North Central Accountable Community of Health

Governing Board Meeting

1:00 PM – 3:30 PM April 2, 2018

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 Action:**	**Attachments:**
1:00 PM	Introductions - **Barry Kling** • Board Roll Call • Review of Agenda & Declaration of Conflicts • Public Comment	Discussion	Agenda
1:10 PM	Approval of March Minutes - **Barry Kling**	***Motion to Approve:*** • Minutes	Minutes
1:15 PM	Treasurer's Report - **Sheila Chilson** • Monthly Financial Additional Budget Requests – **Christal & John** • SIM/FIMC – line item • Summer Internship – line item • General Budget Approval	***Motion to Approve:*** • Financial Report • Approval of budget adjustments	Financial Report Board Motion Form with supporting documents
1:30 PM	Parkside Update – **Senator Parlette**	Information	
1:45 PM	Executive Director's Update - **Senator Parlette**	Information	ED Report
1:55 PM	Board Election – Carlene Anders / Business Seat – **Barry Kling**	***Motion to Approve:*** • Carlene Anders for Business Seat	Bio
2:00 PM	Presentation: CCHE Stakeholder Survey - **Carly Levitz & Lisa Schafer, Center for Community Health and Evaluation**	Discussion	Presentation
2:45 PM	CHI Update – **Brooklyn Holton & Mike Beaver**	Information	Roles, Vision, Possibilities
3:00 PM	Staff / Project Updates • **John Schapman** • **Christal Eshelman** • **Caroline Tillier** • **Peter Morgan**	***Motion to Approve:*** • Opioid Funding Process (Christal)	Board Motion Form
3:30 PM	Adjourn		

North Central Accountable Community of Health

Governing Board Meeting

Monday, March 5, 2018 1:00 – 3:00 PM
Samaritan Healthcare, Moses Lake WA

Board Attendance: Barry Kling, Bruce Buckles, Molly Morris, Scott Graham, Kate Haugen (replacing Kayla Down)
Board Phone Attendance: Brooklyn Holton, Blake Edwards, Rick Hourigan, Michelle Price, Ray Eickmeyer,
Absent Board Members: Nancy Nash Mendez, Theresa Sullivan, Sheila Chilson, Mike Beaver, Senator Warnick, Doug Wilson
Public Attendance: Amanda Rosales, Ken Sterner, Gwen Cox, Rosalinda Kibby, Deb Miller, Karen McMaster White
Phone: Laurel Lee, Donny Guerrero, Maddy Osborne, Kris Davis, Teresa Davis, Jerry Perez, Carly Levitts, Ramona Hicks, Rosalinda Kibby
Staff: Sahara Suval, John Schapman, Caroline Tillier, Linda Evans Parlette **Minutes:** Teresa Davis

Approval of Minutes Public Comment: Conflicts of Interest:	• MCO Sector has decided that Kate Haugen will replace Kayla Down on the Board for today until they can decide on a permanent replacement. ❖ Minutes: Scott Graham moved to approve the February minutes, Molly Morris seconded the motion, no further discussion, motion passed. • No public comment. • No conflicts of interest disclosed.
Treasurer's Report:	• Barry discussed the idea of having a Finance Committee. The Executive Committee feels that they can serve as the Finance Committee. Scott said that the Finance Committee generally protects the Executive Committee, but believes for now it will work. John noted that we will be taking formal minutes at the Finance Committee meetings. • Monthly Financial Report: John went over the January monthly financials, he has conferred with Sheila and she does not see any concerns. ❖ Molly Morris moved to approve the January financial report, Rick Hourigan seconded the motion, no further discussion, motion passed.
Executive Directors Report	• There is legislation around the B & O Tax. Linda has asked the Department of Revenue to do a White Paper after the decision has been made. • Kayla Down has resigned from her position at Coordinated Care and in turn the NCACH Governing Board. • Sue Birch will be a speaker at our summit on April 20th. She is coming a day ahead of time and Linda plans to take her to a few locations and possibly set up a conference call with providers so that she can hear our region's prospective early on.
Board Election	❖ Nomination of Rosalinda Kibby for Grant County CHI Seat. Bruce Buckles moved to accept the nomination of Rosalinda Kibby for the Grant County CHI Seat, Scott Graham seconded the motion, no further discussion, motion passed.

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❖ Scott Graham moved, that Rick Hourigan serve as the Vice Chair of the Executive Committee, Bruce Buckles seconded the motion, no further discussion, motion passed.
❖ Blake Edwards moved that Brooklyn Holton serve as Secretary of the Executive Committee, Rick Hourigan seconded the motion, no further discussion, motion passed

• Discussed the need for a renewal of the conflict of interest disclosures, please email them to Brooklyn.
</td></tr>
<tr><td>Finance and Budget Update</td><td>
• NCACH received 100% on the project plan application.
<u>Dollars going directly to NCACH:</u>
<table>
<tr><th>Breakdown of Funds Earned</th><th>Amount</th></tr>
<tr><td>Project Incentive Funds:</td><td>$5,151,550</td></tr>
<tr><td>Integration Funds</td><td>$2,312,792</td></tr>
<tr><td>Bonus Funds</td><td>$1,455,842</td></tr>
<tr><td>Total Funds</td><td>$8,920,184</td></tr>
</table>
<table>
<tr><th>Timeline to Receive Funding</th><th>Amount</th></tr>
<tr><td>March 2018</td><td>$7,691,357</td></tr>
<tr><td>May 2018 (Funding affected by IGT)</td><td>$1,228,827</td></tr>
</table>
<u>Dollars going to IGT Contributors and Their Partners:</u>
<table>
<tr><td>Funding Paid out to IGT Contributors (Shared Domain 1 Investments) in May:</td><td>$2,048,045</td></tr>
</table>
• IGT Funding - Barry gave an overview of the IGT Funding and how it affects our ACH.
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	❖ Bruce Buckles moved, Molly Morris seconded that The Governing Board approves the payment of $2,048,045 to partnering providers as allocated under the Shared Domain 1 Investments worksheet to be distributed when the funding is placed in the NCACH account under the Shared Domain 1 Investment Category held by the Financial Executor in May of 2018. The above approval is contingent on Health Care Authority (HCA) adhering to the following conditions: ○ HCA will indemnify NCACH against potential claims by including hold harmless language. ○ HCA will provide NCACH with the opportunity to partner directly with IGT Contributors for Shared Domain 1 Investment selection. ○ HCA will explore opportunities with NCACH to explore other Eastern WA IGT Contributors. ○ HCA will provide in writing a clear process on how funds flow, fiduciary responsibilities and authorizations will work. Discussion: Molly asked if there will be monthly report outs. This is money in and money out. We are not responsible for monitoring the payments. This will continue for the 5 years. No further discussion, motion passed.
	The Opioid work group has adopted two cycles for funding…Rapid Cycle funding and Annual Cycle Funding. Workgroup is revising the funding application, OHSU is assisting in refining this application. The application period for the 2018 rapid cycle funding will start in early April and close in May, will be open during the annual summit. Both approaches will tailor to the strategies that are outlined in the toolkit. Barry added that in the past the Board has been approving items piece meal. We want to eventually get to a point that we go through the demonstration funding. We will discuss the overall demonstration budgeting at a Board Retreat on April 13th, each Board member can bring one additional staff person to the retreat, Teresa will reach out to get names. Examples of funding: Drug take back boxes, education, law enforcement training, and needle exchange. Opioid project is already a little ahead because there were already local groups started. The workgroup vetted all of the strategies and will select from the narrowed down strategies. Scott noted that this is not a lot of money for the amount of work that needs to be done. Will be bringing requests for additional funding in 2019. ❖ Scott Graham moved to allocate $100,000 to the Opioid Project in 2018 for partners to implement approaches that are in alignment with the Medicaid Transformation Project Toolkit. Ray Eickmeyer seconded the motion, no further discussion, motion passed.
Staff Updates	• John Schapman gave an update on TCDI, Eric Skansgaard has agreed to be the workgroup chair. Went over the funding model, the group has decided to use a model similar to the WPCC but it is still being refined. Will be looking at what partners would receive funding, and how we can help partners that would not be receiving funding. Creating two smaller groups this month: Ray is convening a group of EMS providers to discuss community para medicine program, another group to discuss a regional model to transitional care that we can use to present to HCA in place of the model that they have given us. ED diversion: will be sending a survey to assess what is happening in our region. Goal is to have approaches finalized in the next month, funding principles by May, application by June and implementation by October.

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	• Sahara Suval: Summit registration is now open on our website and will share via Mail Chimp newsletter. She has worked directly with all three CHI's. They have convened a leadership council and have had one group call and plan on more. The CHI Leaders have requested Board support and would like them on the calls. • Caroline reported out on the Pathways Community HUB, had our first workgroup meeting. Created a lead agency RFP sub group to develop a process for selecting the lead agency. Next meeting we will dig into data to see how the HUB will intersect with the other projects. • SDOH Focus groups: Will have three meetings in Moses Lake, Omak, and Wenatchee. These meetings will be facilitated by our consultant at OHSU. Focus will be on transportation and housing.
WPCC	Caroline gave an update on the WPCC, Learning Community Kick off is on March 24th. The WPCC Learning Community charter specifies eligibility criteria, including the requirement that eligible partners must "serve a significant volume of Medicaid Beneficiaries (based on parameters set by the WPCC Workgroup prior to contracted work)". In order to resolve the definition of "significant volume" sooner rather than later, Peter Morgan asked the broad WPCC body to make a recommendation at their February meeting. After a brief discussion focused on making the parameters inclusive but targeted, it was proposed that eligibility include dual parameters: organizations would be eligible if they serve at least 300 beneficiaries and 1000 encounters. This motion was unanimously passed at the WPCC meeting in February 2018. The Board's action today would formally approve this decision. ❖ Scott Graham moved to approve <u>300 Medicaid beneficiaries and 1000 Medicaid encounters</u> as the parameters defining "significant volume" in the eligibility criteria of WPCC Learning Community charter. Bruce Buckles seconded the motion, no further discussion, motion passed. Discussion: Who would not qualify? The single provider practices and IHS. We are mindful that we need to figure out a way of pushing out the information to the smaller agencies. It was communicated that most clientele will be that of a qualifying organization and that future re-examination for tribal inclusion is an option.
Roundtable	Discussion around the date of the Board Retreat. Many in the room can't make it on April 13th. Teresa will send a Doodle Poll to the Board with two options 4/13 and 4/27. Teresa will also send a save the date to the Board for the April 20th Summit.
Adjourn	Meeting adjourned at 2:45 PM, Next meeting April 2nd at the CTC in Wenatchee, WA

Board Decision Form

TOPIC: NCACH Budget Amendments

PURPOSE: Approve changes made to the 2018-2019 SIM budget and changes made to the 2018 Demonstration Budget

BOARD ACTION:

☐ Information Only

☑ Board Motion to approve/disapprove

BACKGROUND:

The following changes were made to the NCACH monthly financial report to reflect the current dollar amount approved by the Governing Board. In addition, staff is requesting two budget amendments that are reflected in the monthly financial report. They are as follows:

1. The 2018-2019 SIM budget for 2018-2019 is $92,359.95 which is a mix AY4 SIM funds and remaining FIMC project coordinator funds from AY3.
    a. **Revenues:** $70,629 of the $92, 359.95 funds in the SIM budget are from the AY4 SIM contract. $21,731.16 of the $92,359.95funds in the SIM budget are remaining funds from the 2018-2019 FIMC Project Coordinator contract that have been rolled over into the SIM 2018-2019 budget.
    b. **Expenses:** In the SIM budget $80,313 has been allocated to staffing costs. $12,046.95has been allocated to CDHD hosting fees.
2.

3. Demonstration Budget Spreadsheet:
    a. The staffing costs of the 2018 Demonstration budget have been decreased by $80,313 to offset in the increased allocation from the remaining SIM funds.
    b. Previously approved contracts for OHSU, Healthy Generations, and CCMI & CSI, totaling $668,461, have been added.
    c. A 3-month extension to the Providence CORE contract was added for $4,128. This contract has been approved by the NCACH Executive Director..
    d. The following requests have been added to the Budget:
        i. $10,000 for a Summer Internship Program (See attachment for background information and justification)
        ii. $21,731.16 for FIMC funding to be allocated at the discretion of the Executive Director (See attachment for background information and justification)

4. Changes to the Summary Spreadsheet:
    a. The summary spreadsheet was adjusted to include funding NCACH will receive through the Financial Executor. This created three additional columns.

5. Addition of a Financial Executor Budget Tab:

a. A tab was created that reflects approved budget items approved that will be paid out of the Financial Executor account. Items listed in the Financial Executer Budget Tab have previously received Governing Board approval.

PROPOSAL:
Motion to approve the budget as presented which reflects the following budget amendments:

1. Approval of the 2018-2019 SIM budget as outlined on the financial spreadsheet totally $92,359.95.
2. Reducing Demonstration budget staffing by $80,313 to reflect that expense being placed into the SIM budget
3. Allocation of up to $10,000 for expenses associated with becoming a University of Washington Masters in Healthcare Administration host site and hiring a summer intern in 2018.
4. Allocate $21,731.16 to provide technical assistance to providers for the transition to FIMC to be spent at the discretion of the Executive Director.

IMPACT/OPPORTUNITY (fiscal and programmatic):
The budget amendment will ensure NCACH can proceed forward with its operating budget and pay for staffing with the funding available. SIM funding will be utilized to pay for direct staffing to allow NCACH to utilize more flexible funding sources (i.e. Demonstration Funds) for other NCACH expenses. Having FIMC technical assistance funds allocated and available to the Executive Director will allow the ACH to be responsive to provider needs and technical assistance requests soon after they are identified.

TIMELINE:
This is adjustments to reflect current spending parameters set for NCACH with addition of two requests. This is current information that should be approved at the meeting to allow for general operations to proceed forward.

Submitted By: NCACH Staff
Submitted Date: 04/02/2018
Staff Sponsor: John Schapman

Summer Internship Program

PURPOSE: To have a summer Intern from the University of Washington's Master in Healthcare Administration (MHA) program work with NCACH staff on the Medicaid Transformation project.

BACKGROUND:

NCACH staff were approached by a University of Washington MHA student requesting that we consider being a host site for her summer internship program. NCACH staff met with the student to learn what she was looking for in a program and the length of time (June 2018 – August 2018).

NCACH staff met internally to decide what potential applicable projects would be available for a summer intern to complete. The following projects were recommended:

1. Assist in enhancing/creating an asset map for the North Central Region that could be used to identify gaps in services, identify organizations that care coordinators could utilize to complete pathways, and NCACH could utilize to determine further community needs that would be incorporated into the September 2018 Transformation Project implementation plans.
2. Work with the Pathways Hub project (and other applicable projects) to current assess care coordination work in our region and/or develop trainings for Community Health Workers in the region.

Interns are usually paid during the summer internship program while they are gaining experience in a specific profession. NCACH staff is recommending that the intern be paid at a rate of $15 per hour for a total of 10 weeks ($6,000 total).

The student who is interested in interning at the NCACH comes highly recommended by area providers. NCACH has assigned internal staff (Christal Eshelman & John Schapman) to be leads on the Internship program, if the Board decides to proceed forward.

Get the details about internships for the Master of Health Administration program at the University of Washington. https://www.mha.uw.edu/academic-experience/internships/

IMPACT/OPPORTUNITY (fiscal and programmatic):

1. NCACH has a discrete project that needs to be completed in the summer of 2018 that would be align well with the goals and timeline of the University of Washington MHA program. NCACH understands that training interns will take time, but believe this will be a mutually beneficial endeavor for both the organization and intern.
2. NCACH believes healthcare transformation also includes enhancing workforce in our region and supports agencies who develop local internship programs that will encourage individuals entering the workforce to find jobs in the North Central region. NCACH feels this is an opportunity to internally demonstrate our commitment to local training programs.

TIMELINE:

The University of Washington MHA summer internship runs from June 2018 – August 2018 (10 weeks). Exact timing may vary based on the individual student's schedule.

Allocation of Fully-Integrated Medicaid Contracting (FIMC) Funds

PURPOSE: *Allocate funds remaining from the SIM contract Project Coordinator funding for FIMC in 2017 to provide technical assistance to providers for the FIMC transition.*

BACKGROUND:

In January of 2017, HCA contracted with NCACH to provide funding to hire a part-time project coordinator to manage/facilitate the transition to Fully-Integrated Medicaid Contracting in Chelan, Douglas, and Grant Counties. The contract period was Feb 2017-Jan 2018. The total amount associated with this contract was $55,000. As of January 31, 2018, NCACH had a remaining balance of $21,731.16 HCA paid out the remaining funds to NCACH in January 2018 with no specific deliverables associated with this funding. Okanogan County will be transitioning to FIMC on Jan. 1, 2019. Though there is no dedicated staff funding, NCACH staff will continue to utilize a portion of a Program Development Staff time already budgeted to coordinate FIMC efforts.

Staff is proposing an amount equal to the amount of the remaining FIMC funds be allocated in the Demonstration budget be allocated to FIMC transition efforts and technical assistance opportunities for providers to be used at the discretion of the Executive Director. This will allow for flexibility of spending while utilizing the SIM budget to pay for staffing.
A specific technical assistance opportunity has already been identified which is a Managed Care Contracting Training provided by Adam Falcone in Wenatchee WA (estimated cost is $12,500). This training would be offered to Whole Person Care Collaborative members and Critical Access Hospitals in the North Central ACH region.

IMPACT/OPPORTUNITY (fiscal and programmatic):

1. *Adam Falcone has provided this training to other Behavioral Providers in Washington State with very good reviews. This training will help provider prepare, evaluate and negotiate managed care contracts and identify leverage points. Bio for Adam Falcone and draft training agenda are attached.*
2. *After the Managed Care Contracting Training expense, it is estimated there will be $9,231.16 funds remaining. Having these funds allocated and available to TA requests as needed will help the ACH to quickly be responsive to provider needs as they are identified.*

TIMELINE:

Managed Care Contracting Training with Adam Falcone would occur in May. Allocation of remaining FIMC funds would be available through Dec. 2018. Any funds not used, would be re-allocated in the Demonstration budget for 2019.

Exhibit A

Draft Training Agenda (Subject to Change)

Managed Care Contracting from a Position of Strength!	
8:00 am to 9:00 am	Breakfast and Registration
9:00 am to 10:30 am	**PART 1: P.E.N. (Prepare, Evaluate, Negotiate) Managed Care Contracts** ***Step 1: Prepare for Managed Care Contracting*** ▪ Contracting Strategy: Know Your Advantage ▪ Assessing Regulatory Leverage ▪ Assessing Market Power ▪ Assessing Timing Leverage ▪ Competing on Value ▪ Value-Based Payment Methodologies
10:30 am to 10:45 am	Break
10:45 am to 12:00 pm	***Step 2: Evaluate Managed Care Contracts*** ▪ Contract Review Team ▪ MCO Operational Performance ▪ MCO Financial Stability ▪ How to Read a Contract ▪ Prioritizing Issues ***Step 3: Negotiate Managed Care Contracts*** ▪ Understanding Negotiation ▪ Negotiation Logistics ▪ Bargaining over Positions vs. Interests ▪ Negotiating Tips ▪ Bottom Line Decisions
12:00 pm to 1:00 pm	Lunch
1:00 pm to 2:15 pm	**PART 2: Key Terms and Legal Protections** ▪ Scope of Services vs. Covered Services ▪ Timing Claiming Rules ▪ Prompt Payment and Denied Claims ▪ Overpayment Recoupments (and Underpayments) ▪ All Product Clauses ▪ Cost-Sharing Provisions ▪ Regulatory Penalties ▪ Access and Appointment Standards ▪ Licensure Requirements ▪ Credentialing and Delegated Credentialing ▪ Prior Authorization / Utilization Review
2:15 pm to 2:30 pm	Break

2:30 pm to 3:00 pm	***Key Terms and Legal Protections Continued*** ▪ Contract Term ▪ Termination Provisions ▪ Amendments ▪ Insurance ▪ Indemnification ▪ Compensation Exhibits ▪ Regulatory Appendices
3:00 pm to 4:00 pm	**PART 3: Participating or Forming Provider Networks** ▪ Types of Provider Networks (e.g. IPAs) ▪ Accountable Care Organizations ▪ Federal Antitrust Law ▪ Financial Risk-Sharing Arrangements ▪ Clinically Integrated Networks (CINs) ▪ Messenger Model Arrangements

ADAM J. FALCONE, JD, MPH

Contact:
202-466-8960
afalcone@ftlf.com

Education:
Boston University School of Law, Boston, Massachusetts, J.D., cum laude
Edward F. Hennessey Scholar
Concentration in Health Law, with honors

Boston University School of Public Health, Boston, Massachusetts, M.P.H.
Concentration in Health Services
Certificate in Gerontology

Brandeis University, Waltham, Massachusetts, B.A.
Concentration in Biology
Legal Studies Program in Law, Medicine, and Health Policy

Bar Admissions:
District of Columbia
Massachusetts
Pennsylvania
U.S. Supreme Court

Faculty Affiliation:
George Washington University, School of Public Health and Health Services, Washington, DC, Department of Health Policy and Management

Adam J. Falcone is a partner in FTLF's national health law practice group, where he counsels a diverse spectrum of community-based organizations that render primary and behavioral healthcare services. Adam counsels clients on a wide range of health law issues, with a focus on fraud and abuse, reimbursement and payment, and antitrust and competition matters.

Adam leads the firm's health care corporate compliance practice, offering proactive counsel to avoid costly legal missteps that can jeopardize vital health services within communities. To that end, he has championed the development of online compliance support services to assist clients in the development of effective corporate compliance programs. He also conducts compliance trainings and internal investigations, defends clients in audit proceedings, and negotiates settlements related to fraud allegations.

Drawing on his extensive knowledge of health care policy and markets, Adam regularly speaks to groups across the country on managed care contracting, value-based payment methodologies, and health reform opportunities. In particular, he brings strategic counsel to clients that are responding to changes in their local marketplace, negotiating participating provider agreements, and seeking to establish provider networks such as Accountable Care Organizations.

Prior to joining the law firm, Adam served as Program and Policy Counsel at the Alliance of Community Health Plans, a national association of non-profit and provider-owned health plans advocating federal policies to improve health care quality. Working at the intersection of law and policy, he represented the Alliance before the Congress and Executive Branch.

Adam began his legal career in Washington, D.C. as a trial attorney in the Antitrust Division of the U.S. Department of Justice. As a member of the Health Care Task Force, he led and participated in civil antitrust investigations and litigation of anticompetitive activity among health care providers.

Adam understands how the law can both promote and impede his clients' missions. He seeks to provide innovative legal solutions that minimize his clients' legal risks while preserving their resources to serve their communities.

Community Service:
Allies for Health + Wellbeing, Pittsburgh, PA. Board Member (2015-Present); Board Treasurer (2016-Present)

Whitman-Walker Health, Washington, DC. Board Member (2008-2014); Chair of the Board (2012-2014)

EXECUTIVE DIRECTOR'S REPORT

North Central Accountable Community of Health

As the Medicaid Transformation Projects continue to progress, it is becoming increasingly more important for the North Central Accountable Community of Health to remain transparent and accessible to the region. In 2017, you told us that we needed to increase our communication and community engagement efforts. We listened, and have since begun offering several new tools and channels for information around North Central Washington's Medicaid Transformation Work. As my team works to funnel information through these new channels, I wanted to take a moment to share with you these new resources and how to find the information you need quickly and efficiently.

A Guide to North Central Accountable Community of Health's communications tools:

- Board Packet – issued before the Governing Board meeting. Contains my monthly executive report, board motion forms and accompanying documents.
- Website – where we publish news, events, meeting documents, and resources about the Transformation. *Looking for something? Start here: https://ncach.org/*
- Monthly Newsletter – issued after the Governing Board meeting. Contains the Monthly Meetings Round-Up, news, events, and features on health-related-happenings in our community. *Read last month's here: https://mailchi.mp/b8a65d3634b4/march-ing-ahead-in-the-states-medicaid-transformation*
    - Monthly Meetings Round Up – issued with the Monthly Newsletter. Includes a brief synopsis from each month's Governing Board, Workgroup, and Coalitions for Health Improvement meetings into an easy-to-read list. *Read them all here:* https://us17.campaign-archive.com/home/?u=d4eeb723170662c199d7968dd&id=aadb447ad3
- NCACH Master Calendar – All NCACH's events on one convenient location! *Download events from our calendar directly onto yours – visit: https://ncach.org/calendar/*
- MyDocVault – Before NCACH had its own website, we used MyDocVault, which was graciously shared with us by local partner in health, Community Choice. We now encourage you to use NCACH.org moving forward

In other recent news, we successfully hosted our first ever Whole Person Care Collaborative Learning Community Kickoff on March 24, an event for partnering primary care and behavioral health providers across the North Central region. Nearly 100 representatives from 17 different healthcare organizations convened to identify shared goals and help design learning activities that will meet their needs as they work on practice transformation. Looking ahead in April, we are excited to welcome HCA Director, Sue Birch, on Wednesday, April 18, as she comes into town to speak at the NCACH 2018 Annual Summit on April 20. My goal is to show Sue as much of our 4-county region as possible. There will also be a video conferencing opportunity from 4:30 pm – 5:30 pm on Thursday, April 19, at three locations (Omak, Moses Lake, and Wenatchee.) Details to follow.

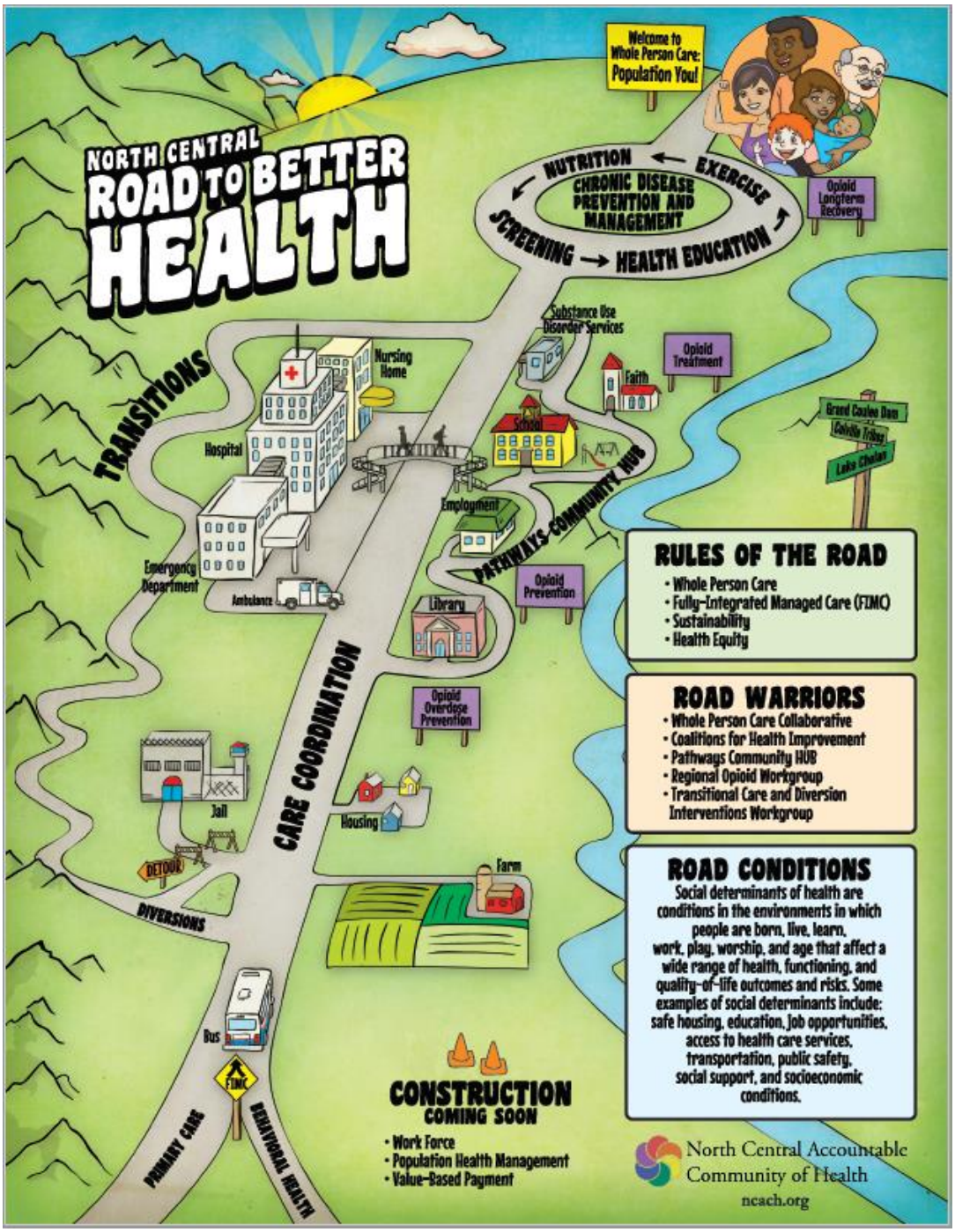
Please reach out should you ever want to schedule some time to meet with my staff or me to learn more about our vision of Whole Person Care across the North Central Accountable Community of Health.

Charge On!

1

NCACH NEWS

Introducing, the "North Central Roadmap to Better Health"



We're pleased to share with you the "North Central Roadmap to Better Health," a graphic diagram developed in partnership with local designers, Gibbs Graphics. The Roadmap is intended to capture our vision of Whole Person Care, the importance of cross-sectoral partnerships in the Transformation, and the interaction between the six selected Transformation projects. We invite you, our Board, to share feedback and comments with us as we work to finalize the graphic in preparation for its big reveal at the Annual Summit.

STAFF UPDATES

John Schapman

The Transitional Care and Diversion Intervention Workgroup has been busy refining the evidence based approaches our region will select and reviewing how these projects will be funded through the Transformation Project. Our workgroup Leaders in Transitional Care have formed a small subgroup and selected the transitions approach our region will incorporate. Staff have met with local EMS providers to identify the barriers and gaps to implementing community paramedicine, and have reached out to ED providers in our region to determine where NCACH can support ED Diversion.
As project plan funding is allocated to the ACHs, NCACH staff is also modeling funds flow processes for the Board and creating formal decision process charts that will help the workgroups, Board, and staff, and community understand the process of how funds will be distributed in the NCACH region throughout the course of the projects.

Christal Eshelman

The Pathways Community HUB Workgroup created a subgroup to develop a Request For Proposals (RFP) for selecting an agency to serve as our HUB organization. We were able to turn this around very quickly with a lot of support from the subgroup and our technical assistance team. The HUB RFP is set to open early in the week of March 26th, with a lead agency being selected in early May. Selecting a lead agency to serve as the HUB has been our highest priority since many planning tasks are contingent of having this agency selected. Other tasks on the horizon for the HUB Workgroup include selecting a target population, completing a current state assessment, and budgeting. We are in the process of scheduling a two-day on-site meeting with our technical assistance team to do a deep dive into target population, capacity assessment, and budgeting.

The Opioid Workgroup has continued to make progress on establishing a process for community partners to engage in this work. The Workgroup has developed a Rapid Cycle Application process which is intended to provide short cycles of start-up funding to implement shovel-ready projects. The Workgroup developed and will be recommending an application, scoring criteria, funding process, and funding principles on April 2nd for this Rapid Cycle Application process. Once approved, it is anticipated that applications will open April 9th and be due May 11th. Applications will be evaluated and a slate of applications will be recommended for funding to the Governing Board in June with funding distributions to partners taking place in early July.

We are moving forward with holding three facilitated discussions on how to incorporate social determinants of health into the Medicaid Transformation. These discussions will focus on transportation and housing as these have consistently been identified as barriers to health in our region. These discussions are scheduled for April 3rd and 4th with a session being held in each of Wenatchee, Omak, and Moses Lake. Chris Kelleher from the Center for Evidence-based Policy will be facilitating these discussions and will synthesize the information into a set of recommendations. Chris will present these recommendations and accept audience feedback at the NCACH Annual Summit on April 20th. The recommendations will then be presented to the Governing Board for consideration.

Caroline Tillier

March was a busy month for our team as we prepared for the WPCC Learning Community Kick-Off which took place on March 24th in Wenatchee. On my end, this included working with our consultants to develop the change plan template, map out the Change Plan Learning and Action Network (LAN) that we will offer to the Learning Community starting in April, and developing the portal for our WPCC Learning Community. The portal will be a one-stop shop for our members to find resources, events, and other tools as they work on health system improvements and will facilitate cross-region communication and collaboration. In between all this activity, I continued to track data and HIT related information coming from HCA, and also organized a webinar for data leads from other ACHs to learn more about EDIE and PreManage. We've all been eager to understand how this tool might provide more real-time ED utilization data to ACHs (since ED utilization is a measure that is being used to assess the impact of all Medicaid Transformation projects), and how it might be of use to our implementation partners.

Peter Morgan

I returned from an extended vacation on March 16th in time for the kick-off Meeting for the WPCC Learning Community on March 24th. Over 100 people attended the meeting at the Red Lion in Wenatchee, including teams from the 17 participating organizations. I really appreciate the commitment and support shown by all who gave up a Saturday to attend. This was a momentous occasion. For those who've been planning this learning collaborative for over two years, it was incredibly rewarding to see this process get underway. Attendees at the kick-off listened to a few presentations which set the context for the day and participated in a number of exercises to clarify the specific learning needs and interests of each organization. The results from the meeting are being tabulated and will inform the selection of learning topics and the types of activities to be launched in the coming weeks. Many thanks to the NCACH staff and consultants from CCMI, CSI, Qualis, and the UW AIMS center for their support in creating a successful event.

Sahara Suval

March has been a busy month for the team! After months of planning and collaborating with our partners CCMI and CSI, we hosted the long-awaited Whole Person Care Collaborative Learning Community Kickoff on March 24th! As a newer member of the team, it was really rewarding to witness local providers coming together in their commitment to improving quality of care for our community. In other event news, the NCACH 2018 Annual Summit planning is still coming along. We've booked all of our presenters and are now finalizing the flow of the day and the bits and pieces. We will be releasing the final agenda soon, and hope to see a wide variety of partners in health at the event. I'm pleased to also share another event in the works: an annual convening of the three Coalitions for Health Improvement (CHIs). More info coming soon!

The CHI Leadership Council has been meeting regularly, and we have been working on creating an internal alignment document to help all three Coalitions identify strategic goals over the next year, and for the remainder of the Transformation. I've been working closely the three CHI leadership teams to develop materials for CHI meetings and am pleased to share an "ACH 101" presentation at the upcoming Chelan-Douglas CHI meeting on April 11, 2018. In addition to working closely with events and the Coalitions, I've also

been working behind-the-scenes to continue advancing NCACH's communications tools and visual aids, like the "North Central Roadmap to Better Health."

North Central Accountable Community of Health

200 Valley Mall Pkwy

East Wenatchee, WA 98802

www.ncach.org

Contact for Questions:
Executive Assistant
Teresa Davis
509.886.6432
Teresa.davis@cdhd.wa.gov

Board Decision Form

TOPIC: *Business Community Board Seat*
PURPOSE: *Nomination of Carlene Anders for Business Community Seat*
BOARD ACTION: ☐ Information Only ☑ Board Motion to approve/disapprove
BACKGROUND: *The Executive Committee nominates Carlene Anders for the Business Community Seat on the NCACH Board*
PROPOSAL: *Nomination of Carlene Anders to fill the Business Community Seat on the NCACH Board effective 04/02/18.*
IMPACT/OPPORTUNITY (fiscal and programmatic):
TIMELINE: *As soon as possible*
RECOMMENDATION: *To approve the nomination of Carlene Anders for the Business Community Seat on the NCACH Governing Board.*

Submitted By: Executive Committee
Submitted Date: 04/02/2018

Carlene grew up in an apple orchard family in the lower Methow valley graduating from Pateros High School in 1984. She received her degree from Washington State Univ. from the Dept. of Physical Education, Sport and Leisure Studies, majoring in Commercial and Outdoor Recreation. In 1988, she married her husband Gene Dowers and has one daughter, Jessi (1996) and son Danny (2002). Carlene taught Physical Ed. at Pateros HS in the mid 90's, however when her daughter was born, she opened her own business in pre-school and childcare which has now been in operation 20+ years. Beyond education, Carlene had many athletic passions; coaching crew at Gonzaga Univ. and WSU, volleyball at PHS, track & field at PHS and many years as a alpine ski instructor and ski school director.

In 2014, she became the Executive Director of the Okanogan Co. Long Term Recovery Group, in charge of the recovery efforts for the Eastern WA Wildfire disasters of 2014/15. Nov 2016, following 18 months in an appointed City Council position, Carlene was elected Mayor of the City of Pateros.

Current Boards/Committees:

NCWEDD (North Central WA Econ. Develop. District) - Chair Jul 2017-Current.
OCOG (Okanogan Council of Governments) - Vice Chair Jan 2018-Current
TRANGO (Okanogan Co. Transit Authority) - Vice Chair Dec
OCCAC (Okanogan County Community Action Council) - BM
LLSEF (Loup Loup Ski Education Foundation) - Feb 1999 (Secretary 7 yrs)
DLT (Disaster Leadership Team) - Feb 2016 Currently Secretary
PVFA (Pateros Volunteer Firefighters Association) - Treasurer since Fall 2012
AWC (Association of Washington Cities) Small Communities Representative

Personal: PO Box 295 Pateros, WA 98846 (509)923-2141 h
Fire Recovery: PO Box 655 Pateros, WA 98846 (509)733-0318 c
City of Pateros: PO Box 8 Pateros, WA 98846 (509)923-2571 o

North Central Accountable Community of Health

Coalitions for Health Improvement

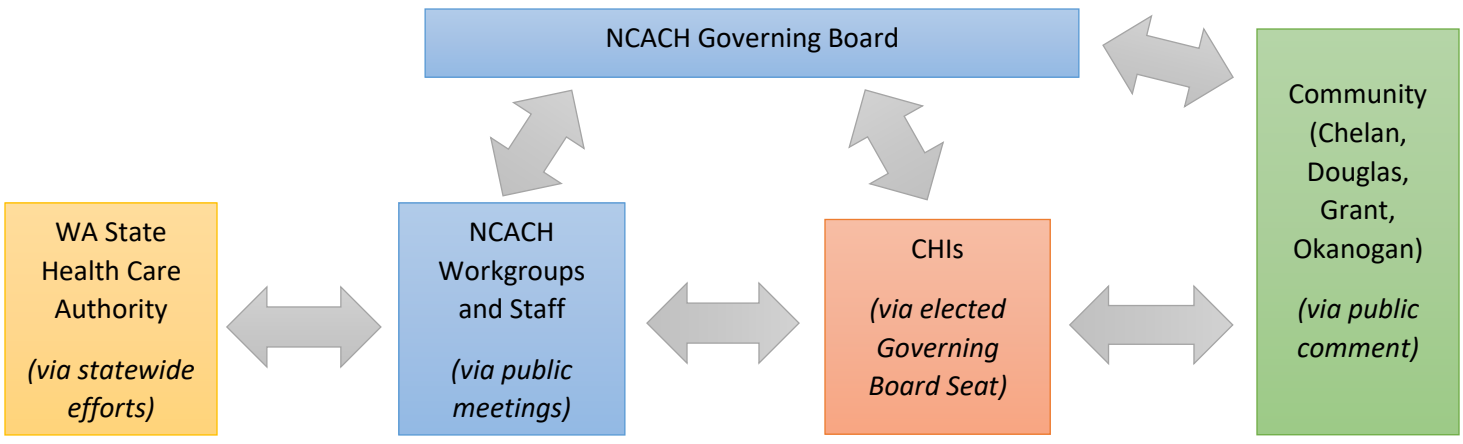
Vision, Purpose, and Possibilities

The purpose of this document is to create a shared understanding around the intention, purpose, and roles that Coalitions for Health Improvement (CHI) play in each of their local communities, and within the Medicaid Transformation projects that the North Central Accountable Community of Health (NCACH) is implementing across Chelan, Douglas, Grant, and Okanogan Counties.

History

Coalitions for Health Improvement (CHI) were formed in 2014 in each public health jurisdiction (Chelan-Douglas, Okanogan, and Grant) to engage a wide variety of provider partners and stakeholders in the work of the NCACH. CHIs originally provided input regarding the formation of an ACH in this region, and development of the NCACH Leadership Group. They were utilized to distribute information about Design Grants and upcoming State Innovation Model Transformation efforts. In 2016, the North Central Accountable Community of Health was officially formed as a standalone organization, and entered the Design phase of the Medicaid Transformation, including the adoption of a Governing Board. In April 2017, the NCACH Governing Board determined that the CHIs should be NCACH's primary means for community-level input and representation in NCACH's work. In July 2017, a voting seat for each CHI was established by the Governing Board which ensures that each Coalition's voice is heard. In 2018, NCACH formally contracted with three hosting organizations to facilitate each Coalition with operational funding from the NCACH.

The North Central Accountable Community of Health *Information Flow*



Vision

To foster connectedness, resiliency, and collective impact to support whole person care among our community members through cross-sector, solution-oriented approaches.

Purpose

Coalitions for Health Improvement (CHI) are the critical access point for the voice of our community to be reflected in NCACH's Medicaid Transformation work. They are open to anyone interested in improving whole person care at a local level through education, outreach, and coordinated efforts. Partners whose sectors represent the social determinants of health, behavioral and physical health, criminal justice system, education, and others are encouraged to participate. As CHIs engage with local project implementation efforts, they ensure that county-level priorities and needs are not lost in regionalization and are uniquely positioned to help address social determinants of health based on their expertise and knowledge of local resources.

Structure and Governance

There are three Coalitions for Health Improvement (Chelan-Douglas, Grant, Okanogan). Each are open to anyone living or practicing within Chelan, Douglas, Grant, and Okanogan counties. Each are managed through a hosting agreement with a local partner in public health within each health jurisdiction. Each Coalition has a representative seat as a voting member of the NCACH Governing Board for a term of three years. To support the efforts of each Coalition and its Governing Board member, each Coalition is led by a local leadership body, who comprise the Coalitions for Health Improvement Leadership Council.

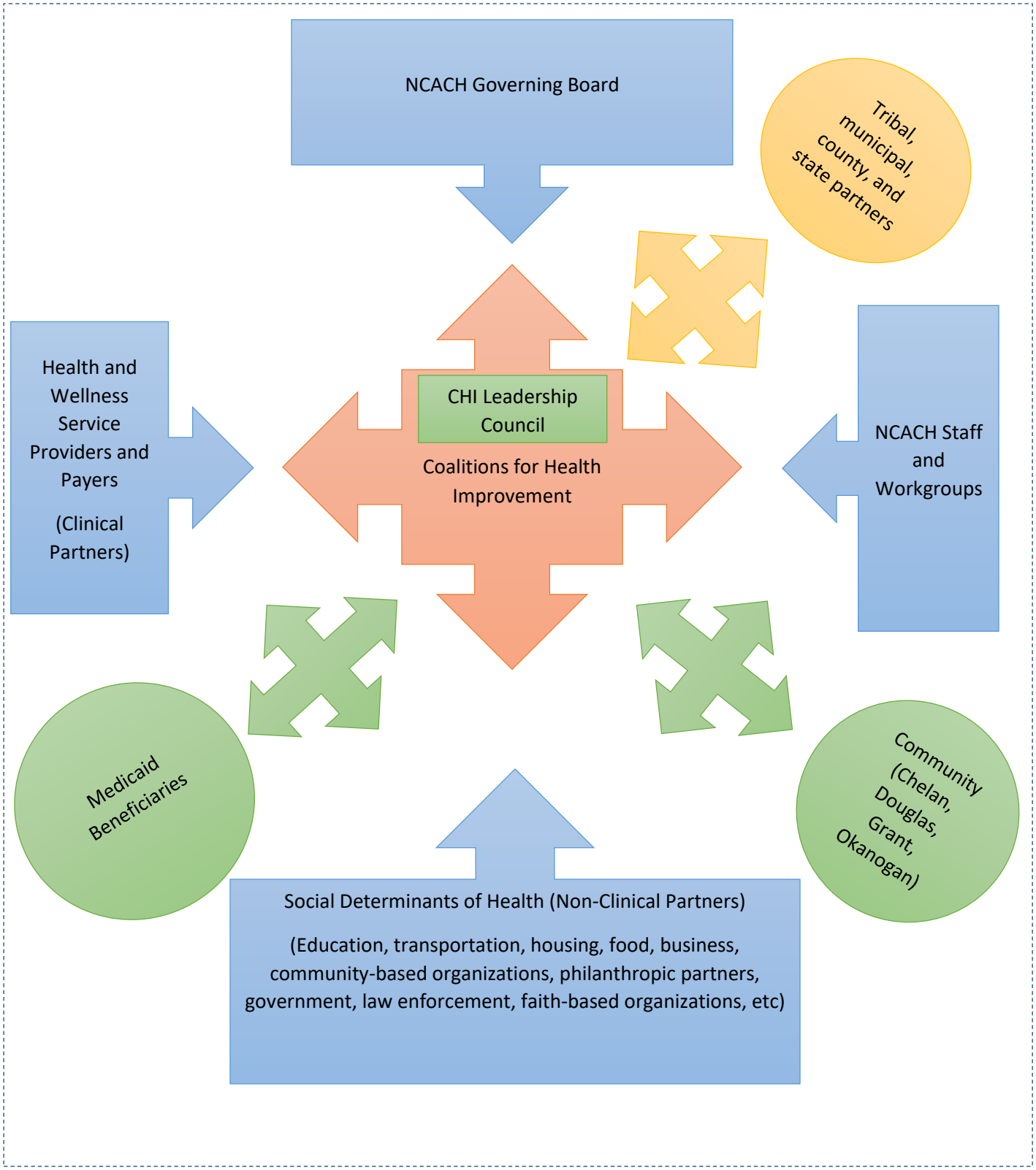
The Coalitions for Health Improvement Leadership Council consists of locally selected CHI members who have signed a membership agreement and are committed to facilitating and coordinating their local Coalition's efforts and goals. The CHI Leadership Council meets on a monthly basis and convenes with the Governing Board as needed.

While anyone can attend a Coalition for Health Improvement, voting is reserved for members and organizations who sign a "Coalitions for Health Improvement Charter and Membership Agreement."

North Central Accountable Community of Health

Coalitions for Health Improvement

(Within the work of the NCACH Medicaid Transformation Projects)



https://ncach.org/coalition-for-health-improvement

Medicaid Transformation Project Interactions

The six selected Medicaid Transformation Projects for the North Central Accountable Community of Health were identified through community surveys implemented in 2016. After identifying the projects, the NCACH formed Workgroups consisting of local leaders, providers, and agencies to inform, advise, and design processes to ensure successful and sustainable project delivery across the North Central Region. In 2018, the projects all entered their implementation stages, and are currently on track to receive funding and begin operating as early as June. All of the projects are intended to promote Whole Person Care as a guiding tenant, while improving access and quality of services while reducing excess per capita costs of health care across Chelan, Douglas, Grant and Okanogan counties. The Coalitions for Health Improvement are a critical voice in the project implementation process, and in some cases, can even apply to receive project implementation funding. As the projects progress, the Coalitions for Health Improvement will be a key voice in continuous monitoring and improvement efforts.

https://ncach.org/coalition-for-health-improvement

North Central Accountable Community of Health's Six Selected Transformation Projects

1. Bi-Directional Integration – Address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need.
2. Community-Based Care Coordination – Promote care coordination across the continuum of health for Medicaid beneficiaries, including coordinating with sectors and service providers within the Social Determinants of Health.
3. Transitional Care – Improve transitional care services of Medicaid beneficiaries moving from intensive medical care or institutional settings (including correctional or in-patient facilities.) Improvement to these services will lead to a reduction of avoidable hospital utilization and ensure people are getting the right care in the right place.
4. Diversion Interventions – Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations. Target populations include those who present at the Emergency Department or access EMS systems for a non-emergency condition, or Medicaid beneficiaries with mental health and/or substance abuse conditions coming into contact with law enforcement.
5. Addressing the Opioid Use Public Health Crisis – Reduce opioid-related morbidity and mortality through strategies that target prevention of opioid misuse, abuse, treatment of opioid use disorder, overdose prevention programs, long-term recovery, and whole person care.
6. Chronic Disease Prevention and Management – Improve chronic disease (e.g. heart conditions, asthma, diabetes, obesity, etc.) management and control through the Chronic Care Model (CCM), an organizational approach to caring for people with chronic diseases in a primary care setting.

Possibility Matrix

The "Possibility Matrix" is intended to serve as a guiding tool outlining the realm of possibilities that the CHIs have within their scope, focus, and vision. This is a dynamic list, not comprehensive by any means, and is intended to serve as a strategy resource.

CHI Possibilities	Support from NCACH
Apply for grant funding or other project funding outside of Transformation funding (any chartered member organization can apply for funding with support from the CHI).	• Support grant funded projects • Write letters of support
Use NCACH to leverage and support passage of local policy and measures that improve population health across the 4 counties, in accordance with our mission, vision, and values.	• Formalized letters of support from the NCACH Governing Board* • Use our projects and P4P/P4R metrics as evidence to back and support
Leverage CHI Governing Board members to ensure that CHI voice is being represented	• CHI Board Members can schedule time to review Board motion forms as released in the "Public Packet" with CHI members. Voting CHI members can make recommendations to the CHI Governing Board Member before they vote at the Governing Board level
Engage with Implementation funding (including, but not limited to: applying for Implementation funds; partnering with other organizations receiving Implementation funding)	• Funding
Serve as local conveners by: • Fostering strong linkages between local clinical and social service partners through organized trainings, featured partner presentations, identifying gaps in partnership, etc.	• Site hosting – serve as a robust community resource • Funding • Data

- Promoting education and awareness of what services are provided in your community especially where they intersect and impact each other (to foster collaboration across agencies.)
- Assist with identifying universe of local resources and improving resource directories, to improve access to services for community members. These asset maps could also be built into NCACH's care coordination resources.
- Identifying local social determinants of health opportunities that NCACH should invest in.
- Through community conversations, surface local barriers to whole person care and identify local capacity building investments that NCACH's projects and resources could support
- Build awareness of local Medicaid Transformation implementation efforts by inviting NCACH funded partners from your county to make presentations. Invite feedback from the community to promote continuous improvement.
- Request NCACH staff to provide progress updates around projects, share and explore data (including anecdotal on-the-ground information) to track impact and provide input where we might need to adjust and course correct (in other words, CHI's are a key voice in NCACH's continuous monitoring and improvement efforts)

*****_To be issued and decided at the discretion of the NCACH Governing Board_

Board Decision Form

TOPIC: *Opioid Project Funding Process*

PURPOSE: *Approve the process and documents developed by the Opioid Workgroup for funding allocations of the Opioid Project (funding period: July – December 2018).*

BOARD ACTION:

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

BACKGROUND:

In March 2018, the NCACH Governing Board approved the allocation of $100,000 for the Opioid Project for the rapid cycle application process funding period July – December 2018. The rapid cycle application process is designed for relatively quick, shovel ready projects (ie. they can be started soon and can be done in 6 months). The Workgroup has developed a Rapid Cycle Implementation Partner Application, Scoring Criteria, Funding Principles, and a Funding Process for rapid cycle funding (documents attached). These documents will guide the Workgroup in selecting partners and applications to implement the work of the Opioid Project.

PROPOSAL:

Motion to approve the attached NCACH Rapid Cycle Application and associated scoring criteria, funding principles, and funding process.

IMPACT/OPPORTUNITY (fiscal and programmatic): *Approval of these documents will signal to the Workgroup endorsement of the process being developed to implement the Opioid Project.*

TIMELINE:

The application will be released on or around April 9th and close on May 11th. The Opioid Workgroup will recommend applications to be funded to the Governing Board in June.

RECOMMENDATION:

Submitted By: Regional Opioid Workgroup
Submitted Date: 03/26/2018
Staff Sponsor: Christal Eshelman

NCACH RAPID CYCLE APPLICATION: OPIOID PROJECT

North Central Accountable Community of Health - Medicaid Transformation Project

Introduction

The North Central Accountable Community of Health (NCACH) is accepting applications from partners who are interested in implementing projects under the Medicaid Transformation to *Address the Opioid Use Public Health Crisis* in one or more of the following counties: Chelan, Douglas, Grant, and Okanogan Counties.

Through cross-sector, regional collaboration, NCACH is working to improve community health in North Central Washington. NCACH is one of nine Accountable Communities of Health formed in Washington through the Healthier Washington initiative. AS part of this initiative, the NCACH is undertaking a regional project addressing the opioid use public health crisis in North Central Washington. **The project objective, as described by the Washington State Health Care Authority, is to support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, overdose prevention, and recovery supports.**

Menu of Approaches

Through community and partner input, NCACH has identified high priority approaches for our region, listed on the next page. These approaches were selected for their alignment with the 2016 Washington State Interagency Opioid Working Plan.

	Priority Approaches
Prevention	Promote accurate and consistent messaging about opioid safety and to address the stigma of addiction to healthcare providers, law enforcement, community coalitions, schools/students including community colleges, dentists, public health, the public, and other relevant parties.
	Promote safe storage and appropriate disposal of medications through building awareness and education of 1) medication take back programs, 2) home lock boxes, 3) safe medication disposal options
	Promote use of best practices among dentists for prescribing opioid for pain (ie. The Dental Guideline on Prescribing for Acute Pain Management developed by the Bree Collaborative and WA State AMDG).
	Expand Medication Take Back programs.
	Build structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers and staff to implement and sustain chronic pain management.
Treatment	Increase the number of providers certified to prescribe Opioid Use Disorder (OUD) medications in the region (ie. hospitals, primary care clinics, correctional facilities, mental health and SUD treatment agencies, methadone clinics and other community based sites).
	Build structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers and staff to implement and sustain medication assisted treatment, such as methadone and buprenorphine; examples of evidence-based models include the hub and spoke and nurse care manager models.
	Promote and support pilot projects that offer low barrier access to buprenorphine in efforts to reach persons at high risk of overdose; for example in emergency departments, correctional facilities, syringe exchange programs, SUD and mental health programs.
	Increase OUD treatment, particularly MAT, during incarceration and ensure continuity of treatment for persons with an identified OUD need upon exiting correctional facilities by providing direct linkage to community providers for ongoing care.
	Organize or expand syringe exchanges. Develop/support linkages between syringe exchange programs and physical health/OUD treatment providers.
	Establish or enhance community pathways to support pregnant and parenting women with connecting to care services that address whole-person health (physical, mental and substance use disorder treatment) needs during, through, and after pregnancy.
OD Prevention	Provide technical assistance to first responders, chemical dependency counselors, and law enforcement on opioid overdose response training and naloxone programs.
	Assist emergency department to develop and implement protocols on providing overdose education and take home naloxone to individuals seen for opioid overdose.
	Establish standing orders in all counties to authorize community-based naloxone distribution and lay administration.
	Collaborate with the MCOs to provide residential, outpatient and withdrawal management programs with guidelines, training and tools to provide overdose prevention education to all clients.
Recovery	Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.
	Establish or enhance community-based recovery support systems, networks, and organizations to develop capacity at the local level to design and implement peer and other recovery support services as vital components of recovery-oriented continuum of care.
	Connect Substance Use Disorder providers with primary care, behavioral health, social service and peer recovery support providers to address access, referral and follow up for services.
	Establish or expand adult and/or juvenile drug courts.
PHM[1]	Use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.

[1] PHM - Population Health Management

Please note, the above list of approaches is **not** exhaustive and additional approaches **will be** considered for funding by NCACH. Each application must select at least one approach. If the selected approach is not a priority approach listed on page 2, the application must clearly articulate justification for this approach (ie. provide rationale between the approach and intended impact). Additionally, an application may select more than one approach.

The NCACH reserves the right to fund all, some, or none of the approaches described in an application.

Award Information

The NCACH will fund community partners to implement aspects of the Opioid Project. NCACH is interested in funding projects which are collaborative, innovative, culturally sensitive, and specific in their approach toward reduction in opioid-related morbidity and mortality in North Central Washington.

Length of Project Period

The project period is July 1, 2018 through December 31, 2018. Additional funding will be available in future years to partners through a competitive application process.

Award Size

Anticipated total available funding for the Opioid Project period (July 2018 – December 2018) is $100,000. Individual award amounts will vary based on the scope of proposed project but will generally range from $2,500 to $10,000.

Funding

Funding is available to the NCACH from the Health Care Authority to fund opioid-related initiatives through the Washington Medicaid Transformation Project. These funding are not a grant but rather a performance-based incentive program for earning funds through achievement of milestones and outcomes. Funding in future years is contingent upon meeting certain milestones, processes, and performance metrics. Awards are subject to the availability of funds.

Allowable Expenditures

Funding is intended to be used to catalyze new efforts and/or expand current efforts to address the opioid-use public health crisis. Funding should not be used to replace existing funding streams.

Funding is intended to be seed money to support the development of sustainable efforts. Funding is **not** intended to provide sustained programmatic support but rather to provide monetary support where there are short term financial barriers to implementing initiatives. The most competitive applications will show how these funds will be utilized to create long-term, sustainable change.

Application Review and Selection

Applications will be evaluated based on application scoring criteria and the final selection process will involve a ranking system based on application score and geographical distribution used in conjunction with funding principles to guide the equitable selection of successful applicants. Application scoring criteria are described in Appendix A.

Eligibility Information

This funding opportunity is open to community partners located in Chelan, Douglas, Grant, and Okanogan Counties who are interested in Opioid Use Disorder (OUD) prevention, treatment, overdose prevention, and recovery support services, especially to low-income populations. NCACH is seeking responses from a broad range of partners from throughout the region, including but not limited to community-based organizations, social service agencies, educational institutions, law enforcement agencies, and clinical partners. In order to be eligible, Whole Person Care Collaborative member organizations must include a minimum of one non-Whole Person Care Collaborative member organization or tribal entity as a contributing organization in the application. Grass-roots, community-driven efforts and coalitions are eligible for funding but will be required to identify a lead organization that can enter into contracts on their behalf.

Reporting Requirements

NCACH will require periodic written and verbal reports from successful applicants. During the project period (July 2018 – December 2018) one verbal report (≤20 minutes) will be required during an NCACH Regional Opioid Stakeholders Workgroup Meetings. In the spirit of continuous monitoring, learning, and improvement, this will allow NCACH and Opioid Workgroup members to learn about activities on the ground, build relationships with community partners, celebrate successes, and understand barriers. Similarly, one additional verbal report (≤20 minutes) will be required during a partner meeting. A partner meeting is any coalition or gathering of partners where information sharing is happening; these could be Coalition for Health Improvement meetings, Local Opioid Stakeholder Meetings, Regional Prevention meetings, etc.

Funded entities will be required to submit a final written report electronically through an online portal. Reporting requirements will be detailed in Memorandums of Understanding between the NCACH and each successful applicant.

Participation at the NCACH Annual Summit is encouraged. The Annual Summit generally takes place in April each year. This will allow community partners to share successes and challenges in implementing these projects and encourage collaboration among partners across our entire NCACH region.

Application Submission Information

Email completed applications to Christal Eshelman (christal.eshelman@cdhd.wa.gov) by 5:00pm on May 11th, 2018 If you need technical assistance filling out the template, please email Christal Eshelman or call 509-886-6434.

NCACH IMPLEMENTATION PARTNER APPLICATION: OPIOID PROJECT

Project Information

Project Title:
Funding Requested: $
Lead Organization: *This organization will sign the MOU and will be responsible for reporting requirements.*
Contact Name:
Email:
Physical Mailing Address:
Phone:
Contributing Organizations and Tribes: *Please list all the organizations in the region that participated in developing the project application and will participate in implementing the described project.* ***We encourage applicants to collaborate on project applications.*** *Please attach attestation of support letters for all organizations or tribes that are not the lead organization. These letters should be brief statements of commitment signed by a person of authority in the partnering organization or tribe.*
Counties Served by Project: (check all that apply): ☐ Chelan ☐ Douglas ☐ Grant ☐ Okanogan
The project is: ☐ New ☐ Enhancing or expanding an existing project or set of projects
Select sectors engaged by this project: ☐ Education ☐ Public Health ☐ Housing ☐ Transportation ☐ Hospitals ☐ Primary Care ☐ Mental Health ☐ Substance Use Disorder ☐ Employment ☐ Social Services ☐ Emergency Medical Services ☐ Other (please list)
Optional: Select all other NCACH project areas addressed by this project (refer to Appendix B for information about each project): ☐ Bi-Directional integration of primary care and behavioral health ☐ Community Based Care Coordination ☐ Transitional Care ☐ Diversion Interventions ☐ Chronic Disease Prevention and Control

Approach

Please select which approach(es) this project will implement. Mark all that apply.

	Priority Approaches	
Prevention	Promote accurate and consistent messaging about opioid safety and to address the stigma of addiction to healthcare providers, law enforcement, community coalitions, schools/students including community colleges, dentists, public health, the public, and other relevant parties.	☐
	Promote safe storage and appropriate disposal of medications through building awareness and education of 1) medication take back programs, 2) home lock boxes, 3) safe medication disposal options	☐
	Promote use of best practices among dentists for prescribing opioid for pain (ie. The Dental Guideline on Prescribing for Acute Pain Management developed by the Bree Collaborative and WA State AMDG).	☐
	Expand Medication Take Back programs.	☐
	Build structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers and staff to implement and sustain chronic pain management.	☐
Treatment	Increase the number of providers certified to prescribe Opioid Use Disorder (OUD) medications in the region (ie. hospitals, primary care clinics, correctional facilities, mental health and SUD treatment agencies, methadone clinics and other community based sites).	☐
	Build structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers and staff to implement and sustain medication assisted treatment, such as methadone and buprenorphine; examples of evidence-based models include the hub and spoke and nurse care manager models.	☐
	Promote and support pilot projects that offer low barrier access to buprenorphine in efforts to reach persons at high risk of overdose; for example in emergency departments, correctional facilities, syringe exchange programs, SUD and mental health programs.	☐
	Increase OUD treatment, particularly MAT, during incarceration and ensure continuity of treatment for persons with an identified OUD need upon exiting correctional facilities by providing direct linkage to community providers for ongoing care.	☐
	Organize or expand syringe exchanges. Develop/support linkages between syringe exchange programs and physical health/OUD treatment providers.	☐
	Establish or enhance community pathways to support pregnant and parenting women with connecting to care services that address whole-person health (physical, mental and substance use disorder treatment) needs during, through, and after pregnancy.	☐
OD Prevention	Provide technical assistance to first responders, chemical dependency counselors, and law enforcement on opioid overdose response training and naloxone programs.	☐
	Assist emergency department to develop and implement protocols on providing overdose education and take home naloxone to individuals seen for opioid overdose.	☐
	Establish standing orders in all counties to authorize community-based naloxone distribution and lay administration.	☐
	Collaborate with the MCOs to provide residential, outpatient and withdrawal management programs with guidelines, training and tools to provide overdose prevention education to all clients.	☐
Recovery	Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.	☐
	Establish or enhance community-based recovery support systems, networks, and organizations to develop capacity at the local level to design and implement peer and other recovery support services as vital components of recovery-oriented continuum of care.	☐
	Connect Substance Use Disorder providers with primary care, behavioral health, social service and peer recovery support providers to address access, referral and follow up for services.	☐
	Establish or expand adult and/or juvenile drug courts.	☐
PHM[2]	Use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.	☐
Other	Other, please describe:	☐

[2] PHM - Population Health Management

Please note, the above list of approaches is **not** exhaustive and additional approaches **will be** considered for funding by NCACH. Each application must select at least one approach. If the selected approach is not a priority approach listed on the previous page, the application must clearly articulate justification for this approach (ie. provide rationale between the approach and intended impact). Additionally, an application may select more than one approach.

Project Description

Suggested word count 750 - 1000 words, maximum word count is 2000 words.

Problem Statement: *What is the problem you seek to address with these funds?*
Goal Statement: *How will the population you serve benefit from the intervention you are proposing?*
Project Description: *Provide a description of the project including how you plan to implement the selected approaches above.*
Collaboration: *Describe how you will work with the contributing organizations and tribes listed above. List each partners key roles and/or responsibilities.*
Target Population: *Describe the population that you are expecting to reach with this project.*
Community Served: *Describe the community this project will serve (e.g. three counties, four primary care clinics, educational service district, approximate number of individuals served by a Social service agency in one city) and any specific needs of this community.*
Timeline: *Describe the timeline and major milestones for implementing this project. Demonstrate that your project is shovel ready (ie. is ready to implemented quickly).*
Risks: *Identify potential obstacles to successful implementation.*
Sustainability: *How does this project lead to lasting and self-sustaining improvement?*

Project Budget

Provide an estimated project budget using the template provided including information about additional funding applied for or obtained for this and related initiatives. Provide a budget narrative (suggested word count 200-300 words; maximum word count is 500 words)

Project Budget: July – December 2018		
EXPENSES	***NCACH funded***	***Other funding***
Salaries, wages, and benefits		
Travel		
Equipment		
Supplies		

Training		
Printing		
Other Expenses (itemize):		
Total		

Evaluation and Reporting

Measurement and Evaluation: *In order to measure progress, it is important to track process and outcome metrics. What key indicators will you utilize to measure success of this project? How will you know the project has been impactful?*
Reporting: *Attest that you understand and accept the responsibilities and requirements for reporting. These responsibilities and requirements include:* • *One verbal report at an NCACH Regional Opioid Stakeholders Workgroup meeting on project implementation progress* • *One verbal report at a partner meeting on project implementation progress* • *Final written report on project implementation and outcomes (Due January 4th, 2019)* ☐ Yes ☐ No

Appendices

- Appendix A – Rapid Cycle Opioid Project Application Scoring Criteria
- Appendix B – Description of NCACH selected projects

Opioid Workgroup Rapid Cycle Application Scoring Criteria

Funding Period: July 2018 through December 2018

Criteria

Pass/Fail and Bonus Scoring

Section	Questions	Scoring
Completeness	Are all parts of the application complete?	Pass/Fail
Contributing Organizations	5 Points for each partner organization (that is not the lead organization)	Variable bonus points
Counties Served	3 points for each county served	Variable bonus points
Sectors	1 bonus points for each sector engaged	Variable bonus points
Approach	Does the applicant select a minimum of one approach? If the selected approach is not a priority approach, does the applicant clearly articulate justification for this approach (ie. provides rationale between the approach and the intended impact)?	Pass/Fail
Attestation to Reporting requirements	Does the applicant attest to understanding and accepting the responsibilities and requirements for reporting.	Pass/Fail

Main Scoring

Scores should be selected as follows:

1 – Poor: very few strengths and numerous major weaknesses
2 – Fair: some strengths but with at least one major weakness
3 – Good: Strong but also some moderate weaknesses
4 – Strong: strong with minor weaknesses
5 – Exceptional: Exceptionally strong with essentially no weaknesses

Section	Questions	Score	Weight	Points
Problem Statement	Does the applicant clearly state the problem they are trying to address?		1	
Goal Statement	Does the application clearly articulate the benefit that the proposed intervention will provide to the population?		1	

Project Description	*Clarity* – Does the applicant clearly articulate the proposed project?		2	
	Specificity and Detail – Does this project provide sufficient detail of the proposed project?		1	
	Implementation – Does the applicant address implementation of the project?		2	
Collaboration	Does the applicant attribute a role or responsibility to each partner listed?		1	
Target Population	Does the applicant describe the specific population they are expecting to reach with the proposed project?		1	
Community	Does the applicant describe the specific community the proposed project will serve?		1	
Timeline	Does the applicant describe major milestones and the implementation timeline and demonstrate that the project is shovel-ready?		1	
Risks	Does the applicant successfully identify a minimum of risk to implementation?		1	
Sustainability	Does the applicant state how the proposed project will lead to lasting and self-sustaining improvement?		3	
Project Budget	Does the applicant provide a budget that accounts for all the requested funds		1	
Measurement and Evaluation	Does the applicant state key indicators they will be utilized to measure success?		2	
	Does the applicant clearly articulate how they know if the project is impactful?		2	

Opioid Workgroup Funding Principles

Principles applied to the distribution of funds specific to the Opioid Project for the funding period: July 2018 through December 2018

Stronger partnerships across clinical and community settings

1. Supports investments that builds or strengthens partnerships between clinical and community settings or that address Social Determinant of Health in order to improve opioid-related mortality and morbidity.
2. Projects that demonstrate Cross-sector and/or regional collaboration will be considered more competitive

Sustainability

3. In alignment with the Board's intent to fund projects that will lead to sustainable change, projects should demonstrate a clear path toward sustainability. Except where a clear path toward sustainability is articulated, funds will not be allocated to pay for short-lived provision of direct services.

Capacity Building

4. Funding will be distributed to partners to create or build on existing capacity and infrastructure. Funding will not be awarded to replace existing funding sources.

Measurable Impact

5. Funding will be distributed to partners that state key indicators they will utilize to measure success and indicate how they know if the project is impactful.

Scope

6. Projects that demonstrate the following will be considered more competitive:
    a. Serving a larger geographical area and/or larger Medicaid population
    b. Addressing more than one priority area (prevention, treatment, overdose prevention, and recovery)
7. In order to receive funding, a minimum of one approach must be identified. If the approach identified is not a priority approach, the applicant must clearly articulate justification for this approach.

Readiness

8. Funding will be awarded to applicants who demonstrate 'shovel ready' projects. Shovel ready means that the applicant is ready to make use of funds immediately and expend them on the proposed project within six months (without extensive planning).

Geographical Distribution

9. Funding will be equitably distributed across the North Central Accountable Community of Health Region.

Definitions

- Health Equity - Reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.
- Local Health Jurisdiction – Local Health Jurisdictions are defined by Public Health service areas. There are three Local Health Jurisdictions in the North Central Accountable Community of Health region. They are comprised of 1) Chelan and Douglas Counties, 2) Grant County, and 3) Okanogan County.
- Priority approach - Through community and partner input, NCACH has identified high priority approaches for our region, listed on page 3. These approaches were selected for their alignment with the 2016 Washington State Interagency Opioid Working Plan.
- Priority area – Four areas specifically targeted through he Medicaid Transformation to reduce opioid-related morbidity and mortality include 1) Prevention, 2) Treatment, 3) Overdose Prevention, and 4) Recovery.
- Social Determinants of Health - economic and social conditions that influence the health of people and communities. Examples of social determinants of health include education, transportation, socioeconomic conditions, and language/literacy, among many others.

	Approaches
Prevention	Promote accurate and consistent messaging about opioid safety and to address the stigma of addiction to healthcare providers, law enforcement, community coalitions, schools/students including community colleges, dentists, public health, the public, and other relevant parties.
	Promote safe storage and appropriate disposal of medications through building awareness and education of 1) medication take back programs, 2) home lock boxes, 3) safe medication disposal options
	Promote use of best practices among dentists for prescribing opioid for pain (ie. The Dental Guideline on Prescribing for Acute Pain Management developed by the Bree Collaborative and WA State AMDG).
	Expand Medication Take Back programs.
	Build structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers and staff to implement and sustain chronic pain management.
Treatment	Increase the number of providers certified to prescribe Opioid Use Disorder (OUD) medications in the region (ie. hospitals, primary care clinics, correctional facilities, mental health and SUD treatment agencies, methadone clinics and other community based sites).
	Build structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers and staff to implement and sustain medication assisted treatment, such as methadone and buprenorphine; examples of evidence-based models include the hub and spoke and nurse care manager models.
	Promote and support pilot projects that offer low barrier access to buprenorphine in efforts to reach persons at high risk of overdose; for example in emergency departments, correctional facilities, syringe exchange programs, SUD and mental health programs.
	Increase OUD treatment, particularly MAT, during incarceration and ensure continuity of treatment for persons with an identified OUD need upon exiting correctional facilities by providing direct linkage to community providers for ongoing care.
	Organize or expand syringe exchanges. Develop/support linkages between syringe exchange programs and physical health/OUD treatment providers.
	Establish or enhance community pathways to support pregnant and parenting women with connecting to care services that address whole-person health (physical, mental and substance use disorder treatment) needs during, through, and after pregnancy.
OD Prevention	Provide technical assistance to first responders, chemical dependency counselors, and law enforcement on opioid overdose response training and naloxone programs.
	Assist emergency department to develop and implement protocols on providing overdose education and take home naloxone to individuals seen for opioid overdose.
	Establish standing orders in all counties to authorize community-based naloxone distribution and lay administration.
	Collaborate with the MCOs to provide residential, outpatient and withdrawal management programs with guidelines, training and tools to provide overdose prevention education to all clients.
Recovery	Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.
	Establish or enhance community-based recovery support systems, networks, and organizations to develop capacity at the local level to design and implement peer and other recovery support services as vital components of recovery-oriented continuum of care.
	Connect Substance Use Disorder providers with primary care, behavioral health, social service and peer recovery support providers to address access, referral and follow up for services.
	Establish or expand adult and/or juvenile drug courts.
PHM[1]	Use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.

[1] PHM - Population Health Management

Opioid Workgroup Funding Process

Funding Period: July 2018 through December 2018

Funding Process

1. Anticipated total available funding for the Opioid Project period (July 2018 – December 2018) is $100,000.
2. Application will open April 9th.
3. Applications due to NCACH staff via email by May 10th.
4. Opioid Workgroup will form an Application Evaluation Committee (AEC). Note: members who have applied for funding, or who are affiliated with organizations that have applied for funding, are restricted from joining the AEC. The AEC will also include NCACH staff and external consultants (The Center for Evidence-based Policy). Efforts will be made to ensure equitable representation of each County on the AEC. If necessary, the Workgroup may solicit non-Opioid Workgroup member participation on the AEC.
5. The AEC will review, score, and rank applications.
    a. Applications will be sorted by geography.
    b. Applications will be randomly assigned to reviewers who are not from the same local health jurisdiction (LHJ) as the applicant lead organization. LHJ's in the North Central Accountable Community of Health region include Grant County, Okanogan County, and Chelan-Douglas County.
    c. Reviewers will be blinded to the names of applicants (when possible) and other reviewers.
    d. Each application will be reviewed by one workgroup member and one NCACH staff or consultant using pre-determined scoring criteria.
        i. If the reviewer scores are within 10 points of one another, the scores will be averaged to determine the final score for the application.
        ii. If the scores are not within 10 points of one another, the application will be assigned to an additional reviewer.
            1. After the third reviewer scores the application, the reviewers will meet as a group to discuss the scoring and reviewers will have an opportunity to change their scores.
            2. Once each reviewer finalizes his/her score, the three scores will be averaged to determine the final score for the application.
6. This highest ranked applications summing to $20,000 in each Local Health Jurisdiction will be recommended for funding (based on location of lead organization and/or counties served). The remaining applications shall be recommended for funding in the order of rank so that the total of the recommended applications to be funded does not exceed $100,000.
7. The AEC will recommend a *funding package* (projects and funding amounts) for approval by the Workgroup at the May Workgroup meeting (May 25, 2018).
8. The Workgroup will approve recommendation of *funding package* to the Governing Board.
9. The *funding package* will be presented to the Governing Board for approval the June Board Meeting (June 4, 2018).

10. Successful applicants will be notified on June 6, 2018 with an award letter/email. MOUs will be distributed to successful applicants June 6th and will be due back to NCACH staff by June 29th. The MOUs will reference each successful applicant's application in order to determine expectations and deliverables. Additionally, on June 6th information needed to register organizations in the Financial Executor Portal will be requested (ie. EIN number.)
    a. This is a tight timeframe. Organizations that do not return the MOU by June 29th will not forfeit funding but will not receive funding until their MOUs are returned.
    b. A requirement of the MOU will be to register in the Financial Executor Portal (by June 29th).
11. The full funding amount will be distributed to lead organization of successful applicants on or around July 2, 2018.
12. July 1 - December 31, 2018 Reporting requirements:
    a. One verbal report at an NCACH Regional Opioid Stakeholders Workgroup meeting on project implementation progress
    b. One verbal report at a partner meeting on project implementation progress. Partner meetings include but are not limited to Coalition for Health Improvement meetings and Local Opioid Stakeholder groups.
    c. Final written report on project implementation and outcomes (Due January 4th, 2019)
13. Only applicants who are in compliance with all NCACH reporting requirements will be eligible for future NCACH funding

Note: This process calls for advance payment of NCACH DSRIP funds to partners for specified purposes (as outlined in successful applications). Partners shall use those funds only for the purposes specified, and must return any funds tied to deliverables not met under the MOU to the Financial Executor or the NCACH by February 28th, 2019.

Note: All dates are subject to change and funding is contingent on availability of funds.