**Governance Charter for North Central ACH**

**Draft of March 11, 2015**

**NCACH Purpose and Rationale**

The purpose of the North Central Accountable Community of Health is to improve the health of our communities in Okanogan, Grant, Chelan and Douglas Counties through achievement of the Triple Aim, which 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. Significant, even disruptive change is already beginning in our health care system. The way health care is currently organized and delivered will not be effective in achieving our shared aims. 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 and are committed to providing continued leadership in transforming our care delivery system.
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 different from 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 recognized 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 can stabilize the health of our most vulnerable community members. Given that most drivers of health occur outside the health care delivery system, significant improvements in community-based prevention are needed if we are to sustain health care savings in the long run. A substantial percentage of the savings from health care delivery system improvement must be invested in 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 constituencies such as primary care, specialty medicine, dentistry, behavioral health, social services, long term care, the business community, consumers and others. The purpose of the Advisory Council is to provide to the Governing Board advice on matters that affect the health of people n 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, three-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 3-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 3-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.

The Governing Board must include representatives from all NCRSA counties.

Total Members: 11

**Governing Board Standing Committees**

Care Transformation Workgroup Rapid and potentially disruptive changes in our health care system are under way. Although the Governing Board will provide leadership for this ACH, it will be occupied with organizational work over the next year or more. There is an urgent need for provider organizations, community partners and health plans to begin the transition to integrated whole person health care. We believe this can be done most effectively through an initial focus on one major clinical entity, such as diabetes or hypertension, which is common and whose treatment entails key issues such as physical and mental health integration, the potential for prevention of unnecessary utilization, whole-person care which integrates community resources, etc. When we have learned how to do that well, we will be able to apply those learnings to other kinds of care. The alternative – attempting to transform all kinds of care at once – is simply not practical. The Governing Board, as one of its first activities upon formation, will appoint a Care Transformation Workgroup. Members will come from all four counties. The Workgroup will include providers, health plans and community partners. It will develop a work plan that includes identification of the clinical entity that will be the focus of its early work; identification of key issues and opportunities; identification of evidence-based options for care transformation; and development of specific plans and timelines for care transformation in the region, beginning with the initial clinical entity.

Population Health Improvement Workgroup The ACH’s mission of improving population health goes beyond improved medical care to include community-based measures that prevent health problems. As for Care Transformation, this body of work will require an active workgroup. It is expected that this workgroup will be created by the Governing Board once the Care Transformation Workgroup is operational. This aspect of the ACH effort will be shaped in part by the state’s Population Health Improvement Plan, which is being developed during 2015. It will also be shaped by the Community Health Plan to be developed by the ACH in 2016. In addition, it will depend on the eventual availability of funds, the nature and extent of which remain to be seen. Although it is just as important as care transformation, formation of this workgroup can be done after the Care Transformation Workgroup is up and running.

Health Plans 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 ACH stakeholders from al four counties 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 and Group Norms** 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, employer 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.

**COMMENTS ON OTHER GOVERNANCE ISSUES:**

**Workload** Peter Morgan commented: I am concerned that the amount of work required could be greater than our small group can achieve. I think it’s worth doing some scoping and workplanning to estimate the number of meetings, and follow up work across all communities.

Barry Kling has expressed a similar concern about our capacity to do all the things needed to develop an effective ACH. Everyone involved already has a full time job in addition to our ACH work. The Design Grant provides half an FTE of staff support (Deb Miller’s position) but that addresses only part of the need. Is there a need to acquire funding for a full time or half time 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? The question may have to wait for resolution until the Governing Board is up and running, but it is an issue that should be kept on the agenda for the GB.

**Geographic Equity on Governing Board** It is critical that all of our counties be adequately represented on the Governing Board. How can we assure that this will happen? With only 1 hospital, 1 clinic and 1 behavioral health provider on the board, this will be difficult. And when one of them leaves the board (at the end of a term or for other reasons) this balance will be upset unless the replacement happens to be from the same county. But this would tend to lock each seat into a particular county. Concerns about GB size were raised when the proposal had more seats, but one advantage of having three seats for each major provider group (hospitals, primary care and behavioral health) is that one seat could be allocated to each jurisdiction (Okanogan, Grant, Chelan-Douglas). If that change was made to the current proposal, the result would look like this:

Behavioral Health (3 representatives, selected by area BH providers)

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

Hospitals other than Confluence (3 representatives, selected by area hospitals)

Primary care clinics other than Confluence(3 representatives, selected by area primary care clinics)

Elected Officials (Senator Parlette, *ex officio*)

Public Schools (1 representative, selected by NC ESD)

Public Health (1 representative, selected by public health administrators)

Area Agency on Aging (1 rep, selected by Aging and Adult Care director)

Hispanic community representative

Health Plans (1 representative, selected by Health Plan Engagement Committee – see below)

Total Membership: 17

Perhaps 17 would be a manageable number, given an effective executive committee of the officers to address week-by-week operational matters.

Another alternative would be to allocate two instead of 3 seats each to hospitals, primary care and behavioral health, for a total of 14 seats. This would make it easier to deal with geographic representation, though not as simple as it would be with three seats of each type.

Regarding the process of getting feedback on the Governance Proposal, a region-wide session (using video links) has been proposed. This could be timed to follow the CHI discussions in each jurisdiction, perhaps in mid or late April, and could help finalize the proposal before it is adopted and the GB is appointed in early May.