties, Executive Orders and benefits to which we are entitled under the laws and constitution of the United States and several states, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the welfare of the Indian people, do hereby establish and submit the following resolution:

WHEREAS, the Affiliated Tribes of Northwest Indians (ATNI) are representatives of and advocates for national, regional, and specific tribal concerns; and

WHEREAS, ATNI is a regional organization comprised of American Indians/Alaska Natives (AI/AN) and tribes in the states of Washington, Idaho, Oregon, Montana, Nevada, Northern California, and Alaska; and

WHEREAS, the health, safety, welfare, education, economic and employment opportunity, and preservation of cultural and natural resources are primary goals and objectives of ATNI; and

WHEREAS, mental health and substance abuse disparities in the AI/AN population are well-documented; and

WHEREAS, among other issues, underage drinking increases the risk of suicide and homicide, physical and sexual assault, use and misuse of other drugs, and is a risk factor for heavy drinking later in life; and

WHEREAS, among adolescents ages 12 to 20, AI/ANs had the highest major depressive episode prevalence in the past year; and

WHEREAS, the suicide rate among AI/AN adolescents and young adults ages 15 to 34 (31 per 100,000) is 2.5 times higher than the national average for that age group (12.2 per 100,000); and

WHEREAS, the 2013 Youth Risk Behavior Survey reports that AI/AN youth had higher rates of drinking alcohol before age 13 compared to national rates (28.2 compared to 18.6 respectively) and data from the American Drug and Alcohol Survey administered to Native youth at 33 schools from 2009-2012 showed much higher prevalence of drug and alcohol use amongst 8th and 10th grade Native youth in comparison to national averages; and

WHEREAS, access to treatment facilities is critical to the well-being of AI/AN people who suffer from mental health or substance abuse issues; and

WHEREAS, the Medicaid Institutions for Mental Diseases (IMD) exclusion under section 1905(a)(B) of the Social Security Act, prohibits “payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases except for inpatient psychiatric hospital services for individuals under age 21;” and

WHEREAS, the law defines “institutions for mental diseases” as any “hospital, nursing facility, or other institution of more than 16 beds, that is the primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services;” and

WHEREAS, the IMD 16-bed capacity restriction and funding limitations keep many AI/AN people from accessing needed in patient treatment services; and

WHEREAS, the IMD exclusion was intended to ensure that states, rather than the federal government, would have principal responsibility for funding inpatient psychiatric services; and

WHEREAS, legislation amending Title XIX of the Social Security Act (SSA) would provide States with an option to provide medical assistance to individuals between the ages of 22 and 64 for inpatient services to treat substance abuse at residential treatment facilities would benefit AI/AN people; and

WHEREAS, amending the SSA to increase the institutions for mental diseases 16-bed limit to 40 or more beds would benefit AI/AN people in need of residential treatment under the Medicaid or Children’s Health Insurance Program (CHIP) program; and

WHEREAS, grant awards are needed to expand the infrastructure and treatment capabilities, including augmenting equipment and bed capacity, of youth addiction treatment facilities serving AI/AN at-risk youth that provide addiction and mental health treatment services to Medicaid or CHIP beneficiaries who have not attained the age of 21 and who are considered part of a medically underserved population; and

WHEREAS, such grant awards must allow for expanding infrastructure, staffing, and treatment capacities of existing facilities (including construction) and new facilities construction; and

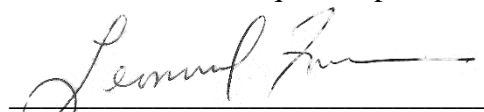
WHEREAS, any grant awards must give priority to providing addiction treatment services to AI/AN Medicaid or CHIP beneficiaries who have not attained the age of 21; now

THEREFORE BE IT RESOLVED, that ATNI urges the U.S. Congress to support legislation that:

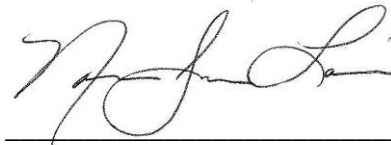
- Amends title XIX of the Social Security Act (SSA) to provide States with an option to provide medical assistance to individuals between the ages of 22 and 64 for inpatient services to treat substance abuse at residential treatment facilities under the Medicaid/CHIP program;
- Amends the SSA to increase the institutions for mental diseases 16-bed limit to 40 or more beds;
- Provides grant awards to expand the infrastructure and treatment capabilities, including augmenting equipment and bed capacity, of eligible youth addiction treatment facilities serving AI/AN at-risk youth that provide addiction and mental health treatment services to Medicaid or CHIP beneficiaries who have not attained the age of 21 and who are considered a medically underserved population;
- Provides that grant awards may be used to expand infrastructure, staffing and treatment capacities of existing facilities (including construction) and new facilities construction; and
- Appropriates at least \$50,000,000 for grant awards with at least 25% of such funds to youth addiction treatment facilities serving AI/AN at-risk youth who are Medicaid or CHIP beneficiaries and who have not attained the age of 21; and with no matching funds requirements.

CERTIFICATION

The foregoing resolution was adopted at the 2017 Annual Convention of the Affiliated Tribes of Northwest Indians, held at the Davenport Grand Hotel, Spokane, Washington on September 18-21, 2017, with a quorum present.



Leonard Forsman, President



Norma Jean Louie, Secretary



2017 Annual Convention Spokane, WA

RESOLUTION #17 – 62

“SUPPORT FOR RECOMMENDATIONS TO CONGRESS TO OBTAIN ADDITIONAL DATA ON INDIAN HEALTH SERVICES (IHS) HEALTH CARE FACILITIES CONSTRUCTION FUNDING AND DISTRIBUTION METHODOLOGIES”

PREAMBLE

We, the members of the Affiliated Tribes of Northwest Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants rights secured under Indian Treaties, Executive Orders and benefits to which we are entitled under the laws and constitution of the United States and several states, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the welfare of the Indian people, do hereby establish and submit the following resolution:

WHEREAS, the Affiliated Tribes of Northwest Indians (ATNI) are representatives of and advocates for national, regional, and specific tribal concerns; and

WHEREAS, ATNI is a regional organization comprised of American Indians/Alaska Natives and tribes in the states of Washington, Idaho, Oregon, Montana, Nevada, Northern California, and Alaska; and

WHEREAS, the health, safety, welfare, education, economic and employment opportunity, and preservation of cultural and natural resources are primary goals and objectives of ATNI; and

WHEREAS, the Indian Health Care Improvement Act (IHCIA) is the legislative embodiment of the federal trust and treaty responsibilities to American Indian and Alaska Natives (AI/AN) for healthcare; and

WHEREAS, the IHCIA was first enacted in 1976 and then permanently enacted in 2010 as part of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148); and

WHEREAS, the IHCIA requires the Health and Human Services (HHS) Secretary to submit a report to Congress that describes the comprehensive, national, ranked list of all health care facilities' needs for the Indian Health Service (IHS), Indian Tribes, and Tribal Organizations carrying out health programs under the IHCIA, initially by March 23, 2011, and thereafter update the report every five years¹; and

WHEREAS, the IHCIA also requires the IHS to maintain a health care facility priority system which is to be developed in consultation with Indian Tribes and Tribal Organizations and serve as the basis for the HHS Secretary to submit the above referenced report to Congress²; and

WHEREAS, the initial report submitted to Congress estimated facilities needs and costs based on unfunded projects in the existing Health Care Facilities Construction Priority List (Priority List), in addition to those projects identified in Area Health Services and Facilities Master Plans (Masters Plans) developed in FY 2005 with their costs estimated by using the health care facility priority system; and

WHEREAS, ATNI, Northwest Portland Area Indian Health Board (NPAIHB), and many other Tribes and Tribal organizations do not believe that the report submitted to Congress was adequate to identify a national comprehensive list of facilities needs in light of the fact that the Priority List has been locked since approximately 1991 and Tribes and Tribal Organizations have not had an equitable opportunity to compete for funding in order to be placed on the list; and

WHEREAS, the 2005 Area Master Planning process included inconsistent planning criteria (and the necessary resources to complete thorough and comparable master plans) across the entire IHS system, and neither of these two processes incorporated new authorities for health services or facility types authorized in the 2010 amendments to the IHCIA; and

WHEREAS, the 2016 IHS/Tribal Health Care Facilities' Needs Assessment Report to Congress stated that the current Priority List will not be complete until 2041 and at the current rate of construction appropriations and the replacement timeline, a new 2016 facility would not be replaced for 400 years; and

WHEREAS, many Tribes and Tribal organizations have had to assume substantial debt to build or renovate clinics for Indian people to receive IHS-funded health care; now

THEREFORE BE IT RESOLVED, that ATNI urges the U.S. Congress to instruct the Government Accountability Office to review and issue a report on the IHS Facilities Construction Priority System, including historical and current funding distribution inequities; and

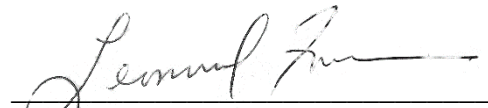
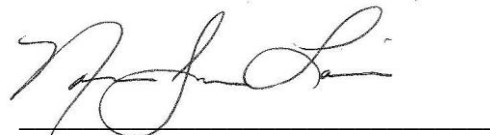
¹ 25 USC § 1631(c)(2)(A)(ii)(I).

² See "Report to Congress on Estimated Need For Tribal and Indian Health Service Health Care Facilities," submitted by the Indian Health Service, circa March 2011.

BE IT FINALLY RESOLVED, that based on results of the requested Government Accountability Office report, ATNI urges the U.S. Congress to increase funding to the Indian Health Facilities account in the IHS budget to provide construction, repair and improvement, equipment, and environmental health and facilities support for all IHS Areas equitably, and for Tribal governments through self-determination contracts and self-governance compacts.

CERTIFICATION

The foregoing resolution was adopted at the 2017 Annual Convention of the Affiliated Tribes of Northwest Indians, held at the Davenport Grand Hotel, Spokane, Washington on September 18-21, 2017, with a quorum present.


Leonard Forsman, President
Norma Jean Louie, Secretary



NATIONAL CONGRESS OF AMERICAN INDIANS

The National Congress of American Indians Resolution #MOH-17-013

TITLE: Funding for Correctional Health Care in Tribal and BIA Facilities

EXECUTIVE COMMITTEE

PRESIDENT
Brian Cladoosby
Swinomish Tribe

FIRST VICE-PRESIDENT
Fawn Sharp
Quinault Indian Nation

RECORDING SECRETARY
Aaron Payment
*Sault Ste. Marie Tribe of Chippewa
Indians of Michigan*

TREASURER
W. Ron Allen
Jamestown S'Klallam Tribe

REGIONAL VICE- PRESIDENTS

ALASKA
Jerry Isaac
Native Village of Tanacross

EASTERN OKLAHOMA
Joe Byrd
Cherokee Nation

GREAT PLAINS
Larry Wright
Ponca Tribe of Nebraska

MIDWEST
Roger Rader
Pokagon Band of Potawatomi

NORTHEAST
Lance Gumbs
Shinnecock Indian Nation

NORTHWEST
Mel Sheldon, Jr.
Tulalip Tribes

PACIFIC
Jack Potter, Jr.
Redding Rancheria

ROCKY MOUNTAIN
Darrin Old Coyote
Crow Nation

SOUTHEAST
Larry Townsend
Lumbee Tribe

SOUTHERN PLAINS
Liana Onnen
Prairie Band of Potawatomi Nation

SOUTHWEST
Joe Garcia
Ohkay Owingeh Pueblo

WESTERN
Bruce Ignacio
Ute Indian Tribe

EXECUTIVE DIRECTOR
Jacqueline Pata
Tlingit

NCAI HEADQUARTERS
1516 P Street, N.W.
Washington, DC 20005
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WHEREAS, we, the members of the National Congress of American Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants the inherent sovereign rights of our Indian nations, rights secured under Indian treaties and agreements with the United States, and all other rights and benefits to which we are entitled under the laws and Constitution of the United States and the United Nations Declaration on the Rights of Indigenous Peoples, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the health, safety and welfare of the Indian people, do hereby establish and submit the following resolution; and

WHEREAS, the National Congress of American Indians (NCAI) was established in 1944 and is the oldest and largest national organization of American Indian and Alaska Native tribal governments; and

WHEREAS, the Bureau of Indian Affairs (BIA) has oversight of all corrections facilities in Indian Country and the inmates that are incarcerated in them, whether they are operated directly by the BIA or by the tribe pursuant to a 638 contract or self-governance compact; and

WHEREAS, the BIA has no correctional health care budget, and as a result generally does not provide health care personnel or services in its detention facilities; and

WHEREAS, the absence of medical staff in tribal jails compromises the health and safety of inmates and detention personnel because inmates often are not given a medical evaluation when they are taken into custody, which in one instance, resulted in a serious tuberculosis outbreak in a newly constructed tribal jail that effected over 40 inmates and staff; and

WHEREAS, correctional officers must transfer inmates to their local Indian Health Service (IHS) or tribal 638 healthcare provider for all medical services (i.e. emergency, primary, dental, mental and behavioral health); and

WHEREAS, tribes are using significant portions of their BIA corrections allocations to transport and supervise inmates receiving health care – a single inmate with diabetes may need to be transported three times a week for dialysis and be supervised at the health facility for 3 hours each visit; and

WHEREAS, the federal government provides health care in Bureau of Prisons (BOP) and Immigration and Customs Enforcement (ICE) detention facilities through the use of Public Health Service Commissioned Corps Officers, but none of these personnel are working in BIA jails; and

WHEREAS, the Indian Health Service is chronically underfunded and tribal health facilities increasingly rely on Medicaid reimbursements to partially make up the severe shortfall in Indian health care appropriations; and

WHEREAS, Medicaid has an exclusion for outpatient health services for inmates based on the rationale that Congress already directly appropriates funds to pay for the healthcare costs of federal prisoners and that state and local jurisdictions do the same; and

WHEREAS, the Indian Health Service has no correctional health care budget; and

WHEREAS, Medicaid's "inmate exclusion" combined with the lack of funding for correctional health care at either BIA or IHS jeopardizes the financial sustainability of tribal healthcare facilities, forcing IHS and 638 tribal healthcare facilities to absorb, on average, \$1.5 million in annual uncompensated cost when a new tribal jail opens in their service area; and

WHEREAS, there is uncertainty about the extent to which a non-Indian inmate sentenced in tribal court pursuant to VAWA 2013 would be able to receive health care at a local IHS facility; and

WHEREAS, a number of tribes report that they need clear guidance from the IHS and BIA about how health care will be provided to non-Indian inmates and how the costs of that care will be covered before they implement Special Domestic Violence Criminal Jurisdiction over non-Indians; and

WHEREAS, the federal government's failure to budget and pay for tribal correctional healthcare places additional strain on inadequate tribal corrections and health care budgets, exacerbates the already challenging problem of health disparities for American Indians, undermines successful inmate re-entry, and contributes to recidivism.

NOW THEREFORE BE IT RESOLVED, that BIA should partner with the U.S. Public Health Service through a Memorandum of Agreement to get Commission Corps Officers assigned to tribal jails just as they are already assigned to FBOP and ICE detention facilities; and

BE IT FURTHER RESOLVED, that BIA should include a correctional healthcare line item in its annual budget to fund Commission Corps Officers in tribal jails; and Congress should appropriate funds for Commission Corps Officers to be assigned to tribal jails; and

BE IT FURTHER RESOLVED, that Congress should amend Medicaid to allow reimbursement for outpatient services that are provided to individuals who are incarcerated in Indian Country detention facilities; and

BE IT FURTHER RESOLVED, that Congress should create a catastrophic inmate health care fund that can be used if an inmate sentenced in tribal court needs major medical care; and

BE IT FURTHER RESOLVED, that the Bureau of Prisons (BOP) pilot program that allowed certain inmates to serve their sentence in BOP rather than BIA facilities be reauthorized; and

BE IT FINALLY RESOLVED, that this resolution shall be the policy of NCAI until it is withdrawn or modified by subsequent resolution.

CERTIFICATION

The foregoing resolution was adopted by the General Assembly at the 2017 Midyear Session of the National Congress of American Indians, held at the Mohegan Sun Convention Center, June 12 to June 15, 2017, with a quorum present.


Brian Cladoosby, President

ATTEST:


Aaron Payment, Recording Secretary



NATIONAL CONGRESS OF AMERICAN INDIANS

The National Congress of American Indians Resolution #MOH-17-038

TITLE: Support for Reauthorization of the Special Diabetes Program for Indians

EXECUTIVE COMMITTEE

PRESIDENT
Brian Cladoosby
Swinomish Tribe

FIRST VICE-PRESIDENT
Fawn Sharp
Quinault Indian Nation

RECORDING SECRETARY
Aaron Payment
*Sault Ste. Marie Tribe of Chippewa
Indians of Michigan*

TREASURER
W. Ron Allen
Jamestown S'Klallam Tribe

REGIONAL VICE- PRESIDENTS

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Larry Wright
Ponca Tribe of Nebraska

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Roger Rader
Pokagon Band of Potawatomi

NORTHEAST
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Shinnecock Indian Nation

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Mel Sheldon, Jr.
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PACIFIC
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ROCKY MOUNTAIN
Darrin Old Coyote
Crow Nation

SOUTHEAST
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WHEREAS, we, the members of the National Congress of American Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants the inherent sovereign rights of our Indian nations, rights secured under Indian treaties and agreements with the United States, and all other rights and benefits to which we are entitled under the laws and Constitution of the United States, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the health, safety and welfare of the Indian people, do hereby establish and submit the following resolution; and

WHEREAS, the National Congress of American Indians (NCAI) was established in 1944 and is the oldest and largest national organization of American Indian and Alaska Native tribal governments; and

WHEREAS, AI/AN adults are 2.3 times more likely to have diagnosed diabetes compared with non-Hispanic whites; and

WHEREAS, the death rate due to diabetes for AI/ANs is 1.6 times higher than the general U.S. population; and

WHEREAS, the Balanced Budget Act of 1997 established the Special Diabetes Program for Indians (SDPI) for “the prevention and treatment of diabetes in American Indians and Alaska Natives (AI/AN) for five years; and

WHEREAS, Congress reauthorized SDPI for one to three year periods from 2002 to 2015; and

WHEREAS, the current renewal of SDPI expires in September, 2017; and

WHEREAS, SDPI provides grants for diabetes treatment and prevention services to over 330 IHS, Tribal, and Urban Indian health programs in 35 states and funds Community Directed Grant Programs; and

WHEREAS, SDPI has had positive clinical and community outcomes, including: the average blood sugar level (A1c) decreased from 9.0% in 1996 to 8.1% in 2010; the average LDL (“bad” cholesterol) declined from 118 mg/dL in 1998 to 95 mg/dL in 2010; and more than 80% of SDPI grant programs now use recommended public health strategies to provide diabetes prevention activities and serves for AI/AN children and youth; and

WHEREAS, Tribes have successful SDPI programs with consistent positive clinical and community outcomes; and


WHEREAS, Tribes' support permanent reauthorization of SDPI at \$200 million per year with medical inflation rate increases annually or, in the alternative, reauthorization of SDPI for 2018 to 2024 at \$150 million in 2018 with medical inflation rate increases annually thereafter.

NOW THEREFORE BE IT RESOLVED, that the National Congress of American Indians (NCAI) supports permanent reauthorization of SDPI at \$200 million per year with medical inflation rate increases annually or, in the alternative, reauthorization of SDPI for 2018 to 2024 at \$150 million per year in 2018 with medical inflation rate increases annually thereafter; and

BE IT FURTHER RESOLVED, that this resolution shall be the policy of NCAI until it is withdrawn or modified by subsequent resolution.

CERTIFICATION

The foregoing resolution was adopted by the General Assembly at the 2017 Midyear Session of the National Congress of American Indians, held at the Mohegan Sun Convention Center, June 12 to June 15, 2017, with a quorum present.


Brian Cladoosby, President

ATTEST:


Aaron Payment, Recording Secretary

Pathways: Community Care Coordination ACH Advisory and Training Agreement

Foundations for Healthy Generations (Healthy Gen), Pathways Community HUB Institute (PCHI) and Care Coordination Systems (CCS) will provide advisory, support and training to ACH Staff to support the successful pre-launch preparation, CHW and supervisor training, and post-launch quality assurance and quality improvement leading to Pathways Community HUB (HUB) certification.

In order to maximize effectiveness and efficiency and to nurture cross-ACH learning and cooperation, Pre-Launch and Post-Launch advisory services will be provided to a cohort of three to four ACH teams at a time. Care Coordination Training will be provided to 20-25 individuals at a time and can be for care coordinators in a single ACH or multiple ACHs.

Healthy Gen will serve as the contract lead on this work, including the services of Pathways Community HUB Institute and Care Coordination Systems.

Additionally, a separate systems proposal is being sent by Care Coordination Systems. The systems proposal covers licensing, data security monitoring, customization, connectivity and data center hosting and maintenance, and ongoing system upgrades.

Together, the ACH Advisory and Training Proposal, and the CCS Systems Proposal provide a comprehensive program for supporting development, implementation, and post-launch learning and quality improvement for participating ACHs.

Pre-Launch – Community Engagement and Implementation Preparedness:

The Pre-Launch Advisory Services provide support to Executive Directors and ACH staff to plan and prepare the ACH and stakeholders for launch.

Core Advisory Services:

- Engagement with key stakeholders at the regional and State level, participating in calls and meetings as necessary
- Education on the Pathways Community HUB model to ACH staff and community partners
- Guidance on contracting with health plans and other payors, participating in calls and meetings as required
- Technical assistance for each ACH on selecting populations, educating and engaging care coordination agencies, recruiting care coordination staff, training and supporting supervisory staff, working with health care partners, identifying and educating referral partners
- Project Timeline Development with weekly updates and tracking.
- Weekly cohort meetings, with at least monthly face-to-face engagement.
- ACH / Pathways Community HUB implementation best practices
- Planning, Implementation, Contract and Presentation templates.
- Document and plan review and feedback.

- Facilitate shared learnings and communication across ACH cohorts.
- Regular engagement and briefings of ACH Executive Directors as required.
- ACH staff system training.
- Facilitate engagement and potential partnering with other care coordination models and CHW networks.
- Establish peer to peer introductions with other Pathway Community HUBs

Key Outcomes achieved by ACH staff:

- Knowledge of the Pathways Community HUB model
- Knowledge of requirements for Pathways Community HUB certification and development of a work plan to achieve certification
- Identification of HUB partners, including referral partners
- Priority Population development and approval
- Preliminary forecasts and pro-forma budget
- Environmental Scan of potential community care coordination agencies
- ACH Policy and Procedures for HUB operations
- Referral process and partner identification
- Care Coordination Agency identification, recruitment and contracting
- Health system identification and engagement
- Community resource identification and classification
- Potential payer identification and engagement toward revenue
- Pre-launch preparation
- Training planning

Timeline: 4 – 6 months

Task Name	Duration	Q1			Q2			Month 7
		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	
Pre-Launch Advisory	26w							
Initial Stakeholder Engagements	4w							
Priority Population and Initiatives	8w							
Environmental Scan	4w							
Pro-Forma Budgeting	2w							
Contract Standards, Policies & Procedures Development	4w							
Stakeholder Education, Engagement, Agreements	18w							
Care Coordination Agencies	8w							
Payers / MCOs	12w							
Health Systems / Providers	8w							
Community Resources	8w							
Referral Partners	8w							
Training Planning	6w							
System Inputs and Customization	2w							
First Cohort Training	8w							
Soft Launch								
Hard Launch								
Post Launch: Quality Assurance and Improvement	52w							

Cost: \$75,000 per ACH. Includes travel by Healthy Gen, PCHI and CCS personnel.

CHW Training: 20 to 25 CHWs and Supervisors per Training

Core Training Elements:

- Phase I Training
 - ½ Day Supervisor Training
 - 4 ½ Day CHW and Supervisor Training
- Practicum – 6 weeks
 - 1 field visit with each CHW
 - 1 Day training for Supervisors 2 weeks after initiation of Practicum
- Phase II Training
 - 4 ½ day CHW and Supervisor Training
 - ½ Day Supervisor Quality Assurance and Reporting Training

Task Name	Duration	Q2	Q3
		Month 6	Month 7
Pre-Launch Advisory	25w		
First Cohort Training	8w		
Training Part 1	5d		
Practicum	6w		
Training Part 2	5d		
Soft Launch			
Hard Launch			
Post Launch: Quality Assurance and Improvement	52w		

Cost: \$4,500 per CHW Participant (no fee for supervisors), minimum 20 paid participants, max 25 participants per cohort. Cohorts may include multiple ACH participants. Fee includes training, training materials, facility charges and lunch / refreshments. Participants are responsible for their own travel and lodging costs.

Post Launch - Advisory, Quality Improvement and Certification Preparation

Post Launch Advisory Services provides support, analysis and training to ACH staff to ensure consistent implementation and data quality, and collaborative development of quality improvement steps where needed. In addition, Post Launch Advisory Services include assistance in preparation for Pathways Community HUB Certification.

Core Services:

- Quality Assurance coaching for ACH Staff
- Monthly data assessment and quality improvement recommendations
- Formal Implementation Review Meetings
 - Weekly check-in for first month
 - Monthly for three months
 - Quarterly for 3 quarters
- Assist in evaluation of opportunity and timing for other population initiatives
- Pathways Community HUB certification preparation assistance, documentation review and gap analysis
- Pathways Community HUB certification action plan resolution based on any Rockville Institute feedback.

Time Period: 12 months from pilot launch.

Task Name	Duration	Q3		Q4			Q1			Q2		
		Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18
Hard Launch												
Post Launch: Quality Assurance and Improvement	52w											
Weekly Review	4w											
Monthly Review	8w											
Quarterly Review w/ Monthly Reports	36w											
Certification Preparation	8w											
Certification Submission												

Cost: \$25,000

Team Leads:

Foundations for Healthy Generations:

Kathy Burgoyne, Ph.D., Senior Director of Applied Research

Overseeing the Pathways team will be Dr. Kathy Burgoyne. Dr. Burgoyne leads Healthy Gen's efforts to create equal opportunity for health by supporting key organizations to advocate for and provide innovative and effective prevention programs for people who are most affected by health inequities.

Dr. Burgoyne has advocated for and promoted the CHW workforce throughout Washington for nearly a decade. She designed and oversaw the development and implementation of a Community Health Worker Program at New Salishan, Tacoma Housing Authority's largest community and the most racially diverse public housing community in Washington State. The model is being scaled by partners in multiple communities across the state. She has also provided technical assistance to cross sector coalitions that work with CHWs and has supported CHW learning networks focused on quality improvement. Dr. Burgoyne led Healthy Gen's effort to partner with state agencies, private sector representatives and CHWs in the design and implementation of the statewide CHW Task Force.

Dr. Burgoyne began her career as a teacher and counselor for middle school students and their families. She has worked in the prevention field for 30 years as both a practitioner and researcher. Dr. Burgoyne has a Ph.D. in educational policy and leadership from the University of Washington.

Pathways Community HUB Institute:

Sarah Redding, MD, MPH, Executive Director, Key Advisor on HUB model and development of model within Washington

Dr. Sarah Redding currently serves as the Director of the nonprofit Pathways Community HUB Institute (PCHI). Prior to that, she served as the Chief Executive Officer for Care Coordination Systems, and the Executive Director of the Community Health Access Project (CHAP). CHAP is a nonprofit organization based in Mansfield, Ohio that she and her husband Mark helped start in 1999. Sarah has been involved with community health workers (CHWs) for over 25 years and was instrumental in obtaining state certification for CHWs in Ohio under the Board of Nursing. She worked to develop and implement Pathways and the Pathways Community HUB model. The Pathways model was developed in 2000, and the HUB model was piloted in 2004-2005. Her

recent work has focused on community care coordination to address health disparities. Sarah received her medical degree from Wright State University and a Master's of Public Health degree from Johns Hopkins University. She completed her residency in General Preventive Medicine at Johns Hopkins.

Care Coordination Systems:

Adam Borut, Customer Development and Project Implementation Director

Adam's key role is project implementation management; HUB manager support, systems implementation coordination, and post launch reporting and quality improvement advisory services. Adam leads business development, business consulting and project implementation consulting for new and established HUBs at CCS.

Adam has over 25 years of experience in international business management and technology development. Operational experience includes P&L accountability, sales and marketing management, and sales channel and business development. Adam has co-founded two technology companies and worked for multiple Fortune 500 companies, including SC Johnson, AC Nielsen and Booz-Allen and Hamilton.

Adam graduated with honors from the Kellogg School of Management with a Master of Management (MBA) in Marketing, Finance and Organizational Behavior. He also holds a Bachelor of Arts in History from Yale University.

Total ACH Advisory and Training Program Proposal:

Pre-Launch: \$75,000. Terms: 50% upon signing. 25% upon pro-forma budget completion. 25% upon ACH Executive Director approval of initial launch date.

Post-Launch: \$25,000. Terms: 50% upon launch. Four 12.5% payments every 12 weeks from launch

Care Coordinator Training: \$4,500 per Participant (No Charge Supervisors). 20 – 25 per Training Cohort. 50% Payment at least 4 weeks prior to training secures the training dates. Remaining 50% due prior to training.

Sincerely,

Kathy Burgoyne
Foundation for Healthy Generations
Kathyb@healthygen.org
206-498-2993



Care Coordination Systems

Mr. Barry Kling
Chairman of the Board
North Central ACH
Chelan-Douglas Health District
200 Valley Mall Parkway
East Wenatchee, WA 98802

October 12, 2017

Dear Barry,

The following engagement proposal represents the discovery and design proposal to provide the ACH with sufficient information to determine the viability and potential benefits of a Pathways community HUB project. The engagement will include the community, ACH and key stakeholders in multiple presentations and meetings to educate and discuss their requirements, resources, and objectives. As necessary, demonstrations of the Pathways HUB Connect platform will be conducted.

At least one group discussion regarding the HUB and community-based care coordination should be held with Confluence Health to discuss integration with their care coordination initiatives and information technology. It is expected that a system demonstration will be provide at this meeting. Beyond referrals to the HUB, integration of care coordination services and information technology, we recommend that short and longer term business strategies be discussed with Confluence Health. These business strategy sessions should be conducted in private at the latter part of the engagement. The anticipated IT integration needs and solutions discussion is expected to be in-depth and not normally part of a discovery and design discussion. We recommend that they should take place while Bob Harnach is onsite.

Identifying and interviewing potential Pathways Community HUB candidates is key to the engagement. Furthermore, determine request for purchase (RFP) criteria to be used by the ACH in qualifying HUB entities, is not a normal aspect of discovery, yet is a crucial deliverable of this engagement.

The primary deliverables of this engagement are:

- 1) Present and discuss with key stakeholders the Pathways Community HUB model and community-based care coordination.
 - a. ACH Board and its members
 - b. Community Service Organizations
 - c. Confluence Health
 - d. Health centers
 - e. Others as may be required

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Akron, Ohio 44308
708.906.3057



Care Coordination Systems

- 2) Discuss and recommend possible information technology integration between Confluence Health and the HUB via Pathways HUB Connect and EPIC.
- 3) Discuss and recommend possible information technology integration between health centers and the HUB via Pathways HUB Connect.
- 4) Identify community resources as possible community care coordination agencies within the HUB network.
- 5) Develop request for proposal (RFP) criteria to be used to evaluate HUB entity candidates. The body of the RFP will be developed by the ACH.
- 6) Identify and evaluate potential HUB entities that may be engaged by the ACH's request for proposal process.
- 7) Develop a viability budget based on projected populations to be served, community care coordinators available, ACH/HUB requirements, and expected revenue requirements to reach a break-even status in each of the next five years. In essence, provide a plan with proper substantiation in which activation decisions may be made.
- 8) Present to ACH Board the engagement's findings, budget and recommendations.
- 9) Transfer Pathways knowledge and presentation materials to ACH leaders in order that they may continue fostering community engagement with their ACH/HUB Pathways initiative.

The above deliverables are solely intended to provide the ACH with suitable information to properly determine a course of action with regards to the manner and process of health transformation in the North Central ACH.

The following are additional services that are known not to be deliverables of the engagement above and may be contingently necessary based on the ACH's decisions:

- 1) Deep evaluation and contracting of community-based care coordination resources.
- 2) Modifications to the software system that may be necessary to support the operations, information gathering, contracts, and stakeholders.
- 3) Executive coaching for key managers in operations, evaluation, strategy, performance, and personnel growth.



Care Coordination Systems

- 4) Creation of a Pathways Community HUB with policies, procedures, contracts, strategic plans, business plans, and other collateral in accordance and readiness for HUB certification.
- 5) Training of community-based care coordinators in the Pathways model and with the Pathways software.
- 6) Training of supervisors of care coordinators and the use of the Pathways software to efficiently manage care coordination and the completion of Pathways.
- 7) Training of HUB staff and management in the operations of a HUB and the use of the Pathways software to efficiently operate the HUB and report.
- 8) Preparation of people, processes, and organizations for launch of the HUB initiative.

Discovery and Design Process:

CCS has an evolved consulting process for assessing feasibility in communities. We work closely with the local ACH lead(s) and advocate team in order to maximize outcomes and value.

We have experienced that these activities are most successful with a small nimble team especially when meeting with key partners. Too many participants in these discussions may create confusion among the partners with mixed agendas.

At least, two weeks prior to an onsite visit, we will conduct a kickoff meeting where introductions, discuss initiative objectives, assign tasks, and distribute collateral in preparation for the first onsite visit.

At least one additional conference call will be conducted to determine the readiness for the onsite visits and specifically the scheduling of meetings. Additional calls and/or delay of the onsite visit may be necessary if the group determines it necessary or if scheduling of meetings is problematic.

We anticipate that the ACH team will designate one or two individuals to work directly with us to

- schedule appointments with community stakeholders and other key stakeholders
- coordinate with CCS itineraries efficiently
- attend stakeholder meetings, in person or by telephone

While onsite at the North Central ACH, the key objective is to maximize the use of time with the ACH board and stakeholders. Scheduling and coordinating concentrated daily sessions of meetings and stakeholder discussions is the responsibility of the ACH team. Additional, stakeholder meetings can be interwoven to provide for an optimal use of time and resources.



Care Coordination Systems

Each day there will be a debriefing session to discuss findings and suggest the next day's meeting and possible adjustments.

The first week onsite is reserved for education, presentation, and discovery meetings with key stakeholders.

A second week or portion, thereof, may be necessary to be onsite for additional meetings with key stakeholders.

It is anticipated that a major portion of the second week will involve strategic planning and budgeting. We will decide, together, if it is more efficient to conduct these meetings onsite or by conference call, as the meeting can be very long and protracted. We would recommend an in-person intensive for two or three days is most successful. This may be done onsite or in Chicago.

The third week involves reporting to the ACH leads the findings and recommendation from the CCS team. ACH Board presentations need to be developed and agreed. The CCS team recommends that they be onsite at North Central ACH to present to the board and facilitate discussion and questions.

Depending on the specific need of the leg of the initiative, CCS will provide 1-4 people. Dr. Sarah Redding is expected to be an important part of the delivery team especially focused toward community and clinical needs as well as the Pathway Community HUB model. Bob Harnach will engage on business process, strategy, and information systems including interoperability with other systems and Pathways HUB Connect. Kathy Burgoyne, Foundation for Healthy Generations, may be included on this engagement to assist with community engagement.

It is not anticipated for this Discovery and Design engagement, however, if the initiative needs warrant government, hospital, FQHC or opioid knowledge, CCS will make available Rick Wilk, CCS Director for Community Engagement and former HRSA Administrator, Region 5. Additionally, Mr. Wilk is an experienced executive coach with extensive experience and background in FQHCs, healthcare, community services, and the Pathways Community HUB.

Key Timelines of Engagement:

Pre-Onsite visit

Week 1: Discovery Kickoff Meeting – conference call
 Introductions
 Initiative objectives
 Determine stakeholders lists
 Assign tasks
 Distribute collateral for scheduling
 Set next meeting date/time



Care Coordination Systems

Pre-Onsite Visit

Week 2 Review readiness for meeting at onsite visit
Distribute collateral for meetings
Confirm itineraries

Onsite

Week 3: Educate, Present, and Discuss with community and other key stakeholders
Document and Debrief with teams

Possible Onsite

Week 4: Reserve for additional stakeholder meetings and presentations
Follow-up meetings with key stakeholders
Strategic planning and budget discussions and development

Week 5: Team discussion of findings, budget and recommendations.
Development of ACH Board presentation.
CCS Presentation to ACH Board and facilitate discussions.

An additional week of onsite visits may need to be inserted given the potential schedules of key stakeholders.

- **Timeframe:** To be discussed. Recommendation is to complete the onsite stakeholders meetings prior to Thanksgiving week 2017.
- **Engagement Cost:** \$30,000 + travel costs for anticipated 3 week engagement + pre-onsite preparation efforts. If a 4th engagement week is necessary, an additional \$10,000 may be necessary, yet must be mutually agreed.
- **Payment Terms:**
 - Due at signing: \$20,000
 - Due upon determination of 4th week: \$10,000
 - Due upon final report: \$10,000
 - Business expenses per week as invoiced (Airfare, car rental, hotel, food per diem)

We are very pleased to assist the North Central ACH and its stakeholder partners' in their transformative efforts within Washington. Thank you for considering CCS as a potential partner to enable the initiatives of the ACH successfully. Please let us know how we can help.

Sincerely,

Bob

Robert D. Harnach, Chief Executive Officer

75 Market Street
Akron, Ohio 44308
708.906.3057

Health Information Technology and Health Information Exchange (HIT/HIE) Workgroup Charter

Background

Washington State's Medicaid Transformation Project Demonstration grant was approved by the federal Centers for Medicare & Medicaid Services (CMS) in January 2017. As part of this 5-year contract initiative, nine Accountable Communities of Health (ACHs) across the state are supporting health improvement projects in their region by bringing together leaders with a common interest in improving health and health equity. The North Central ACH region, which includes Chelan, Douglas, Grant and Okanogan counties, has selected 6 health improvement projects to plan and implement.

Planning and implementation of these projects involves infrastructure investments, including investments in information technology and population health management systems that will facilitate bi-directional communication and care coordination (a goal inherent to many of our projects).

Definitions

The following definitions linked to population health management systems are provided to ensure clarity and shared understanding within the workgroup:

- *Health Information Technology (HIT)*: The range of information technologies used to store, share, and analyze health information, including clinical and claims related data. Examples of HIT tools include, but are not limited to, electronic health/medical records, electronic prescribing, telehealth, and clinical data repositories.
- *Health Information Exchanges (HIE)*: The secure access and exchange of health information allowing providers, patients, and other participants to share patient information. Today's HIE context is focused on electronic tools allowing secure and efficient transfer of information to facilitate delivery system and payment transformation, care coordination, and improved health outcomes.
- *Interoperability*: The ability of two or more systems or components to **exchange** information and to **use** the information that has been exchanged. Health information exchange is a prerequisite for interoperability, but it is not sufficient by itself to achieve health information interoperability. The shared information must be useable by all parties involved.

While this workgroup will focus on HIT/HIE issues, it may also consider broader information technology and information exchange issues, especially where social service providers and other partnering providers are contributing to our Demonstration project goals.

Charge

The purpose of the HIT/HIE Workgroup is to provide leadership and insight to inform regional planning and investments related to Health Information Technology and Health Information Exchange. As much

as possible, this workgroup will consider and align resources and efforts across multiple levels (i.e. providers, counties, NCACH, and statewide.) Generally, members will provide strategic advice and input into population health management systems required to implement Demonstration projects in the short-term, and to promote continued health improvement and care coordination in the long-run. This involves assessing the availability, use, and barriers to providers' use of technology solutions (identifying needs and gaps), and providing input and direction to build on and improve our current ACH-region's data infrastructure. A goal would be to catalyze HIT/HIE investments that are sustainable and useful beyond the life of the Medicaid Demonstration. This workgroup will re-evaluate its charge and deliverables on an annual basis and dissolve when all deliverables under their purview are met.

Composition

The HIT/HIE workgroup will consist of 10-15 members who have experience and knowledge of health information technology and health information exchange. This may include familiarity with:

- Health care quality and performance data metrics and reporting
- Familiarity with clinical workflows and point of care data needs
- Data sharing and governance
- Health data compliance issues
- Interoperability needs
- Value-based purchasing arrangements

Members will include representatives from Grant, Chelan, Douglas, and Okanogan Counties. The Governing Board will approve members, assuring representation from:

- Decision-makers from member organizations involved in the Whole Person Care Collaborative (WPCC)
- Management information services (MIS) and data officers from various health systems across the region, including primary care, behavioral health, and hospitals.
- Managed Care Organizations (Operating in all 4 NCACH counties after Jan. 1, 2018)
- Other providers involved in Demonstration Projects (e.g. IT staff from criminal justice, housing, and other social service sectors)
- Health Care Authority (HCA) representatives involved in statewide HIT/HIE efforts
- Other Data and health researchers or health policy specialists

Workgroup composition will likely evolve during the course of the Demonstration, as our region moves from planning to implementation.

Meetings

Meetings will be held once per month, with additional meetings scheduled to address emerging issues. Meetings will be held in Chelan, Douglas, Grant, and Okanogan Counties; locations will vary and an effort will be made to hold meetings in each of the Local Health Jurisdictions throughout the year. Whenever possible, meetings will have an option to participate via teleconference or audioconference

for those unable to attend in person, although in-person participation is encouraged. NCACH program staff and the Workgroup Chair shall be responsible for setting agendas, facilitating meetings, and ensuring overall coordination with NCACH leadership and other workgroups. Notes for all meetings will be provided to the Workgroup by NCACH staff within two weeks of each meeting. Meeting minutes and materials will be posted on the NCACH website (www.ncach.org).

Member Responsibilities

- Workgroup members are required to comply with NCACH's conflicts of interest policy.
- Attend at least 75% of regular meetings of the Workgroup and actively participate in the work of the Workgroup.
- Sign a Membership Agreement (attachment A)
- Provide input into mechanisms required to meet reporting requirements of the Demonstration
- Serve as a forum for NCACH member organizations to develop a coherent strategy for organizing, governing, analyzing, and deploying health information
- Help advance the use of interoperable health IT and health information exchange across the care continuum in support of regional and statewide health system and payment priorities
- Facilitate information sharing and coordination among NCACH member organizations on data related matters, including data system requirements and standardization, and privacy and security issues
- Coordinate with other NCACH workgroups regarding issues of common interest

Anticipated Deliverables

An early deliverable for the HIT/HIE workgroup will be to develop a work plan with timelines for the following tasks, as well as any other tasks identified by the group.

- Identify barriers, gaps, and needs related to data, information technology, information exchange, and interoperability
 - Participate in and review regional HIT/HIE infrastructure assessments in our region and identify opportunities for alignment with Washington State investments
 - Identify health system stakeholder needs for population health, social service, and social determinants of health data
 - Discuss provider requirements to effectively access and use population health data necessary to advance VBP and new care models
- Identify, review, and recommend potential solutions and articulate a regional HIT/HIE strategy that will provide a path for community-based, integrated care.
 - Identify potential Health IT solutions that could be leveraged through ACH projects to support Participating Provider organizations, (e.g. technologies needed to transition to VBP, One Health Port services including the CDR, EDIE/Pre-manage, Pathways, Prescription Drug Monitoring Programs (PDMP), telehealth, etc)
 - Identify feasible strategies and recommend capacity investments (whether leveraging existing technology, or investing in new systems) to improve systems for population health management that will support NCACH's Demonstration projects

- Identify opportunities and needs for shared acquisition of HIT/HIE and other care coordination tools
 - Prioritize potential NCACH investment opportunities that will support integrated care and community-based care coordination in our region
- Review and provide input into Washington State Health Care Authority (HCA) plans focused on HIT/HIE investments
 - Provide collective feedback and recommendations to HCA with respect to investments and resources they are developing statewide (e.g. OneHealthPort, All Payer Claims Database)
 - Engage in periodic review and provide feedback on HCA's Health IT Operational Plan and Strategic Roadmap, as it evolves.

Authority

The HIT/HIE Workgroup is an advisory body that will inform decision-making by the NCACH Governing Board and ensure regional priorities and local considerations are incorporated in planning and investment decisions. Activities, analysis, and recommendations developed by the Workgroup will be shared with the NCACH Governing Board on a regular basis and are subject to review and approval by the Board.