

# **Governance Charter for North Central Accountable Community of Health**

**July 8, 2015**

## **Purpose of This Charter**

This North Central Accountable Community of Health (NCACH) Governance Charter was developed by the Leadership Group after an earlier version was shared and discussed widely among NCACH partners in the spring of 2015. This charter does not address every important issue related to NCACH governance; for example, it does not include complete by-laws for the Governing Board or Regional Council. Many of those issues are best addressed by the Governing Board and Regional Council once they are in place. This document is meant to provide a good basis on which the Leadership Group can establish the Governing Board as soon as possible. At that point the Leadership Group will disband and the Governing Board will take over leadership of the NCACH. The primary objectives of the Governing Board for the rest of 2015 will be to firmly establish the governance structure and prepare for official designation as an ACH in late 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;
- 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.
8. It is critical for NCACH to operate in a transparent and inclusive manner. Meetings will be open to all interested parties to the extent possible, and partners from various sectors will be encouraged to attend.
9. NCACH leaders are chosen in part because of the organizations or communities they represent. It is appropriate for them to assure that the views and interests of those they represent are included in NCACH discussions. When making ACH decisions, however, members of the Governing Board and Regional Council must consider issues from a regional perspective, rather than from the narrower perspective of their organization, affiliations or localities.
10. Information related to upcoming Governing Board decisions will be widely distributed to all interested partners as early as possible.
11. Because important health care sectors (MCOs, for example) may have multiple members in attendance at Governing Board meetings, the Board will be as flexible as possible in allowing time for groups to caucus to assure that their representatives on the Board are well informed of their views before decisions are made.
12. The Governing Board will allow regular opportunities for public comment at its meetings.

## 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 **Regional 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 Regional Council is to provide to the Governing Board advice from a broad range of stakeholders on matters that affect the health of people in the region. The Governing Board is required to consult the Regional Council on significant decisions, and the Governing Board will also include two non-voting Regional Council representatives to assure that the Regional Council has a voice in all Governing Board discussions. Any interested partner will be able to join the Regional Council by signing an agreement accepting basic member responsibilities.
3. **The Coalition for Health Improvement** in each public health jurisdiction (Okanogan, Grant and Chelan-Douglas) is a broad-based local 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 including 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. If an existing organization is selected to function as the backbone organization, it will be necessary for the host organization to agree that the Governing Board will control ACH functions, funds and staffing. The Governing Board will establish the process and criteria for backbone selection soon after its establishment.

**Governing Board Membership** Initial board membership will include the types of members listed below. Governing Board terms will last for three years, but initial appointments will be for terms of different lengths to avoid simultaneous turnover of the entire board. Before the end of each term, the group making the initial appointment will be asked to select a member for the next term. No member may serve more than three consecutive three-year terms.

Behavioral Health (1 representative, two-year initial term. Nominated by the Medicaid mental health and chemical dependency treatment contractors from the four counties, selected by Leadership Group.)

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

Public Hospitals (2 representative, selected by the CEOs of NCACH public hospitals, one seat with an initial term of three years and the other with an initial term of one year.)

Federally Qualified Health Clinics (1 representative, selected by NCRSA FQHC CEOs, two year initial term.)

Business Community (1 representative, selected by the Leadership Group with input from business leaders in the region, initial term three years.)

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

Education (1 representative, selected by NCESD Superintendent, 3-year initial term.)

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

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

Hispanic Community (1 representative, nominated through contacts with Hispanic community leaders, selected by Leadership Group, 3-year initial term.)

Medicaid Managed Care Organizations (1 representative, selected by MCOs doing business in the region, two year initial term.)

Tribal Representative (1 representative, nominated through contacts with tribes in the region, selected by Leadership Group, 2 year term.)

At-Large Seat (1 representative, initial 1 year term, selected to help balance the board in terms of geographic representation or other important factors)

Regional Council Representatives (Two representatives of the Regional Council, non-voting, one seat for a 3 year initial term, the other for a one year initial term. Selected by Regional Council.)

Total Voting Members: 15

**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. Terms for Executive Committee positions are two years, with no members serving in the same position for more than two consecutive terms.

**Governing Board Objectives in 2015** Once established, the Governing Board will assume responsibility for achieving the objectives of the HCA Design Grant in 2015. These include establishment of the Regional Council, continued development of the Coalitions for Health Improvement, implementation of two small health improvement initiatives related to Diabetes care and prevention, the selection of a backbone organization, completion of an inventory of regional health improvement resources, and development of a proposal to HCA for ACH designation.

**By-Laws** The Governing Board will develop and adopt by-laws soon after its creation. These by-laws will include provisions which:

- Establish board membership and selection as described above, including terms and term limits.
- Establish an executive committee as described above, including terms and term limits.
- Require regular attendance (in person or via remote connections approved by the board) by members at Board meetings and provide for replacement of members not able to attend regularly. Attendance by a non-voting alternate will be encouraged when a regular member cannot attend. An absent member may arrange for a proxy vote by notifying another member in writing in advance, but the absence will still be counted against the attendance record of the absent member.
- Establish the principle of open meetings and transparency.
- Establish the following decision process:
  1. Every effort will be made to resolve Governing Board decisions by consensus. Consensus is defined as the unanimous agreement of the members.
  2. 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 these concerns. 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.
  3. If the Governing Board makes a good faith effort to achieve consensus but finds that consensus 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. Robert's Rules of Order will be used to facilitate Governing Board decision making.
  4. The Governing Board shall seek Regional Council input on matters of substance prior to making decisions. Regional Council input will be provided by vote of the Council whenever

that can be achieved within a reasonable period of time, and in other cases will be provided by the non-voting Regional Council representatives on the Governing Board. Regional Council input may include one or more minority reports on an issue, to assure that the views of all groups are heard. Matters of substance include, but are not limited to, allocation of NCACH or other resources, by-laws changes, changes in the make-up of the Governing Board, and the approval of major contracts.

- The Governing Board will oversee development of appropriate by-laws or charters for the Regional Council and the Coalitions for Health Improvement.

**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 annually thereafter, and will include a revised plan for the Board's composition in its ACH designation proposal to HCA.

**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.