**Governance Charter for North Central ACH**

**Draft of March 12, 2015**

**Purpose of This Draft**

This draft of the North Central ACH Governance Charter was accepted by the NCACH Leadership Group to be used as a basis for discussions with a very wide range of health partners in the coming weeks. The purpose of these discussions is to develop a Governance Charter that can be adopted by the Leadership Group so that an initial Governing Board can be formed and assume direction of NCACH activities.

**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 the patient experience of care (including quality and satisfaction)
* Reducing 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 health plans 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.
6. A substantial percentage of the savings from population health improvement and health care delivery system improvement should be invested in effective community-based prevention programs and initiatives identified at the local level through community health improvement plans and other efforts.
7. Improved data on health and health care will be a critical tool informing our decisions and will empower us to leverage best practices.

**Governance Structure**

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

1. The **Governing Board** will be the primary decision making body of the ACH. The Governing Board will establish standing committees for critical functions.
2. The **Advisory Council** will consist of region-wide representatives from relevant 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 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. Governing Board terms will last for three years, but initial appointments will be for staggered terms to avoid simultaneous turnover of the entire board.

Behavioral Health (1 representatives, two-year term. Selection method TBD.)

Confluence Health (2 representatives, one for Central Washington Hospital, one for primary care, selected by Confluence CEO; 1 year term for CWH representative, two year term for primary care representative.)

Hospitals other than Confluence (1 representative, selected by NCRSA hospital CEOs, three-year term.)

Primary care clinics other than Confluence(1 representative, selected by NCRSA primary care clinic CEOs, two year term.)

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

Public Schools (1 representative, selected by NC ESD, 3-year term.)

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

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

Hispanic community (1 representative, selection method TBD, 3-year term.)

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

Tribal Representative (1 representative, selection method TBD, 2 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.

The Governing Board will designate at least one member to serve as an active liaison with the Advisory Committee.

Total Members: 12

**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, a problem 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; development of specific plans and timelines for care transformation in the region, beginning with the initial clinical entity; and implementation of those transformation plans.

Population Health Improvement Workgroup The ACH’s mission of improving population health goes beyond improved health 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.

**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 Council Creation**

The Governing Board will invite Advisory Council nominations from appropriate partner groups. The Advisory Council will be formed in time for it to have its first meeting in June, 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 member 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 submitted to a vote of the board and decided by a simple majority of members present, provided there is a quorum.

The Governing Board will seek input from the Advisory Council and the Coalitions for Health Improvement on all major policy decisions.