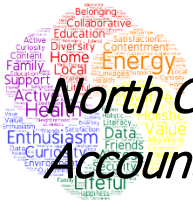


North Central Accountable Community of Health

December 28, 2015

Chase Napier
Healthier Washington Community Transformation Manager
Washington State Health Care Authority
P. O. Box 42700
Olympia, Washington 98504-2700

VIA EMAIL

Dear Chase:

Thanks very much for your letter of December 10, 2015, requesting more information on North Central ACH's Readiness Proposal. In this letter I will provide a response, while welcoming any further questions or discussions you or the Review Team may suggest.

I'll show the questions from you letter, followed by a response to each:

Category 5 Requirements:

The Review Team requires additional documentation or narrative to clarify the priority identification process and how it connects to the Regional Health Needs Inventory (RHNI) effort. There is a care transformation workgroup and population health workgroup focusing on diabetes, but it isn't clear if these groups reflect final priorities or if North Central is still in the process of reviewing the assessments and identifying final priorities. If these are the final priorities, please provide an overview of the process to reach agreement. If these are not final priorities, what are the anticipated next steps to identify priorities and projects in light of regional initiatives, resources and gaps? This information is required prior to designation although we will continue to move forward with the assumption that this information will be provided prior to the anticipated designation date.

Development of the Regional Health Needs Inventory is planned for 2016, in collaboration with the region's hospitals which must also complete CHNAs in 2016. But we do have access to CHNAs completed in 2013 by area hospitals, some of which collaborated on a CHNA effort managed by Community Choice and Chelan-Douglas Health District. CHNAs in the region were remarkably consistent in the health issues they addressed as priorities. These included:

Access to health care, especially primary care

Chronic disease prevention including the obesity epidemic, diabetes and related issues

Lack of adequate mental health services, including prevention

Pre-conceptual and perinatal health, including teenage pregnancy

The workgroups referenced in your question were not intended to be NCACH's response to the region's overall health needs, but only as small-scale activities conducted as we were getting organized in order

to gain experience in delivering health improvement initiatives through the ACH partnership. Through the lessons learned in these small-scale activities the NCACH is better positioned to launch the proposed regional initiatives for 2016. The standard tools and processes developed in 2015 will be useful in identifying priority projects moving forward. In selecting the health issues involved the Leadership Group (precursor to the Governing Board) wanted to focus on health issues that were included in CHNA priorities, without attempting a comprehensive approach. Diabetes was selected as a focus for each of the workgroups because it fits this pattern.

At the Governing Board's November meeting members had a wide ranging discussion on the purposes and value of our ACH. There was a strong consensus that whatever may happen with the Waiver and other state-level initiatives, the primary value of our ACH is the potential of this partnership to collaborate on the improvement of health and health care in our region. Although not prominently mentioned, this was essentially an endorsement of the Collective Impact model on which the ACH concept was originally based. Beyond that, the Board agreed that the key to building greater engagement among ACH partners is to actually do something about health. Assessing needs and making plans are necessary steps, but many of our major concerns are quite evident and, as noted above, were highlighted in earlier assessments. The Waiver may provide additional opportunities for health improvement initiatives, but its acceptance by CMS is unknown and in any case would not result in much action until 2017. The Board decided to identify one or two health improvement initiatives that are consistent with available needs assessments and will provide our ACH a meaningful opportunity to move ahead on health improvement activities in 2016. By focusing on important problems that are already evident, we can be assured that these efforts will be consistent with any further regional health improvement plans and with any state initiatives in which we may be engaged. The Board also discussed the importance of selecting initiatives that could begin in a relatively small and focused manner, but which can be scaled up to have regional significance. We do not need yet another isolated demonstration project that disappears when the special funding is gone. An *ad hoc* workgroup was appointed to develop proposals for the December meeting.

At the December meeting, the Initiatives Workgroup presented a proposal for two initiatives. These were not full blown implementation plans, but concepts to be developed into action plans by ACH workgroups that are now in the process of being formed. As adopted by the Board, the initiatives are described as follows:

> **Care Transformation** Form a standing workgroup on Care Transformation to develop a regional initiative that enhances the preparation of health care providers in the region for the delivery of whole person care. The Patient Centered Medical Home approach could form the basis for this effort, but to be effective it will be necessary to go well beyond that model. In addition, it will probably be necessary to begin by focusing on one particular kind of care, such as the treatment of Diabetes, since it isn't feasible to change everything at once. Board members on the work group would initially include Peter Morgan, Patrick Bucknum, Jeffrey Davis and Kevin Abel and Jesus Hernandez. Additional members from outside the board will be recruited. The workgroup will report monthly to the Governing Board beginning in January 2016. It should be funded and staffed through support from the SIM grant's Care Transformation Hub, administered through the state health department. One key next step would be to convene leaders of the region's health care delivery organizations to define a common purpose and establish buy-in for the effort. Although every health care organization must address these changes internally, common

goals, shared resources and access to appropriate expertise could significantly accelerate the necessary change. The high level of integration and cooperation among the health care providers delivering virtually all of the primary care in this region gives us opportunities for transformation not found elsewhere in the state.

Population Health Improvement Form a standing workgroup on Population Health Improvement to develop community-based primary prevention initiatives designed to address the obesity epidemic. Board members on the workgroup would initially include Winnie Adams, Nancy Nash-Mendez, Barry Kling, Jesus Hernandez and Theresa Sullivan. Additional members from outside the board will be recruited. This workgroup will be staffed primarily by backbone staff working under the direction of the NC ACH Executive Director to be hired in 2016. Because this initiative addresses a multi-faceted problem, it will eventually support separate task groups, each addressing a distinct domain. For example, there could be separate task groups addressing domains such as childhood obesity (primarily involving schools and day care), the food environment (healthy food availability and marketing, measures to reduce the popularity of unhealthy foods, etc.), the message environment (multifaceted messaging, including traditional and digital media, about healthy eating and active living), policy (addressing issues such as complete streets, healthy food service at public venues, and other public policies affecting healthy eating and active living), etc. CHIs could have an important role in these initiatives. A critical point here is that the workgroup would create only as many task groups as it could effectively support, knowing that it is a basic finding of the Collective Impact Model that adequate backbone (mainly staffing) support is critical for effectiveness. Staffing for this initiative would be funded through requests to MCOs and the region's larger provider organizations, among others.

Category 6 Requirements:

The Review Team requires additional documentation or narrative to demonstrate a pathway toward sustainability planning. Specifically, please provide information regarding preparation for the sustainability planning discussions in early 2016. For example, will the region consider projected operating costs, lessons learned from 2014-2015, or past discussions with other regions and state partners? The Review Team would also like to note that there are other ACH sustainability frameworks that outline many contributing factors to consider as part of sustainability planning. One of these frameworks may serve as a solid foundation for the North Central discussion. This information is required prior to designation although we will continue to move forward with the assumption that this information will be provided prior to the anticipated designation date.

North Central ACH is participating in the staffing workgroup organized by the Technical Assistance contractor. It is expected that this will be helpful in proving position descriptions and other information based on the experience and plans of other ACHs.

The following document was introduced and discussed at the December 7 Governing Board meeting:

SIM Funding for NC ACH

HCA has provided the following guidance regarding the SIM Grant funds we can expect from HCA in support of North Central ACH, once we achieve official designation as an ACH. Designation is expected to occur by the end of January 2016, but probably sooner.

Basic ACH Grant for 2015-2016 *Upon designation, we will be eligible for a grant of $150K. The award must be made by the end of January, 2016, and must be expended by January 2017, so it is essentially 2016 money. There will be no such grants in future years.*

Additional SIM Funds 2016-2018 *In addition to the one-time $150 basic grant, HCA has allocated a total of $660K for each ACH for 2016, 2017 and 2018. (Technically, these funds can be spent through the end of January 2019, but they are in effect meant to cover 2016, 17 and 18.) There is some flexibility in the way NC ACH spends these funds over the three year period. HCA is awaiting final approval from CMMI on this, but for example we could probably use as much as 50% of these funds in 2016 if we wished, with 25% allocated to each of the following two years.*

Proposed Approach *Obviously SIM funds are not sustainable beyond 2018 and are best understood as seed money to enable creation of a more sustainable approach. Funds other than the ones described above may become available. For example, the Care Transformation Hub could provide some support for an NC ACH care transformation initiative, and we may be able to raise funds to support population health initiatives. NC ACH itself will take some time to ramp up its activities, suggesting that our need for SIM funds will be greater in 2017 and 2018 than in 2016. On that basis, the following approach to SIM funding is suggested for the Governing Board to consider:*

> ***2016 –*** *Use the $150K basic grant along with $50K of the Additional Funds for total SIM funding of $200K in 2016. Using rough estimates of salaries and benefits (at 25% of salaries) a 2016 budget could look something like this:*
>
> | | | |
> |---|---|---|
> | *Executive Director Salary & Benefits* | *$ 95K* | *($125K annual, for 9 months)* |
> | *Administrative Assistant S&B, .5 FTE* | *24K* | *($25K annual, 9 months)* |
> | *Initiative staffing, S&B 1 FTE* | *50K* | *($75K annual, 6 months)* |
> | *Other backbone expenses* | *31K* | |
> | | | |
> | *2016 Total* | *$200K* | |
>
> *This same budget over a full year would be:*
>
> | | | |
> |---|---|---|
> | *Executive Director Salary & Benefits* | *$125K* | |
> | *Administrative Assistant, .5 FTE* | *32K* | |
> | *Initiative staffing, 1 FTE* | *95K* | *($75K annual, 6 months)* |
> | *Other backbone expenses* | *48K* | |
> | | | |
> | *Annual Total* | *$300K* | |

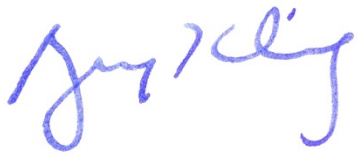
These are admittedly very rough budgets which will require further discussion, but the point here is to envision a basic approach to year-by-year SIM funding.

2017 & 2018 *-- After 2016, a total of $610K of additional SIM funding would remain. At this point, we would plan to use half of that ($305K) in 2017 and the same in 2018. Clearly it would be necessary to generate other sources of funding over that period to sustain the effort beyond 2018.*

No action was taken on these points at the December meeting, but further discussion of funding and sustainability will be on the Boards January meeting agenda.

I believe the information above addresses the points raised in the Review Team's questions, but please let me know if the Review Team needs any further information or documentation.

Best regards –



Barry Kling, MSPH
Chair, North Central ACH Governing Board

C: NCACH Governing Board