**Governance Charter for North Central ACH**

**Draft of February 28, 2015**

**NCACH Purpose and Rationale**

The purpose of the North Central Accountable Community of Health is to work toward achievement of the Triple Aim in Okanogan, Grant, Chelan and Douglas Counties. The Triple Aim includes:

* Improving patient care, including quality and satisfaction;
* Lowering the *per-capita* cost of health care, and;
* Improving the health of the population.

There is a diversity of opinion in North Central Washington about health care reform, but one common principle informs NCACH’s work. Major changes are coming to our health care system, and it is critical for our communities to have a strong voice in that process. NCACH is the primary vehicle through which our communities can be heard and can participate in the process of change.

**Guiding Principles**

1. To achieve the changes needed for improvement in the health and health care of our communities, purposeful collaboration between health care, social service, government, education, business and community-based sectors is required.
2. To be successful, communities must be engaged to shape their goals and strategies for community health improvement. Thus, our governing and decision making bodies will include substantial representation from outside the medical care delivery sector. Members will be drawn from public health, education, social services, community-based organizations, business, government, tribes and other community leaders, as well as from the long-term care, medical, and behavioral health care delivery systems, including payers and purchasers, hospitals, primary care and specialty providers.
3. The way health care is currently organized and delivered will not be effective in achieving our shared aims unless there is considerable delivery system and payment reform. We recognize that in order to be successful as an ACH some of our strategies must focus on: a) improving connections between health care system and the community, and b) giving people the tools needed to help them make informed and responsible decisions about managing their own health. The region already includes provider organizations that are leading these changes.
4. Reform efforts will present serious challenges, and in some cases even survival threats, to health care organizations in this region. Providers in rural areas face challenges that go beyond those seen in more densely populated areas. An important purpose of NCACH is to assure that rural providers and health care organizations in this region have a voice in upcoming health system changes, and that the needs of rural communities are taken into account as state, regional and local health care system decisions are made.
5. To improve overall community health we need to address upstream determinants of health and health disparities, and strengthen the system of home and community based supports that stabilize the health of our most vulnerable community members. Given that 90% of the drivers of health occur outside the health care delivery system, we propose to re-invest a substantial percentage of the savings from health care delivery system improvement into effective community-based prevention programs and initiatives identified at the local level through community health improvement plans and other efforts.

**Governance Structure**

**Overall Structure** NCACH’s governance structure has three main components:

1. The **Governing Board**, which is the primary decision making body of the ACH.
2. The **Advisory Council**, which consists of representatives from key health care disciplines such as primary care, specialty medicine, dentistry, behavioral health and others. The purpose of the Advisory Council is to provide to the Governing Board advice on matters that affect the delivery of health care services in the region.
3. A **Coalition for Health Improvement** in each public health jurisdiction (Okanogan, Grant and Chelan-Douglas) will be a broad-based community coalition intended to assure the engagement of a wide variety of partners in the work of the ACH. Its functions will include input to the Governing Board on major ACH activities such as needs assessment and the meaning of local health data, community health improvement plans and priorities, health improvement initiatives, delivery system transformation and other aspects of the ACH’s efforts to achieve the triple aim.

**A Backbone Organization** will be formed or identified during 2015 to provide administrative support and infrastructure for the work of the ACH.

**Governing Board Membership**

**Founding Membership** Initial board membership will include the following types of members:

Behavioral Health (1 representatives, selected by ??, two-year term.)

Confluence Health (2 representatives, one for Central Wa. Hosp, one for primary care, selected by Confluence CEO.)

Hospitals other than Confluence (1 representative, selected by N. Central WA Council of Hospitals, two-year term.)

Primary care clinics other than Confluence(1 representative, selected by ??, a two year term.)

Elected Officials (Senator Parlette, *ex officio*, no term limit.)

Public Schools (1 representative, selected by NC ESD for 2-year term.)

Public Health (1 representative, selected by public health administrators, 2 year term.)

Area Agency on Aging (1 rep, selected by Aging and Adult Care director for a 2-year term.)

Hispanic community representative (selected by ??, for a 2-year term.)

Health Plans (1 representative, selected by Health Plan Engagement Committee – see below – one year term.)

Appointments for expiring terms will be made by June 30 of each year by the party making the original appointment.

Total Members: 11

**Governing Board Standing Committees**

In developing this proposal for the Governing Board it was recognized that the Medicaid Health Plans active in the region can and should play an important role in the ACH. At the same time, our need for a board of manageable size meant it would not be possible to have multiple board seats for the Plans. Instead the Lead Group is proposing that one of the Governing Board’s standing committees be a Health Plan Engagement Committee, consisting of representatives from each of the Health Plans active in the region along with appropriate Governing Board members.

Additional Governing Board Standing Committees will be formed as needed to manage key ACH issues and to assure that key ACH stakeholders have an effective voice in ACH activities.

The Advisory Council and Coalitions for Health Improvement will provide opportunities for a wide variety of stakeholders to have a voice in ACH decisions. Some key sectors have already formed groups to which the Governing Board will look for input. For example, hospitals have the North Central Washington Council of Hospitals.

**Governing Board Member Obligations** Members of the Governing Board must agree to:

1. Participate in Board decisions with the health of the region’s people uppermost in mind, rather than narrowly representing a sector or geographical area.
2. Be open with other members of the Board when professional or personal commitments complicate or affect decisions faced by the Board.
3. Fairly and respectfully consider the views and perspectives of others on the Board and others involved in the ACH effort.
4. Work to communicate regarding Board decisions and issues with stakeholder groups, and especially with any group or sector the board member represents on the Board.
5. Attend meetings as regularly as possible, sending an appropriate non-voting alternate when unable to attend.
6. Come to Board meetings having prepared by reading related materials and consulting colleagues and others as needed about issues addressed by the Board.

**Executive Committee Membership and Functions** The Governing Board will elect officers (Chair, Vice-Chair, Treasurer and Secretary) who will form an Executive Committee, which will make operational decisions for the ACH on a week-by-week basis. Policy and major priority decisions will be made by the Governing Board.

**Re-evaluation in late 2015**  Because the roles and functions of an ACH are evolving, the Governing Board will re-evaluate its composition by the end of 2015 and will include a revised plan for the Board’s composition in its ACH designation proposal to HCA.

**Advisory Board Creation**

The Governing Board will appoint the Advisory Board in time for it to have its first meeting in June, 2015.

**CHI Activities in 2015**

**Engagement efforts** [Describe efforts to broaden engagement in CHIs.]

**CHI meetings** [Describe plans and agendas for CHI meetings in 2015]

**Governing Board Decision Process**  Every effort will be made to resolve Governing Board decisions by consensus. Consensus is defined as the unanimous agreement of the members.

If a Governing Board members cannot support an emerging agreement of the group, the member is obligated to make his or her concerns known, and the rest of the group is obligated to listen with an interest in resolving them. Members are expected to work to address the concerns, including asking the concerned party to clarify any underlying interests or other dynamics that could be interfering with an agreement. All Committee members are obligated to try to find an alternative that meets the interests of the concerned party as well as their own.

If the Governing Board makes a good faith effort to achieve consensus but finds that it is not possible, the decision will be made by polling the members to select the option that is supported by the majority.

**Leadership time during 2015** [Not really a charter issue but included here for discussion.] Some Lead Group members have expressed the concern that volunteer time may not be sufficient to provide adequate leadership for this effort in 2015. Is there a need to acquire funding for a leadership position, or identify someone who can take this on without additional funding? Should some Design Grant funds be repurposed for this (keeping in mind that about half the $100K total is needed for staff support)? Should local sources of funding be considered?