## **Phase I Certification Submission Template**

ACH Certification	CH Certification Phase I: Submission Contact	
ACH	North Central Accountable Community of Health	
Name	Name John Schapman	
Phone Number	Phone Number (509) 886-6435	
E-mail	<u>john.schapman@cdhd.wa.gov</u>	

#### Theory of Action and Alignment Strategy

#### **Description**

Each ACH is expected to adopt an alignment strategy for health systems transformation that is shared by ACH partners and staff. The goal is to ensure the work occurring within the region (e.g., clinical services, social services and community-based supports) is aligned and complementary, as opposed to the potential of perpetuating silos, creating disparate programs, or investing resources unwisely.

Provide a narrative and/or visual describing the ACH's regional priorities and how the ACH plans to respond to regional and community priorities, both for the Medicaid population and beyond. Please describe how the ACH will consider health disparities across all populations (including tribal populations), including how the ACH plans to leverage the opportunity of Medicaid Transformation within the context of regional priorities and existing efforts.

References: ACH 2016 Survey Results (Individual and Compilation), SIM Contract, Medicaid Transformation STC Section II, STC 30

#### Instructions

Please ensure that your responses address of the questions identified below. Total narrative word-count range for entire section is 400-800 words.

#### ACH Strategic Vision and Alignment with Healthier Washington Priorities and Existing Initiatives

- What are the region's priorities and what strategies are in place to address these priorities across the region?
- Describe how the ACH will consider health disparities to inform regional priorities.
- Describe strategies for aligning existing resources and efforts within the region. How is the work oriented toward an agreed upon mission and vision that reflects community needs, wants and assets?
- Describe how the ACH will leverage the unique role of DSRIP and consider the needs of Medicaid partners and beneficiaries to further the priorities identified above.
- Describe how the ACH will leverage the Demonstration to support the ACH's theory of change and what other opportunities the ACH is considering to provide value-add to the community.
- Describe any in-kind contributions and non-Medicaid resources that have been identified for supporting the ACHs work over the near-term and long-term.

#### Narrative (796 words):

North Central Accountable Community of Health (NCACH) works with clinical and community partners to implement Whole Person Care for Medicaid recipients through the bi-directional integration of behavioral and medical care, and through the creation of better connections between clinical care and community resources which assist patients in dealing with the impacts of the social determinants of health outside the walls of clinics. The point is not to pay for new services during the life of the Demonstration but to transform our region's delivery system so that this vision is realized in a manner that is sustainable after the Demonstration is over.

North Central Washington is a rural community with many provider organizations whose financial viability is at risk as we transform how we deliver and pay for care. The vision of the North Central Accountable Community of Health is to have community members reach a state of the best possible physical, mental, and social well-being while creating a health care system that is sustainable and meaningful to all provider organizations. This vision of change will be achieved through 4 regional principles:

- Use Demonstration resources to create sustainable systems inside and outside of the clinical setting to connect Medicaid patients with services that achieve whole person care.
   Involvement of front-line providers is a critical element in this work.
- Include our community based organizations in the work of care delivery redesign, and ensure their work is compensated in the new payment delivery models developed under the Demonstration
- 3. Share the goal of financial viability that provider organizations have as they pursue the new value-based payment model
- 4. Distribute resources and funding to our partnering organizations to develop care transformation while minimizing the creation of additional administrative overhead in the ACH.

To ensure this consistent message is delivered to our partner groups, the NCACH will develop and adopt an Alignment Strategy for Health System Transformation prior to Phase 2 certification that will be shared with our community partners.

NCACH will align our goals with the regional priorities defined by our Community. To better understand those priorities, the Board focused on the results of our Community Health Needs Assessments (CHNAs). This intensive process brought community members from the entire region together to identify key health issues. The assessment revealed the following regional priorities: Mental Healthcare Access, Access to Care, Education, Obesity, Affordable Housing, Drug and Alcohol Abuse, Access to Healthy Foods, and Diabetes. NCACH also incorporated information from our Community Input survey which identified Care Coordination, Transitional Care, Diversion Intervention, and Chronic Care as the 4 projects that community members felt provided the biggest impact on the above health disparities. These priorities were reviewed at our recent board retreat and were used by the Board in Demonstration project selection. As we develop project proposals, we will structure projects to address these priorities. We will incorporate Mental Health Care Access and Access to Care into bi-directional integration (project 2A), and emphasize care coordination (Pathways HUB) to improve the way Medicaid addresses social determinants of health such as education and affordable housing.

To achieve the NCACH vision and address regional priorities, it is critical to align the priorities of our clinical and community support systems in the region. A prime example of this is the current community partnerships occurring within three regional opioid workgroups. The NCACH will assist these workgroups to find common alignments under the Demonstration project that can enhance their work. As well, community organizations (i.e. housing specialist) will see an increase in the need for services under this new model. Moving forward, it will be important to identify how we will pay for those services through new payment delivery models.

Though a majority of work is completed at the local level, it is important that the NCACH influence extends to the State level. NCACH can act as a collective community voice to the Health Care Authority throughout the course of the Demonstration project and as new payment models are developed between providers (Medical and Community Service Organizations), Managed Care Organizations (MCOs), and the Health Care Authority. The NCACH can also act regionally to educate local and state elected officials and other State agencies on the health priorities specific to our region.

Lastly, sustainability of this work will not be achieved without the support our region receives from local organizations. A specific example is the in-kind support and contract support we have received from our region's Local Health Jurisdictions, support from community partners around website hosting and meeting set-up, and the clinical expertise we have received from our local Health Centers and Hospitals. Our regional partners constantly come forward to support the goals of Healthier Washington, and as we progress through the Demonstration project, NCACH needs to ensure our partners involved are able to establish a mutual benefit.

#### Attachment(s)

- A. Community Health Needs Assessment Summary
- B. Medicaid Demonstration Project Selection Community Input Results
- C. Press Release NCACH Project Selection

#### **Governance and Organizational Structure**

#### **Description**

The ACH is a balanced, community-based table where health care, social, educational, and community entities influence health outcomes and align priorities and actions. To support this, the ACH must clarify roles and responsibilities, adopt bylaws that describe where and how decisions will be made, and describe how the ACH will develop and/or leverage the necessary capacity to carry out this large body of work.

References: ACH Decision-Making Expectations, Medicaid Transformation STC 22 and STC 23, Midpoint Check-Ins for Accountable Communities of Health, DSRIP Planning Protocol

#### Instructions

Please ensure that your responses address all of the questions identified below. Total narrative word-count range is 800-1,500 words.

#### **ACH Structure**

- What governance structure is the ACH using (e.g., Board of Directors/Board of Trustees, Leadership Council, Steering Committee, workgroups, committees, etc.)?
- Describe the process for how the ACH organized its legal structure.

#### **Decision-making**

- What decisions require the oversight of the decision-making body? How are those decisions made? (E.g. simple majority, consensus, etc.)
- How and when was the decision-making body selected? Was this a transparent and inclusive process? Include decision-making body's term limits, nominating committees, and make-up, etc.
- If a board seat is vacant, how will the ACH fill the vacancy?
- How is decision-making informed? What are the documented roles and communication expectations between committees and workgroups to inform decision-making?
- What strategies are in place to provide transparency to the community?
- If the decision-making body makes a decision that is different from recommendations
  presented by committees and/or workgroups, how does the ACH communicate how and why
  that decision was made?
- Describe how flexibility and communication strategies are built into the ACH's decisionmaking process to accommodate nimble decision-making, course corrections, etc.
- Describe any defined scope, financial accountability or other limits placed on staff or the Executive Director regarding decision-making outside of board approval.

#### **Executive Director**

- Provide the below contact information for the ACH's Executive Director.
- How long has the Executive Director been in that position for the ACH? Provide anticipated start date if the Executive Director has been hired but has not yet started.

Name	Information provided on page 8
Phone Number	
E-mail	
Years/Months in Position	

#### **Data Capacity, Sharing Agreement and Point Person**

- What gaps has the ACH identified related to its capacity for data-driven decision making and formative adjustments? How will these gaps be addressed?
- Has the ACH signed a data sharing agreement (DSA) with the HCA?

#### Information provided on page 9

Data	Data Sharing Agreement with HCA?		
YES		NO	

Provide the below contact information for the ACH point person for data related topics.

Data Point Person	
Name	Information provided on page 9
Phone Number	
E-mail	

#### Narrative (1,465 words):

The NCACH Governance structure consists of two principal components, The Governing Board ("Board"), and the Coalitions for Health Improvement (CHIs).

The Board is the principal and ultimate decision-making authority for the NCACH. The North Central Accountable Community of Health (NCACH) is currently comprised of 17 board seats that are elected based on sector representation. Two Board members are currently non-voting members representing what was termed the Leadership Council (referenced below). At full representation, we have 47% of our membership representing providers and payers while 53% represents community based organizations, tribal authorities, governmental agencies, and consumers. The Board has an executive committee that is composed of a Chair, Vice-chair, Treasurer, and Secretary. As work arises, the Board will develop workgroups with defined charters that will provide the scope of work to be completed by the workgroups.

Included in the original charter and bylaws of the NCACH, there is a provision to develop a Leadership Council that would act as an advisory council to the Board. The leadership council has not been developed but does have two filled non-voting seats on our Board. Since the original bylaws were

developed the CHIs have become vibrant and active vehicles for community engagement and we believe it makes more sense to support and empower the CHIs than to create a separate Leadership Council, which would in many ways be redundant. As part of a NCACH Governance restructure, the Board voted at our May 1<sup>st</sup> meeting to forgo establishing the leadership council and develop a formalized structure that will allow the CHI's to provide direct feedback to the Board. This will remove the current 2 non-voting member seats of the leadership council and add a voting seat for each CHI. The Board also voted to increase the board membership from 17 to 20 members by adding a Consumer seat and one additional At-Large seat. At full representation, this will change our board makeup to have 35% representing providers and payers and 65% representing community and governmental agencies.

To become a legal entity, The Board voted to become a Washington State not-for Profit Entity and was officially incorporated on March 22<sup>nd</sup>, 2017. The NCACH currently has a resolution with the Chelan-Douglas Health District to provide administrative services. With incorporation, the resolution will be changed into a formalized contract. This is currently in process and a new contract will be established and submitted during Phase 2 Certification.

The NCACH's future plan is to maintain the administrative backbone structure with the Health District. In alignment with our Theory of Action and Alignment Strategy, the Board does not plan to build an organization that will need future funding to be sustainable, and therefore chooses to contract our administrative functions with the Health District.

The CHIs are the formalized structure on how the Board will provide bi-directional communication for community and consumer input. The NCACH has three Coalition of Health Improvement (CHI) groups that are located in each of the region's Local Health Jurisdictions (Chelan-Douglas, Grant, and Okanogan). Each CHI is intended to engage a wide variety of partners in the mission and work of the NCACH, and provide input to the Board on significant issues directly related to NCACH mission and activities. The interaction between the Board and the CHIs will be developed in a charter and/or policy, and each CHI will also have a voting representative on the Board.

The decision making process of the Board is outlined within the NCACH Bylaws. Unless otherwise specified in the Bylaws, decisions of the Board are made at a public meeting and require a >50% vote of approval from a quorum of board members. Decisions that require oversite from the Board include but are not limited to: the financial approval of large purchases, funding for staff positions, contracts with state and local entities, and other decisions that may affect the long term vision of the organization. The Board will delegate duties through both workgroups and the Executive Director. The Executive Director will be responsible for the management of the day-to-day operations including hiring and oversite of NCACH staff. The Workgroups will have defined charters that will outline responsibilities and reporting requirements to the Board.

Any documentation related to that decision is posted on the NCACH webpage (mydocvault.us) and shared at the Board meeting during the decision making process. The Board follows Roberts Rules of Orders and allows time for a discussion period to occur prior to a Board vote. Once the Board votes and approves the decision, it is documented in the meeting minutes and posted on the NCACH webpage.

The decision making body is selected to represent specific sectors. To fill current board vacancies, the representatives of the board seat sector, executive committee members, and members of the nominating committee work together to nominate a replacement member. Vacancies of the Board may be voted on and ratified at any regular or special board meeting by the remaining board

members. Currently, the Board is actively identifying and recruiting members to join its open board seats.

To inform decision making of our Board, the NCACH makes every effort to collect data and feedback from community partner engagement. The formalized process to communicate Board decisions is through the local CHI. NCACH will encourage interested parties to actively engage in their local CHI to ensure they can provide a voice in the work of the Demonstration. If the Board makes a decision that is different from recommendations presented by committees, CHI, and/or workgroups, the Board will provide rationale of the change to the group that made the initial recommendation. The Board is responsible to ensure decisions enhance the quality of care throughout the whole region and fall into alignment with the overall vision of the ACH. Final decisions of the Board may not always fall in alignment with the recommendation brought forth by the workgroup, CHI, or Committee. If members of a group have questions around the decision making process, they are able to attend governing board meetings and provide input, or directly address their concerns to the Board Members.

To ensure a nimble decision making process, the Board has established an executive committee that has been delegated powers and duties that can be made between Board meetings. The Board has also established mid-month board phone call (3<sup>rd</sup> Wednesday of the month) to allow board members to stay educated on the demonstration work. Currently, the Board will not vote on these calls and board members are able to provide a proxy representative to gather information if they are unable to attend. Any decisions of the executive committee or the Board made between meetings will be addressed and ratified by the whole board at the next scheduled board meeting.

In the instance that the board will have to amend a previous decision voted on at a meeting, the Board will review the new data available to justify the change and provide recommendations. Documentation on rationale for the change in direction will be clearly outlined in the Board minutes.

To maintain the fiduciary requirements of the Board members, the board has established the following limitations on spending without a board vote: Any non-budgeted expenditure in excess of \$5,000 dollars made by the executive director shall require prior approval by the board. The Executive committee shall not authorize a single occurrence of \$5,000 and an annual accumulation of \$10,000 without vote of the full board. Any additional clarification on the roles and responsibilities of Board Members, their committees/workgroups, and the Executive Director are outlined in the NC ACH Bylaws.

#### **Executive Director**

Senator Linda Parlette has been in the position since July 2016. Senator Parlette was also a member of the governing board representing the Elected Office position prior to accepting the position of Executive Director.

Name	Linda Parlette
Phone Number	509 – 886 - 6439
E-mail	Linda.parlette@cdhd.wa.gov
Years/Months in Position	10 Months

#### **Data Capacity, Sharing Agreement and Point Person**

NCACH does not currently have a contract in place with the HCA. Over the next few weeks, we will reach out to the HCA to determine and complete the needed contracts we need to establish.

Data Sharing Agreement with HCA?			
YES		NO	x

Data Point Person	
Name	John Schapman
Phone Number	509 – 886 -6435
E-mail john.schapman@cdhd.wa.gov	

As an organization, we have been focused on reviewing data from community partners around project selection and the RHNI. Moving forward, we will work with our Technical Assistance to identify data we need to collect and analyze to ensure we are able to meet project goals and progress our region towards value based payment. As we complete this analysis, we will address the current gap we have in data collection by either contracting with an agency or hire a data manager internally. We plan to have a better structure in place when we submit details for Phase 2 certification.

#### Attachment(s) Required

- A. Visual/chart of the governance structure.
- B. Copy of the ACHs By-laws and Articles of Incorporation.
- C. Other documents that reflect decision-making roles, including level of authority, and communication expectations for the Board, committees and workgroups. (i.e. Example Charter and CHI Contract)
- D. Decision-making flowchart.
- E. Roster of the ACH decision-making body and brief bios for the ACH's executive director, board chair, and executive committee members.
- F. Organizational chart that outlines current and anticipated staff roles to support the ACH.
- G. Conflict of Interest Policy
- H. Proposed update to Governing Board Roster (Approved at May 1st Governing Board Meeting)

#### **Tribal Engagement and Collaboration**

#### Description

ACHs are required to adopt either the State's Model ACH Tribal Collaboration and Communication policy or a policy agreed upon in writing by the ACH and every Indian Health Service, tribally operated, or urban Indian health program (ITU) in the ACH's region. In addition, ACH governing boards must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on their local ITUs and on the needs of both tribal and urban Indian populations.

Provide a narrative of how ITUs in the ACH region have been engaged to-date as an integral and essential partner in the work of improving population health. Describe and demonstrate how the ACH complies or will come into compliance with the Tribal Engagement expectations, including adoption of the Model ACH Tribal Collaboration and Communication Policy or other unanimously agreed-upon written policy.

References: Medicaid Transformation STC 24, Model ACH Tribal Engagement and Collaboration Policy, workshops with American Indian Health Commission

#### Instructions

Please ensure that your responses address all of the questions identified below. Total narrative word-count range is 700-1,300 words.

#### **Participation and Representation**

- Describe the process that the ACH used to fill the seat on the ACH governing board for the ITUs in the ACH region to designate a representative.
- Describe whether and how the ACH has reached out to regional ITUs to invite their participation in the ACH.
- Describe, with examples, any accomplishments the ACH has realized in collaborating and communicating with ITUs, including when in the planning and development process the ACH first included or attempted to include ITUs.
- Describe key lessons the ACH has learned in its attempts to engage with ITUs and the next steps the ACH will take to support meaningful ITU engagement and collaboration.

#### **Policy Adoption**

 Describe the process the ACH used to adopt the Model ACH Tribal Collaboration and Communication Policy. If the ACH has not yet adopted the Model ACH Tribal Collaboration and Communication Policy, what are the next steps, including anticipated dates, to implement the requirements?

#### **Board Training**

Describe how the ACH governing board will receive ongoing training on the Indian health care delivery system with a focus on their local ITUs and on the needs of both tribal and urban Indian populations.

#### Narrative (795 words):

The NCACH has prioritized outreach and engagement efforts to achieve full participation of our region's sovereign tribal nations and communities, and will continue to do so throughout the Demonstration. Even prior to the adoption of the Model Tribal Communication and Engagement Policy, our region has consistently followed the principles and processes outlined in the policy.

The first step in the process of tribal engagement has been to reach out to leaders of the sovereign tribal nations and communities to fill the voting Tribal Representative Seat on the Governing Board. The Board does not nominate the tribal seat themselves, but recognizes sovereign tribes' right to determine their own representation. Throughout the past 2 years, Board members have made it a priority to reach out to sovereign tribal nations and communities to inform tribal leaders of their right to appoint a person to this seat and engage them in the NCACH. The NCACH learned through this process the additional steps needed to build relationships and authentic engagement with tribal leaders. The current accomplishments to reach out to sovereign tribal nations and communities has been realized by using the personal relationship held between our Executive Director (Linda Parlette) and Tribal leaders.

Our Executive Director reached out to the Colville Tribal Council Vice Chair (Mel Tonasket) to request an in person meeting in Omak, WA (March 24th). At that meeting, our Executive Director asked Vice Chair Tonasket for his recommendation for tribal member Board participation. On his recommendation, our Executive Director reached out to the Colville Health and Human Services Director to continue the discussion. The Director (Alison Ball) recommended that the Deputy Director (Carmella Alexis) join us for a Board meeting to learn more about the NCACH and determine if she would like to serve on the Board. Our Executive Director invited Deputy Director Alexis to the May 1st Governing Board meeting to listen in by phone. She was unfortunately unable to attend. To ensure that we grow this partnership, our Executive Director again contacted Director Ball and Deputy Director Alexis on May 3<sup>rd</sup> to schedule a meeting at their offices and discuss how they envision future tribal engagement with the NCACH. Our Executive Director continues to maintain contact with Vice Chair Tonasket, and on May 3 sent him a status update of her outreach to Director Ball and Deputy Director Alexis. On May 4<sup>th</sup>, our Executive Director met with Vice Chair Tonasket in person. We will continue seek his guidance and assistance in achieving full ACH participation by our sovereign tribal nations and communities.

Knowing that this continues to be a challenge for ACH's across the state, NCACH will prioritize working with the HCA, with Manett for TA support, and/or the American Indian Health Commission to enhance engagement with our sovereign tribal nations and communities. Our Executive Director has initiated this process by contacting Jessie Dean (HCA) on May 3<sup>rd</sup> to request his assistance in outreach to the sovereign tribal nations and communities in our region. NCACH will request best practices from our TA support to help us move forward in an effective and appropriate way. If we are unable secure a dedicated tribal representative at this time, NCACH's board will continue to maintain an open board seat for tribal representation. We will also continue to pursue tribal engagement outside of the board. If a sovereign tribal nation and community approaches the NCACH to collaborate on one project, we will honor our policy of collaboration and engage them in the development and implementation of that project.

The NCACH recently adopted the State's Model ACH Tribal Collaboration and Communication Policy at the May 1<sup>st</sup> meeting. NCACH board members reviewed the policy at the April Governing Board retreat and decided that it would provide the best level of engagement with our sovereign tribal nations and communities to adopt the statewide policy instead of developing a region specific policy. As part of this process, the NCACH will initiate discussion with leaders of the sovereign tribal nations on the establishment of a committee of ACH and Tribal/HIS/UIHP designees. If the sovereign tribal nations and communities are not interested in establishing a committee at this time, the NCACH governing Board commits to regularly evaluate how the NCACH decisions will impact of AI/ANs, tribes, HIS, or UIHPs and provide information to those entities of specific decisions.

To ensure ongoing training on the Indian Health Care Delivery System, The Governing Board will work with our Tribal Board Member, our sovereign Tribal nations and communities (i.e. Colville Tribe), and/or the American Indian Health Commission to ensure we schedule and complete routine training to Board Members. Once we have developed a relationship with these groups, we will determine the best time to schedule an initial board education and then continue with ongoing training throughout the demonstration.

#### Attachment(s):

- A. Demonstration of adoption of Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes, correspondence or other written documentation.
- B. Colville Tribe Communication log

#### **Attachment(s) Recommended:**

A. Statements of support for ACH certification from every ITU in the ACH region.

#### **Community and Stakeholder Engagement**

#### Description

ACHs are regional and align directly with the Medicaid purchasing boundaries. This intentional approach recognizes that health is local and involves aspects of life and community beyond health care services. The input of community members, including Medicaid beneficiaries, is essential to ensure that ACHs consider the perspectives of those who are the ultimate recipients of services and health improvement efforts.

Provide a narrative that outlines how the ACH will be responsive and accountable to the community.

References: Medicaid Transformation STC 22 and 23, Midpoint Check-Ins for Accountable Communities of Health, NoHLA's

"Washington State's Accountable Communities of Health: Promising Practices for Consumer Engagement in the New Regional Health Collaboratives," DSRIP Planning Protocol

#### Instructions

Please ensure that your responses address all of the questions identified below. Total narrative word-count range is 800-1,500 words.

#### **Meaningful Community Engagement**

- Describe the ACH vision for fostering an authentic relationship with the community members, including Medicaid beneficiaries.
- What barriers/challenges has the ACH experienced or anticipate experiencing toward meaningful community and Medicaid beneficiary engagement?
- What opportunities are available for bi-directional communication, so that the community and stakeholders can give input into planning and decisions?
- How is that input then incorporated into decision making and reflected back to the community?

#### **Partnering Provider Engagement**

- What strategies does the ACH employ, or plan to employ, to provide opportunities for engagement beyond the decision-making body to ensure that community partners are addressing local health needs and priorities?
- What barriers/challenges has the ACH experienced or anticipate experiencing toward meaningful engagement of a broad spectrum of partnering providers?
   What opportunities are available for bi-directional communication to ensure that partnering providers can give input into planning and decisions?

#### **Transparency and Communications**

- Describe how the ACH does or will fulfill the requirement for open and transparent decisionmaking body meetings. Please include how transparency will be handled if a decision is needed between public meetings.
- What communication tools does the ACH use? Describe the intended audience for any communication tools.

#### Narrative (1,472 words):

Community members and partnering providers have four main venues to directly engage in the work of the NCACH. These are through direct voting representation on the Governing Board, participation in workgroups, engagement in local Coalitions for Health Improvement (CHIs), and attending open Governing Board meetings.

Each member of the Governing Board represents a specific sector of the community. That member is elected by both sector representatives and members of the Board Executive Committee. Each Board member is expected to report back the current work and decisions of the NCACH to their assigned sector to ensure we continue to update the larger community.

Workgroups are developed under the direction of the NCACH Board to complete tasks and provide recommendations on specific projects related to the Demonstration. Though these are workgroups of the Board, every effort is made to ensure community partners that provide meaningful input to the workgroup deliverables are represented. A current example of this work is the NCACH Whole Person Care Collaborative. This is a workgroup of physical health, behavioral health, MCO, and community based partners who are providing input on how partnering providers can adapt their clinical processes to deliver whole person care.

The Coalitions for Health Improvement (CHIs) located within each Local Health Jurisdiction are composed of a broad-base of local stakeholders. The CHIs are intended to engage a wide variety of partners in the mission and work of the NCACH. Each Coalition will provide input to the Governing Board on significant issues directly related and material to NCACH's mission and activities, including needs assessment and local health data; community health improvement plans and priorities; health improvement initiatives; and delivery system transformation. To ensure this group has a strong voice, each Coalition has one voting seat on the Board.

The Board will gather input and recommendations from both workgroups and CHIs. That input will be summarized for the NCACH Governing Board and will be incorporated into the decision making process of the Board. Once a decision is made a report will be provided back to the group with additional details/rational on why the decision was made (including supporting data if applicable). Lastly, Governing Board meetings are open to the public to encourage community partners to stay engaged and informed on the work of the NCACH. All meeting materials are on our public webpage and a meeting reminder is sent via email to our partner list one week prior with the meeting with callin details and meeting agenda. This is beneficial to those individuals who need to understand the bigger direction of the ACH, but are still determining how their organization aligns directly with our work

This format has proven very effective in engaging partnering providers, both healthcare and community partners. We have an average Governing Board attendance of 25 individuals, excluding board members. We have also utilized this mechanism for bi-directional engagement into the selection of our Medicaid Demonstration Projects. NCACH staff and Board members provided six public presentations (2 in each Local Health Jurisdiction), and one presentation to the North Central Hospital Council on the Demonstration project. Members of the community were able to provide input on project selection by completing paper surveys or online surveys (Survey Monkey) that were distributed to all partners on our distribution list. NCACH compiled survey results and shared the

overall results with both the Board members and with community partners. As our board finalizes project selection, our NCACH will utilize our distribution list and local newspapers to send press releases to the community to notify our partners about the Demonstration Projects selected by the NCACH.

As we move forward into the demonstration project, we must recognize we are at risk of losing this engagement. This is because time, resources, and money are limited in all our rural organizations. Specific to community based organizations, we must find them an active role in the demonstration that will help them align the services they provide with the new delivery systems and payment models of Medicaid beneficiaries. In relation to medical providers, we need to ensure we align our work with current workflows occurring in their organizations. With so many competing quality improvement initiatives occurring in the medical sector, provider organizations do not have the resources available to them to manage one more competing change process.

Though we know that this model provides ample ability to engage partnering providers, the barriers for Medicaid beneficiaries have been different and the NCACH will enhance our engagement strategies to ensure we receive meaningful engagement from consumers.

As we move toward Fully Integrated Medicaid Contracting and development of Demonstration proposals, our NCACH recognizes the urgency to proactively reach out to Medicaid consumers. This will formally be done through a variety of venues. First, the Board has approved adding a voting consumer representative on the Board. The NCACH will formalize our relationships with the CHIs to include an emphasis in consumer involvement. Finally, NCACH staff will develop a communication and engagement plan that includes a focus on Medicaid beneficiaries. As part of this plan, NCACH recognizes that we must consider limiting factors to participation such as meeting times, locations, childcare, and other factors that may influence an individual's ability to participate. We plan to work with our Manatt technical assistances team and local experts to utilize evidence —based approaches that will help us connect and engage with Medicaid Beneficiaries. This plan will also include a strategy to include bi-directional feedback to Medicaid consumers. Assigned workgroups and/or NCACH Staff members will share consumer input at Board meetings. After Board decisions are made, the NCACH will make a concerted effort to report back those decisions to the participating entities/individuals who provided input through both the CHI, board announcements, and local outreach.

One area that will ensure continued engagement of both community and partnering providers is to continually strive to be transparent as an organization. To ensure transparency, the NCACH holds open Governing Board meetings and posts all documents online (<a href="www.mydocvault.us">www.mydocvault.us</a>). Any decision that is made in between meetings will be in alignment of the NCACH Bylaws and will be ratified by a full vote of the Board at the next Board Meeting.

NCACH recognizes that transparency is only good if someone has the ability to access the information. This is why we have a current focus to share information through website updates, email communication, presentations to local organizations, and local newspaper articles. The current NCACH website provides a location where all community partners can access meeting materials and view a calendar of all NCACH meetings, however it is lacking in usability. Over the next 2 months, NCACH has contracted with a web design vendor (Firefly) to create a new website (New domain: www.ncach.org) that has an enhanced layout, is more user friendly, and that will be utilized as a marketing tool for the organization.

NCACH's main form of direct communication is through our partner distribution list (email). This is where we directly notify community partners of upcoming meetings, important documents, and any board decisions that should be shared with the greater community. NCACH staff routinely updates this list (494 participants: 44% of which are from the healthcare sector and 56% from other community sectors) to ensure we have correct information and include all community members who want to be involved in this work. Any interested community member is able to email a NCACH staff member to have their name added to the distribution list to receive updates (List is not provided in certification as an attachment to maintain privacy of partner member's individual emails).

To promote public events and to share the work of the Demonstration, NCACH continues to communicate with our local newspaper reporters. Two prime examples of this is when HCA went on their statewide tour to share the work of the Whole Demonstration, and recently when both our Governing Board Chair and Executive Director interviewed with a reporter to discuss the work being done locally with the demonstration.

Lastly, to ensure we reach the community, NCACH's Executive Director and Board Chair have been going to community groups directly (i.e. Rotary Clubs, Coalition for Children and Family, and North Central Hospital Council), to share NCACH's story and the work of the Demonstration. As we connect with these local community leaders, we will encourage them to become actively engaged in the work of the NCACH, and provide them with the contact information they need to provide meaningful input into the work of the demonstration.

Overall NCACH recognizes the current successes and barriers we have had around meaningful engagement and will develop a more comprehensive communication plan by Phase 2 Certification. NCACH recognizes that in order for this this work to be successful we will need significant involvement of the whole community and will continue to make it a priority to reach out to representatives of all community members affected by this work.

#### Attachment(s) Required:

- A. Document with links to webpages where the public can access meeting schedules and other engagement opportunities, meeting materials, and contact information.
- B. New Website Quote and Report
- C. NCACH Wenatchee World Newspaper Articles

#### **Budget and Funds Flow**

#### Description

ACHs will oversee decisions on the disbursement of Demonstration incentive funds to partnering providers within the region. This requires a transparent and thoughtful budgeting process. Demonstration funds will be earned based on the objectives and outcomes that the state and CMS have agreed upon. Demonstration funds and funds from other federal sources (e.g., State Innovation Model sub-awards) should be aligned but ACHs cannot duplicate or supplant funding streams.

Provide a description of how Project Design funding will support Project Plan development.

References: Medicaid Transformation STC 31 and STC 35, DSRIP Planning Protocol

#### *Instructions*

Please ensure that your responses address all of the questions identified below. Total narrative word-count range is 800-1,500 words.

#### **Project Design Funds**

 Describe how the ACH plans to use the Project Design funds to support Project Plan development and other capacities or infrastructure.

#### **Fiscal Integrity**

- Provide a description of budget and accounting support, including any related committees or workgroups.
- Define the levels of expenditure authority held by the Executive Director, specific committees (e.g., Executive Committee), and the decision-making body.
- Provide a description of the tracking mechanisms to account for various funding streams (e.g., SIM and Demonstration).
- Describe how capacities for data, clinical, financial, community and program management, and strategic development (specified in STC 22) will be met through staffing, vendors or inkind support from board/community members.

#### Narrative(1,090 words):

The NCACH strategy related to the expenditure of funds is to minimize direct administrative expenses and ensure we allocate a portion of the funding we receive to support the capacity needs of our community partners. With that theory, we plan to utilize up to 65% of our design funds (7% of overall Demonstration funds) to support the direct cost of the organization while utilizing the remaining funds to support our community partners in the development of project planning and implementation.

For financial support, the NCACH will continue to contract with the Chelan Douglas Health District (CDHD) to be the backbone organization. The CDHD has received annual state audits that include federal fund audits. For several years, the CDHD has had zero findings and recommendations from those audits. The CDHD has qualified accounting staff and allocated budget codes within their finance department to ensure all funding is coded appropriately for both Demonstration and State Innovation

Model (SIM) dollars. All expenditures that are not staff related are done through an invoice process utilizing purchase orders (PO) to track payments and code dollars to the correct account. Staff timesheets are tracked through Microsoft Access and each hour is coded to the department and funding source (i.e. SIM) that the staff worked. Currently NCACH tracks expenses under SIM funding, but as demonstration dollars become available, coding will be created to designate funding and expenditures to Demonstration related projects.

To ensure the board meets it fiduciary responsibility, the overall budget is approved by the NCACH Governing Board annually and as needed to approve non-budgeted expenses. Budget updates are provided by the CDHD on a quarterly basis to both the Executive Director and the Board Treasurer. The Treasurer reviews the organization's financials and provides an update to board members at the next available Governing Board meeting.

The NCACH Bylaws outlines the financial requirements of the Executive Director and the Governing Board. The Executive Director is required to receive prior approval by the board of any non-budgeted expenditure in excess of \$5,000. The Executive Committee cannot incur any single monetary obligation in excess of \$5,000 or cumulatively up to \$10,000 annual, or bind the NCACH to an obligation exceeding 1 year, whether budgeted or not. Any non-budgeted expenditure decisions made by either the Executive Director and/or Executive Committee will be shared and ratified by the whole Board at the following Board meeting.

Design funds will be utilized to develop project proposals and build NCACH capacity. To support the initial development of project planning, NCACH will hire a Program Development Specialist position to act as the lead author for project proposals. In collaboration with community partners and other NCACH Staff, the Program Development Specialist will compile the supporting documents and contracts for each project plan and ensure timely submission of all proposals. After project proposals are submitted, this individual or another designated NCACH staff member will act as the main contact between partnering organizations, the Health Care Authority, and the NCACH to coordinate the collection of data, submission of progress reports, and measurement of our progress towards project outcomes.

To build community engagement capacity, we will fund both direct NCACH staff time for community outreach and contract with a Local Health Department/District to support the Coalitions for Health Improvement (CHI). NCACH staff will ensure direct community engagement occurs by providing ongoing support to the NCACH webpage, ensuring community and consumer input is gathered through local outreach to Medicaid beneficiaries, and assisting in developing and scheduling presentations for community partner groups.

Financial support for the NCACH Coalitions for Health Improvements (CHIs) is established by contracts between the Local Health Jurisdictions (LHJ) and the NCACH. Each LHJ will receive a deliverable based contract that will provide funding to support staffing, room rental, and other administrative expense needed to organize and convene the CHI in each LHJ. Chelan-Douglas does the work of the CHI through its current contract as an administrative backbone organization and therefore a separate contract is not in place. If the local LHJ is unable to support the deliverables outlined in the contract, the Board will be able to select an alternate organization within that LHJ that can fulfill the contract requirements. The NCACH will also provide direct support and oversite to each CHI to ensure contract deliverables are met and address issues that arise throughout the course of the contract.

Furthermore, in-kind support will be provided by having Board members take an active role in their local CHI.

The NCACH is reviewing the option to develop a similar model with the local tribal organizations. This model could provide funding for the tribe to support a position that would be the liaison between NCACH and the local tribal nations.

Clinical capacity will be supported through the Whole Person Care Collaborative. The NCACH is establishing a Director of Whole Person Care who will guide our partnering providers through the process of change management. This part of the demonstration work will be very time intensive and additional staff will be provided to support the director in this work as needed. To encourage providers to get involved and assist them in building capacity to make changes in their own organization, a portion of design funds will be utilized for provider engagement in the work of the collaborative.

The NCACH does not currently have a specific plan to address data management. As we select demonstration projects and evaluate the data requirements of the Health Care Authority, we will determine if this function is best suited by contracting with another entity or developing the needed infrastructure and staff support to house this expertise within our organization.

Finally, Program Management and Strategic development will be provided by the Executive Director and the Governing Board. The Board is responsible for the overall alignment and direction of the NCACH. As need arises, the Governing Board will create a standing committee to review the strategic needs of the organization and provide recommendations back to the whole Board. The Executive Director will ensure that the daily operations of the organization continues to align with the direction approved by the Board.

Lastly, a portion of design funding will be reserved to support and/or incent our partner agencies to participate in the work of the Demonstration. This includes both traditional medical providers and Community Based Organizations. This funding will be spread out throughout the course of the demonstration project and the exact funding mechanics related to this work will be determined in greater detail after we have made our project selections and prepare to submit documentation for Phase 2 certification.

#### Attachment(s) Required:

- A. High-level budget plan (e.g., chart or excel document) for Project Design funds to accompany narrative required above.
- B. Resume, Chelan-Douglas Health District Accounting Lead Kandis Boersema

#### **Clinical Capacity and Engagement**

#### **Description**

The demonstration is based on a Delivery System Reform Incentive Payment (DSRIP) program. As such, there needs to be engagement and input from clinical providers, including but not limited to MDs, RNs, ARNPs, CHWs, SUD providers, and mental health providers such as therapists and counselors.

References: Medicaid Transformation STC 36, DSRIP Planning Protocol

#### <u>Instructions</u>

Please ensure that your responses address all of the questions identified below. Total narrative word-count range is 500-1,000 words.

#### **Provider Engagement**

- Provide a summary of current work or plans the ACH is developing to engage clinical providers. Include a summary of input the ACH has already received from clinical providers or subject matter experts regarding the mechanisms and strategies to engage providers.
- Describe how the ACH is approaching provider engagement, as well as identification of provider champions within the ACH. Include any targeted committees, panels or workgroups.

#### **Partnerships**

• Demonstrate how the ACH is partnering with local and state clinical provider organizations (e.g., local medical societies, statewide associations, and prospective partnering providers).

#### Narrative (916 words):

Since the start of Healthier Washington, NCACH has known that value based purchasing and Fully Integrated Medicaid Contracting were two key projects that would occur in Washington State. With that knowledge, NCACH made it a priority to engage clinical providers in a forum to discuss how we will provide "Whole Person Care (WPC)" for the Medicaid patients in our region. This has led to the strong partnership NCACH has with providers through the collaborative, connections with local and state organizations, and active participation on our Governing Board. Currently, NCACH has consistent communications with the Federally Qualified Health Centers, Hospitals, and Behavioral Health Providers in the region.

The main vehicle to achieve this vision has been through the establishment of the NCACH Whole Person Care (WPC) Collaborative. To set the framework for this group of primary care, behavioral health, and hospital providers, the WPC Collaborative first developed the Whole Person Care Vision Statement document. This document outlines the tools needed for providers to deliver whole person care and a picture of what it will look like once operational.

To engage more providers in the vision of Whole Person Care, the WPC Collaborative held the Whole Person Care Workshop in January 2017. This workshop brought together 100+ individuals from the region to learn about NC ACH's vision of Whole Person Care and the components involved in implementing the vision. Through that process, the WPC Collaborative gathered feedback from participants on both the vision statement and the different components of Whole Person Care (i.e. Advanced Primary Care and Care Coordination) that the Collaborative used to help define its next steps. This input was later shared with workshop participants with additional details on how they can better engage in the NCACH.

The WPC Collaborative is now in the process of developing a functional work plan that will give more concrete steps to achieve our vision. Two main goals of this work plan are to engage provider organizations to develop a change process for their specific clinic, and to establish the WPC Collaborative as a "Learning Collaborative" with a formalized membership process. This process is still in draft version, but will be the foundation on how we engage our clinical providers through the demonstration project. To accelerate our ability to accomplish the objectives of the Collaborative, the Board approved hiring a Director of Whole Person Care (0.5 FTE). This individual will work with

local providers and state resources to ensure providers receive the technical assistance and funding needed to develop the changes needed to deliver new models of care in their organization.

A key first step in this work is the completion of practice assessments for all primary care and behavioral health providers. NCACH is working directly with Qualis Health, in partnership with the Pediatric – Transforming Clinical Practice (P-TCPI) Initiative and the National Rural Accountable Care Consortium (NRACC) to coordinate transformation efforts into one regional evaluation. These assessments will provide NCACH with an understanding of our current region's state in achieving Whole Person Care, and provide each individual provider with a comprehensive report on the steps needed to enhance care at the clinic level. This spring, NCACH Leadership and Qualis Health reached out directly to every major provider in the region to encourage them in both the assessments and the collaborative.

Outside of the collaborative, the NCACH continues to reach out to our local provider organizations. In April, our Executive Director met with the North Central Hospital Council to gather input on the projects we will select through the Demonstration. In the future, our Executive Director will continue to attend these meetings to ensure alignment in the work of both groups through the demonstration. Our ACH has also maintained a strong partnership with our North Central Behavioral Health Organization (NCBHO) and its workgroups. This has been an integral forum in which we have engaged our region's Behavioral and Substance Use Disorder providers in the work currently being completed to prepare for Fully Integrated Medicaid Contracting.

Finally, even small organizations in rural communities can get lost in this work. We have engaged with the Quality Improvement Focus Group (Leavenworth, WA) and the Methow Valley HealthCare Network (Twisp, WA) to stay connected with the work of our rural providers and ensure they have input on the NCACH work.

On a statewide level, NCACH continues work with state associations and workgroups to connect with regional providers and find areas of collaboration on local projects. Specifically in North Central, both the Washington State Hospital Association and NCACH are interested in the ability of our Critical Access Hospitals to survive under value based payment. This partnership has lead NCACH to review the Washington Rural Health Access Preservation Project (WRHAP) to determine if it can be incorporated into the work of the Demonstration. NCACH has connected with Washington State Medical Association to determine how we can enhance our partnership, and hope to have a stronger collaboration with this association in the future. Finally, NCACH recognizes the need to define how we engage in statewide collaborative such as the Bree Collaborative and the Clinical Accelerator committee. Both workgroups bring a number of these partners to the table, and will be good resources to maintain connections and foster new ones in the future.

Even with strong collaboration, we realize the demonstration will not be successful without a robust engagement of direct service line providers. With that in mind, we will continue to reach out to those providers through local networks, committees, and through direct contact with our provider organizations.

#### Attachment(s) Required:

- A. Bios or resumes for identified clinical subject matter experts or provider champions
- B. Whole Person Care Vision Statement and Overview [Draft]
- C. Discussion Draft #2: Functions of the Whole Person Care Collaborative
- D. Whole Person Care Workshop January 2017

#### **Attachments Checklist**

Application Section	Required Attachments	Recommended Attachments
Theory of Action & Alignment Strategy	None	None
Governance & Organizational Structure	<ul> <li>A. Visual/chart of the governance structure</li> <li>B. Copy of the ACH's By-laws and Articles of Incorporation</li> <li>C. Other documents that reflect decision-making roles, including level of authority, and communication expectations for the Board, committees, and workgroups</li> <li>D. Decision-making flowchart</li> <li>E. Roster of the ACH decision-making body and brief bios for the ACH's executive director, board chair, and executive committee members</li> <li>F. Organizational chart that outlines current and anticipated staff roles to support the ACH</li> </ul>	None
Tribal Engagement Expectations	A. Demonstration of adoption of Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes, correspondence, or other written documentation	B. Statements of support for ACH certification from every ITU in the ACH region
Community & Stakeholder Engagement	A. Document with links to webpages where the public can access meeting schedules and other engagement opportunities, meeting materials, and contact information	None
Budget & Funds Flow	A. High-level budget plan (e.g. chart or excel document) for Project Design funds to accompany narrative required above.	None
Clinical Capacity & Engagement	A. Bios or resumes for identified clinical subject matter experts or provider champions	None

#### Addendum To:

North Central Accountable Community of Health - Certification Submission Template
Submitted: May 15<sup>th</sup>, 2017

This addendum is effective immediately and is submitted in response to additional information received late last week from HCA about requirements related to upcoming HCA contracts.

The Following Paragraph should be included under the Budget and Funds Flow Section of the North Central Accountable Community of Health – Certification Submission Template to better define the flow of funds between The Health Care Authority (HCA), the North Central Accountable Community of Health (NCACH), and the Chelan-Douglas Health District (CDHD).

• North Central ACH will receive state and federal funds in an account to be established at a local bank or credit union. This account will be established by June 15, 2017. The NCACH Executive Director will have signature authority for those funds, and day-to-day oversight of those funds will be vested in the ACH's Program Manager (currently John Schapman); this position is already responsible for day-to-day oversight of ACH Operations. The NCACH Board will review account statements on a monthly basis. NCACH currently contracts with Chelan-Douglas Health District for backbone functions and will continue to do so. Funds will be transferred from the NCACH account to CDHD per terms and conditions of the contract for backbone services. CDHD is a public organization subject to all laws and conditions of local government in the state of Washington, including annual public auditing and public records. CDHD provides capacity, transparency, and community accountability for public dollars and services. Consistent with the HCA's direction for a backbone organization, our arrangement with CDHD prevents redundant overhead and leverages public sector community capacity.

## 2016 Chelan-Douglas Health District Community Health Needs Assessment

### Purpose:

A Community health needs assessments (CHNA) identifies key health needs and issues through systematic, comprehensive data collection and analysis. The 2016 CHNA was regional in scope, encompassing Chelan, Douglas, Grant, and Okanogan counties, and benefitted from participation of representatives from 39 community partners.

A current CHNA is a requirement of Public Health Accreditation, should Chelan-Douglas Health District choose to pursue accreditation, we will be well positioned.

### Process:

County Meetings SWOT Community Voice Survey

Health Indicators Community Assessments

16 potential needs were identified:

Transportation Education

Access to healthy food

Homelessness

Affordable housing

Drug/Alcohol abuse

Accidents/Homicide Suicide Access to mental health care

Access to care

Pre-conceptual and perinatal health

Obesity

Diabetes

Cancer

Lung Disease

Sexually transmitted infections

Regional Report-out and Consensus Workshop October 6<sup>th</sup>, Wenatchee

Participants voted on the 16 potential needs by the following criteria:

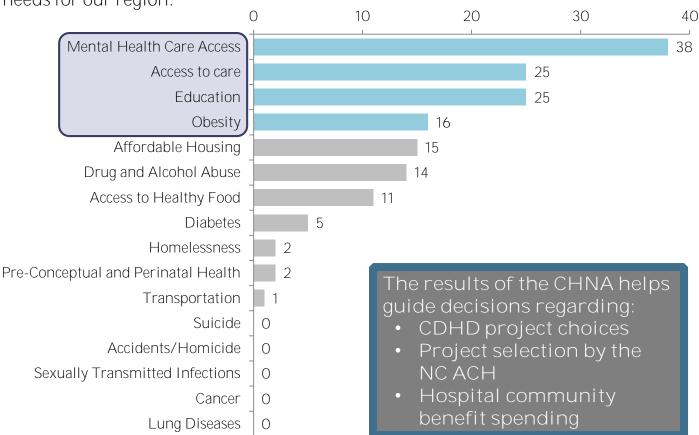
Impact of the health need in our region

Doability: how feasible is addressing this need?

Personal Preference: which is the need you would most like to see as a priority focus area?



Results: The CHNA process ultimately resulted in the identification of four health needs for our region:



## Participants:

- · Aging & Adult Care of Central Washington
- Amerigroup
- Big Bend Community College
- Cascade Medical Center
- Chelan County Regional Justice Center
- Chelan Douglas Community Action
- Chelan Douglas Health District
- City of Wenatchee
- Columbia Basin Hospital
- Columbia Valley Community Health Center
- Community Choice
- Community Health Plan of Washington
- · Coordinated Care Health
- Confluence Health
- Family Health Centers
- Grant County Health District
- Housing Authority of Chelan County and the City of Wenatchee
- Housing Authority of Grant County
- Initiative for Rural Innovation and Stewardship (IRIS)

- Lake Chelan Community Hospital
- Mid Valley Hospital
- Molina Healthcare of Washington
- Moses Lake Community Health Center
- National Alliance on Mental Illness (NAMI)
- North Central Educational Service District
- North Central Emergency Care Services
- North Valley Hospital
- Okanogan Behavioral Health Care
- Okanogan VA
- Room Öne
- Samaritan Healthcare
- Serve Moses Lake
- The Center for Alcohol & Drug Treatment
- Three Rivers Hospital
- Together! For Youth
- United Healthcare
- Wenatchee Valley College
- Wenatchee Valley Lutheran Latino Ministry
- Wenatchee World

### **Medicaid Demonstration Project Selection Feedback Summary**

#### **Project Selection Outreach:**

To gather continual survey results an online Survey Monkey was created with a recorded webinar presentation to gather feedback from all community partners. This survey was sent out to the 494 members on our partner list. We also encourage local partners to send the survey link to members of their partner lists that may not be part of the NC ACH.

In-Person presentations were made available to individuals in the 3 Coalition for Health Improvements and the North Central Hospital Council meeting. Each area had a total of 2 presentations in person where people could attend. A paper survey as well as a link to the survey monkey was provided for people interested in filling out the feedback form. Presentations were as follows:

March 6 <sup>th</sup>	Wenatchee, WA (Chelan-Douglas CHI)
March 8 <sup>th</sup>	Twisp, WA
March 21st	Brewster, WA (North Central Hospital Council)
March 23 <sup>rd</sup>	Moses Lake, WA (Grant CHI)
March 24 <sup>th</sup>	Omak, WA (Okanogan CHI)
April 10 <sup>th</sup>	Moses Lake, WA (Grant CHI)
April 13 <sup>th</sup>	Wenatchee, WA (Chelan-Douglas CHI, also available by webinar)

#### **Feedback Received**

The following items were received and available on the following pages.

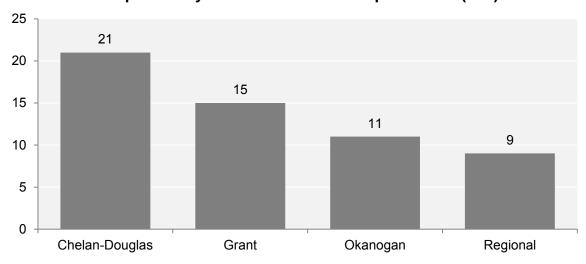
- Medicaid Demonstration Project Survey Summary (n=60)
- North Central Hospital Council endorsement of projects
- Grant County CHI roundtable report out
- Methow Valley Health Care Network response letter

## **Medicaid Demonstration Project Survey Summary**

#### **Number of Surveyed Individuals: 60**

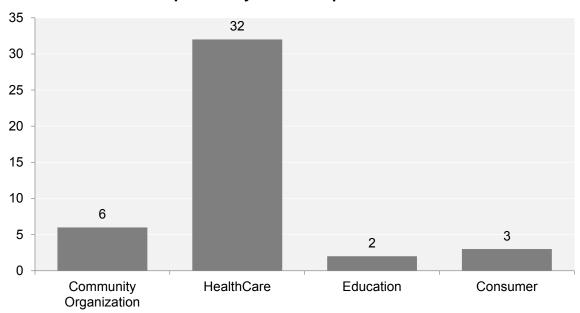
56 respondents (93%) identified what Coalition for Health Improvement they represented. Of responses: 38% where Chelan-Douglas, 27% where Grant, 20% were Okanogan, and 15% identified as regional partners.

### Responses by Coaltion for Health Improvement (CHI)



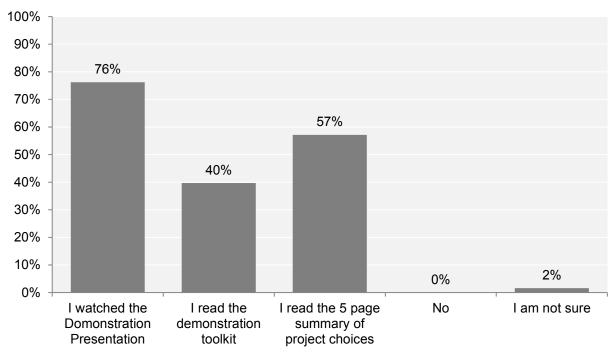
43 respondents (72%) identified what sector they represented. Of responses: 74% where Healthcare, and 26% identified as a representative outside of the Healthcare sector.

#### **Responses by Sector Representation**

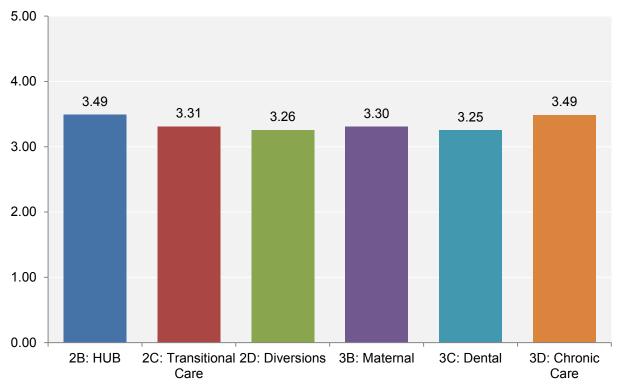


The table below demonstrations the level of basic knowledge respondents had about the Medicaid Demonstration project prior to competing the survey.

# Have you watched the demonstration presentation or read the demonstration toolkit or 5 page summary of project choices? (n=60)



## **Overall Project Score**



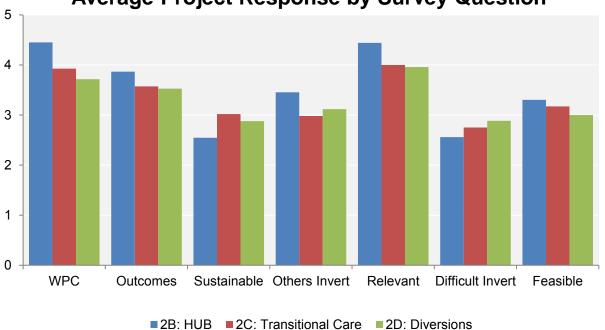
Overall project score is the average of the responses to all seven questions.

## The below table is a key to correlate results for the Domain 2 and Domain 3 graphs on page #4 to the survey questions:

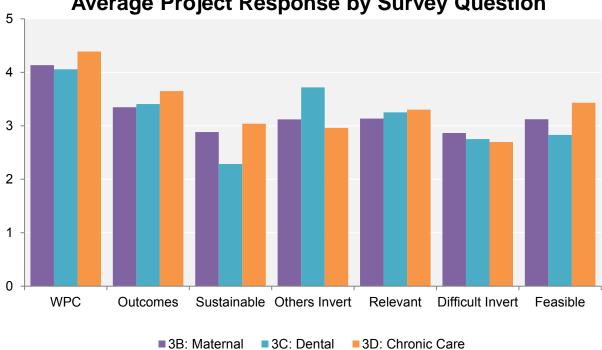
Graph Key	Survey Questions:
WPC	1. How critical is this project to the establishment of Whole Person Care in the
	region?
Outcomes	2. How likely is it that we will be able to improve outcomes in 4 years of
	implementation?
Sustainable	3. Would changes be sustainable after Demonstration dollars are gone?
Others Invert*	4. Is this project addressed in part by other projects, making a separate project of
	this kind less necessary?
Relevant	5. Is this relevant and needed in all 4 counties?
Difficult Invert*	6. How difficult would it be to implement this project on a region-wide basis? (The
	whole region will be judged and funded on the basis of each project's region-wide
	success. So a project effective only in a limited area could affect funding negatively
	for the whole region.)
Feasible	7. How feasible is it to successfully address this problem with the relatively limited
	funds available through the Demo?

<sup>\*</sup>Response scores were inverted to maintain consistency of 1 to 5 rating score (i.e. 1 least desirable, 5 most desirable)

Domain 2
Average Project Response by Survey Question



Domain 3
Average Project Response by Survey Question



#### **Survey Comment Results Summary:**

30% of Survey responses included comments. Main themes of each project are summarized below. Full comments are attached in separate PDF document.

#### Project 2B: Pathways HUB (n = 29)

- Ability to implement HUB, measure, and meet outcomes required by state in 4 years
- Need to be a dynamic partner in the community and not just a referral source
- Ability to sustain the HUB model after the Demonstration
- Comments are generally positive

#### Project 2C: Transitional Care (n = 19)

- It could be addressed through programs such as care coordination (i.e. Project 2B Pathways HUB)
- Hard to address due to rural nature of counties
- Already being addressed through current programs

#### <u>Project 2D: Diversion Intervention (n = 18)</u>

- Could be addressed by other toolkit projects (i.e. Project 2B Pathways HUB)
- It would be a high cost project to implement
- Current financial incentives do not align with project
- Not generally positive about project

#### Project 3B: Reproductive and Maternal/Child Health (n = 16)

- Focusing on childhood interventions has the biggest impact on health
- Long term ROI hard to demonstrate in 4 years
- It would be very expensive to implement
- Could be addressed by other projects in the Toolkit (i.e. Project 2B Pathways HUB)

#### Project 3C: Access to Oral Health Services (n = 19)

- Do not have the local dentist willing to accept Medicaid patients
- A lot of agreement this is a big need and very important, but unlikely to achieve.

#### Project 3D: Chronic Disease Prevention and Control (n = 19)

- Needs coordination and partnerships to be successful
- Complements other projects (i.e. 2A Bi-Directional Integration & Project 2B Pathways HUB)
- Good long term ROI, but concerned that would not be achieved during demonstration.
- Needs to be different than previous chronic disease prevention projects if it is to be successful.

## Q3 Comments on Project 2B: Pathways HUB

Answered: 29 Skipped: 39

#	Responses	Date
1	I understand that in Southwest, there are now care coordinators managing care for the individuals who are the high utilizers. They are in their second year with a much simpler system as far as implementation and it is not yet working well from the provider perspective. While not the same model, that model is less complex. The Hub model may be a better model, but how long has it taken to get it up and running well in the states that are using it? I would guess that it would take a minimum of 2 years, but likely 3 to get it fully operational, and it would be fledgling for the first year. That data (along with what was done to get it up and fully functional) could be valuable in determining the projected timeline, but only if their work force mirrors the workforce in central WA. The workforce issues we face here could substantially delay full implementation of the model when you get to the hiring and training part. When does the Medicaid Transformation Demonstration period begin? Where would the funding come from for the hub after the demonstration project is over? Don't know if one hub is needed in each countyseems like it would be easier to do a smaller area than it would hubs that cover the entire region.	4/17/2017 3:52 PM
2	Great concept!	4/14/2017 3:21 PM
3	The 3 means I don't know. I know a lot about our area, but not some of the other areas in the region.	4/13/2017 12:22 PM
4	211 is a key partner that needs to be at the table in order to meet goals, create healthy outcomes for clients and for sustainability after the demonstration funding is gone. 211 has the infrastructure in place to connect clients to the social determinants of health and to continue to build, update and sustain the regional database of resources. With 211 there is no need to recreate this aspect of the project.	4/13/2017 9:01 AM
5	Care traffic controllers models only work if there are resources to direct traffic too.	4/12/2017 4:34 PM
6	Can't exactly picture what the HUB will look like. Concerned about the viability of the program after initial funding is expended. But I like it (as I picture it anyway)	4/12/2017 2:05 PM
7	My biggest concern is that we invest in technology that will help to "coordinate the coordinators" as opposed to hiring people. A centralized data bank of community resources and shared info about who has interacted with specific patients is what I feel is most important.	4/12/2017 1:46 PM
8	On how difficult it would be to implement - I think this depends largely on who will be taking on the "hub" what experience they have and how well connected they already are to the four county area.	4/12/2017 9:47 AM
9	This project should be implemented with careful consideration of how to blend it with the existing care coordination model in our region/state. There has been significant investment in the regional Health Homes program with many lessons learned that can help inform an improved implementation of a second care coordination model. While Health Homes is now realizing a shared savings model based on the Medicare savings from the Duals demonstration project, it has been slow to come to fruition based on slow data reporting and other factors. I highly support this project.	4/11/2017 8:05 PM
10	due to how money/contract would funnel funds through the hub, the sustainability is dependent on the payment reform possible during the demonstration being 'retained' afterwards. If payors see ROI and savings by paying for the services of the HUB coordinators through the HUB, they would need to be ready to continue that methodology after the demonstration period.	4/11/2017 11:10 AM
11	Sustainability is dependent on reimbursement through the development & implementation requires start up (project funds)	4/11/2017 10:47 AM
12	This project is key to NCW success for the goal of the triple aim.	4/10/2017 9:09 AM
13	The NCACH should strongly consider initiating this proven system for addressing social determinants of health.	4/8/2017 9:35 PM
14	If left only to the healthcare sector to accomplish this, it will fail its intent and less likely to be sustainable. Other policy making bodies in the region need to have buy in.	4/8/2017 6:23 AM
15	Many questions about implementation so feedback is limited at this time.	4/7/2017 12:16 PM
16	Pathways presentation at Chelan conference indicated that implementation process takes at least 5 years. Very labor intensive and intensive communication - base process will face difficulty over such a large geographic area with home base services & mulitple agencies.	4/7/2017 12:13 PM
17	How difficult is it for a HUB to connect with a variety of BHR's?	4/7/2017 12:09 PM

18	If done effectively, this project could provide the medical & mental health professionals with needed coordination.  Providing both diversion & transitional guidance. If not effective, it would create another layer on medical/mental health team. There is alot of potential with this project to cover the needs of all 4 counties, focusing on specific needs of their residents and available resources.	4/7/2017 12:04 PM
19	Difficulty depends on 1. resources available in each area. 2. Degree of cooperation in communities. If few resources, it is challenging to complete the referral process.	4/7/2017 11:56 AM
20	A single source is smart4 seems a bit burdensome and might promote inefficiencies with technology, high speed connectivity would be anywhere. Retail facetime unnecessary.	4/7/2017 11:42 AM
21	"Primary Care Case Managers are not nearly as effective as staff providers who know their patients and have strong relationships. PT's need access to a person more than just phone calls & layers of filters. *What stands out as needed & evidence-based is the community health worker, home visits. *Baseline population assessments can be done through collaboration with social service agencies, primary care clinics & school districts. This is more than ""Healthy Youth"" data and census data, more specific that county health assessment data. Aces questionnaire at well child visits, at risk seniors ID's with Medicare Wellness HUB concept needs to have some decentralization of implimentation. Regional and cultural population characteristics have a bearing on who & how care coordination & service delivery is done. So #6 needs to be flexible with room for several regional modes of delivery. The immigration/refugee population will be more challenging to reach. The spiritual community should be tapped into! "	4/7/2017 11:33 AM
22	Barry Kling's comments in the recorded webinar appeared to favor this model of an intervention. To me most important will be to design a system that will show measurable and achievable treatment and outcomes. Where I put a "3", it was my next-best selection to a "don't know." I marked 3s in cases where I'm not clear how important it is for our entire state to improve performance vs. our region v. each of the four counties within NC ACH.	4/6/2017 1:47 PM
23	The idea behind this HUB is brilliant. This implementation and design, as well as hiring highly qualified employees will be key. The idea of the air traffic controller is incredible; it would allow those with specialized care coordinating positions, such as nurse case managers, health homes care coordinators, early headstart home visitors,BH, ECEAP, CPS, DD, APS, Section 8, have a place to go when each position is at the limitations of what the positions can/cannot do. It would free up a nurse case manager to let someone else do housing, or help a 0-3 home visitor refer for a parent of the child s/he is working with. However, what worries me is to be effective and trusted in a community, the person/people running the HUB will need to be Mary Poppins and crew. They will need to really know their communities, be easy to work with across agencies, trusted, and knowledgeable in a variety of ways. My concerns is the HUB would end up an office full of brochures and a glorified receptionist pushing referrals through rather than a dynamic coordination center for the needs of a community.	4/6/2017 1:25 PM
24	Needs more definition between clinical case management and home-based, face to face, care coordination. The MCO's have not bought into the Care Coordination model but continue to try and provide clinical case management. The model needs to include the Predictive Risk Model related to how client access their care instead of clinical measures. These savings are easier to measure than clinical outcomes over a 4 yr period.	4/6/2017 9:27 AM
25	Pathways is solid and flexible enough model. It provides standardization and a data platform that solves key problems.	4/5/2017 2:44 PM
26	THE PATHWAYS HUB WIL BE DIFFICULT TO SHOW roi IN JUST 5 YEARS	4/5/2017 2:24 PM
27	This would be my choice.	4/5/2017 1:50 PM
28	The idea of the Hub would bring (maybe mandate) together agencies and services that are already available. It is important with limited funds to get ALL the players working for the individuals. Agencies need to work in concert and understand what each client needs. smaller numbers may be served, but if it is more holistic it will be better. And NOT creating new efforts and jobs and housing, but using the current experts is much more efficient.	4/5/2017 12:47 PM
29	Due to our ruralness - it may be difficult to coordinate programs. Transportation is a challenge that may not have been fully addressed yet. Many in our community don't have access to transportation nor internet/phones to coordinate these needs.	4/5/2017 11:49 AM

## Q5 Comments on Project 2C: Transitional Care

Answered: 19 Skipped: 49

#	Responses	Date
1	Need to have a good understanding of how the systems work in order to address challenges. For example, there is funding for transition services for individuals who are incarcerated, but there are so many barriers to how the jail works that it is next to impossible to work with someone prior to their transition out of jail. However, in theory it is a great idea. BTW the link to the APIC information in the document does not work.	4/17/2017 4:04 PM
2	3= I don't know	4/13/2017 12:22 PM
3	in both this group and the last, the question about difficulty in implementing the project makes the answers 1-5 kind of hard to judge what is meant. I put in 5s because i think it would be very difficult.	4/12/2017 3:37 PM
4	We are very rural in our region and don't have real access to Interventions or Acute Care Transfers. Mental health office is open only a couple of days per week.	4/12/2017 2:07 PM
5	I think that the potential for saving money is significant but because of that, there may be varying degrees of interest in this project.	4/12/2017 1:49 PM
6	Transitional Care is already a priority (specifically in hospital and nursing homes) in the Health Homes program which demonstrates the ability to address the issue in part by other projects such as Pathways HUB.	4/11/2017 8:10 PM
7	this has care coordination at its core. And the pathways hub has the structure to implement this as a pathway.	4/11/2017 11:12 AM
8	Sustainability is dependent on reimbursement through the development & implementation requires start up (project funds)	4/11/2017 10:47 AM
9	I believe there are already systems in place that address this. Using the Pathway HUB will improve those systems.	4/10/2017 9:11 AM
10	Transitions of care could be strengthen by NCACH sanctioned multi-sector agreements demonstrating commitment and accountability to measurable actions supporting transitions of care.	4/8/2017 6:27 AM
11	This effort could be accomplished by a strong hub that focused on both physical & mental health needs. Personal experiences had me to believe that transitional services from intensive services into the community are poor for elderly clients and certainly not reflective of whole patient care or the specific needs of elderly population. The need behind transitional care should be addressed, but could be done with an effective HUB rather than a stand alone project.	4/7/2017 12:05 PM
12	I don't know much about transitional care.	4/7/2017 11:42 AM
13	The problem population does not get discharged to nursing home, home health, or even follow through with following up on outpatient care. They just go "home" so case managers (CHW's) need to go to where they are, their home, etc. Behavioral health services would help.	4/7/2017 11:34 AM
14	Can some of these outcomes and measures be included as part of project 2B?	4/6/2017 1:54 PM
15	For the most part, the changes in health care have focused on transitional care, and it's one of the peices working better than some of the other transformations. IT could still use work, but is being addressed by clinics, hospitals, and insurances.	4/6/2017 1:27 PM
16	The use of Transitional care RN's is expensive and not necessary. Care Coordinators with specific training and abiility to provide home-based visits has proven more effective. Health Homes is a good example.	4/6/2017 9:30 AM
17	NOT SURE WE COULD SHOW THE TYPE OF ROI THE STAE IS LOOKING FOR WITH JUST THIS PROJECT	4/5/2017 2:26 PM
18	The four county area might be challenged by trying to implement this plan. While transition is important there are not always places available for that to happen. I am not as familiar with this area.	4/5/2017 12:49 PM
19	The coordination of these types of needs may be difficult if the services and programs are too distant (rural)	4/5/2017 11:50 AM

## Q7 Comments on Project 2D: Diversion Interventions

Answered: 18 Skipped: 50

#	Responses	Date
1	I think diversion interventions can save the system a lot of money, but it is not clear how that would work in terms of sustaining the project when there is not project fundingfunding for diversion activities (all of which are not Medicaid reimbursable to do it right) has to be built into the system, and it is not clear if it would be possible under the CMS regulations. I think again, work force issues are a consistent challenge across all the project options.	4/17/2017 4:08 PM
2	Our location within the region is multi city, multi county, multi jurisdictional and has many moving parts. Lincoln County, Grant County, Okanogan County Sheriff's, Colville Tribal Police, Homeland Security (Dam), Electric City, Grand Coulee, and Coulee Dam Police Depts - just to name some - oh and Washington State Patrol.	4/12/2017 2:16 PM
3	As with transitions, entities that do well financially in the status quo will be less inclined to embrace changes that will reduce their reimbursement.	4/12/2017 1:52 PM
4	Seems to need more approaches listed. Not completely sure what Community Paramedicine entails, but I think social service agencies could be instrumental here	4/12/2017 11:53 AM
5	Similar to Care Transition, Diversion Interventions (ER Diversion) are happening in existing programs and therefore should easily be incorporated into another project.	4/11/2017 8:13 PM
6	This is also a key care coordination and non-traditional referral pathway that can be significantly addressed and measured through the pathways HUB system. Once again, the workforce of the pathways HUB system needs to be grown and a means to pay them agreed upon. And that funding stream, which is itself a diversion of \$ spent in high cost services over to care coordination resources(which should be lower \$).	4/11/2017 11:15 AM
7	This is a heavy lift	4/11/2017 10:47 AM
8	See comments in previous project.	4/10/2017 9:12 AM
9	This low hanging fruit is probably already addressed to a large degree. This and much more would likely be addressed by the pathways model.	4/8/2017 9:42 PM
10	Attention must be given to address the current underlying perverse financial incentives that drive the system. Otherwise, system will not engage meaningfully.	4/8/2017 6:30 AM
11	#4 OBHC & juvenile court system are already engaged in diversion program in our county. I don't know how successful this is.	4/7/2017 12:14 PM
12	The rationale for this project is almost identical to the Transitional Care project definition (NC ACH PPT Demonstration Decisions). Diverting the community from services through the use of EMS is a way to reduce costs, but does not necessarily help the community member or address underlying causes for requests for help.	4/7/2017 12:06 PM
13	In response to the last question, I can see the argument for selecting fewer options to increase the likelihood of a targeted plan for sustainability to occur after the demo ends.	4/6/2017 4:41 PM
14	To have a coordinated effort in this direction is needed. IT's possible the HUB would do this agenda too?	4/6/2017 1:29 PM
15	This will be an expensive and difficult project, best done on a community basis instead of regionally. I do not have enough knowledge of this to have good input.	4/6/2017 9:32 AM
16	COST OF ER DIVERSION WTIH PARAMEDICINE COLD BE LINMITED WITH A BIG IMPACT IN OVERUSE OF THE ER. IT SHOUILDEASILY SHOW AN ROI AND WOULD ALSO DOVETAIL WITH ANOTHER PROJECT OF POST HOSPITAL FOLLOW UP BY PARAMEDICAINE THAT COULD BE ROLLED OUT IN CONJUNCTION OR AFTER THIS PROJECT IS SHOWING SUCCESS	4/5/2017 2:28 PM
17	If there was enough money, this project might be doable, but what are the risks of regular relapse. Again the number of individuals served might be small to do it right.	4/5/2017 12:51 PM
18	These may be added to other projects at a much lower cost as an add-on then a stand alone project.	4/5/2017 11:53 AM

### Medicaid Demonstration Project Selection

## Q9 Comments on Project 3B: Maternal and Child Health

Answered: 16 Skipped: 52

#	Responses	Date
1	Longer term return, but I think you will see a spike in the problems and costs if resources for women's reproductive health are cut by Congress if you don't do something in this area. In that case a static outcome might actually reflect a higher degree of success than you otherwise might think.	4/17/2017 4:12 PM
2	Nurse Family Partnership is very expensive and unless the "requirements" were less stringent, it may not be feasible at this time. Home visit programs could be done and outcomes achieved without the hoops that one needs to go through to provide NFP	4/14/2017 3:28 PM
3	I don't have enough knowledge in this area to honestly answer the questions.	4/13/2017 12:24 PM
4	Wellness and population health begins at birth. Healthy Mother's Healthy Families	4/12/2017 4:36 PM
5	While the long term savings from a program such as this are possible, the savings would likely be minimal in the demonstration project period.	4/11/2017 8:15 PM
6	This is very much a front end early intervention with long term ROI. It can easily piggy back on the pathways HUB care coordination program as a specific pathway.	4/11/2017 11:17 AM
7	Research shows this has the biggest impact on maternal & child health.	4/10/2017 9:13 AM
8	Probably represents a relatively small portion of health cost. This would largely be addressed by the pathways model.	4/8/2017 9:47 PM
9	Engagement of child care providers, Head Start, preschools, schools led by primary car providers and supported by WPC wrap-around services to families will be needed.	4/8/2017 6:33 AM
10	The effects of poor family planning & teen pregnancy, poor prenatal care, lack of parental engagement and lack of prevention & health maintenance create lifelong negative impacts on health & well-being. We should focus on helping the current generation of teens & young adults produce the next generation of healthier adults.	4/7/2017 12:06 PM
11	There is no better investment than zero to 5 years old. Building the brain architecture (neural synapse), early learning, mental, physical and relationships is the very best return on investment. A win in this optional will have an impact on the other optionals and will give these children a chance to escape poverty, incarseration, drag on social services & physically, mentally and spiritual whole success for their entire life.	4/7/2017 11:44 AM
12	Part of outreach needs to be sensitive to the concerns of undocumented individuals and families. This is a key group in addressing and educating parents about adverse childhood experiences and partnering with them to mitigate these risks, which are social determinants of health. It would also help address the teen pregnancy prevention for young mothers, sequelae of post partum depression if unchecked/untreated.	4/7/2017 11:36 AM
13	I believe home visiting programs are effective, but if chosen, measures such as vaccine adherence, better birth outcomes, and other short term measures would be needed. There are home visiting programs in existence, and it would likely be better to coordinate those existing programs than to add more.	4/6/2017 1:31 PM
14	A pathways HUB could include this piece nicely.	4/6/2017 9:33 AM
15	this area of health care is extremely important, but I am not sure how it would be implemented over the whole area.	4/5/2017 12:53 PM
16	The ruralness of our area would make something like this almost impossible.	4/5/2017 11:54 AM

### Medicaid Demonstration Project Selection

## Q11 Comments on Project 3C: Access to Oral Health Services

Answered: 19 Skipped: 49

#	Responses	Date
1	It would seem that dental services would be feasible, as Medicaid at least will pay for services for children, so if screening could be implemented in a cost effective way that can be integrated with health (can a pediatrician be taught a quick screening process that can be incorporated with the well child check-ups?) it would seem to be more sustainable over the long term.	4/17/2017 4:15 PM
2	While adult oral health is a huge concern, private providers accepting Medicaid adults is an ongoing problem.	4/14/2017 3:30 PM
3	3= I don't know	4/13/2017 12:24 PM
4	I am not sure what providers are currently available to provide the resources to the project.	4/12/2017 4:37 PM
5	The region struggles with a sufficient number of dental professionals willing to work with underserved populations.	4/12/2017 1:55 PM
6	I think it would take longer than the demonstration period to show savings with this program. Building the provider capacity to fit the need would take most if not all the allowed time.	4/11/2017 8:18 PM
7	Oral health can also be a pathway in the HUB model. But this is a high \$ resource and slow to grow provider base that will be difficulty to show 4 year return. Dental capacity is a concern.	4/11/2017 11:18 AM
8	Need dentists	4/11/2017 10:52 AM
9	Relevant and important, but ability to effect change and to achieve sustainability are not clear to me.	4/8/2017 9:48 PM
10	With continuation of ACA expansion funding, there is a good chance this can be achieved.	4/8/2017 6:35 AM
11	#6 Very difficult	4/7/2017 12:12 PM
12	"#2 - Depends on strategy Poor dental care & dental maintenance lead to many other conditions. But without changes in dental insurance, it would be hard to implement and sustain. Would be good to have some dental input on NC ACH. Even if this is not the selected project, the dental professionals may have good ideas on regional efforts/needs. "	
13	I can see this being a priority for kids based on community fundraisers/donations. It shouldn't be funded by government agencies.	4/7/2017 11:44 AM
14	Need to recruit more family dentists, mobile dental services, sliding scale for non-covered services. Basic dental assessment/screening in primary care pediatrics (long term outcome). Adults - catch it early, prevent chronic inflammation and chronic disease.	4/7/2017 11:36 AM
15	It's unlikely the demonstration dollars can "fix" oral health. There are several efforts currently out there, but the sustainability of the demonstation project for oral health is dismal.	4/6/2017 1:34 PM
16	Dollars best spent on high risk medical populations to see most savings along with a prevention program through primary care.	4/6/2017 9:35 AM
17	GREAT PROJECT BUT THAT COULD BE ROLLED OUT TO AL PCP CLINICS ADN INSTITUTED WITH RELATIVE LOW COST BUT NOT SURE HWO WELL IT WOULD SHOW ROI IN JUST 4 YEARS	4/5/2017 2:30 PM
18	I do believe that oral health care is critical to the medicaid population and would help with over all health. Again, not sure how many people can be helped across the entire area.	4/5/2017 12:55 PM
19	We have absolutely no dental office in our community that take Medicaid. It is a huge issue for us, but I believe it can be added to other projects as an add-on at a lower cost.	4/5/2017 11:55 AM

### Medicaid Demonstration Project Selection

## Q13 Comments on Project 3D: Chronic Disease Prevention and Control

Answered: 19 Skipped: 49

#	Responses	Date
1	This is a huge undertaking—it will take generations to educate people to take charge of their own health. As people are socialized health care costs should decrease, but it is a long term venture. The health care systems have begun implementing this, but considerable public education is going to be required over the long term. That doesn't mean it isn't a good idea to foster productive interactions between informed patients who take an active part in their care, and providers with resources and expertise.	4/17/2017 4:20 PM
2	Not my area of expertise	4/13/2017 12:25 PM
3	The Department of Health and 211 are key partners for chronic disease prevention. Both agencyies have been partnering statewide since 2103 to expand self management resources and awareness of resources through community outreach. The expansion of the statewide 211 database of services has opened and opportunity for community health outreach workers to expand information and resources into more rural areas. Through the use of the new DOH CHART software program that connects to the 211 database of services, community health outreach workers will have more immediate access to resource information to make referrals for clients.	4/13/2017 9:17 AM
4	I think that this is a project with almost universal support. It also has the potential to reduce the cost of healthcare through reduced specialty and inpatient costs. This will result in the State viewing this project as a success.	4/12/2017 1:57 PM
5	Coordination of the existing chronic disease programs across agencies in our region, improvements on patient incentives for participation and the initiation of a bi-directional communication system could result in a successful project.	4/11/2017 8:22 PM
6	This is one of the most widely pursued opportunities for improvement in health care. But it continues to be a silo approach in need of relationship based, patient specific, locally trusted, care coordination. The structures and measures of the pathways HUB model create the most relevant workforce (CHW's or ?) to build the Behavior changing/influencing engine needed to affect change.	4/11/2017 11:22 AM
7	Chronic diseases are preventable and controllable. Improving our health systems and community involvement is much needed.	4/10/2017 9:17 AM
8	Dovetails with Patient Centered Medical Home efforts.	4/8/2017 10:06 PM
9	Success in this project is a must, as it has the highest probability to generate system savings that can be applied to sustaining other efforts.	4/8/2017 6:37 AM
10	Our primary care delivery system is not really designed to support the CCM effectively, especially in regards to prevention. Unless the system itself is redesigned (HUB, Home Visiting Models), we will just get the same result we've been getting.	4/7/2017 12:08 PM
11	Community Choice & WSU Extension have a diabetes prevention program at this time.	4/7/2017 12:02 PM
12	My feeling is that messaging marketing should mostly be communicated at young age (middle school up) in schools, in churches, etc. (sporting events). I don't believe older demographics should be the targets for messages.	4/7/2017 11:45 AM
13	How do we get folks to allow community health workers in their homes? I suspect a local, established, trusted team of individuals is necessary, preferred to "outsiders".	4/7/2017 11:37 AM
14	so so many programs are tried via current medical outlets. So many have low participation or adherence. I truly believe coordinating these current efforts and offering trainings to social service and medical staff would be much more effective than throwing yet another diabetes, SAIL, foot care, etc into communities.	4/6/2017 1:37 PM
15	Would need to be measured by a predictive risk model and not clinical model to see outcomes in 4 yrs.	4/6/2017 9:37 AM
16	AGAION THE 4 YEAR WINDOW OF SHOWING IMRPOVED OUTCOMES AND roi IS VERY DIFFICULT	4/5/2017 2:31 PM
17	This would also be my choice	4/5/2017 1:54 PM
18	shine a light on SUD as a chronic disease.	4/5/2017 12:13 PM
19	This combined with Project 2A makes the most sense to me as a Community Health Worker. It is doable and trackable. Those two combined make this a viable project.	4/5/2017 11:56 AM

#### **Email Verifying North Central Hospital Council Project Endorsement**

From: Kevin Abel [mailto:kabel@lcch.net] Sent: Thursday, March 30, 2017 8:43 AM

To: Linda Parlette <Linda.Parlette@cdhd.wa.gov>

Subject: RE: NCWACH Project Options

Hi Linda,

I agree we have what we need to make our decision and the detailed information can go to the board members.

I heard back from some that were not at the meeting and we are at a point where we have consensus on Chronic Disease Prevention and Control and Community Based Care Coordination Pathways HUB as the two optional projects for our region from the hospital standpoint. We still need the input from other community groups but it is a start.

Kevin Abel Chief Executive Officer Lake Chelan Community Hospital & Clinics Post Office Box 908 Chelan, WA 98816 (509) 682-8501

### Grant County Summary of CHI answers from April 10<sup>th</sup>.

### Pathways HUB

Concerns	Excites
Data sharing-patient consent (Health Info	Relationship with the person
Exchange)	
Pathway resources lacking (mental health access	Connecting people to resources
to care)	
Operationally how it will work	Key to other projects; essential service
Educating CHW's; recruiting good CHW's→not	Partnership with 211
making training too rigorous	
Making appointments- delays in starting CC	Address social determinants of health
Caseload restrictions?	Measurement-tracking success and failures, lack
	of resources to be tracked
Who will make referral to HUB?	Focusing on specific population, i.e. ER utilizers
Health homes role?	
Who is the HUB?	

#### Chronic disease

Concerns	Excites
We do not have people in community that	You can measure some of the successes in certain
currently do this follow up/tracking	clinical settings
Poor compliance with chronic disease patients	Possible home monitoring would be beneficial
	since limited transportation in this area
Lack of transportation in rural area	This would have to work/would work well with
	the Pathways HUB
Once you diagnose a chronic disease, how do you	This would be getting ahead of the curve, finding
know there will be follow up?	root cause, different than current clinical model
4 years is a short time to measure chronic disease	This will hopefully keep the diagnosis from
improvement	developing/getting worse
The provider will need a team, who will provide	This will provide relief for providers seeing same
the team to make this possible?	patients with same issues over and over
How will data be shared?	Hopefully reduce repeat ER users

### MCH/Oral Health

Concerns	Excites
Will primary care take on oral health?	Outcomes of home visits
Resources?	Prevention focus, early intervention
See results, but perhaps not savings	Both address transportation issue
What has worked well in other communities?	Support for whole family/outreach for whole
	family (MCH)
Increased needs in rural areas; mobile unit	Mobile visits (dental)
prepared?	
Dentist at the table	Addresses children (most vulnerable group)
Who will (MCH) it be open to?	Will collaborate with HUB
Home visits must be culturally relevant	Oral health crosses over with MCH, chronic
	disease
Cost over time	
You would need care coordination/care	
coordinator	

### ED Diversion/Transitional Care

Concerns	Excites
Very circular, what is the difference?	Types of services are not as big of a concern
Diversion will take a lot more	Diversion sounds more appealing for work
resources/investments to address	
Still addresses people with acute situations, want	Overlaps with HUB
to reach them prior to preventative services.	
Cannot do this without care coordination	Transitional interventions would be best to
	achieve outcome → payment on admission
Resources available in community for this?	Long term care → other initiatives
Not successful without HUB	Focus on opioid work
	Addresses areas of high cost of medical care
	Potential for high cost savings
	It is a more proactive approach

Most groups agreed that in order for each option to succeed, the Pathways HUB would need to be implemented.

#### **Methow Valley Response to Survey**

Community Based Care Coordination & Diversion Intervention

#### **Background**

The Methow Valley Health Care Network has identified Community Based Care Coordination and **Diversion Intervention** as significant health care gaps in our region, with Diversion Intervention being of highest priority for implementation. We believe that a more integrated health care approach is needed to address these specific issues hence an initial partnership has been established with the following valley health care providers: 1) Aero Methow Rescue Service; 2) Lookout Coalition; 3) Frontier Home Health & Hospice; 4) Family Health Centers, Twisp; and 5) Three Rivers Hospital (plans are to extend the network to a broader range of local providers). In addition, the network has recently submitted a revised grant application to the Rural Health Network Development Planning Program. (HRSA-16-017) to obtain support to develop a detailed plan to address these specific needs. For the Methow Valley community the planning grant outlines in detail the following: valley history, demographics of target populations, relevant community services, unmet needs, barriers and challenges, project objectives including performance metrics, and roles and responsibilities of network partners. This planning grant funding is for a 12 month period (initiation June 2017 if funded) but will only support the development of a strategic plan; whereas, plan implementation will occur in 2018. The planning grant is directly focused on the need for community based coordination to alleviate loss of local services and better access to care by enhancing emergency medical services with an overarching goal of improving the quality of essential health care services. Although this planning grant was developed specifically to address the needs of the Methow Valley, we believe it is highly relevant to the North Central Accountability Community of Health. (If you would like a copy of the grant contact Cindy Button)

#### Comments to survey questions (1-7), ranking score range- 1 (not at all), 5 (very much)

- 1. We believe that it is critical to establish "Whole Person Care" in the Methow Valley and the region. To accomplish this, well integrated community networks are vital. The overarching "unmet need" can be summed up as, a lack of health care gap management to fully address chronic, mental and behavioral health needs. Health care needs can be broad in scope where patients may be dealing with a range of short- and long-term health issues. These patients may also be struggling with numerous confounding factors such as poor compliance with medicines, lack of family support, lack of primary care, difficult living conditions among other factors that further compromise their overall health status. Hence, effective strategies need to be developed to address "Whole Person Care". Ranking (5)
- 2. Once care coordination and diversion interventions are established, and assuming the appropriate performance metrics are developed and used, then health outcome improvements will be realized (in less than 4 years). We believe this is particularly true in the Methow Valley since we've already made progress via our Network. **Ranking (5)**
- 3. A critical component of both care coordination and diversion intervention is network communication. We envision limited resource allocation will be needed to maintain efficient care coordination and ongoing efforts focused on community paramedicine with available resources should enable sustainability with limited additional cost. Ranking (4)
- 4. At this point in time we do not believe that the goals of the HUB and diversion intervention would be addressed by other projects. The HUB as a care coordination strategy in an important health care integrating tool. For example, when we consider diversion intervention, care coordination is a critical component needed for successful integration. Depending upon the scope of the care coordination efforts (local vs. regional

#### **Methow Valley Response to Survey**

Community Based Care Coordination & Diversion Intervention

- focus) it may or may not be appropriate to integrate into other projects. However, from our perspective we wish to stress the need for a local HUB strategy, since we believe it will best facilitate addressing the unmet needs of our community. **Ranking (2)**
- 5. We believe it is critical for the Methow Valley and potentially Okanogan County (Ranking 5). It may likewise be equally critical to all counties in the region since they share similar issues with regards to rural health care needs; however, we lack adequate information to fully assess. Ranking (3)
- 6. The care coordination could readily be integrated region wide. However, we believe that local coordination is critical since there are unique differences within various communities. For example, in Okanogan County Methow Valley demographics are quite different than those in Omak or Eastern Okanogan County; hence, local coordination is important. However, it is envisioned that the entire region would benefit from care coordination and diversion intervention but how that would look may vary from community to community. **Ranking (3)**
- 7. The demo project will establish the proof of principle, and once appropriate metrics are developed and measured long-term and broader feasibility can better be assessed. Since each community is unique the results from the demo project will need to be tailored to other communities within the whole region. Ranking (4)

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## PRESS RELEASE

FOR IMMEDIATE RELEASE

May 4, 2017

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### North Central Accountable Community of Health Selects Six Medicaid Transformation Demonstration Projects

Project proposals expected to bring up to \$50 million to NCW over next 5 years

East Wenatchee, WA— The North Central Accountable Community of Health (NC ACH) has selected the six projects that it will pursue through the Medicaid Transformation Demonstration that are expected to bring up to 50 million dollars into North Central WA to transform Medicaid care delivery. Through a five-year demonstration, each ACH (there are nine in Washington) will have the ability to develop and implement projects to address regional health priorities and improve care by providing high quality, cost-effective care that treats the whole person.

The NC ACH, which is comprised of Chelan, Douglas, Grant, and Okanogan Counties, has selected six care transformation projects to implement. They are:

- Bi-directional Integration of Physical and Behavioral Health through Whole Person Care
- Community-Based Care Coordination
- Transitional Care
- Diversion Interventions
- Addressing the Opioid Use Public Health Crisis
- Chronic Disease Prevention and Control

Brief descriptions of each project are provided on the following page. The projects were carefully selected by the Governing Board of the NC ACH after considering significant community input from all four counties and the regional health priorities recently identified through an extensive regional Community Health Needs Assessment. The six projects that will be developed in NCW have a strong focus on promoting whole person care, improving health care by strengthening clinical and community partnerships, and enabling care givers to better address the social determinants of health.

"Big changes are coming in the way health care is paid for, and that presents challenges for the excellent providers already working in our region to care for Medicaid patients and others. Our job is to support them with better tools to provide the Whole Person Care they already work to achieve. We are extremely fortunate to have strong clinical and community partnerships in our region to share in this work and opportunity" said Barry Kling, Chelan-Douglas Health District Administrator and Chair of the NC ACH Governing Board. The magnitude of this undertaking is not lost on him though, Kling said "The weight of responsibility to do this well is very humbling."

NC ACH Executive Director, Senator Linda Evans Parlette, also has high expectations for these projects saying, "After five years of the Demonstration, I hope we will have a true 'value-added' effect on the health care delivery system with a noticeable impact due to more effective care coordination. If we can improve the coordination of care for those that we serve in our very rural four county region, maybe we can be a rural health care model for the nation."

#### For more information:

- North Central Accountable Community of Health visit: www.MyDocVault.us
- Medicaid Transformation Demonstration visit: <a href="https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation">https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation</a>

### Medicaid Transformation Demonstration Selected Projects

Chelan, Douglas, Grant, and Okanogan Counties



#### Bi-directional Integration of Physical and Behavioral Health through Care Transformation

Address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through Managed Care Organizations, for people enrolled in Medicaid to address the whole person.



#### **Community-Based Care Coordination**

Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. This will rely on the development of the Pathways HUB infrastructure which will coordinate care coordinators and allow current care coordinators to provide more effective and efficient care coordination.



#### **Transitional Care**

Improve transitional care services of Medicaid beneficiaries moving from intensive medical care or institutional settings. This includes those discharged from acute care to home or to supportive housing, those with serious mental illness discharged from inpatient care, or client returning to the community from prison or jail. Improvement in these services will lead to a reduction in avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.



#### **Diversion Interventions**

Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations. Strategies will be targeted at Medicaid beneficiaries presenting at the Emergency Department for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergency condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.



#### Addressing the Opioid Use Public Health Crisis

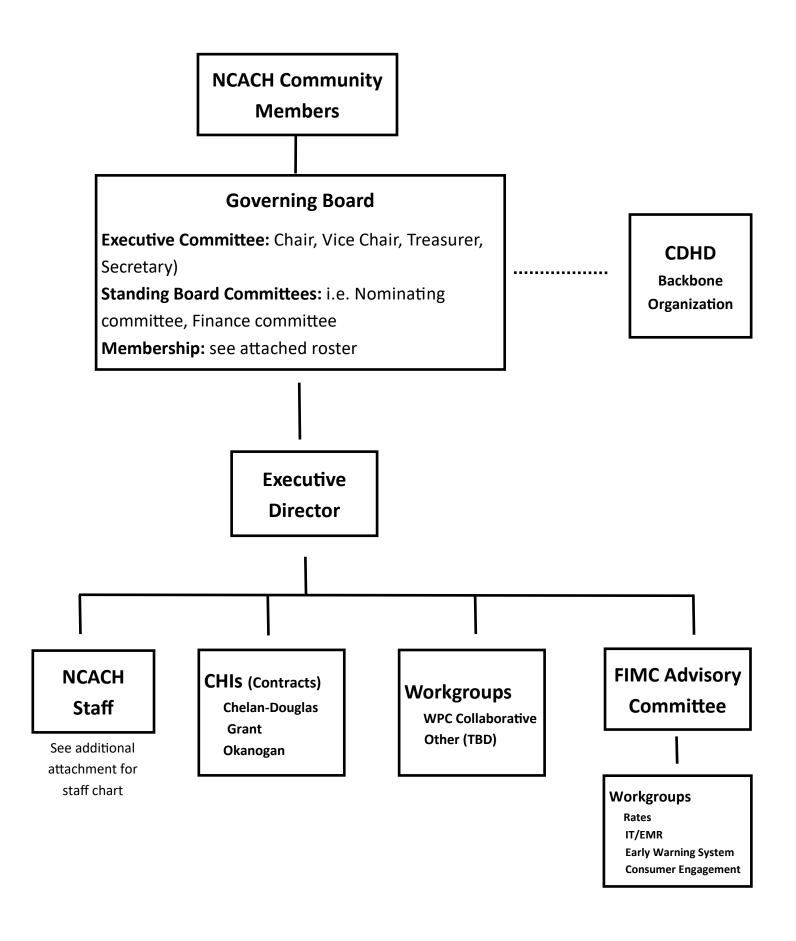
Reduce opioid-related morbidity and mortality through strategies that target prevention of opioid misuse and abuse, treatment of opioid use disorder, overdose prevention interventions, long-term recovery, and whole-person care.



#### **Chronic Disease Prevention and Control**

Improve chronic disease management and control by using the Chronic Care Model. The Chronic Care Model is an organizational approach to caring for people with chronic disease in a primary care setting. The CCM identifies essential elements of a health care system that encourage high-quality chronic disease care: the community; the health system; self-management support; delivery system design; decision support, and clinical information systems.

### **NCACH Governance Structure**



#### **BYLAWS OF**

## The North Central Accountable Community of Health

#### (NCACH)

#### I. OFFICES AND REGISTERED AGENT

The registered office of the North Central Accountable Community of Health, hereinafter "NCACH," shall be located in the State of Washington at such place as may be fixed from time to time by the Governing Board upon filing of such notices as may be required by law.

NCACH shall be a Washington nonprofit corporation, organized under RCW 25.03. Until otherwise designated by the Governing Board, the Registered Agent shall be the Administrator of Chelan-Douglas Health District (CDHD), and NCACH shall have a business office identical with such registered office.

#### **II. ORGANIZATION MISSION AND PURPOSE**

- 2.1 <u>Mission</u>. The mission of NCACH is to improve the health of the North Central region's communities and the people who live in them, improve health care access, quality, and the experience of care, and lower per capita health care costs in the North Central region which includes Chelan, Douglas, Grant and Okanogan counties (the "North Central Regional Service Area").
- Purpose. At such time as the Governing Board resolves to seek treatment and qualification as an exempt organization under the Internal Revenue Code of 1986 (as amended) and without necessity of amendment to these Bylaws, the NCACH shall operate exclusively for charitable and educational purposes under 501(c)(3) of the Internal Revenue Code, or any successor provision of the Internal Revenue Code. Consistent with this purpose, the property of the NCACH shall be irrevocably dedicated to charitable purposes and no part of the net earnings, properties or other assets shall inure to the benefit of any private person, individual, Board member, Council or Coalition member, or officer of the NCACH. Notwithstanding the foregoing, this provision shall not prevent payment of reasonable compensation for services performed for the NCACH in carrying out is public or charitable purposes, provided that such compensation is approved by the Governing Board and not prohibited by the Articles of Incorporation, these Bylaws, or any statute governing the NCACH, and that no person shall be entitled to share in the distribution of, and shall not receive any of the NCACH's assets upon dissolution of the corporation.

#### III. GOVERNANCE STRUCTURE

3.1 <u>Overview</u>. The NCACH governance consists of three principal components: the Governing Board, the Regional Leadership Council (the "Council"), and Coalitions for Health Improvement ("Coalitions"). The NCACH shall have no Members.

The Governing Board will be the principal and ultimate decision-making authority for the NCACH, with input from the Council and the Coalitions. While the interaction between the Governing Board, the Council and the Coalitions will be developed and set forth in separate policies and/or charters, below is the basic description of the Council and the Coalitions' roles:

- 3.1.1 The Council will be an advisory council to the Governing Board composed of region-wide representatives from relevant sectors such as primary care, specialty medicine, dentistry, behavioral health, social services, long term care, the business community, consumers and others. The Council's purpose is to provide to the Governing Board advice and input from a broad range of stakeholders on matters affecting the health of people in the region and to consult with the Governing Board. Two Council representatives will be non-voting members of the Governing Board to facilitate the Council's advisory and consulting role with the Governing Board. An interested sector representative will be able to become a member of the Council by signing an acknowledgement and acceptance of Council responsibilities.
- 3.1.2 Each public health jurisdiction of the North Central Regional Service Area will have a broad-based local community Coalition intended to engage a wide variety of partners in the mission and work of the NCACH. Each Coalition will provide input to the Governing Board on significant issues directly related and material to NCACH's mission and activities, including needs assessment and local health data; community health improvement plans and priorities; health improvement initiatives; and delivery system transformation.
- 3.1.3 The Board shall establish and adopt the policies, charters and rules governing the Council and the Coalitions, including the procedures for appointment and removal of the members of the Council and Coalitions.

#### 3.2 Governing Board - Power and Duties

- 3.2.1 <u>Powers</u>. Prudent management of all the NCACH's affairs, assets, property shall be vested in the Governing Board (the "Board"). The Board shall have the powers expressly conferred by these Bylaws, any Articles of Incorporation, and any and all applicable laws, rules and regulations, including House Bill 2572 (2014) and the RCWs referred to therein. While, the Board may delegate the management of the day-to-day operation of the organization to another public or private entity, committee, or person, the activities and affairs of the organization shall be managed and all organization powers shall be exercised under the ultimate direction of the Board. Board members shall not delegate or proxy their respective responsibilities and rights as members of the Board pursuant to these Bylaws.
  - 3.2.2 **General Duties**. The Board shall have the following general duties:
- A. Provide strategic direction and work in partnership with the Council on approved projects.
- B. Act as liaison for NCACH to Washington State on issues of funding, governance, alignment of state initiatives with regional preferences and other health care initiatives or topics that may arise relevant to the NCACH's mission.
- C. Work to secure any necessary funding for the core collaborative activities of NCACH partners that benefit the shared aims.
- D. Oversee and develop a long-range the sustainability plan for the NCACH.

- E. Be responsible for ensuring that NCACH complies with applicable federal, state, and local laws and regulations, and that it adheres to its stated purposes, and that its activities advance its mission.
- F. Oversee, monitor and review as necessary the governance documents of the NCACH, including bylaws, policies and articles of incorporation.
- G. Enact policies and charters to delineate the duties, selection and responsibilities of the Council and the Coalition, and their interaction with the Board.
- H. Enact policies relating to the responsibilities of the NCACH's Executive Director, and any administrative or backbone organization engaged and authorized to carry out, facilitate or support the administrative and business activities of the NCACH.
- 1. Select, evaluate and terminate the Executive Director.
- 3.2.3 <u>Responsibilities</u>. In addition (and without limiting) the powers and duties described above and reserved to a Board by statute, the Board shall:
- A. Oversee and facilitate a community based process intended to improve healthcare access in the North Central Regional Service Area.
- B. Assess health care issues from a community-wide perspective, with the health of the North Central Regional Service Area's people uppermost in mind, rather than narrowly representing a sector, employer, or geographic area.
- C. Approve an annual budget and provide financial oversight.
- D. Insure legal and ethical integrity in all its dealings and maintain accountability with regard to its purposes.
- E. Determine, carry out, evaluate and revise the NCACH's strategic priorities to fulfill the NCACH's mission and purpose.
- F. Enhance the NCACH's public awareness.
- 3.3 <u>Board Number</u>. The number of Board members shall be determined from time to time by a vote of the Board, provided the Board shall consist of not less than eleven (11) and not greater than nineteen (19) members, together with the Executive Director, who shall be an ex officio member of the Board. The Board shall have the power to add additional members by a vote of sixty percent (60%) of the total voting members of the Board at any regular or special meeting of the Board. The change in number of Board members shall not shorten or extend the term of any incumbent Board member, whose term may be impacted only as provided by these Bylaws.
- 3.4 <u>Board Term.</u> Except as to the initial term designations described in 3.5, Board terms shall be three (3) years, which term shall end on the latter of the date of the annual meeting or the appointment of a new Board member. No Board member may serve more than three (3) consecutive terms, unless such member has been appointed by a Tribal entity. Notwithstanding the foregoing, Medicaid Managed Care Organizations ("MMCOs") may rotate their sector

representative by proposing through mutual agreement among the MCCOs active in the region a candidate for Board membership for that position on an annual basis.

3.5 <u>Board Membership Composition: Sector Representation</u>. The Board shall consist of community leaders, representatives of key community institutions, and others who are considered representative of the North Central Regional Service Area and interested in community healthcare access and improvement issues. The Board is intended to reflect the breadth and diversity of the community and will include representatives from a variety of healthcare organizations, business, government, social services, and healthcare consumers. The Board composition includes representations from the sectors listed below, and the Board may approve inclusion of additional sectors. Board members may represent more than one sector.

	SECTOR REPRESENTED	NUMBER OF BOARD SEATS	INITIAL TERM
а	Behavioral Health	1	2 years
b	Confluence Health	1 (primary care)	1 year
		1 (Central Wa Hospital)	3 years
С	Public Hospitals	1	3 years
	•	1	1 year
d	Federally Qualified Health Clinic	1	3 years
е	Business Community	1	3 years '
f	Elected Officials/ Ex Officio	1	3 years
g	Education	1	3 years
h	Public Health	1	1 year
i	Area Agency on Aging	1	2 years
j	Hispanic Community	1	3 years
k	Medicaid Managed Care Organizations	1	1 year
1	Tribal Representative	1	2 years
m	At-large Seat	1	1 year
n	Regional Leadership Council Representatives	1	1 year
	(non-voting)	1	3 years

3.6 <u>Nomination and Election of Board Members following Initial Term.</u> The Executive Committee, and the Nominating Committee described in Section 5.2, shall work together to vet and nominate potential members to the Board and shall forward the list of nominees to the Board for consideration at least thirty (30) days before the annual meeting. The Board approves membership to the Board and shall elect the Board members at the annual meeting, or in the case of a vacancy caused by removal, resignation or death of a Board member,

at any regular or special meeting of the Board. The Executive Committee is responsible for maintaining the list of Sectors and accompanying representative selection procedures.

#### 3.7 Meetings.

- 3.7.1 <u>Annual Meeting</u>. An annual meeting of the Board shall be held each year in December. At this meeting the Board shall approve a budget for the activities of the NCACH for the following year, and elect new Board members and officers to fill expiring terms.
- 3.7.2 <u>Regular Meetings</u>. Regular Board meetings shall be scheduled by the Board at least four (4) times per year. By resolution, the Board may specify the date, time and place for the holding of regular meetings without other notice than such resolution. If there is no resolution in place, the Board shall use best efforts to provide thirty (30) calendar days notice of a regular meeting as a courtesy, and shall provide not less than ten (10) calendar days notice.
- 3.7.3 <u>Meetings by Telephone</u>. Members of the Board or any committee designated by the Board may participate in a meeting of the Board or committee by means of a conference telephone or similar communication equipment provided that all persons participating in the meeting can hear each other at the same time. Participation by such means shall constitute presence in person at a meeting.
- 3.7.4 <u>Place of Meetings</u>. All meetings shall be held at the principal office of the organization or at such other place within the State of Washington designated by the Board or by any persons entitled to call a meeting.
- 3.7.5 Special Meetings; Notice. A special meeting of the Board may be called by the Chair or by any five (5) voting members of the Board. Notice of special Board or committee meetings shall be given to Board members in writing by email or regular mail, or by personal communication with the Board member not less than ten (10) calendar days before the meeting. Notices in writing may be delivered, mailed, emailed or faxed to the Board member at his or her address, facsimile number or e-mail address shown on the records of the organization. Neither the business to be transacted at, nor the purpose of any special meeting need be specified in the notice of such meeting except that the notice shall specify the consideration of any removal of a Board member or officer if such action is to be considered at the meeting. If notice is delivered by mail, the notice shall be deemed effective when deposited in the official government mail properly addressed with postage thereon prepaid. If notice is by email or facsimile, it shall be effective on the earlier of: twenty-four (24) hours after sending without receipt of an error or non-deliverable message by the sender, or such time as the sender receives a "delivered" notification or confirmation via e-mail or facsimile.

#### 3.7.6 Waiver of Notice

3.7.6.1 <u>In Writing.</u> Whenever any notice is required to be given to any Board member under the provisions of these Bylaws, the Articles or applicable Washington law, the party entitled to such notice may waive it. A waiver in

writing, signed by the person entitled to such notice, or delivered from an email address belonging to the person entitled to such notice shall be deemed equivalent to the giving of such notice. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board need be specified in the waiver of notice.

- 3.7.6.2 <u>By Attendance</u>. The attendance of a Board member at a meeting shall constitute a waiver of notice of such meeting, except where a Board member attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.
- 3.7.7 **Quorum**. A simple majority of the voting Board members then in office at the beginning of each meeting shall constitute a quorum for the transaction of business.
- 3.8 <u>Attendance</u>. Board members are expected to regularly attend Board meetings and shall notify the Board Chair in advance if they are not able to attend a meeting. A Board member may be removed if such member is absent from more than one-third (1/3) of the regularly scheduled Board meetings in any given calendar year.

#### 3.9 Voting and Manner of Acting

- 3.9.1 <u>Board Actions</u>. Each Board member will have one (1) vote, except the Council representatives who are non-voting. The act of the majority of the Board members present at a meeting at which there is a quorum shall be the act of the Board, unless the vote of a greater number is expressly and clearly required by these Bylaws, the Articles of Incorporation or applicable Washington law. Notwithstanding the foregoing, if the MMCO sector has more than one (1) representative as a Board member, such sector representatives shall nonetheless collectively have only one (1) single collective vote, which the MMCO Board members must cast consistent with an agreement between or among the representatives, which agreement shall include the designation of the MMCO representative entitled to cast the vote. If the MMCO Board members are unable to agree as to a particular vote, then the MMCO sector shall have no vote for that particular action. Notwithstanding the non-voting status of the Council representatives, it is expected that the Council representatives will participate in the discussion and debate leading up to a particular action to be taken at a meeting, consistent with their advisory role.
- 3.9.2 <u>Presumption of Assent</u>. A Board member at a Board meeting at which action is taken shall be presumed to have assented to the action taken unless his or her dissent or abstention is entered in the minutes of the meeting, or unless such Board member files a written dissent or abstention to such action with the person acting as Secretary of the meeting before the adjournment thereof, or forwards such dissent or abstention by registered mail to the Secretary of the organization immediately after the adjournment of the meeting. Such right to dissent or abstain shall not apply to a Board member who voted in favor of such action.

- 3.9.3 Action by Board Without a Meeting. Any action which could be taken at a meeting of the Board may be taken without a meeting if a written consent setting forth the action so taken is signed by each of the Board members. Such written consents may be signed in two or more counterparts, each of which shall be deemed an original and all of which, taken together, shall constitute one and the same document. Written consent may be delivered electronically. Any such written consent shall be inserted in the corporation's records and minutes, as if it were the minutes of a Board meeting.
- 3.9.4 <u>Resignation</u>. Any Board member may resign at any time by delivering written notice to the President or the Secretary at the registered office of the NCACH, or by giving oral or written notice at any meeting of the Board members. The resignation shall be effective at the time stated in the resignation, or if there is no time specified, then upon delivery of such resignation. The acceptance of such resignation shall not be necessary to make it effective.
- 3.9.5 <u>Removal from Office</u>. Any Board member (except a Tribal entity representative) may be removed by a sixty percent (60%) vote of all of the voting members of the Board (determined without counting the vote of the Board member subject to removal) for any reason and without necessity of cause. A vote to remove may occur at an annual, regular or special meeting of the Board; provided that if such vote is to occur at a special meeting, the notice of special meeting must include the consideration of removal in the notice of meeting.
- 3.9.6 <u>Vacancies on the Board</u>. Sector representatives will work with the Executive and Nominating Committee to identify candidates to the Board to fill vacant positions. Vacancies occurring on the Board may be voted on and ratified at any regular or special Board meeting by the remaining Board members. Newly elected Board members shall serve the remaining term of the vacant position. The Board shall use its best efforts to fill the vacancy within sixty (60) days of the resignation, removal or death of a Board member.
- 3.9.7 <u>Duty of Loyalty</u>. Board members shall put the NCACH interests ahead of their own when making all decisions in their capacities as NCACH fiduciaries. They must act without personal economic conflict, and are required to sign a conflict of interest policy upon election to the Board, as further set forth in Article VII.

#### IV. OFFICERS: EXECUTIVE COMMITTEE

- 4.1 <u>Membership and Term</u>. The Board will elect officers to the following positions: Chair, Vice Chair, Secretary, and Treasurer. These officers will form the Executive Committee, together with the Executive Director of the NCACH who will be an ex-officio member. Executive Committee members will serve a two-year term, and no member may serve in the same Executive Committee position for more than two (2) consecutive terms.
- 4.2 <u>Purpose and Authority</u>. The Executive Committee will make operational decisions for NCACH on a week-by-week basis, consistent with the NCACH's mission, purpose and current policies. Policy and significant substantive decisions shall be reserved to the Board. A majority of

the Executive Committee members shall be sufficient to constitute a quorum for the transaction of business; provided that both members must affirmatively agree to the carrying out of any action if the quorum consists of only two (2) Executive Committee members.

By way of example, and without limitation as to the Executive Committee's purpose and authority, the Executive Committee is responsible for:

- a. working with the Chair and the Executive Director and staff (including any administrative or backbone organization with whom the NCACH has contracted) to ensure the carrying out of the business of the NCACH, including acting on any matters as directed by the Board;
- acting on urgent or emergent business which may arise between regularly scheduled NCACH meetings, and for which the Executive Committee determines that acting without a meeting as provided under these Bylaws is not practicable due to time constraints of the matter requiring action; and
- c. additional duties as delegated by the NCACH Board.

The Executive Committee shall meet on a regular basis, sufficient to enable to it to carry out its purposes. The Executive Committee shall inform and report to the Board regarding decisions made by the Executive Committee, including any urgent action taken by the Executive Committee between Board meetings and seek ratification and approval by the Board for such actions at the next meeting of the Board. If the Board does not ratify any such action taken, the Board may limit or suspend the Executive Committee's ability and authority to take similar actions, or any action. The Board may at any time vote to provide a written delegation of authority to the Executive Committee expressly outlining the Executive Committee's specific authority. The failure of the Board to ratify an Executive Committee action at the next Board meeting shall not nullify such act, if it was relied upon in good faith by a third party. Unless specifically delegated by the Board, the Executive Committee shall not have the authority to incur any single monetary obligation in excess of \$5,000, or cumulatively up to \$10,000 annually, or bind the NCACH to an obligation exceeding one (1) year, whether budgeted or not.

- Chair. The Chair shall preside at all meetings of the Board and the Executive Committee, shall have general supervision of the affairs of the organization, including the Executive Director of the NCACH and shall perform such other duties as are incident to the office or are properly required of the Chair by the Board. The Chair shall work with the staff to plan Board agendas and programs. When required, the Chair shall act as a spokesperson for the NCACH (consistent with any direction by the Board and the mission and purpose of the NCACH) as required and shall carry out such other duties as are incident to the office or are properly required of an effective Chair or the Board.
- 4.4 <u>Vice Chair</u>. During the absence or disability of the Chair, the Vice-Chair shall exercise all of the functions of the Chair. The Vice-Chair shall have such powers and discharge such other duties as may be assigned to him or her, from time to time, by the Board.
- 4.5 <u>Secretary</u>. It shall be the duty of the Secretary of the Board to keep all records of the Board and of the NCACH, to give notice of meetings, retain minutes of meetings and make

such reports and to perform such other acts as are incident to the office or as the Chair or Board may direct.

- 4.6 <u>Treasurer</u>. The Treasurer is accountable, and shall have oversight responsibility, for all funds belonging to the NCACH. The Treasurer shall advise the Board on its fiscal responsibilities and shall insure that policies and procedures regarding financial transactions, accounting procedures and the disposition of assets are followed as prescribed by the Board, the Bylaws and applicable law.
- 4.7 <u>Delegation</u>. If any other officer of the NCACH is absent or unable to act and no other person is authorized to act in such person's place by the provision of these Bylaws, the Board may, from time to time, temporarily delegate the power or duties of such officer to any other Board member.
- 4.8 <u>Resignation</u>. An officer may resign by delivering written notice to the other members of the Executive Committee. Such resignation shall be effective at the time stated in the resignation, or if there is no time specified, then upon delivery of such resignation. The acceptance of such resignation shall not be necessary to make it effective.
- 4.9 <u>Removal</u>. Any officer may be removed by the Board with or without cause by a sixty percent (60%) vote of all of the voting members of the Board, if they deem it in the best interest of the NCACH.
- 4.10 <u>Vacancies</u>. Any vacancy on the Executive Committee (whether due to removal, death or resignation) shall be filled by a majority vote of the remaining members of the Executive Committee. Any officer appointed by the Executive Committee shall serve until such time as the Board votes to fill the vacancy, or confirm the Executive Committee's appointment. Any officer appointed or confirmed by the Board under this Section 4.10 shall serve the remainder of the term of the officer who vacated the position.

#### V. COMMITTEES AND WORKGROUPS

- Appointment. The Board may appoint, from time to time, from its own members and/or the public, standing or temporary committees or workgroups consisting each of no fewer than two (2) Board members. A "workgroup" will be charged with working on a specific or discrete issue, as determined by the Board. Board members are expected to serve and participate on such committees and workgroups.
- Mith such powers as the Board may determine by resolution passed by a majority of the Board. No committee or workgroup (including the Executive Committee) shall have the authority of the Board in reference to amending, altering, or repealing these Bylaws; electing, appointing, or removing any member of any such committee or any Board member or officer of the organization; amending the Articles, adopting a plan of merger or adopting a plan of consolidation with another organization; authorizing the sale, lease, or exchange of all or substantially all of the property and assets of the organization other than in the ordinary course of business; authorizing the voluntary dissolution of the organization or adopting a plan for the distribution of the assets of the organization; or amending, altering, or repealing any resolution

of the Board which by its terms provides that it shall not be amended, altered, or repealed by such committee or workgroup. All committees so appointed shall keep regular minutes of the transactions of their meetings and shall cause them to be recorded in books kept for that purpose in the office of the organization. The designation of any such committee and the delegation of authority thereto shall not relieve the Board or any member thereof of any responsibility imposed by law.

- 5.3 <u>Standing Committees</u>. In addition to the Executive Committee, as of the date of these Bylaws, the Nominating Committee is a standing committee.
  - 5.3.1 <u>Nominating Committee Functions</u>. Not less than 90 days before the annual meeting, or as may be necessary to fill a vacancy, the Chair will appoint a Nominating Committee to evaluate Sector representatives as nominated by interested parties, or propose such Sector representatives. At least 30 days before the annual meeting, the Nominating Committee will forward the nominations to the Board for approval and voting at the annual meeting.

#### VI. FINANCE

6.1 <u>Finance</u>. It is anticipated that the finances of the NCACH will be administered by a backbone organization pursuant to a written agreement, which organization may be a public entity and with the NCACH finances administered consistent with the regulations governing a public entity. The annual budget shall be prepared by the Executive Director (working with the backbone organization, if applicable) and approved by the Board at the annual meeting of the Board. NCACH shall operate on a fiscal year which runs from January 1 to December 31.

If consistent with the operation of the backbone organization, the Board may establish by resolution a general fund of the NCACH with said fund administered by the Executive Director. This fund may be utilized for the payment of general operating expenses. Any non-budgeted expenditure in excess of \$5,000 dollars shall require prior approval by the Board, unless authorized under Section 4.2.

- 6.2 <u>Contracts</u>. The Board may authorize any officer or officers, agent or agents, to enter into any contract or execute and deliver any instrument on behalf of NCACH, and that authority may be general or confined to specific instances.
- 6.3 <u>Checks, Drafts, Deposits Etc</u>. Unless the agreement with the backbone organization provides otherwise, all checks, drafts or other orders for the payment of money, notes or other evidences of indebtedness issued in the name of NCACH shall be signed by the Executive Director and at least one (1) Board officer, and the funds of the NCACH shall be deposited in a timely manner to the credit of NCACH in the banks, trust companies or other depositories as the Board may select.
- 6.4 <u>Remuneration</u>. No salary shall be paid to members of the Board, committee, workgroup, Council or Coalition. Members may be reimbursed for reasonable and necessary expenses incurred for the purposes of doing business, and attending meetings on behalf of NCACH. Such expenses incurred may be reimbursed provided appropriate documentation and timely submission of expense receipts are provided within sixty (60) days of such occurrence.

#### VII. CONFLICT OF INTEREST AND PROHIBITED TRANSACTIONS

- 7.1 <u>Conflict of Interest: Policy and Annual Review</u>. The NCACH shall have a conflict of interest policy in effect at all times, which policy shall be adopted by the Board. All Board members will review, ratify and sign the policy at the beginning of their initial term and annually thereafter. To ensure ongoing compliance and operation of the NCACH consistent with its mission and purpose and if necessary to preserve any tax-exempt election made by the NCACH, the Board shall periodically review the conflict of interest policy and these Bylaws for compliance.
- 7.2 <u>Contents of Policy</u>. The conflict of interest policy shall define what constitutes a conflict of interest, the conflict notification and disclosures required by each member of the Board not less than annually, and the protocol for considering, approving or disapproving a transaction involving a conflict of interest.
- 7.3 No Loans. No loans shall be contracted on behalf of the NCACH and no evidences of indebtedness shall be issued in its name unless authorized by a resolution of the Board. That authority may be general or confined to specific instances. No loans shall be made by the NCACH to a Board member nor shall the NCACH guarantee the obligation of a Board member unless either: (a) the particular loan or guarantee is approved by the vote of a majority of the votes represented by members in attendance at the meeting upon which the matter is considered, except the vote of the benefited Board member, or (b) the Board determines that the loan or guarantee benefits the NCACH and either approves the specific loan or guarantee or a general plan authorizing loans and guarantees.

#### VIII. INDEMNIFICATION OF BOARD MEMBERS AND OFFICERS

8.1 <u>Indemnification.</u> As permitted by RCW 24.03.043 Indemnification of NCACH's Officers and Board members, shall be governed by RCW 23B.17.030 as presently enacted or hereafter amended, unless otherwise set forth herein.

#### 8.2 **Definitions.** As used in this Article.

- 8.2.1 "Act" means the Washington Nonprofit Corporation Act, as presently enacted or hereafter in force.
- 8.2.2 "Board member" means any person who is or was a Board member of NCACH and any person who, while a Board member of NCACH, is or was serving at the request of NCACH as a director, partner, trustee, employee, or agent of another corporation, partnership, joint venture, trust, other enterprise, or employee benefit plan. Board member includes, unless the context requires otherwise, the estate or personal representative of a Board member.

- 8.2.3 "Expenses" includes attorney's fees and costs.
- 8.2.4 "Indemnitee" means an individual made a party to a proceeding because the individual is or was a Board member or Officer of NCACH, and who possesses indemnification rights pursuant to the Articles, these Bylaws, Washington law, or other NCACH action.
- 8.2.5 "Liability" means the obligation to pay a judgment, settlement, penalty, fine, including an excise tax assessed with respect to an employee benefit plan, or reasonable expenses incurred with respect to a proceeding.
  - 8.2.6 "Official capacity" means:
  - 8.2.6.1 when used with respect to a Board member, the office of Board member in NCACH; and
  - 8.2.6.2 when used with respect to a person other than a Board member, the office in NCACH held by the officer.
- 8.2.7 "Party" includes a person who was, is, or is threatened to be, made a named defendant or respondent in a proceeding.
- 8.2.8 "Proceeding" means any threatened, pending, or completed action, suit, or proceeding whether civil, criminal, administrative or investigative.
- 8.3 Standard of Conduct--General. NCACH shall indemnify any person made a party to any proceeding (except as otherwise provided herein) by reason of the fact that he or she is or was a Board member or Officer against judgments, penalties, fines, settlements and reasonable expenses actually incurred by him or her in connection with such proceeding if he or she conducted himself or herself in good faith, and in the case of conduct in his or her own official capacity with NCACH, he or she reasonably believed his or her conduct to be in NCACH's best interest; or in all other cases, he or she reasonably believed his or her conduct to be at least not opposed to NCACH's best interests; and in the case of any criminal proceeding, he or she had no reasonable cause to believe his or her conduct was unlawful. The termination of any proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself be determinative that the person did not meet the requisite standard of conduct set forth in this paragraph.
- 8.4 <u>Standard of Conduct NCACH or Derivative Action</u>. NCACH shall indemnify any person made a party to any proceeding by or in the right of NCACH by reason of the fact that he or she is or was a Board member or Officer against reasonable expenses actually incurred by him or her in connection with such proceeding if he or she conducted himself or herself in good faith, and:
  - 8.4.1 In the case of conduct in his or her official capacity with NCACH, he or she reasonably believed his or her conduct to be in NCACH's best interests; or
  - 8.4.2 In all other cases, he or she reasonably believed his or her conduct to be at least not opposed to its best interests; provided that no indemnification shall be made

pursuant to this Section in respect of any proceeding in which such person shall have been adjudged to be liable to NCACH.

- 8.5 <u>Improper Personal Benefit</u>. A Board member or Officer shall not be indemnified in respect of any proceeding charging improper personal benefit to the Board member or Officer whether or not involving action in his or her official capacity, in which he or she shall have been adjudged to be liable on the basis that personal benefit was improperly received by the Board member or Officer.
- 8.6 **Expenses; Court Determination.** Unless otherwise limited by the Articles of Incorporation:
  - 8.6.1 A Board member or Officer who has been wholly successful, on the merits or otherwise, in the defense of any proceeding shall be indemnified against reasonable expenses incurred by him or her in connection with the proceeding; and
  - 8.6.2 A court of appropriate jurisdiction upon application of a Board member or Officer, and such notice as the court shall require, shall have authority to order indemnification in the following circumstances:
    - 8.6.2.1 if the court determines a Board member or Officer is entitled to reimbursement, the court shall order indemnification, in which case the Board member or Officer shall be entitled to recover the expenses of securing such reimbursement; or
    - 8.6.2.2 if the court determines that the Board member or Officer is fairly and reasonably entitled to indemnification in view of all the relevant circumstances, whether or not he or she has met the standards set forth herein or has been adjudged liable under the provisions herein, the court may order such indemnification as the court shall deem proper.
- 8.7 <u>Determination of Meeting Standard of Conduct</u>. No indemnification under these Bylaws shall be made by NCACH unless authorized in the specific case after a determination that indemnification of the Board member or Officer is permissible in the circumstances because he or she has met the standard of conduct set forth in the applicable subsection. Such determination shall be made:
  - 8.7.1 By the Board by a majority vote of a quorum consisting of Board members not at the time parties to such proceeding; or
  - 8.7.2 If such a quorum cannot be obtained, then by a majority vote of a committee of the Board, duly designated to act in the matter by a majority vote of the full Board (in which designation Board members who are parties may participate), consisting solely of two or more Board members not at the time parties to such proceeding; or
  - 8.7.3 In a written opinion by special legal counsel other than an attorney who has been retained by or who has performed services within the past three years for NCACH or any party to be indemnified, selected by the Board or a committee thereof by vote, or if the requisite quorum of the full Board cannot be obtained therefor and such

committee cannot be established, by a majority vote of the full Board (in which selection Board members who are parties may participate).

- 8.8 <u>Payment of Expenses in Advance</u>. Reasonable expenses incurred by a Board member or Officer who is party to a proceeding may be paid or reimbursed by NCACH in advance of the final disposition of such proceeding:
  - 8.8.1 After a determination based on the information then known to those making the determination (without undertaking further investigation for purposes thereof) that indemnification may be permissible under this Article; and
  - 8.8.2 Upon receipt by NCACH of a written affirmation by the Board member or Officer of his or her good faith belief that he or she has met the standard of conduct necessary for indemnification by NCACH as authorized in this Article; and a written undertaking by or on behalf of the Board member to repay such amount if it shall ultimately be determined that he or she has not met such standard of conduct; and
  - 8.8.3 The undertaking required above shall be an unlimited general obligation of the Board member or Officer but need not be secured and may be accepted without reference to financial ability to make the repayment.
- 8.9 <u>Inconsistent Provisions Invalid</u>. No provision for NCACH to indemnify a Board member or Officer who is made a party to a proceeding, whether contained in the Articles of Incorporation, these Bylaws, a resolution of members or Board members, an agreement, or otherwise shall be valid unless consistent with this Article VIII of the Bylaws, or to the extent that indemnity hereunder is limited by the Articles of Incorporation, consistent therewith. Nothing herein shall limit NCACH's ability to reimburse expenses incurred by a Board member or Officer in connection with his or her appearance as a witness in a proceeding at a time when he or she has not been made a named defendant or respondent in the proceeding.
- 8.10 Officers, Employees and Agents. Unless otherwise limited by the Articles of Incorporation:
  - 8.10.1 NCACH shall provide indemnification, including advances of expenses, to an officer of NCACH to the same extent that it may indemnify Board members pursuant to this Article; and
  - 8.10.2 NCACH, in addition, shall have the power, but not the requirement, to indemnify employees and agents of NCACH who are not Board members or officers, consistent with law, as may be provided by the Articles or these Bylaws, upon advance approval of such action of the Board.
- 8.11 <u>Insurance</u>. NCACH shall have power to purchase and maintain insurance on behalf of any person who is or was a Board member, officer, employee, or agent of NCACH or is or was serving at the request of NCACH as an officer, employee or agent of another association, partnership, joint venture, trust, other enterprise, or employee benefit plan against any liability asserted against him or her and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not NCACH would have the power to indemnify him or her against such liability under the provisions of this Article.

8.12 <u>Authority to Indemnify</u>. This Article is intended to authorize NCACH to indemnify officers, Board members, employees or agents to the fullest extent permitted by RCW 23B.17.030, RCW 23B.08.320 and RCW 23B.08.500 through 23B.08.600, as now enacted or hereafter amended. In the event of a change in the applicable law permitting greater indemnification, the Board is authorized to take the appropriate action to cause NCACH to provide such indemnification.

#### IX. DISTRIBUTION.

Upon dissolution of the NCACH, all assets shall be distributed solely to one or more charitable, educational, religious or scientific organizations that qualify as exempt under section 501(c)(3) of the Internal Revenue Code, or any successor statute. Decisions regarding dissolution will be made by the Board; provided that no transfer will be made that will adversely affect the NCACH's exempt status.

#### X. AMENDMENTS

The Board shall have power to make, alter, amend and repeal the Bylaws of NCACH, provided the Board will not approve any such alteration, amendment or repeal on which such action shall first have received approval of sixty percent (60%) of the voting membership of the Board. The Board shall receive ten (10) business days' notice of any proposed action to alter or amend the Bylaws of NCACH. This may be accomplished at either a regular or special meeting with notice given as specified in Article XII.

#### XI. PARLIAMENTARY PROCEDURE

As set forth in Section 3.9.8, the rules contained in "Robert's Revised Copy," Robert's Rules of Order, shall govern the NCACH in all cases to which they are applicable and which are not inconsistent with the Articles and these Bylaws of NCACH. The Board, in its discretion, may adopt alternate rules of procedure provided such rules are not inconsistent with the Articles and these Bylaws, or any amendments thereto.

I certify that the foregoing Bylaws of the North Central Accountable Community of Health were duly adopted by the members of the Governing Board on March  $\underline{6}$ , 2017.

	D. J. W. J
Barry Kling	Douglas Wilson
Theresa Sullivan	Kevin Abel
Sheila Chilson	
Bruce Buckles	Nancy Nash-Mendez
 Kat Ferguson-Mahan Latet	Rick Eickmeyer
Jesus Hernandez	Peter Morgan
Jesus nei nanuez	
Linda Evans Parlette	



Secretary of State

I, KIM WYMAN, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

### CERTIFICATE OF INCORPORATION

to

### NORTH CENTRAL ACCOUNTABLE COMMUNITY OF HEALTH

a/an WA Non-Profit Corporation. Charter documents are effective on the date indicated below.

Date: 3/22/2017

UBI Number: 604-107-439



Given under my hand and the Seal of the State of Washington at Olympia, the State Capital

Kim Wyman, Secretary of State

Date Issued: March 30, 2017

Office of the Secretary of State Corporations & Charities Division

# **Washington Nonprofit Corporation** See attached detailed instructions

Filing Fee \$30.00 FilingFee with Expedited Service \$80.00

This Box For				

### **ARTICLES OF INCORPORATION**

**UBI Number:** 

Chapter 24.03 RCW				
ARTICLE 1 NAME				
OF CORPORATION:				
North Central Accountable Community of Health				
( <u>MAY NOT</u> contain any of the following designations or abbreviations of: Corporation, Company, Incorporated, Limited, Limited Partnership, Limited Liability Company, or Limited Liability Partnership. If one of the prohibited designations is used, it will be removed when processed.)				
ARTICLE 2				
EFFECTIVE DATE OF INCORPORATION (please check one of the following):				
f F Upon filing by the Secretary of State $$				
F Specific Date: (Specified effective date must be within 30 days AFTER the Articles of Incorporation have been filed by the Office of the Secretary of State.)				
ARTICLE 3				
TENURE (please check one of the following and indicate the date if applicable):				
F Perpetual existence √				
F Specific term of existence (Number of years or date of termination)				
ARTICLE 4				
PURPOSE FOR WHICH THE NONPROFIT IS ORGANIZED: (if necessary, attach additional information)				
See attached				
ARTICLE 5				
IN THE EVENT OF A VOLUNTARY DISSOLUTION, THE NET ASSETS WILL BE DISTRIBUTED AS				
FOLLOWS: (if necessary, attach additional information) Any non-allocated NET assets will be returned to the entity  That the North Central Accountable Community of Health received those funds from.				

Page 2 of 2

	ARTICLE 6				
NAME AND ADDRESS OF EACH INITIAL Additional Names Attached	DIRECTOR: (If neces	sary, attach additio	nal names and	addresses) –	
Name:Linda Parlette					
Address: _200 Valley Mall Parkway					
CityEast Wenatchee	State _ <b>WA</b> _	Zip Code _	98802		
	ARTICLE 7				
NAME AND ADDRESS OF THE WASHING	GTON STATE REGIS	TERED AGENT:			
Name:Linda Parlette					
Physical Location Address (required):					
200 Valley Mall Parkway					
CityEast Wenatchee		WA	A Zip Code	98802	
Mailing or Postal Address (optional):	•				
200 Valley Mall Parkway					
CityEast Wenatchee		Zip Code _	98802		
CONSENT TO SERVE AS REGISTERED AGENT:  I consent to serve as Registered Agent in the State of Washington for the above named corporation. I understand it will be my responsibility to accept Service of Process on behalf of the corporation; to forward mail to the corporation; and to immediately notify the Office of the Secretary of State if I resign or change the Registered Office Address.  A LINDA LAZLETTE 3/20/2017					
Signature of Registered Agent	ARTICLE 8	ed Name		Date	
NAME, ADDRESS AND SIGNATURE OF (If necessary, attach			atures)		
Name: _Linda Parlette	·····				
Address: 200 Valley Mall Parkway	<u>-</u>				
CityEast Wenatchee		State <u>WA</u>	Zip Code	98802	
This document is hereby executed under positive of incorporator	enalties of perjury, and is Linder Parcere, Printed Name/Title	EXECUTIVE T		8866438	
Important note: If your nonprofit organi	zation is currently fu				

Important note: If your nonprofit organization is currently fundraising, or plans to fundraise from the public, it may also be required to register with the Charities Program of the Secretary of State. Registration with the Charities Program is separate from, and in addition to, filings required under corporate law. Please visit the Charities Program website at www.sos.wa.gov/charities/ to review the registration requirements and forms for Charitable Organizations.

### INSTRUCTIONS - NONPROFIT ARTICLES OF INCORPORATION

Please complete all sections of the Articles of Incorporation. . **USE DARK INK ONLY.** For an electronic, fillable version of this form, please visit our website at <a href="https://www.sos.wa.gov/corps">www.sos.wa.gov/corps</a> RUHPDLOFRUSV#VRVZDJRYIRUPRUHLQIRUPDWLRQ

#### Article 1:

Enter the name of the corporation. In accordance with Chapter 24.03 RCW a nonprofit corporation <u>may not</u> contain any of the following designations or abbreviations of: Corporation, Company, Incorporated, Limited, Limited Partnership, Limited Liability Company, or Limited Liability Partnership, but may use "club," "league," "association," "services," "committee," "fund," "society," "foundation," a nonprofit corporation," or any name of like import. *If one of the prohibited designations is used, it will be removed when processed.* A nonprofit corporate name must be distinguishable upon the records of the Secretary of State from any other formally organized entity registered with the Secretary of State's office. It's advised that you contact the Secretary of State to check for name availability before filing at 360-725-0377.

#### Article 2:

An effective date may be specified. The effective date can be up to 30 days AFTER the Articles of Incorporation have been filed by the Office of the Secretary of State.

#### Article 3:

Please indicate whether the term of existence for nonprofit corporation is perpetual (i.e. ongoing until dissolved) or if it will have a specific term of existence, in which case indicate the number of years it will exist.

#### Article 4:

Indicate the purpose for which the nonprofit is being organized. You may attach additional information if needed. **Do not** attach or refer to the bylaws.

#### Article 5:

Indicate how any assets will be distributed if the nonprofit voluntarily dissolves. **Do not** attach or refer to the bylaws.

#### Article 6:

List the names and address of <u>all</u> initial directors of the nonprofit corporation. If necessary you may attach a sheet with additional names and addresses. <u>Do not</u> include social security numbers, federal tax identification or other personal identifiers.

#### Article 7:

All corporations must have a Registered Agent in Washington State. The Registered Agent may be an individual who is a resident of Washington State, or a business entity registered with the Secretary of State's office. The agent **must have** a physical address in Washington State where personal service of process may be made. An alternative mailing address may be used in addition to the physical address. **The Registered Agent must print their name and sign the consent to serve as Registered Agent.** 

#### Article 8:

An Incorporator is a person(s) forming the corporation. Please provide the full name, signature and address of each Incorporator. All incorporators <u>must</u> sign the articles of incorporation. If necessary you may attach a sheet with additional names, signatures and addresses. <u>Do not</u> include social security numbers, federal tax identification or other personal identifiers.

**Additional Information:** You may attach any optional provisions to these articles (please do not attach bylaws or minutes, these items are not filed with this office).

**FEES:** The filing fee for Nonprofit Articles of Incorporation is \$30.00. If expedited service is requested, include an additional \$50.00 and write "EXPEDITE" on the outside of the envelope. Make the checks or money orders payable to "Secretary of State". **\$00SD\PHQWVPXVWEHUHFHLYHGLQ86'ROODUV\$OOIHHVDUHQRQUHIXQGDEOH** 

#### Mail completed forms and payment to:

Secretary of State Corporations Division 801 Capitol Way S PO Box 40234 Olympia WA 98504-0234

#### ARTICLE 4: PURPOSE IN WHICH THE NON PROFIT IS ESTABLISHED

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.

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.

#### ARTICLE 6 NAME AND ADDRESS OF EACH INITIAL DIRECTOR:

(If necessary, attach additional names and addresses)

Name: Barry Kling

Address: 200 Valley Mall Parkway East Wenatchee, WA 98802

Name: Douglas Wilson

o Address: 17 S Western Ave Tonasket, WA 98855

Name: Theresa Sullivan

Address: 801 East Wheeler Road Moses Lake, WA 98837

• Name: Kevin Abel

Address: 503 E Highland Ave Chelan, WA 98816

Name: Sheila Chilson

Address: 605 S. Coolidge St. Moses Lake, WA 98837

Name: Winnie Adams

Address: 420 Old Station Road Wenatchee, WA 98801

Name: Bruce Buckles

o Address: 50 Simon St. Suite A East Wenatchee, WA 98802

Name: Nancy Nash - Mendez

o Address: 110 Oak St. Okanogan, WA 98840

Name: Kat Ferguson-Mahan Latet

o Address: 1111 3rd Ave Suite 400 Seattle, WA 98101

Name: Ray Eickmeyer

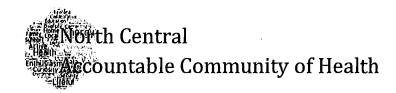
o Address: 503 E Highland Ave Chelan, WA 98816

Name: Jesus Hernandez

o Address: 716 1st Ave S. Okanogan, WA 98840

Name: Peter Morgan

o Address: 716 1st Ave S. Okanogan, WA 98840



### **Fully-Integrated Medicaid Contracting Advisory Committee Charter**

#### Mission

The purpose of the Fully-Integrated Medicaid Contracting (FIMC) Advisory Committee is to serve as the primary local advisory body providing stakeholder input regarding the implementation of fully integrated Medicaid contracting in Grant, Chelan, and Douglas counties beginning January 1, 2018 and incorporating Okanogan County by January 1, 2020.

#### **Background**

In September 2016, Grant, Chelan, and Douglas Counties voted to pursue fully-integrated Medicaid contracting by January 1, 2018. Beginning in January 2018, the Health Care Authority (HCA) will contract with Medicaid Managed Care Organizations (MCOs) to provide the full continuum of physical, mental health, and substance use disorder services to Medicaid enrollees. The selected MCOs will contract with a network of local physical and behavioral health providers to deliver these services.

#### **Purpose**

- Provide information and recommendations to HCA regarding the current health care
  delivery and payment system in North Central Washington, and to inform the
  implementation of fully-integrated managed care; ensuring that regional priorities and local
  considerations are incorporated in program design.
- Provide feedback to the State to inform key decision-making and respond to proposals put forth by the HCA.
- Identify potential opportunities for technical assistance that could assist providers or other stakeholders during the transition to full integration. Inform HCA and the North Central Accountable Community of Health (NC ACH) about technical assistance needs identified in the community.
- Inform HCA and the NC ACH board about any problems, issues or concerns from the local level
- Assist the State in engaging additional stakeholders in North Central, by educating stakeholders who may not be as informed about the transition, keeping regional stakeholders and community members informed of implementation progress and helping to answer questions in the community.

#### **Key Deliverables**

- Develop an Early Warning System for North Central Washington to identify and resolve implementation issues quickly, to be put into use on January 1, 2018
- Deliver a final report by January 31, 2018 that outlines all activities completed and the detailed plan for the Early Warning System.

#### Authority

The FIMC Advisory Committee is not a decision-making body in itself, but is an advisory body that will inform decision-making and ensure regional priorities and local considerations are incorporated in program design decisions.



CHI SUB-CONTRACT Sub-Contract Under HCA Contract Number: K1437 Amendment 5

Plan DISTA										
THIS AGREEMENT made by and between	Chelan-Do	uglas Hea	lth Distric	t, hereinafter r	eferred to as "	CDHD," acting on				
THIS AGREEMENT made by and between Chelan-Douglas Health District, hereinafter referred to as "CDHD," acting on behalf of the North Central Accountable Community of Health ("NCACH") pursuant to HCA Contract K1437 Amendment										
5, and the party whose name appears below, hereinafter referred to as the "Awardee."										
AWARDEE NAME	A\	AWARDEE doing business as (DBA)								
			Okanogan County Public Health							
Okanogan County Public Health			WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)							
AWARDEE ADDRESS			WASHINGTON UNIFORM BOSINESS IDENTIFIER (ODI)							
1234 South 2nd Avenue		60	600 600 607							
Okanogan, WA 98840			602-689-697							
AWARDEE CONTACT	I AWARD	FF TFI F	L ELEPHONE   AWARDEE E-MAIL ADDRESS							
//////DEE COMME				liones@co.okanogan.wa.us						
Eauli Jones, Community Fleatin Directo	Lauri Jones, Community Health Director   509-422-71			1,01100@0010	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
Primary HCA Contractor:			CDF	ID Program:						
Chelan-Douglas Health District		Nort	North Central Accountable Community of Health							
CDHD CONTACT NAME AND TITLE				D CONTACT						
Kandis Boersema, Associate Administrator				Valley Mall Par		•				
Mailuis Boeisema, Abboolato Administrator		*	East	Wenatchee, W	/A 98802					
CDHD CONTACT TELEPHONE				CDHD CONT	ACT E-MAIL	ADDRESS				
(509) 886-6483			Kandis.Boersema@cdhd.wa.gov							
IS THE AWARDEE A SUBRECIPIENT FOR PU	RPOSES OF	THIS	CFDA NU	JMBER(S)		FFATA Form				
CONTRACT?			N/A			Required				
□YES ⊠NO				<del> </del>		□YES ⊠NO				
AWARD START DATE	AWARD	END DA	TE		TOTAL MAXI AMOUNT	MUM AWARD				
Parishina 0047	lanuane	21 2018			\$12,000					
reditally 1, 2017										
PURPOSE OF AWARD: Under general direction of the North Central Accountable Community of Health, organize and document CHI (Coalition										
for Health Improvement) meetings at least quarterly within Okanogan County pursuant to the purposes of HCA Contract										
K1437 Amendment 5. CHI meetings will include a broad range of community health partners and stakeholders interested										
in the activities and projects of the North Ce	entral Accou	ntable Co	mmunity	of Health.						
Billing: Awardee may claim payment from (	CDHD by su	bmitting a	an invoice	to the address	and contact	person identified				
phovo										
Dolly crabbes: Awardee must provide minutes to the NCACH Executive Director from at least 4 CHI meetings conducted										
during the sub-contract period, including a count and a list of attendees to the extent possible (recognizing that call-in										
ettended are not always identifiable) and a summary of the topics discussed at the CHI sessions. Copies of any printed I										
or other materials used at the CHIs will be included with the CHI report. CHI reports must be submitted within 60 days of										
the CHI										
This cub contract incorporates by reference the terms and conditions of HCA Contract K1437 and Amendment 5										
(attached) and the services and activities delivered under this sub-contract are an integral part of achieving the										
deliverables set forth in that contract and amendment. This sub-contract and its references are the initial, entire and										
evaluative understanding between the parties superseding and merging all previous agreements, writings, and										
communications, oral or otherwise, regarding the subject matter of this AWARD. The barries signing below warrant										
that thou have read and understand this Award, and have authority to execute this Award. This Award shall be										
hinding on CDHD only upon approval by the CDHD Board of Health and the signature of the North Central										
Accountable Community of Health's Executive Director.										
AWARDEE SIGNATURE	P	PRINTED NAME AND TITLE				DATE SIGNED				
Y ()			i Joh	3/28/17						
	770				)	7. 3/1/				
CDHD/NCACH SIGNATURE 1/	P	PRINTED NAME AND TITLE DATE SIGNE								

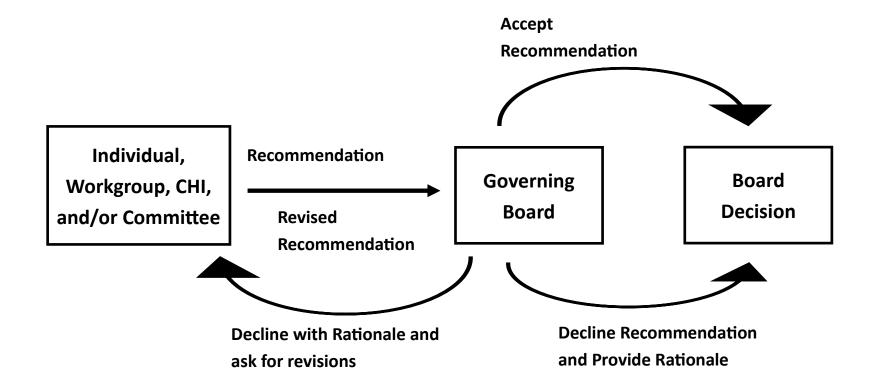


### CHI SUB-CONTRACT

Sub-Contract Under HCA Contract Number: K1437 Amendment 5

THIS AGREEMENT made by and between Cl behalf of the North Central Accountable Comm	nunity of Healt	h ("NC <i>P</i>	("HD	oursuant to He	referred to as "C CA Contract K1	DHD," acting on 437 Amendment			
5, and the party whose name appears below,	T AVAIA	AWARDEE doing business as (DBA)							
AWARDEE NAME			Grant County Health District						
Grant County Health District		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)							
AWARDEE ADDRESS			WASHINGTON ONIFONNI BOSINESS IDENTIFIER (SSI)						
1038 W Ivy St									
Moses Lake WA 98837			602-442-040						
AWARDEE CONTACT AWARDEE TE			ELEPHONE   AWARDEE E-MAIL ADDRESS						
Theresa Adkinson, Administrator				0 ext. 24 tadkinson@granthealth.org					
Primary HCA Contractor:			CDHD Program:						
Chelan-Douglas Health District			North Central Accountable Community of Health						
CDHD CONTACT NAME AND TITLE			CDHD CONTACT ADDRESS 200 Valley Mall Parkway						
Kandis Boersema, Associate Administrator			East Wenatchee, WA 98802						
CDHD CONTACT TELEPHONE			CDHD CONTACT E-MAIL ADDRESS						
(509) 886-6483			Kandis.Boersema@co						
IS THE AWARDEE A SUBRECIPIENT FOR PURP	OSES OF THIS	CF N/		MBER(S)		FFATA Form Required			
CONTRACT?			4			TYES ⊠NO			
☐YES ☑NO AWARD START DATE	AWARD END	DATE			TOTAL MAXI	IUM AWARD			
7,7,7,1,2 017,111, 2.11,2					AMOUNT.				
February 1, 2017	January 31, 2	018			\$12,000				
PURPOSE OF AWARD:									
Under general direction of the North Central Accountable Community of Health, organize and document CHI (Coalition for Health Improvement) meetings at least quarterly within Grant County pursuant to the purposes of HCA Contract									
K1437 Amendment 5. CHI meetings will include a broad range of community health partners and stakeholders interested									
in the activities and projects of the North Central Accountable Community of Health.									
Billing: Awardee may claim payment from CDHD by submitting an invoice to the address and contact person identified									
above									
Deliverables: Awardee must provide minutes to the NCACH Executive Director from at least 4 CHI meetings conducted during the sub-contract period, including a count and a list of attendees to the extent possible (recognizing that call-in									
ettendees are not always identifiable) and a summary of the topics discussed at the CHI sessions. Copies of any printed									
or other materials used at the CHIs will be included with the CHI report. CHI reports must be submitted within 60 days of									
the CHI									
This sub-contract incorporates by reference the terms and conditions of HCA Contract K1437 and Amendment 5									
(attached) and the services and activities delivered under this sub-contract are an integral part of achieving the deliverables set forth in that contract and amendment. This sub-contract and its references are the final, entire and									
exclusive understanding between the parties superseding and merging all previous agreements, writings, and									
communications, oral or otherwise, regarding the subject matter of this Award. The parties signing below warrant									
that they have read and understand this Award, and have authority to execute this Award. This Award shall be									
binding on CDHD only upon approval by the CDHD Board of Health and the signature of the North Central									
Accountable Community of Health's Execut	ive Director.	-D 11414F	AND	T. C.	<del></del>	DATÉ SIGNED			
AWARDEE SIGNATURE ,	PRINT	ED NAME	AND II	ILE		DATE SIGNED			
1 Mr. Adl so.	There	16.6	VAN	hat va		4)2017			
CDHD/NCACH SIGNATURE		D NAME	AND T	TLE		DATE SIGNED			
ODI IDRIONO I GIGIANI GNE			•						

# Individual, Workgroup, Committee, and CHI Decision Making Flowchart



There are multiple ways an individual can provide input and feedback back to the Governing Board. They are through the following channels:

- 1. Local Coalitions for Health Improvement
- 2. Attending Public Board Meetings
- 3. Governing Board Executive Committee
- 4. Governing Board Member
- 5. NC ACH Executive Director

# **NCACH Governing Board**

# **Executive Committee**

**Board Chair** Barry Kling, Chelan-Douglas Health District **Vice-Chair** Kevin Abel, Lake Chelan Community Hospital

Treasure Sheila Chilson, Moses Lake Community Health Center
Secretary Winnie Adams, North Central Educational Service District

# **Board Members**

Behavioral Health Tim Hoekstra, Columbia Valley Community Health

Confluence Health – CWHRick Hourigan MD, Confluence HealthConfluence Health – PCPDoug Wilson MD, Confluence HealthPublic Hospitals – Position 1Theresa Sullivan, Samaritan HealthcarePublic Hospitals – Position 2Kevin Abel, Lake Chelan Community Hospital

Federally Qualified Health Center Sheila Chilson, Moses Lake Community Health Center

**Business Community** Open

**Elected Official** Senator Judy Warnick, State Senator 13<sup>th</sup> District

**Education** Winnie Adams, North Central Educational Service District

Public HealthBarry Kling, Chelan-Douglas Health DistrictAging and Adult CareBruce Buckles, Area Agency on Aging

Hispanic Community Nancy Nash-Mendez, Okanogan Housing Authority

Medicaid Managed Care Organization Kat Ferguson Mahan Latet, Community Health Plan of Washington

Tribal Representative Open

At-Large Seat Ray Eickmeyer, North Central Emergency Care Council

**Leadership Council – Position 1** Jesus Hernandez, Family Health Centers **Leadership Council – Position 2** Peter Morgan, Family Health Centers

# **Governing Board Chair - Barry W. Kling**

Administrator, Chelan-Douglas Health District

After earning a Master of Science degree in Public Health from the University of Missouri-Columbia School of Medicine in 1978, Barry went to work for the Shoshone and Arapahoe Tribes on the Wind River Reservation in Wyoming, to help the Tribes establish a tribal health department. When that job was largely complete he moved to Twin Falls, Idaho, where he worked for two years at an 8-county public health district as Director of Health Education. In that position he was able to attract two of the early CDC Health Education Risk Reduction grants, one focused on childhood injury prevention (an especially common problem in that area) and the other on an innovative school health education curriculum. In 1983 Barry returned to the University of Missouri, initially as State Specialist for Health Education in the Missouri Cooperative Extension Service. For the next twenty years, he developed and implemented rural health and health professions education programs from a base in the School of Medicine, where he was Associate Dean for External Affairs for his last 3 years with the School. His work involved a wide range of projects, including cardiovascular risk reduction projects for small rural communities, medical self-care programs for young families, the support of rural providers including continuing medical education in small communities, organizing national and international medical conferences, and the development of a nationally recognized rural telemedicine network. Barry came to Wenatchee, Washington because he wanted to return to his roots in public health, and wanted to live in a small Western community near good mountains. He has served as administrator of the Chelan-Douglas Health District since 2003, and was involved in the process of developing the North Central ACH from its inception. He serves as the Public Health Representative on its board, and as its current chair.

# **Governing Board Vice Chair - Kevin Abel**

CEO, Lake Chelan Community Hospital and Clinics

Kevin Abel, MBA, M.Ed., CPA, is the Chief Executive Officer of Lake Chelan Community Hospital & Clinics. Mr. Abel has 18 years healthcare experience serving in executive leadership, finance and operations positions. He is a member of the American College of Healthcare Executives, the Healthcare Financial Management Association and the American Institute of Certified Public Accountants. Mr. Abel has extensive board experience including the Washington State Hospital Association, the Association of Washington Public Hospital Districts, the Public Hospital District Unemployment Compensation Trust, Lake Chelan Rotary Club, and the Bend Park and Recreation District Finance Committee. Mr. Abel and his wife Christine live in Chelan Washington.

# **Governing Board Treasurer - Sheila Chilson**

CEO, Moses Lake Community Health Center

Education: Gonzaga University, May 1990, Bachelor of Business Administration – Accounting

Experience: 2008 – Present Chief Executive Officer, Moses Lake Community Health Center

2002 - 2008 Chief Financial Officer, Moses Lake Community Health Center

2000 - 2002 Controller, Piston Service of Wenatchee, Inc.

1998 - 2000 Executive Director Financial Services, Richland School District

1992 - 1998 Business Manager, Ephrata School District

Affiliations: Board member, Boys & Girls Club of the Columbia Basin

Chair, Homeless Taskforce of Grant County

Board chair, Community Health Plan and Community Health network of

Washington

# **Governing Board Secretary – Winnie Adams**

School Nurse Corps Director, North Central Educational Service District

Winnie has been a nurse for 26 years with a wide range of nursing experience from long-term care, clinic nursing, Obstetrics and Pediatric hospital nursing, school nursing and nursing leadership. She hase three boys and two years ago re-married which grew our family to six children ranging from 26 year old to 10 year old (Four boys and two girls). Winnie is finishing up on a dual Master's degree in Nursing Leadership and Business Administration, graduation July 2017. She has been the School Nurse Corps Director for 3 years this June. When I am not working, being a mother and a wife I enjoy biking, running and hiking.

# **Executive Director - Linda Evans Parlette**

Linda is currently the Executive Director of the North Central Accountable Community of Health (NCACH). Prior to accepting this position she was a member of the Washington State Senate and served the state's 12th Legislative District for 20 years, and filled the Elected Official position on the NCACH Governing Board Chair. While in the Senate, Parlette served as Senate Republican Caucus Chair for 10 years, was a member of the Health and Long-Term Care; Ways and Means; and Rules committees, and was the ranking Republican on the Capital Budget in 2011 - 2012. In 1968 Senator Parlette earned her bachelor's degree (with honors) in Pharmacy from Washington State University. She has worked many years as a pharmacist for many independent pharmacies across North Central Washington. Her pharmacy background informs her legislative work to improve access to health care, which includes service on the National Conference of State Legislatures' Health Care Committee; the governor's Blue Ribbon Commission on Health Care; the state's Joint Task Force on Mental Health Services and Financing; and the Adult Behavioral Health System Task Force, which she co-chaired. Locally Senator Parlette has serviced as a former member of the North Central ESD board and a former Chair of the Lake Chelan School board. Parlette served as a member of the William D. Ruckelshaus Center's Advisory Board, is active in Rotary, and other community activities.

### **NCACH Staff Organizational Chart Executive Director** Linda Parlette (1.0 FTE) **Program Manager FIMC Advisory** Bi Directional **Director of Clinical Program Development Executive Assistant** Coordinator Integration (2A) John Schapman **Change Management** Specialist Teresa Davis Program Development (1.0 FTE) **Tentative Open Position** (1.0 FTE or Contracted) Christal Eshelman (1.0 FTE) Data Collection, Analysis, (0.5 FTE) Specialist (0.5 FTE) Oversight/Lead of (0.5 FTE) **Supports Executive** Position through January 31<sup>st</sup> **Demonstration Project and** Supports WPC and Reporting for Support the work of the Director and 2018 **General Operations** Collaborative and initiatives Demonstration Collaborative Director Program Manager Supports FIMC Advisory through Project 2A Committee and FIMC Workgroups Opioid Project (3A) Program Development Specialist (0.5 FTE) Support the Required Project 3A Optional Project #1 Program Development Specialist (1.0 FTE) **Contractors Optional Project #2** Program Development Specialist (0.5 FTE) **Chelan-Douglas Okanogan Public Grant County Health District** Health **Health District** Chelan-Douglas CHI Okanogan CHI **Grant CHI**

(Contractor)

# **North Central Accountable Community of Health**

Conflict of Interest Policies and Procedures

# **Article 1. Purpose**

The purpose of this policy is to help inform the North Central Accountable Community of Health (NC ACH) Board of Directors (Directors) about what constitutes a conflict of interest, and assist the Directors in identifying and disclosing actual and potential conflicts. The NC ACH is a collaborative of interested parties and it is acknowledged that Directors have personal, tribal, organizational and/or sector-specific self-interests.

Whether a disclosed interest constitutes a conflict, a potential conflict or a perceived conflict of interest is determined by the NC ACH in its discretion by the process set forth in this policy. This policy enables individuals to understand, identify, manage and appropriately disclose actual, potential or perceived conflicts of interest. This policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest applicable to nonprofit and charitable organizations.

In addition, this policy is intended to acknowledge those situations in which a conflict of loyalty may exist as to a Director. A Director owes the NC ACH a duty of loyalty to act in the best interest of the NC ACH, which duty may be at odds with a duty of loyalty owed by the Director to, or an affiliation with, another organization. Such conflict of loyalty, however, does not necessarily rise to the level of a personal or financial conflict of interest for the purpose of this policy.

Conflicts of interest arise all the time. They are inevitable especially where the Board composition is based upon representation of various stakeholder groups with particular expertise. It is not possible to avoid all conflict-of interest situations. The purpose of this policy is to help Directors recognize and handle them effectively.

# **Article 2. Definitions**

## 1. Interested Person

Any director, principal officer, member, or delegate who has a direct or indirect financial or personal interest, as defined below, is an interested person.

# 2. Conflict of Interest

An actual conflict of interest occurs where an interested person's judgment could be affected because he or she has a personal interest in the outcome of a decision over which the interested person has control or influence. The conflict of interest is present when an interested person's stake in a transaction or decision is such that it reduces the likelihood that the interested person's influence can be exercised impartially in the best interests of the NC ACH. This policy sets forth two types of conflicts of interest: financial and personal.

# 3. Financial Conflict of Interest

A person has a financial interest if the person has, directly or indirectly, through business, investment, or family:



- An ownership or investment interest in any entity with which NC ACH has a transaction or arrangement,
- b. A compensation arrangement with NC ACH or with any entity or individual with which NC ACH has a transaction or arrangement, or
- c. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which NC ACH is negotiating a transaction or arrangement.

Compensation includes direct and indirect remuneration as well as gifts or favors that are not insubstantial. A financial interest is not necessarily or automatically a conflict of interest and the particular facts and circumstances must be reviewed by the Board of Directors or appropriate Committee for a determination that a conflict of interest exists.

### 4. Personal Conflict of Interest

When a director, principal officer, member, delegate or a member of his or her immediate family, including the individual's spouse, domestic partner, child or parent, stands to directly or indirectly gain or be favorably impacted as a result of a decision.

In general, this policy does not intend that a personal conflict shall necessarily arise where a proposed action implicates a Director's dual duty of loyalty to the NC ACH and loyalty to, or affiliation with, another entity. By way of example, the NC ACH may be called upon to make a recommendation, or take an action that favors one sector over another, without implicating a direct contractual relationship with an entity. In light of the diverse Board composition, such Board recommendation or action will likely favorably or unfavorably impact certain sectors represented by the Board. In the absence of a direct contractual relationship with, or other direct and specific monetary award to, an entity in which the Director has an interest, this policy contemplates that Directors will be able to reconcile their dual obligations, and maintain impartiality. While it shall be the Director's obligation to disclose the Director's affiliations on the annual conflict disclosure, the Director need only disclose as required under Article 3, if the Director believes that there are material facts, apart from sector representation itself that may affect the Director's ability to act impartially. Nothing in this Section 4 shall preclude the Board from finding that a Director's conflict of loyalty rises to the level of a personal conflict of interest and requires disclosure and possible recusal of the Director, as set forth in Article 3, Section 5, below.

# **Article 3. Procedures**

# 1. Duty to Disclose

Each interested person shall disclose all material facts regarding his or her interest in the transaction under consideration promptly upon learning of the proposed transaction or arrangement. The interested person shall err on the side of caution in the disclosure, keeping in mind that the NC ACH wishes to conduct itself with integrity and with the avoidance of appearance of conflict. Upon disclosure by the interested person, the chair shall ask the remaining Directors or Committee Members, as the case may be, to make a determination whether a real or potential conflict of interest exists. In all instances, such determination shall be made before the Board of Directors votes on any agenda item related to an expenditure, awarding of a contract or other monetary transaction.

# 2. Determining Whether a Conflict of Interest Exists

After disclosure of all material facts by a Director (the "disclosing Director"), the remaining Directors or appropriate Committee Members shall determine if a personal or financial conflict of interest exists for the



interested person. The disclosing Director(s) and any other interested person(s) involved with the transaction shall not be present during the discussion or determination of whether a personal conflict of interest exists. The remaining Directors or Committee Members shall decide if a conflict of interest exists. A Director for whom a conflict of interest has been found to exist is an "interested Director".

# 3. Procedures for Addressing a Personal Conflict of Interest

The Directors may ask questions of and receive presentation(s) from the interested Director(s) and any other interested person(s), but shall deliberate and vote on the transaction in their absence. The Directors shall ascertain that all material facts regarding the transaction and the interested Director's conflict of interest have been disclosed and shall compile appropriate data, such as comparability studies, and shall determine fair market value for the transaction if applicable.

After exercising due diligence, which may include investigating alternatives that present no conflict, the Directors shall determine whether the transaction is in the NC ACH's best interest, for its own benefit, and whether it is fair and reasonable to the NC ACH before approving or disapproving the transaction.

# 4. Procedures for Addressing a Financial Conflict of Interest

When a vote is required on a matter, and a conflict of interest is a financial conflict of interest, the conflict will be stated on the record and the Board vote will resume with all voting except the interested Director will abstain from the vote. An interested Director with a financial conflict of interest may be present and participate in the discussion and be present during the voting process as long as the conflict is not a personal conflict and has been disclosed.

# 5. Violations of the Conflict of Interest Policy

If a Director or Committee Member has reasonable cause to believe a person has failed to disclose actual or potential conflict of interest, it shall inform the person of the basis for such belief and afford the person an opportunity to explain the alleged failure to disclose.

If, after hearing the person's response and after making further investigation as warranted by the circumstances, the Director or Committee Member determines the person has failed to disclose an actual or potential conflict of interest, the Board shall take appropriate disciplinary and corrective action. The Board's determination as to the existence of an actual or potential conflict of interest in conformity with this policy shall be conclusive and binding.

# **Article 4. Records of Proceedings**

The minutes of meetings of Board of Directors and all Committees with Board delegated powers shall contain:

- a. The names of the persons who disclosed or otherwise were found to have a financial interest in connection with an actual or potential conflict of interest, the nature of the financial interest, any action taken to determine whether a conflict of interest was present, and the Board's or Committee's decision as to whether a conflict of interest in fact existed.
- b. The names of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed



transaction or arrangement, and a record of any votes taken in connection with the proceedings, together with the identification of those who abstained or recused themselves.

# **Article 5. Compensation**

- a. A voting member of the Board who receives compensation, directly or indirectly, from NC ACH for services is precluded from voting on matters pertaining to that member's compensation.
- b. A voting member of any Committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from NC ACH for services is precluded from voting on matters pertaining to that member's compensation.
- c. No voting member of the Board or any Committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from NC ACH, either individually or collectively, is prohibited from providing information to any committee regarding compensation.

## **Article 6. Periodic Statements**

Each Director and Officer shall annually sign a statement that affirms such person:

- a. Has received a copy of the conflict of interest policy,
- b. Has read and understands the policy,
- c. Has agreed to comply with the policy, and
- d. Understands that NC ACH is a charitable organization and in order to maintain its Washington State Nonprofit corporation status it must engage primarily in activities which accomplish one or more of its purposes in which the Nonprofit is established.

# **North Central Accountable Community of Health**

Conflict of Interest Policy Certification

The undersigned hereby acknowledges that the undersigned:

- (a) Has received a copy of the conflict of interest policy,
- (b) Has read and understands the conflict of interest policy,
- (c) Has agreed to comply with the conflict of interest policy, and
- (d) Understands that NC ACH is a charitable organization and in order to maintain its Washington State Nonprofit corporation status it must engage primarily in activities which accomplish one or more of its purposes in which the Nonprofit is established.

Please	heck one of the following boxes:										
	I have no conflicts or potential conflicts to disclose.										
	I have the following conflicts or potential conflicts to disclose (use the space below):										
	- Disclose personal or professional affiliations, including those of immediate family members, with companies the NC ACH does or might do business with. For instance, do you hold a sizable amount of stock or have other financial interests in a company?										
	- Disclose any personal business dealings (including those of immediate family members) you have or have had with the NC ACH in the previous twelve months.										
	- List other corporate or nonprofit boards on which you (or an immediate family member) serves.										
	<del></del>										
Dated:	Signed:										
	Print Name:										
	Title:										

# **Proposed NC ACH Governing Board Make-up**

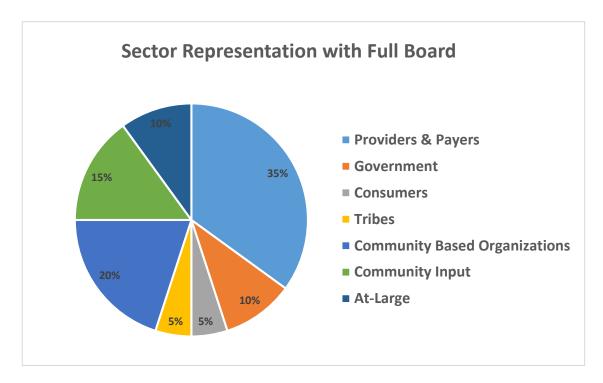
Adding 1 Consumer, 1 At -Large, and 3 CHI Seats; Removing 2 Leadership Council Positions

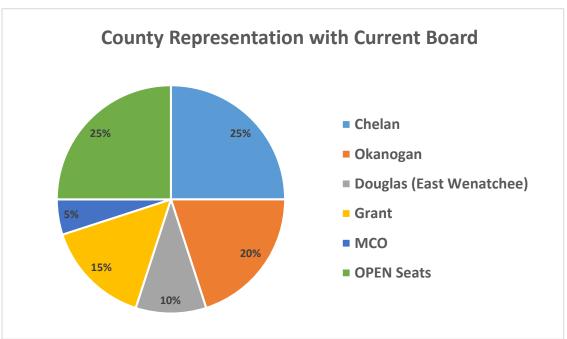
Sector Representation	Board Seat	<b>Current County</b>			
Providers & Payers	Behavioral Health	Chelan			
Providers & Payers	Confluence Health - CWH	Chelan			
Providers & Payers	Confluence Health - Primary Care	Okanogan			
Providers & Payers	Public Hospitals - Position 1	Grant			
Providers & Payers	Public Hospitals - Position 2	Chelan			
Providers & Payers	Federally Qualified Health Centers	Grant			
Community Based Organization	Business Community	OPEN			
Government	Elected Officials	OPEN			
Community Based Organization	Education	Chelan			
Government	Public Health	Douglas			
Community Based Organization	Aging and Adult Care	Douglas			
Community Based Organization	Hispanic Community	Okanogan			
Providers & Payers	Medicaid Managed Care Organization	ALL			
Tribes	Tribal Representative	OPEN			
Consumers	Consumer Position	OPEN			
At-Large	At-Large Seat	Chelan			
At-Large	At-Large Seat	Okanogan			
Community Input	CHI - Grant	Grant			
Community Input	CHI - Okanogan	Okanogan			
Community Input	CHI - Chelan-Douglas	OPEN			

Sector Membership - With Full Board	Members	%		
Providers & Payers	7	35%		
Government	2	10%		
Consumers	1	5%		
Tribes	1	5%		
<b>Community Based Organizations</b>	4	20%		
Community Input	3	15%		
At-Large	2	10%		
Total	20	100%		

<b>Current County Membership</b>	Members	%		
Chelan	5	25%		
Okanogan	4	20%		
Douglas (East Wenatchee)	2	10%		
Grant	3	15%		
MCO	1	5%		
OPEN Seats	5	25%		
Total	20	100%		

# **Proposed NC ACH Governing Board Make-up**





# Model ACH Tribal Collaboration and Communication Policy

# Purpose

To establish a clear and concise collaboration policy and communication procedure between the Accountable Community of Health (ACH) and tribal governments, Indian Health Service (IHS) facilities, and Urban Indian Health Programs (UIHPs) in the development of all ACH policies or actions.

# Governance

The ACH will hold at least one seat on the ACH governing board for the tribes, IHS facilities, and UIHPs in its region to designate a representative.

# III. Collaboration

The ACH will collaborate and communicate with tribal governments, IHS facilities, and UIHPs in a manner that respects the tribes' status as sovereign nations and the IHS facilities' and UIHPs' status as congressionally established entities charged with meeting the federal trust responsibility and U.S. treaty obligations to American Indians/Alaska Natives (AI/ANs).

- The ACH will not refer to tribes, IHS facilities, or UIHPs as stakeholders but as partners.
- The ACH will collaborate with tribes, IHS facilities, and UIHPs from the beginning of and throughout the planning
  and development process and engage in inclusive decision-making with tribes, IHS facilities, and UIHPs for all
  ACH actions that have an impact on AI/ANs, tribes, IHS facilities, or UIHPs (as determined in accordance with
  Section IV) and not just solicit feedback from tribes, IHS facilities, and UIHPs.
- The ACH will respect and support the need for:
  - Tribal representatives to inform their tribal councils and receive directives from their tribal councils on whether and how the tribe would like to proceed with respect to any ACH action.
  - o IHS facility representatives to inform their agency leadership and receive directives from their agency leadership on whether and how the IHS facility would like to proceed with respect to any ACH action.
  - UIHP representatives to inform their boards and receive directives from their boards on whether and how the UIHP would like to proceed with respect to any ACH action.

If a tribe, IHS facility, or UIHP declines an invitation to collaborate, the ACH will maintain a standing invitation for the tribe, IHS facility, or UIHP to collaborate with the ACH.

# IV. Determination of ACH Actions Having Impacts on AI/ANs, Tribes, IHS, or UIHPs

The ACH will establish a committee of ACH and tribal/IHS/UIHP designees. Such ACH designees must include the ACH lead staff member (e.g., ACH executive director) and at least one ACH governing board member who is not a representative of tribes, IHS facilities, or UIHPs. The committee will meet regularly to determine whether any ACH actions being contemplated, including the development of policies, programs, or agreements, will have an impact on AI/ANs, tribes, IHS, or UIHPs. The ACH lead staff person will ensure that sufficient information about ACH actions is

communicated during the meeting, and prior to implementation, to enable the committee to determine whether those actions will have an impact on AI/ANs, tribes, IHS, or UIHPs. If no tribe, IHS facility, or UIHP designates an individual to serve on this committee and until such time when a tribe, IHS facility, or UIHP does designate an individual to serve on this committee, the governing board of the ACH will make determinations of whether any ACH actions being contemplated will have an impact on AI/ANs, tribes, IHS, or UIHPs and inform the tribes, IHS facilities, and UIHPs.

# V. Communication

- A. The ACH will work with each of the individual tribes, IHS facilities and UIHPs to ensure that all contact information is up-to-date and the correct representatives are notified and regularly receive information.
- B. The ACH will effect delivery of written information to tribes, IHS facilities, and UIHPs concurrent with, and in the same format and method as, the delivery of written information to board members for board meetings, to committee members for committee meetings, and to other ACH participants for participant or other meetings.

# VI. Sovereignty and Disclaimer

The ACH respects the sovereignty of each tribe located in the State of Washington and that the tribes and UIHPs have the right to request consultation with the State of Washington and/or the United States government in the event the ACH fails to address the impacts on AI/ANs, tribes or UIHPs. In executing this policy, no party waives any rights, privileges, or immunities, including treaty rights, sovereign immunities and jurisdiction. This policy does not diminish any rights or protections afforded AI/AN persons or tribal governments or entities under state or federal law. The ACH acknowledges the right of each tribe and UIHP to consult with state and federal agencies, including, where appropriate, the Health Care Authority, the Governor of the State of Washington, the Region X Administrator of the U.S. Department of Health and Human Services, or the President of the United States.

VII. Effective Date

This policy will be effective on  $\frac{5}{2}$   $\frac{2}{2}$   $\frac{5}{2}$ , and will be reviewed and evaluated annually at the request of any tribe or UIHP or at the request of a majority of the ACH governing board members.

APPROVED BY:

ACH Chair

# **North Central Accountable Community of Health**

**Tribal Outreach Details:** 

Outreach to Vice Chair Tonasket Page 2 - 5

Outreach to Deputy Director Alexis Page 6 – 8

Outreach to Jessie Dean (HCA) Page 9

North Central ACH continues to make an effort to reach out to our tribal representatives. Below are a few examples of email communications that we have had with both our local and state representatives. This does not encompass all communications that have occurred.

# **Outreach to Vice Chair Mel Tonasket:**

#1:

From: Linda Parlette

Sent: Friday, January 6, 2017 3:05 PM

To: 'mel.tonasket@colvilletribes.com' <mel.tonasket@colvilletribes.com>

Subject: connect by phone

Hi Mel,

I would love to connect with you by phone and talk to you about North Central Washington's Accountable Communities of Health which as you can see, I am the new executive director of.

The Regional Service area covers all of Okanogan, Chelan, Douglas, and Grant counties. I know that someone representing some of the Colville's participates in the Spokane ACH.

I am looking for guidance from you as to who may be interested in sitting on our board. Perhaps we could connect in the middle of next week?

Happy New Year!

**Senator Parlette** 

#2

From: Linda Parlette

**Sent:** Friday, January 20, 2017 1:11 PM

To: 'mel.tonasket@colvilletribes.com' < mel.tonasket@colvilletribes.com >

Subject: RE: connect by phone

Hi Mel,

Just checking in to see if we could connect by phone in the future. I wanted to share what our North Central ACH is doing as I would love To have you attend a meeting and actually be involved, if you are interested.

Linda

## #3

From: Linda Parlette

Sent: Friday, January 20, 2017 2:43 PM

To: Mel Tonasket (CBC) < Mel.Tonasket@colvilletribes.com >

Subject: Re: connect by phone

Hope you are OK.☺

Sent from my iPhone

On Jan 20, 2017, at 2:41 PM, Mel Tonasket (CBC) < Mel.Tonasket@colvilletribes.com > wrote:

Sorry it's taken me this long to respond, life's been sort of hectic the last few weeks and for a couple more weeks. When things slow down for me I will give you a call and you can tell me what your doing and how I "might" help.

Sent from my iPhone

# #4

From: Linda Parlette

Sent: Friday, February 24, 2017 2:56 PM

To: 'mel.tonasket@colvilletribes.com' <mel.tonasket@colvilletribes.com>

**Cc:** Barry Kling < barry.kling@cdhd.wa.gov>; John Schapman < John.Schapman@cdhd.wa.gov>; Christal

Eshelman (Christal.Eshelman@cdhd.wa.gov) < Christal.Eshelman@cdhd.wa.gov>

Subject: connect next week by phone

Hi Mel,

We have our next North Central Accountable Communities of Health board meeting In Wenatchee on March 6<sup>th</sup> and we hope to adopt our by-laws.

In April, we hope to expand our board and would like to have a tribal member.

I would be willing to meet with your or any others you recommend to let you know more About the purpose of Accountable Communities of Health.

I have a related meeting in Omak on March  $8^{th}$  as well as March  $24^{th}$  and would show up Earlier either day if there was an opportunity to connect.

I am copying Barry Kling, the chair of our board as well as two key staff people.

Looking forward to connecting.

Senator Parlette

Linda Evans Parlette, Executive Director

North Central Accountable Community of Health

Chelan-Douglas Health District 200 Valley Mall Parkway East Wenatchee, WA 98802

Phone: (509) 886-6439

Email: <u>linda.parlette@cdhd.wa.gov</u>

Fax: (509) 886-6449

#5

From: Linda Parlette

Sent: Monday, March 27, 2017 6:48 AM

**To:** 'Mel Tonasket (CBC)' < <a href="Mel.Tonasket@colvilletribes.com">Mel.Tonasket@colvilletribes.com</a>>

Cc: Barry Kling <barry.kling@cdhd.wa.gov>; John Schapman < John.Schapman@cdhd.wa.gov>

**Subject:** Thank you

Mel,

Thank you so much for sharing so much of your time, Friday. I truly enjoyed reconnecting With you.

I look forward to having you connect me with Allison Ball.

Linda

Linda Evans Parlette, Executive Director
North Central Accountable Community of Health
Chelan-Douglas Health District
200 Valley Mall Parkway
East Wenatchee, WA 98802

Phone: (509) 886-6439

Email: <a href="mailto:linda.parlette@cdhd.wa.gov">linda.parlette@cdhd.wa.gov</a>

Fax: (509) 886-6449

#6

From: Linda Parlette

Sent: Thursday, March 9, 2017 10:22 AM

To: 'Mel Tonasket (CBC)' < Mel. Tonasket@colvilletribes.com>

Subject: 11 AM- Breadline--Friday, March 24th

Hi Mel,

To confirm, I will see you at 11 AM at the Breadline in Omak on Friday, March 24th.

I may have Barry Kling, Administrator Chelan/Douglas Health District, as well as Chair of North Central ACH, and John Schapman, Program Manager, with me.

We will be presenting the Demonstration Project (pursued as an 1115 Waiver) to a group at the Behavioral

Health building in Omak at 1 PM. You are most welcome to join us.

I will be telling you a bit more about North Central Accountable Community of Health during lunch. Feel free to invite any Colville clinical manager or whomever you feel may be interested.

My cell phone number – is 509 679 9510.

Linda

Linda Evans Parlette, Executive Director North Central Accountable Community of Health Chelan-Douglas Health District 200 Valley Mall Parkway East Wenatchee, WA 98802

Phone: (509) 886-6439

Email: <a href="mailto:linda.parlette@cdhd.wa.gov">linda.parlette@cdhd.wa.gov</a>

# **Outreach to Deputy Director Carmella Alexis:**

## #1

From: Linda Parlette

Sent: Thursday, April 27, 2017 6:22 AM To: Carmella Alexis (ADM); Teresa Davis

Cc: John Schapman

Subject:RE: NC ACH Board Meeting May 1st, 2017

Thank you so much, Carmella,

I am thrilled that you will be able to listen to our Board meeting on May 1st from 12:30 PM to 2:30 PM.

My cell phone number is 509 679 9510; feel free to text me during the meeting if You need any assistance.

Senator Parlette

Linda Evans Parlette, Executive Director North Central Accountable Community of Health Chelan-Douglas Health District 200 Valley Mall Parkway East Wenatchee, WA 98802

Phone: (509) 886-6438

Email: linda.parlette@cdhd.wa.gov

Fax: (509) 886-6449

From: Carmella Alexis (ADM) [mailto:Carmella.Alexis.ADM@colvilletribes.com]

**Sent:** Tuesday, April 25, 2017 3:22 PM

To: Linda Parlette < Linda.Parlette@cdhd.wa.gov >; Teresa Davis < Teresa.Davis@cdhd.wa.gov >

Subject: RE: NC ACH Board Meeting May 1st, 2017

Way' Linda and Teresa, I have included a short update about myself and Alison Ball who I will be representing. Limlmt.

# Alison Ball & Carmella Alexis

Alison (Boyd) Ball is a Colville tribal member born in Colville and grew up in the Inchelium and Nespelem communities. She is the daughter of the late Matilda Absher and Bill Boyd & Russell Carden. She had a Ph.D from the University of Oregon, where she has worked the last 13.5 years conducting behavioral health research and directing a master's level professional development program for Indian teachers. For six years she was the President of the Oregon Indian Education Association as well as serving on other national and state boards. Alison is the Health & Human Services Director and has oversight over 15 programs and research projects.

Carmella Alexis is a Colville Tribal descendant born in Vernon, British Columbia. Carmella grew up in the North Okanagan and more recently has lived in Inchelium and Omak. She is the daughter of Paul and Gloria Alexis. Carmella works for Colville Confederated Tribes as the Health Deputy Director and has management over all direct health services encompassing 6 programs. Carmella has a broad range of experience working for Tribal and Provincial Governments within health. Carmella's postgraduate education has been within the field of Okanagan Health, health policy, rural hospital systems and the Okanagan language.

From: Linda Parlette [mailto:Linda.Parlette@cdhd.wa.gov]

Sent: Tuesday, April 25, 2017 9:24 AM To: Teresa Davis; Carmella Alexis (ADM)

Subject: RE: NC ACH Board Meeting May 1st, 2017

# Carmella,

Teresa will send this out again on May 1st.

I would love to introduce you. Would you like to give me any back ground information?

Linda Evans Parlette, Executive Director
North Central Accountable Community of Health
Chelan-Douglas Health District
200 Valley Mall Parkway
East Wenatchee, WA 98802

Phone: (509) 886-6438

Email: <a href="mailto:linda.parlette@cdhd.wa.gov">linda.parlette@cdhd.wa.gov</a>

Fax: (509) 886-6449

From: Teresa Davis

Sent: Tuesday, April 25, 2017 9:12 AM

To: Carmella.Alexis.ADM@colvilletribes.com

Cc: Linda Parlette < Linda.Parlette@cdhd.wa.gov > Subject: NC ACH Board Meeting May 1st, 2017

Good Morning Carmella,

Senator Parlette wanted to invite you to dial in to our next board meeting. Please see details below, we look forward to the possibility of you attending.

Our next NC ACH Meeting is Monday, May 1<sup>st</sup> 12:30-2:30 at the Confluence Technology Center in Wenatchee. The draft agenda and minutes from the April 3, 2017 meeting are attached. Call in details for this meeting are on the top of the agenda. If you have any questions, please feel free to contact me. Thank you!

Conference Dial-in Number: (415) 762-9988 or (646) 568-7788 Meeting ID: 429 968 472#

Teresa Davis, Executive Assistant
North Central Accountable Community of Health

Chelan-Douglas Health District 200 Valley Mall Parkway East Wenatchee, WA 98802

Phone: (509) 886-6432

Email: teresa.davis@cdhd.wa.gov

Fax: (509) 886-6449

# #2

From: Linda Parlette

Sent: Wednesday, May 3, 2017 2:55 PM

To: 'Carmella Alexis (ADM)' < <a href="mailto:Carmella.Alexis.ADM@colvilletribes.com">Carmella.Alexis.ADM@colvilletribes.com</a>

Cc: 'Alison Ball (HHS ADM)' < Alison.Ball@colvilletribes.com >

Subject: May 1st, 2017

Good afternoon, Carmella and Alison,

We missed you calling in, Carmella, for the Monday NCACH Board meeting.

I am most happy to come to meet the two of you in Omak or where ever appropriate in May to see if you have interest

In becoming a board member of North Central ACH or appointing someone for me to work with in my role as Executive Director.

I could invite Alison White too, if that would be beneficial.

I totally understand how busy you both must be—and none of us need more meetings if there is not a value added end result.

I will look forward to hearing from you.

## Linda Parlette

Linda Evans Parlette, Executive Director North Central Accountable Community of Health Chelan-Douglas Health District 200 Valley Mall Parkway East Wenatchee, WA 98802

Phone: (509) 886-6438

Email: linda.parlette@cdhd.wa.gov

Fax: (509) 886-6449

# Outreach to Jessie Dean, HCA

From: Linda Parlette

Sent: Wednesday, May 03, 2017 2:51 PM

To: <a href="mailto:jessie.dean@hca.wa.gov">jessie.dean@hca.wa.gov</a>
Cc: Duke Shepard; Andrea Bennett
Subject: Yakima and Wanapum tribes

Jessie,

Thank you for the opportunity to listen in to your presentation that Alison White set up. We had planned for a Colville tribal member to participate in the May 1st, NCACH board meeting call, but that didn't happen.

I will continue to pursue a relationship there. I have great relationships with the Colville tribes, even was honored by being "blanketed,"

and have followed the instructions of Mel Tonasket as to whom to reach out to. I will continue to pursue, as mentioned.

It was a surprise for me to learn I should be reaching out to the Yakimas and Wanapum tribe.

Can you please send me the proper contact information as I have no idea where to begin. I could ask Carol Moser for the email addresses but quite frankly, but I know, after today's call, Carol is, like all of us, trying to get our Certification I paper work complete.

Thanks so much. I truly appreciate your assistance.

Senator Parlette

Linda Evans Parlette, Executive Director North Central Accountable Community of Health Chelan-Douglas Health District 200 Valley Mall Parkway East Wenatchee, WA 98802 Phone: (509) 886-6438

Email: linda.parlette@cdhd.wa.gov

Fax: (509) 886-6449

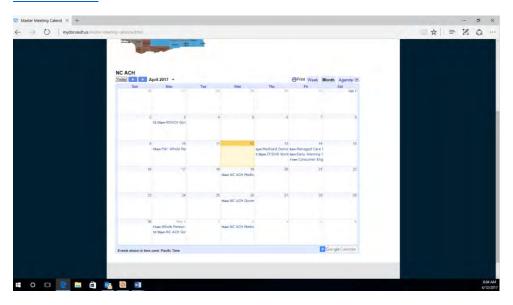
# **Current NCACH Webpage Layout**

The main function of the page is to provide a location to host meeting documents and update community members on upcoming meeting details. All NCACH webpages have public access. Below is are displays of the main NCACH webpage and supporting pages that are open to the public.

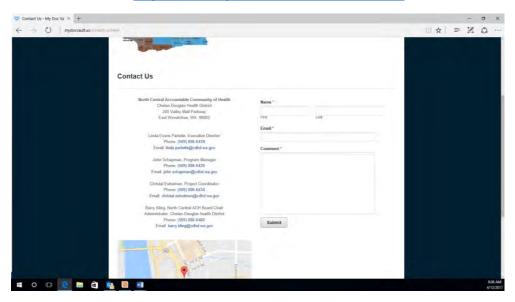
NCACH MAIN HOME PAGE: <a href="http://mydocvault.us">http://mydocvault.us</a>



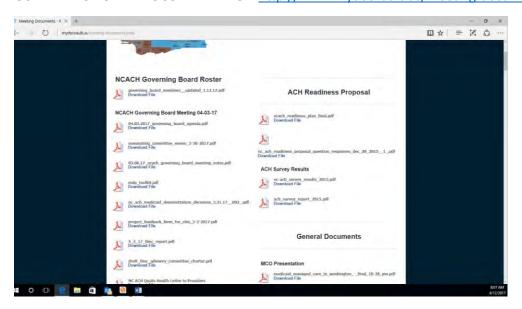
**EXAMPLE CALENDAR OF EVENTS:** <a href="http://www.mydocvault.us/ncach-governing-board--master-calendar.html">http://www.mydocvault.us/ncach-governing-board--master-calendar.html</a>



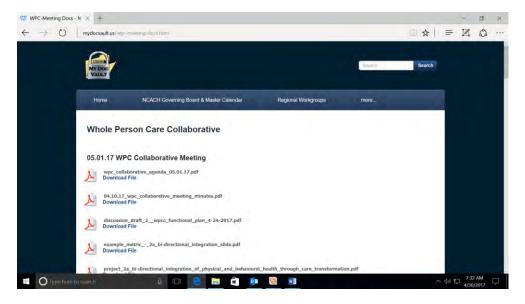
# CONTACT US PAGE: http://www.mydocvault.us/contact-us.html



# GOVERNING BOARD DOCUMENT PAGE: http://www.mydocvault.us/meeting-documents.html



# WHOLE PERSON CARE COLLABORATIVE PAGE (WORKGROUP): <a href="http://www.mydocvault.us/wpc-meeting-docs.html">http://www.mydocvault.us/wpc-meeting-docs.html</a>



# Website Report for the North Central Accountable Community of Health

# **Required functionality:**

- Search function
- Modern, trusted look and feel
- Document repository
- Easy to Use Calendar
- Mobile Site
- Secure
- Responsive Design

**Budgeted Amount:** 

# **Proposed Amount:**

• \$5000

• \$3400

# **Characteristics of Firefly:**

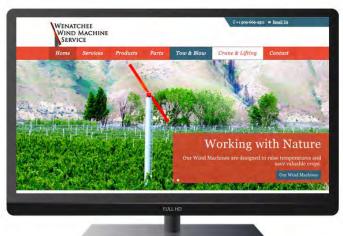
- Established
- Fundamental understanding of goals of website
- · Modern, trusted look in their portfolio
- Experience with large/complex websites

- Website Analytics
- Ability to independently update and add new pages
- Ability to submit forms
- Ability to add/manage contacts with a contact management program through the website (ie. Mailchimp)

# **Firefly Portfolio:**











# NCACH (ncach.org)

# **New Website**

Website Development:

\$3,400

**ETA** for completion:

**TBD** 

# Scope and features:

- Informational consumer-centric document Website with approximately 5-10 pages (each divided into logical sections).
- Visually-appealing, modern, full-width responsive design.
- User-friendly back-end editing of site content (1 hour of personalized training provided).
- All text and document/PDF content will be provided by client in an edited and readyto-use format for placing into each page.
- All necessary photos will be provided by client.
- Website will include clear, logical navigation.
- Site will include meeting minutes and documents organized into appealing sections that expand.
- Site will include embedded audio and video link ability (e.g. hosted on Soundcloud and Youtube).
- Site will include newsletter signup (using a Mailchimp account).
- Site will include a contact form, and contact information.
- Site will include search ability.
- Site will include user-friendly event calendar.
- Site will feature basic SEO optimization.
- Site will be mobile-friendly.
- Site will be secured against hacking.
- Site will feature site-wide SSL certificate for encrypted communications on all pages (separate yearly charge).

# **NCACH** Wenatchee World Articles:

Tuesday May 9th, 2017: Medicaid transformation group picks six projects

Tuesday May 9th, 2017: NCW Health: An argument for 'whole-person' care

Tuesday April 25th, 2017: Transforming health care in NCW

# **Wenatchee Business Journal Article:**

April 2017: 'Medicaid Transformation demonstration' public forum

# Medicaid transformation group picks six projects

By K.C. MEHAFFEY
World staff writer

EAST WENATCHEE — A local organization working to transform Medicaid has picked six projects to focus on over the next four and a half

The North Central Accountable Community of Health says as much as \$50 million will come to Chelan, Douglas, Grant and Okanogan counties—mostly to medical providers and community organizations—as it guides drastic changes in how care is delivered, and billed.

The funds are part of a \$1.5 billion investment of new funds from the federal Centers for Medicare & Medicaid Services that the state applied for seeking to demonstrate how whole-person care could reduce Medicaid costs. They are not tied to the Affordable Care Act.

Nine ACHs across the state are each picking at least four demonstration projects to help them figure out ways to give Medicaid patients higher-quality services at a lower cost. The goal is to show how Medicaid patients can be healthier by developing self-sustaining changes to the health care system that do not require continued funding.

require continued funding.
ACHs will work with health care providers to treat the "whole person," and offer financial incentives if specific care standards are met, instead of being paid on a per-visit basis.

Before selecting the projects to focus on, the North Central ACH held meetings throughout the region, gathering input from those involved in all forms of health care and social

"There's a whole bunch of work to do. But just the fact that we have chosen our projects is a big step," said Linda Evans Parlette, executive director of the North Central CACH. On the CACH.

She said the six projects have a strong focus on promoting whole person care, improving health care by strengthening partnerships, and enabling care givers to help address social barriers — such as a lack of housing or transportation.

Parlette said the process will also help a separate effort by the region's Behavioral Health Organization to fully integrate mental health care with physical health and substance abuse by Jan. 1— two years earlier than most other regions.

She said now that the projects have been selected, the ACH will determine how those projects will be implemented. After the planning phase this year, the ACH will have four years to implement the projects.

Here are the projects:

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• Community-Based Care
Coordination: Ensure that
patients with complex health
needs are connected to the
interventions and services that
will help them manage their
health. This develops infrastructure to coordinate the
care coordinators.

health. This develops infrastructure to coordinate the care coordinators.

Transitional Care: Reduce hospitalizations by ensuring patients continue to get the care they need after being discharged from a hospital, a mental health facility, or a prison or isil

prison or jail.

• Diversion Interventions: Promote better use of emergency care services through increased access to primary care and social services. It includes diverting patients to the appropriate service when they come to an emergency room or call an ambulance with a non-emergency need, or come into contact with law enforcement.

Addressing Opioid Use:
Reduce opioid misuse and abuse through treatment, overdose prevention, longterm recovery and wholeberson care.

person care. The property of the property of the primary care setting. It encourages using the community, the health care system, self-management support, delivery system design, decision support, and clinical information systems.

- 6:30 p.m., City Hall, 548-5275
- ♦ East Wenatchee City Council: 6:30 p.m., City Hall, 884-9515
- ♦ Mansfield City Council: 7 p.m., City Hall, 683-1112
- ◆ Tonasket City Council: 7 p.m., City Hall, 486-2132
- ◆ Twisp City Council: 7 p.m., City Hall, 997-4081

# **Schools**

- ♦ Lake Chelan School Board: 6 p.m., district board room, 682-3515
- ♦ Wenatchee School

  Board: 6 p.m., district office,
  663-8161
- ♦ Orondo School District Board: 7:00 p.m., district office, 784-2443 ext. 221

# WEDNESDAY

# Community

- ♦ Bonga Marimba, live music: 4 to 4:30, Pybus Public Market, pybus publicmarket.org, 888-3900
- ♦ Wenatchee FIDO group: 5:30 p.m., Wenatchee World, 14 N. Mission Ave., wenatcheefido.org
- ◆ "A Field Guide to Edible Mushrooms of the Pacific Northwest" presentation: 6 p.m., Wenatchee Public Library, ncrl.org
- ◆ "Young Frankenstein": 7:30 to 10 p.m., Numerica Performing Arts Center, numericapac.org

# Government

- ♦ Douglas County Commission: 8:30 a.m., courthouse, Waterville, 745-8537
- ♦ North Central Washington Economic Development District Board: 8:45 a.m., Chelan City Hall, 135 E. Johnson Ave., Chelan, 682-6907



World photo/Mike Bonnicksen

Goslings forage for food under the watchful eye of an adult bird at Confluence State Park in Wenatchee.

and operates from December through April. This year, the resort ended its season April 30, the latest closing in its 50-year history.

The Colorado-based NSAA represents 313 alpine resorts that account for more than 90 percent of all skier-snowboarder visits nation-wide, according to the group's website.

- Mike Irwin, World staff writer

# NCW Health: An argument for 'whole-person' care

NCW — A couple weeks ago, I received a call from a Wenatchee-area woman whose story demonstrates why the statewide and local

**NCWHealth** 



important.
Her story,
I'm sure, is not

unique. Given the stigma surrounding mental health,

efforts toward

care are so

"whole-person"

there's no reason to name her. Suffice to say she was diagnosed with Post Traumatic Stress Disorder, resulting largely from growing up with a mother who suffered from paranoid schizophrenia. "I can't convey in a nutshell how that colors your whole entire world, when it's your mom," she told me.

Even so, this woman has found ways to cope. She's been married for almost 35 years, and after moving to the Wenatchee Valley in 2010, she finally found a counselor at Confluence Health who was the right fit for her. The visits helped with her anxiety. Her Medicare Advantage plan through Soundpath — with no premiums — covered all but

NCW Health is a weekly column featuring healthcare and insurance coverage in North Central Washington — what's working, what's not, and what's changing. Call Wenatchee World reporter K.C. Mehaffey with your experiences.

the \$40 copayment each time she found herself in need of a visit.

Then, last August, she got a bill for \$170 from her counselor, owed from an October 2015 visit. She thought it must be a mistake, because she always pays her copay at the time of the visit. So she called billing at Confluence Health. Instead of finding out there was an error, she learned that her visits for almost an entire year had not been covered. And she owed \$3,000.

This sent her into a panic. But instead of going to see her counselor, she canceled her next visit. And the one after that. She said her effort to straighten it out was a nightmare.

After numerous phone calls, and wading through

prompts and being put on hold, and waiting for calls back, she learned there had been a change in her coverage. Soundpath contracted with a third party company — Optum — to cover mental health. And Confluence Health didn't have a contract with them to cover mental health.

Eventually, Optum and Soundpath did cover her past visits, and even approved a few more visits until she got settled with a new counselor.

But more than the issue of money was her fear of being able to find a new counselor who could help her cope when life becomes too overwhelming. "You can't just start over with somebody else," she said. "This is the terror of this whole thing. I do not have this option of seeing her anymore. I have to just do it myself."

She said getting and keeping a mental health plan has always been a challenge. "This disparity between physical health and mental health is not getting better," she added.

A spokeswoman with Soundpath said that when there's a change, they usually contact their members by letter to let them know. It's possible she missed the letter, she said.

Confluence Health, in an email, noted that understanding your medical insurance plan is not always easy. "More and more the patient's medical insurance plan is really a part of their treatment team. Their plan can control who they see, the number of visits, determine the medical necessity of the patient's need for the service and the out of pocket amount the patient must pay," wrote Peggi Ann Arnstutz, Confluence Health's vice president of revenue cycle.

To me, the issue isn't really with the insurance companies or the providers. It's the system. Our health care system sees a person's mental health as separate from their physical health. And forcing someone to change their counselor doesn't seem like a healthy thing to do. It seems so unnecessary.

That's why I'm excited to follow just how well our regional Behavioral Health Organization, and our North Central Accountable Community of Health are able to integrate the two in two parallel efforts to improve health care. It's a long process, and there's a news story in this

edition about that effort. Let's hope it works.

Side note: It was hard not to write this week about the U.S. House of Representatives voting to repeal Obamacare and replace it with a revamped American Health Care Act.

I didn't because my

colleagues here at The Wenatchee World are covering that topic. In Sunday's edition, Jefferson Robbins covered it in his RepWatch column (http://wwrld.us/RepWatch2).
And on Wednesday, Nevonne McDaniels will be reporting about a Monday night forum

in Cashmere on the issue.
I will leave you with these links on the subject:

- ♦ Here's a link to the White House's official news release about it (http://wwrld.us/WhiteHouseNews2).
- Here's a Washington Post analysis piece on what it means. (http://wwrld.us/ WashingtonPost3)
- ♦ And here's what the AARP (http://wwrld.us/ AARP2); Gov. Jay Inslee (http://wwrld.us/Inslee2); and U.S. Health and Human Services Secretary Tom Price (http://wwrld.us/ TomPrice2) have to say about it.



Only one floor matters. Yours.

# Transforming health care in NCV

NCW — As the national debate over repealing and replacing the Affordable Care Act continues, there

NCW Health



By K.C. Mehaffey World staff

is another effort that, to me, is much more worthy of ink.

It's called Medicaid transformation, and it's the happening across the state, and locally, under the direction of the state Health Care Authority.

While the goals and timelines (5 years) for this transformation are ambitious, if it works, it could offer true solutions to some

of the deep-rooted problems in our country's health care system.

It starts by tackling Medicaid. Many local people in health care and other fields are involved. This week, I talked to Barry Kling and Linda Evans Parlette for an overview of this effort at the local level. Kling is the administrator of the Chelan-Douglas Health District and chairman of North Central Washington's Accountable Community of Health or ACH; Parlette is our former state senator who is now executive director of the ACH.

Before I dig into details, there's a

# **NCW Health**

NCW Health is a weekly column featuring healthcare and insurance coverage in North Central Washington - what's working, what's not, and what's changing. Call Wenatchee World reporter K.C. Mehaffey with your experiences.

PowerPoint slide in the Health Care Authority's presentation that sums up the vision. On one side, it shows a jumble of scattered building blocks representing the current system, with fragmented care, patients who are not engaged in their own health with limits on their services, and a payment system based on the number of face-to-face visits with their doctor, dentist, counselor or specialist. On the other side, it shows neatly stacked blocks representing a transformed system of whole-person care, patients who are engaged in their own health care, and who have access to the appropriate services, and a payment system based on how well the patients are doing.

This effort to transform Medicaid is being funded by the Centers for Medicare & Medicaid Services,

with \$1.5 billion to the state over the next five years. It includes three initiatives: a reform of the delivery system; changes in long-term care services to support enabling older people to live at home longer; and services to address housing and employment needs.

Kling's and Parlette's work is focused on the first initiative transforming the health care delivery system, which is being done through our regional Accountable Community of Health. There are nine throughout the state. Ours includes Chelan, Douglas, Grant and Okanogan counties.

This first initiative gets the lion's share of the money: \$1.125 billion statewide. Kling says that will translate to several million dollars each year in our region. The money will go partly to planning — which happens this year. After that, he said, it will go largely to local providers.

"The point of this demonstration funding is not just to pay everybody's bills. The point is to create sustainable changes," Kling said. "It's critical not to be tempted into doing something that's great for four years, but now we need to find a new source of money. This does not create new obligations for the state.

The point is, a transformation has to occur."

That transformation will rely on a new financial incentive for health care providers. For Medicaid patients, a doctor will no longer get paid for simply seeing a patient. Instead, how much he or she is paid will be based on health standards that the patient must meet.

So, for a patient with diabetes, it will depend on whether the patient has been able to keep glucose levels in check, or whether they've slipped into a higher level of care that might require hospitalization or amputation.

For a baby, it will depend on whether their parents have brought them in for all of their well-child visits.

But how do you force a patient to take care of themselves, or their children? The idea is, patients want to take care of themselves, but they often have other problems that are preventing self-care.

Kling said that at least 80 percent of a person's health care issues stem from issues that don't currently involve services offered by a medical take." clinic. "Right now, we don't have a good way to address those. A patient with diabetes may also be homeless. They're not going to do a lot about

their diabetes until they have a home."

Under the new scenario, health care organizations will receive a flatamount of money per patient per month to take care of them, and they can use it in a variety of ways.

Through a risk analysis, a primary care doctor can start to identify the barriers to good health, and connect their patients with a care coordinator, who can hook them up to the social services they need. With their housing, transportation, mental health issues addressed, patients can then focus on their health, and — the hope is — need fewer costly medical services.

The goal is for these patients in the demonstration project to cost the system 2 percent less, per capita, than the national average, Kling said.

Parlette said to her, the effort is a test. "It's really a grand experiment to demonstrate that we can reform the system," she said. "It's a test to see if, at the local level, you really can change the way you deliver care. We'll see if it works. It's a really worthy goal, but it's a big bite to

To hear Kling's full overview of the Medicaid demonstration project, visit http://wwrld.us/ ACHPresentation.

# Immigration enforcement fears cloud agriculture labor forecast

Skagit Valley Herald

MOUNT VERNON —Humberto "Archie"

"It's palpable. There is a lot more concern and worry. Even if you have a

Allen Rozema, executive director of Skagitonians to Preserve Farmland, said he's been told to expect raids.

were scarce. So she decided to for what you make and the come to the U.S.

corruption is terrible ... Police Now she is married and has would steal money from me. It children who were born in the never ends, the corruption. So

# Toyota Town

Since the \$50 million initial expenditure to construct the facility in 2012, the TYC has been able to pay \$2 million a year towards that debt and place \$1 million in reserves.

Only the Public Pacilities District board can touch those reserves and work to so without just cause such as an emergency or major enabled.

million annually, C, under Miller's ip, often uses adership, often us ound 160 employees as pa so whe...
as an emerge...
capital expense.
With total retail revenu
at \$3 million annual
"Ne TTC, under Millio"
"Nip, often v



Going Wild. The Wenatchee Wild hockey team is by far the largest contributor to TTC

timers called in to handle big events and they also extend the economic reach. Miller staid one-third of the revenues are directly related to the successful Wenatchee Wild Junior A hockey team, one-third to the many youth events and one-third to other events and will state to set and feature a rodeo and "stars on locking for a set to ester to a

wider demographic.

For this year, a tourism office with a \$200,000 budget will be put into play by the TTC to draw even more visitors from far and wide into the Wenatchee area. Billboards, direct mail and advertising in the tricity area are all part of the TTC master plan to ensure constructions.

with nocesy game spenies on the average \$44.81 and the toutist or "out-of-towner" spends \$70.56. Even more is spent on concert show altendees who average \$49.78 for locals and \$85.15 for tourists. These figures reflect a 12 percent increase over 2015, according to WVS. by Wenatchee Valley Sports (WVS), in 2016, the average local fan who comes to a Wild hockey game spends on the average \$44.81 and the urch done

"A room night factor computation is used" for events lasting more than one night such as the Apple Ice Classic Figure Stating.

More than \$1.2 million was brought in to the TTC last year through ticketed events. The followers and the content of the company of t

evenues generated were:

• Hell on Hooves (rodeo),

\$213,214

U.S. Figure Skating Regionals, \$186,739
 Pepe Aguilar (Mexican-American singer-songwriter), \$186,463
 Hot Autumn Ice Women's Hockey, \$113,929
 Harlem Globehrotters (basketball), \$112,263
 Ren White (comedian), \$10,000

Rom White (comean..., \$109,822

Apple Ice Classic, \$107,574

Sromp (musicians, dancers), \$10,907

Cheap Trick (rock musicians), \$86,906

PNAHA Youth Camp,

Besides the ticketed events listed above with its \$1.2 million in revenues, by far the biggest contributor for the TTC coffers was the Wenatchee Wild hockey season with \$4.1 million in revenues. So-called non-

"Heads in beds," aka folks who stay in area hotels/ motels, saw 3,411 room nights for non-ticketed events. These events included mostly skating and hockey competitions featuring younger athletes and performers.

The overall dollar amount is a bit misleading, but in a positive way as WVS

states, "These figures do not include economic potential for some events hosted by Town Toyota Center. There are 10-plus such events that are non-ticketed, have significant attendance, but have no foundation for measurement. While there is an obvious community and economic benefit to these events, tools to accurately

economic impact

\$6.5M

Center:

estimate their impact are not available...
Those events include a variety of consumer and trade shows such as the various recreational, sportsmen's exhibitions.

For more information about the reast of the TTC season, call soft-75.

# demonstration' public forum 'Medicaid Transformation



ator Linda Evans Parlette

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# NC ACH Demonstration Project Design Fund Budget

July 2017 - December 2021

ACH STAFFING	Cost of Living Adjustments (COLA)		DY1 7/1/17 - 12/31/17 0%		DY2 01/01/18 - 12/31/18 1%		DY3 01/01/19 - 12/31/19 2%		DY4 1/01/20 - 12/31/20 2%		DY5 01/01/21 - 12/31/21 2%		Total Project 7/1/17 - 12/31/21
Executive Director (1.0 FTE)	cost of Living Adjustments (COLA)		070		170		270		270		2/0		
	Salary @ \$94,909 Annually Benefits @ 25%					\$ \$	97,775.25 24,443.81		99,730.76 24,932.69	\$ \$	101,725.37 25,431.34		299,231.38 74,807.84
D (4.0 FTF)													
Program Manager (1.0 FTE)	Salany @ \$72 427 Appually					ć	74,624.60	ė	76 117 00	ć	77,639.43	ė	220 201 12
	Salary @ \$72,437 Annually Benefits @ 25%	P	ositions paid l	by S	IM Funding	\$ \$	18,656.15		76,117.09 19,029.27		19,409.86	\$ ¢	228,381.13 57,095.28
	Belleties @ 2570					7	10,030.13	Ţ	13,023.27	Y	15,405.00	Y	37,033.20
Executive Assistant (1.0 FTE)													
	Salary @ \$48,340 Annually					\$	49,799.87	\$	50,795.87	\$	51,811.78	\$	152,407.52
	Benefits @ 25%					\$	12,449.97	\$	12,698.97	\$	12,952.95	\$	38,101.88
Program Development Specia	, ,			_				4				_	
	Salary @ \$72,437 Annually	\$ \$	36,218.50	\$ \$	73,161.37 18,290.34		74,624.60 18,656.15		76,117.09 19,029.27		77,639.43 19,409.86		337,760.99
	Benefits @ 25%	Ş	9,054.63	Þ	18,290.34	Þ	18,050.15	Þ	19,029.27	Ş	19,409.86	Ş	84,440.25
Director of Whole Person Car	e (0.5 FTF)												
Director of Whole refson car	Salary @ \$72,437 Annually	\$	18,109.25	\$	36,580.69	¢	37,312.30	ć	38,058.55	¢	38,819.72	¢	168,880.51
	Benefits @ 25%	\$	4,527.31		9,145.17				9,514.64		9,704.93		42,220.13
	Belletits @ 23%	Ç	4,327.31	ڔ	3,143.17	۲	9,328.08	Ą	9,314.04	ڔ	9,704.93	ڔ	42,220.13
Program Development Specia	alist (1.0 FTE)												
8	Salary @ \$72,437 Annually	\$	36,218.50	\$	73,161.37	\$	74,624.60	\$	76,117.09	\$	77,639.43	\$	337,760.99
	Benefits @ 25%	\$	9,054.63	\$	18,290.34	\$	18,656.15	\$	19,029.27	\$	19,409.86	\$	84,440.25
Program Development Specia													
	Salary @ \$72,437 Annually	\$	36,218.50	\$	73,161.37		72,437.00		73,885.74		75,363.45		331,066.06
	Benefits @ 25%	\$	9,054.63	\$	18,290.34	\$	18,109.25	\$	18,471.44	Ş	18,840.86	Ş	82,766.52
ACH SUPPLIES													
IT Equipment		\$	4,500.00	\$	2,000.00	Ś	2,000.00	Ś	2,000.00	Ś	2,000.00	Ś	12,500.00
Misc Office Supplies		\$	1,500.00		3,000.00				3,000.00		3,000.00		13,500.00
CONTRACTS													
CHI Support	\$40,000 Annually per CHI	\$	60,000.00	\$	120,000.00		120,000.00	\$	120,000.00	\$	120,000.00	\$	540,000.00
Tribal Relations Support	\$40,000 Annually	\$	40,000.00	\$	40,000.00				40,000.00		40,000.00	\$	200,000.00
CDHD Hosting Fee (15%)	15% of Annual expendatures	\$	83,993.39	\$	158,337.15		193,049.67	\$	172,354.16	\$	174,194.74		781,929.11
Attorney Fees	Utilizing CDHD Attorney		\$2,000	\$	1,500.00		1,500.00	\$	1,500.00	\$	1,500.00	\$	8,000.00
Data Support	Contract or 1.0 FTE Staff (TBD)	\$	50,000.00	\$	100,000.00		100,000.00	\$	100,000.00	\$	100,000.00	\$	450,000.00
Community Engagement	Contract or 0.5 Staff (TBD)	\$	25,000.00	\$	50,000.00		50,000.00	\$	50,000.00	\$	50,000.00	\$	225,000.00
Community Outreach Events	Outreach to Comm Members	\$	5,000.00	\$	5,000.00	\$	5,000.00	\$	5,000.00	\$	5,000.00	\$	25,000.00
OTHER ACH EXPENDATURES													
Board Liability Insurance	Contactor TBD	\$	2,000.00	Ś	2,000.00	Ś	2,000.00	\$	2,000.00	Ś	2,000.00	\$	10,000.00
Meeting Expenses	Room rental, AV Cost, etc.	\$	10,000.00	\$	10,000.00		•		10,000.00		10,000.00		50,000.00
Website Maintanance	Contracted with Firefly	\$	1,500.00		2,000.00				2,000.00		2,000.00		9,500.00
	•												
PARTNER SUPPORT	Details TBD	\$	200,000.00	\$	400,000.00	\$	350,000.00	\$	200,000.00	\$	200,000.00	\$	1,350,000.00
TOTAL EXPENDATURES		\$	643,949.33	\$	1,213,918.15	\$	1,480,047.46	\$	1,321,381.91	\$	1,335,493.05	\$	5,994,789.82

### Notes:

This is a DRAFT template of the NC ACH Budget. These numbers will be adjusted as we better refine staffing/contracting needs and make annual adjustments due to updated expendatures

Staff Salaries on budget are reflective of the maximum dollars within the salary range. Each Staff will fall below or at maximum at that top salary range

# Kandis Boersema

835 N. Iowa Ave ♦ East Wenatchee, WA 98802 ♦ (509) 860-3688 ♦ kandis.boersema@gmail.com

# Profile -

**Personable and versatile business professional** with exceptional organizational skills, analytical and problem resolution ability. Talent for quickly mastering technology and comprehending complex concepts & theories. Diplomatic and tactful, accustomed to handling sensitive, confidential records. Demonstrated history of maintaining accurate records and high standard of compliance at every level.

**Driven and competent** with the ability to work and thrive in an extremely complex work environment. A leader with a demonstrated ability to easily transition and adapt to new and changing work environments. Successful in deadline-driven tasks. Acute attention to detail with focus on quality and accuracy.

# Skills Summary

- ◆ Auditing/Compliance
- ◆ Report Preparation
- ◆ Grant Management
- ◆ Written Correspondence
- ♦ Insurance Billing
- ◆ Customer Service
- ◆ Tax Reporting
- ◆ Marketing & Sales
- ◆ Project Management
- Accounting/Bookkeeping
- ◆ Payroll/Human Resources
- Professional Presentations

# Professional Experience

## **AUDIT/COMPLIANCE**

- Seven years experience overseeing the accounting and compliance operations of a financial firm with \$165+ million in client assets
- ◆ Planning & conducting internal audits on existing client files, documenting and correcting discrepancies to insure compliance with company policies and IRS regulations
- Preparing internal audit reports for review by Managing Director or Internal Auditors
- ◆ Experience working with external auditors & state surveyors then conducting any reviews or follow-up requested
- Providing reconciliation reporting weekly of 1200+client accounts and related assets
- Ensuring compliance of staff, overseeing daily tasks and monitoring client-staff interaction
- Participating in monthly training to comply with federal banking regulations
- ♦ Maintaning compliance with Medicare/Medicaid and commercial insurance billing practices

# **BOOKKEEPING/ACCOUNTING**

- ◆ Seventeen years overall accounting experience including accounts payable/receivable, billing & collections, deposits, credit card payment processing, account reconciliation, data entry
- ♦ Strong reconciliation skills, seven years experience reconciling and managing \$165+ million in client funds and assets held in over 1200+ accounts
- Recordkeeping and retention (both paper and electronic filing systems)
- ◆ Current payroll experience for 60+ employee payroll
- ◆ Tax reporting: 1099 and 5498, Form TD F 90.22-1, Form 945 generation, W-2

# Kandis Boersema

106 E Iowa Court ♦ Chelan, WA 98816 ♦ (509) 860-3688 ♦ kandis.boersema@gmail.com

# Professional Experience, continued

# **BUSINESS MANAGEMENT/CUSTOMER SERVICE**

- ♦ Management of all aspects of day-to-day operations of financial firm, managing \$15+ million in cash and \$150+ million in assets
- Creating and executing monthly e-marketing campaign, tracking statistics of each campaign
- Fifteen years experience in hiring, training, and/or supervising employees
- ◆ Experience in establishing and implementing policies, procedures and standards consistent with providing optimum service for 1200+ client accounts
- Experienced at communicating complex regulations and processes to clientele using layman's terms to facilitate understanding

# **Employment History**

# CHELAN-DOUGLAS HEALTH DISTRICT – East Wenatchee, WA

Associate Administrator, 2015 to current

**REGENCY MANOR** – Chelan, WA **Business Office Manager**, 2014 to 2015

# REALTRUST IRA ALTENATIVES, LLC – Chelan, WA

Operations Manager, 2006 to 2013

# MARK HODGES & ASSOCIATES, P.S. – Bellevue, WA

**Bookkeeper,** 2008 to 2011

# COLDWELL BANKER ASSOCIATED REALTY, INC. - Chelan, WA

Office Manager, 2004 to 2006

Realtor, 2004 to 2006

# Education

# WESTERN GOVERNORS UNIVERSITY

Bachelor of Science, Accounting, September 2014

Master of Business Administration, March 2016

# Computer Skills

- ◆ Microsoft Office Suite
- ◆ Paychex
- ♦ Kronos
- ♦ HCS / Point Click Care
- ♦ Internet/Email
- ◆ 10-Key Skills: 176 characters per minute

- ♦ QuickBooks
- ◆ TrustProcessor (Trust Accounting Software)
- ◆ Accutrust (Trust Accounting Software)
- ◆ Adobe Acrobat
- ♦ Windows Server 2003
- ◆ Typing Skills: 71 WPM

# **North Central Accountable Community of Health**

**Bios and Resumes from Subject Matter Experts** 

- 1. Timothy Hoekstra, Behavioral Health
- 2. Dr. Richard Hourigan MD, Hospital and Primary Care
- 3. Dr. Doug Wilson, MD, Primary Care
- 4. Theresa Sullivan CEO, Hospital Administration
- 5. Kevin Abel CEO, Hospital Administration
- 6. Sheila Chilson CEO, Federally Qualified Health Clinic
- 7. Winnie Adams, School Healthcare
- 8. Ray Eickmeyer, Emergency Medical Services
- 9. Peter Morgan, Primary Care
- 10. Jesus Hernandez, Primary Care

(208) 964-7189 thoekstra@rocketmail.com

2564 Indy Ln. Wenatchee, WA 98801

#### **PROFESSIONAL PROFILE**

Objective: Healthcare Executive Position

My Why: Twenty-eight years of working in healthcare, today more than ever I am delighted to say that I am engaged in the excellent national, state, and local efforts toward impacting communities and health systems by way of community forums, strategic business-planning and implementation that align legislation, policy, and care-delivery models that are paving the way for full integrated care to drive quality and access to care up and cost down.

#### **Keystone Achievements**

- Lead role in strategic discussions with managed care organization, accountable communities of health, and healthcare leader representative for joint legislative days pertaining to integrated care
- Proven physician and mid-level provider recruitment and retention strategies/tactics
- Strategic alignment of operations, with organizational visions/mission and funding mechanisms (Value-based reimbursement, Capitated payments, and PPS)
- Formal lean projects and value stream mapping for new service line and health systems (ex. patient wait time for outpatient clinic, Joint and Spine perioperative cycle, Crisis Triage Facility, and System of Care for two Countles/four cities)
- Health system operations for multiple service lines—revenue cycle, budgets, capital development, staffing, problem resolution, quality assurance, Lean, EHR, and health integration
- Active member of a community Health Access Team & Patient Safety Coalition (Members: 4 Hospitals, Public Health, Managed Care, and Community Health)

- Government, legislative, health care and managed care association collaboration and provision of education on integrated models of care, best practices, and system/service-line designs
- Lead for organization on contract negotiations with managed care organizations pertaining to integrated care to move from fee-for-service model of payment to value-based compensations
- Hired as consultant to analyze health care governance and operational structures to identify stuck points and increase organizational efficiencies: re-engineered organizational structures to better align with strategic initiatives, increase cooperation & effectiveness with lower cost
- Developed and Implemented robust and measurably effective corporate compliance programs within highly complex and regulated healthcare environments (government, public, and private sectors)
- Advance knowledge and working-relationship with WA State Departments and Medicaid systems (HCA, DSHS, DBHR, OIG); working relationships with Feds (HRSA, BPA, CMS)

#### **EDUCATION**

Masters of Business Administration: Health Care Executive Focus; U of P, Bolse, ID Masters of Science: Applied Psychology; Eastern Washington State University Bachelor of Art: Psychology; Simpson College, CA

2008 1999

1996

#### PROFESSIONAL & PERSONAL DEVELOPMENT

#### **Professional**

- > Member: American College of Healthcare Executives
- Accountable Communities of Health Board Member
- > Lean Certificate-TPS for Health Care
- Leadership Trl-Cities—Class XVIII Graduate
- > 28 Years of HealthCare experience

#### Personal

- Commissioner—Planning Commission (Ex Officio)
- > Church Leadership
- > President-Housing Association (past)
- > Youth Mentorship
- > Family-Centered and Community-Minded

#### **CAREER HISTORY**

**Director of Behavioral Health Services:** Columbia Valley Community Health A FQHC with full integration of Medical and Behavioral Health Services

8/2015 - Current

- > Recruited by CVCH to integrate two behavioral health service lines during a period of vast employee and leadership attrition
  - Stabilized the teams; backfilled all position within 7 months, realigned leadership resources to drive performance and financial turnaround; led by example and through practiced leadership skills that fosters trust, compassion, and by

1 of 5 | Page

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aligning team building activities and service line structures to formalize a shared vision and commitment to CVCHs core values and mission

- o Drove sustainable growth to new levels of production that surpassed all historical markers in just over a year of tenure
- Financial and budgetary responsibility of Integrated Program—Lead for preparatory work for transition from PPS to value-based compensation contracts--\$10 million annual budget with 27 direct reports
- Designated representative to joint legislative committees day addressing healthcare bills and governor's line-item budgets, legislative task forces and committees, and strategic lead for brain trust related to system re-engineering for progressive integrated care service delivery
- Administrator for American Psychological Association accredited internship and post-doc site (Integrated Care Model)
- > Organizational lead on legislative taskforce workgroups addressing constraints and barriers to Integrated Care
- > Presented at State of Reform Washington conference—best practices in Integrated Care
- > Organization resource for contractual conversation with MCO in preparation for risk-based/value-bases payment structures and capitation involving integrated care
- > Operated as organization's vision and strategy counsel regarding population and social-determinants of health, utilization management for cost control and alignment of practices to manage same
- > Intellectual resource for CVCH in designing *health-system* integration, leveraging existing competencies, and assessing practical resolutions to barriers to growth and integration
- Appointed organization's lead to lead discussions with community stakeholders, contractors, and local government leaders to help position CVCH for future growth, for better influence on population health, and to position CVCH for the future of integrated and managed care
- > Articulated a substance abuse program vision that was included in a federally-based substance abuse service expansion grant, which resulted in an award of \$325k in perpetuity (achieved this within 2 months of employment with CVCH)
- Responding to community stakeholder partnership interests that will help CVCH fulfill its mission and prop CVCH up for future growth and achievement of the triple aim of the Accountable Community of Health
  - Improving population health
  - Enhancing the experience and outcomes of patient care
  - Decreasing cost of care
- Outreach to community via radio, news article, fundraisers, and school activities to represent CVCH and to better understand the community's needs
  - Focusing on community needs and keeping CVCH's mission/vision in mind has been key to:
    - developing vital relationships through open, engaged and respectful communication
    - remaining focused by only entering into commitments that CVCH can fulfill; and
    - remaining supportive of community partners while understanding the competitive elements within those partnerships
- > Attending the local Accountable Community of Health forum and participating in local and state-level discussion on the future of managed health care

Office Chief, Compliance: Washington State Department of Social and Health Services Aging & Long-Term Support Services Administration (ALTSA) / Residential Care Services (RCS)

\*1/2015 - 7/2015

- Sought out by State Director to develop the department's first formal Compliance Program—Enforcement of regulations for 3000+ long-term care organizations for individuals with Intellectual disabilities across Washington State--\$34 billion dollar industry
- > Legislation development participant—input on budgetary implication and patient/provider impact
- > Identification of system vulnerabilities—targeted key risk and building measureable outcomes structures to monitor process improvement (PDSA cycles)—Established internal controls and mechanism for intra-organization self-monitoring
- > Contract negotiations with stakeholders across the State of Washington, and contract management for same
- > Engaged with multiple stakeholders and many other state entities to help identify opportunities for shared resources
- > Organizing cross-system initiatives that help improve patient safety and outcomes, increase organizational effectiveness and help decrease duplications in efforts (protects against organizational confusion and decreases cost)
- State-wide presenter on Compliance trends across six (6) facility types
- > Major decision-maker on enforcement and litigation

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- > Organization's lead for state audits, corrective action planning and contracts
- > \* State budgetary out-backs resulted in elimination of my position

Director of Outpatient Behavioral Health Services: Lourdes Health Network (Critical Access Hospital) 4/2011 – 11/2014
Responsible for Southeast Washington State's largest Outpatient mental health system--\$25 million gross annual charges
Integrated Care System (acute care, ambulatory, outpatient mental health and substance abuse, and MH inpatient and crisis services)

- > 3 Year commitment to organization—Outcomes expected: Growth, Streamline System, and Control Cost
- > Highlight of Goals Achieved:
  - o Responsible for \$30 million budget and 100 + employees
  - Hospital's leader on healthcare improvements for addressing social determinants of health, which included business
    presentations addressing strategic positions within the community for market share, financial sustainability while
    expanding services and improving patient outcomes, and leveraging the hospitals specialty service assets to
    negotiate and procure additional contracts and secure funding
  - Organization was in continual decline prior to my tenure—turned system around and realized 3% increase in 1st year; 15% in the 2nd year; 35% in the 3nd (impacted hospitals cash on hand—from 35 days to up to as much as 90 days)
  - o Successfully developed and implemented strategic plan, which resulted in expand service lines, broadened referral base and increased new patient capture rate for the hospital by more than 12%
  - o Identify key system problems that were leading to poor financial performance—created action plans for change and accomplished goals on time
  - o Developed pathways toward practice enterprises—used patient mapping and proven business principles
  - o Spearheaded cross-system initiatives involving revenue cycle, coding, medical records, HR, Mission, Marketing
  - o Restructured service line management structure—allowed better clinical quality, efficiency, and financial oversights
  - Reduced average cost each year of my tenure by an average 4.5%
  - o Provided operational consultation for sister Regional Hospital (32 bed facility)—clinical and financial analytics
  - Full responsibility for revenue cycle for service line, charge master, contracts with managed care and Medicaid—increased collections, expanded contracts, resolved problems with billing procedures, reduced deductions from revenue through lean analyzes and identification of charity care practices (included transition from ICD-9/ICD-10)
  - o Led large multi-service line MIS data export modification from 3rd party system platform to existing Meditech venue
  - o Broke down silos and developed "team" culture—needed for better service throughput and problem solving
  - o Wrote multiple grants that resulted in over \$7 million in funds to build service infrastructures (including a 16 bed crisis triage facility)
  - Streamlined referral to established- appointment process—measured retention rate pre/post (over 6 months) resulted in 60% increase in new patient accounts
  - Community leadership and facilitated communications with large array of stakeholders (Chief of Police, Prosecuting Attorneys, Judges, Managed Care, State Representatives/Senators, DSHS, DBHR, 6 Commissioners, Mayors, other local government, etc.—addressing needs of community and growing programs that will last for years to come

#### Hoekstra Enterprises & Consulting, Inc.

2/2006 - 4/2013

Health care operations, marketing, leadership, quality assurance, corporate compliancy, practice management, and financial/program growth development

- > Successful Company—Discontinued after Great Recession and accepting employment position with Lourdes Health Network
- > Executive Level consultation for health care organization for over 5 years, including non-profit and for-profit organizations
- > Demonstrated success with:
  - o Financial analyses geared toward sustainability, capital investment goals, and growth
  - o Strategic planning, Marketing, and successful re-branding
  - o Revenue Cycle oversight/modifications to increase billing/payment capture rates (led teams of certified coders, health information technicians and administrators)
  - o Worked with Managed Care Organizations to facilitate contract negations and leverage organizational competencies to maximize financial agreements
  - Organizational representative on state committees addressing FQHC operational realities that impact quality and effectiveness of health care practices

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- Established physician brainstorm groups—gamered insights that led to efficient practices and service-line development and standardizations; grew into model for retention and production enhancement (Dyad and Collaborative Models)
- Conducted "through-put" analyzes (needs assessment, market evaluation, outpatient and inpatient capture rate) showed system weakness and opportunities to establish operational priorities and establish new strategic foci
- o Mediated critical stakeholder discussions-lead to shared visions and work plan commitments
- o Property, Land, Lease procurement and other contract negotiations-facility development/expansion
- Conducted regulatory compliance evaluations to determine status against Federal and State regulations—designed and led problem-solving forums that resulted in corrective actions plan and new clinical pathways
- Developed Corporate Compliance and Quality Assurance programs
- Process improvement executive leader—revenue cycle, call center, reception and registrations processes, first established appointment protocols, follow-up, lab relations, hospital support, and many others facets of clinic practices
- o Created systems of clinical comparison for organization against HEDIS measurements
- o Analyzed compliance shortfalls and evaluated organizations risks-prioritized same
- o Identified key physician champions for change and leveraged expertise and positions for positive influence
- o Spearheaded development and implementation of a physician retention program—Built upon premise that retention = quality
- o Created reporting systems for patient and employee incidents to ensure confidentiality
- o Resolved numerous compliance deficits and shored up programs and services through action plans that addressed contractors' and stakeholder concerns
- o Provided CEO's with analyses of liability exposure and recommendations for amelioration
- Analyzed staffing models and wrote business plans that included new staffing models, performance/incentive pay and ROI summary
- Wrote business plans for business expansion-including strategic marketing and stakeholder relationship plans with evaluation of ROI
- Envisioned, built, and executed new programs tailored to community need and business environment
- Designed and implemented HR structures (Training modules, hiring procedures, IT support, clinical caseload establishment)
- Facilitated Values, Mission and Vision statement development
- o Established service quality and utilization review processes for quality and financial control

Chief Operations Officer: Dirne Community Health Center Community Health Center serving over 80,000 annual patient-encounters \* 10/2008 - 9/2009

- > Hired as COO during time of vast physician and leadership turnover
- > Responsible for \$22 million dollar budget and 70 employees
- > Served as interim CFO during vast leadership turnover upon entry into this organization—stabilized financial department and facilitated training for the incoming CFO
- > Stabilized system through facilitative and servant leadership style
- > Established business requirements to position organization for EMR transition
- Lean process application—revenue cycle, call center, reception, front-end/back-end support, best-practices for routine appointments (i.e. nurse responsibilities, length of visit standards), billings, HR new hire training, facility/equipment asset and maintenance routine standards development, inventory controls, supply chain/purchasing
- Recruited and negotiated contracts with 3 additional family practice physicians, 3 dentists, and two MH professionals
- > Strengthened programs that were required by Federal contract
- > Turned two service lines that were loss leaders into financial leaders—used system lean mapping, through-put analysis, benchmarked staff ratio, identified patient retention and no-show problems, and wrote new practices that worked
- > Wrote grant application--awarded over \$2million for rural dental program enhancement—completely renovated dental office, and purchased full array of dental equipment for 4 operatories (chairs, delivery units, panoramic, digital x-rays, etc.)
- \* Left organization due to unethical behaviors occurring in the organization—managed the conflict with respect and dignity while providing clear basis for concerns

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Project Director: Business Psychology Associates

Behavioral Health Service Utilization Management Organization

\* 2/2007 - 10/2008

- > Responsible for \$2 million annual budget—relatively small budget but large state impact on behavioral health performance
- > Pioneered and directed new Mental Health (MH) Credentialing program for the company
- Program liaison between Idaho Medicaid (DHW) and Mental Health Credentialing
- > Wrote cross-walk between Idaho Credentialing standards and Idaho MH service statutes and regulations
- Professional public presentations on MH Credentialing standards and practices
- > Traveled the entire state of Idaho conducting on-site reviews
  - o Quality assurance programs/practice reviews and recommendations
  - o Service utilization management system reviews
  - o Personnel and HR practices against state statutes and regulations
  - Policy and procedures reviews
  - o Facility compliance reviews
  - o Chart reviews
  - o Exit Interviews and timely report writing
- Continuous quality improvement and reporting to Medicaid on MH Credentialing program activities
- > Direct responsibility for multi-million dollar budget
- > Responsible for staff training, development and retention
- \* One year commitment to organization—Wife completed her schooling in that area, we owned a home in N. Idaho, and we moved back to N. Idaho after program was built and fully operational—Took advancement opportunity as COO for Dirne Community Health in N. Idaho

#### Additional Work Experience Available Upon Request

- > 28 years of healthcare experience
- > Over 11 years of experience in healthcare leadership and management
- > Extensive experience with business pro-formas, financial management, and cost-driver/cost-reduction evaluations
- > Extensive experience with integrated service delivery: physical, mental health and substance abuse disorders
- > Significant experience with Lean and quality improvement for healthcare
- > Significant experience with system re-design/re-engineering to align talents, resources, services, and systems to reach identified strategic initiatives while establishing the needed economies

## **CURRICULUM VITAE**

## RICHARD JOSEPH HOURIGAN, MD, MHA

PO Box 1130
Wenatchee. Washington 98807
Tel. (509) 750-7402
Email: Rick.Hourigan@gmail.com

#### **EDUCATION:**

Masters Health Administration: University of Washington 2012-2014.

Residency: University of Kansas, Department of Family Practice, Kansas City, KS. 1988--1991.

Medical: University of Kansas School of Medicine, Kansas City, KS. 1984--1988.

Undergraduate: Benedictine College, Atchison, KS. 1980--1984.

#### LICENSURE:

Washington State: 1991--present. License #: MD00028230

### **CERTIFICATION:**

IHI Healthcare Professional Certification 2014
Fellow, American Academy of Family Practice, 1998
American Board of Family Practice, 1991, re-certified 1997, 2003, 2013
National Board of Medical Examiners, Diplomat, 1989.

#### **MEMBERSHIPS:**

American Medical Group Association American Association of Physician Leadership American Academy of Family Practice Washington State Academy of Family Practice Washington State Medical Association

## POSITIONS HELD:

#### Board Member

- Wenatchee Valley Medical Group. January 2016-present
  - A 270 Physician Owned Medical Group/Confluence Health. January 2016-present
     .Vice Chair February 2017 to present.
- Confluence Health. February 2016- Present
  - o An integrated health system with 3600+ employees, 400 providers and 2 hospitals serving a population of over 250,000 patients over a 12,000 square mile rural region in North Central Washington

Medical Director Accountable Care Services, Confluence Health, Wenatchee, WA. 2012-present. Medical Director Health Alliance Northwest 2013-Present

- Medical oversight and Utilization Management of capitated and at risk insurance plans for 400+ provider practice.
- 32,000 full risk enrollees across all lines of service (Medicare, Self-Funded, Commercial and Medicaid).
- Responsible for prior authorization, utilization management and case management services, evaluation of costs, usage and identification of physician practice patterns and identification of areas for improvement in severity coding, practice efficiency, network adequacy and network utilization. Competency in McKesson InterQual decision support software.

## **CURRICULUM VITAE**

# RICHARD JOSEPH HOURIGAN, MD, MHA

PO Box 1130

Wenatchee. Washington 98807 Tel. (509) 750-7402 Email: Rick.Hourigan@gmail.com

#### **EDUCATION:**

Masters Health Administration: University of Washington 2012- 2014.

Residency: University of Kansas, Department of Family Practice, Kansas City, KS. 1988--1991.

Medical: University of Kansas School of Medicine, Kansas City, KS. 1984--1988.

Undergraduate: Benedictine College, Atchison, KS. 1980--1984.

#### LICENSURE:

Washington State: 1991--present. License #: MD00028230

#### **CERTIFICATION:**

IHI Healthcare Professional Certification 2014
Fellow, American Academy of Family Practice, 1998
American Board of Family Practice, 1991, re-certified 1997, 2003, 2013
National Board of Medical Examiners, Diplomat, 1989.

## MEMBERSHIPS:

American Medical Group Association American Association of Physician Leadership American Academy of Family Practice Washington State Academy of Family Practice Washington State Medical Association

# POSITIONS HELD:

Board Member

- Wenatchee Valley Medical Group. January 2016-present
  - o A 270 Physician Owned Medical Group/Confluence Health. January 2016-present. Vice Chair February 2017 to present.
- Confluence Health. February 2016- Present
  - o An integrated health system with 3600+ employees, 400 providers and 2 hospitals serving a population of over 250,000 patients over a 12,000 square mile rural region in North Central Washington

Medical Director Accountable Care Services, Confluence Health, Wenatchee, WA. 2012-present. Medical Director Health Alliance Northwest 2013-Present

- Medical oversight and Utilization Management of capitated and at risk insurance plans for 400+ provider practice.
- 32,000 full risk enrollees across all lines of service (Medicare, Self-Funded, Commercial and Medicaid).
- Responsible for prior authorization, utilization management and case management services, evaluation of costs, usage and identification of physician practice patterns and identification of areas for improvement in severity coding, practice efficiency, network adequacy and network utilization. Competency in McKesson InterQual decision support software.

- Development and launch of new Medicare Advantage insurance plan co-owned by physician group, network growth and partnering of contracted providers. This plan was awarded a 4.5 Star from CMS in 2015 after its first full year of membership.
- Oversight and development of outpatient Case Managers in order identify and manage high risk and rising risk patients.
- Heavily Involved in development of new employee health plan option to incentivize value based care
- Developed new Wellness Plan for 3,600 employees based on accountability and care coordination geared to drive health plan cost savings over future years

Director, Family Medicine Department, Moses Lake Clinic/Wenatchee Valley Clinic. 2006-2012.

• Duties involved department oversight for 9 physician group, problem solving and interaction with site medical director and area manager for departmental operations and physician and staff issues.

Medical Director, Moses Lake Clinic, Branch of Wenatchee Valley Clinic. 1994-2003

- Physician oversight and review, recruitment, retention, and administrative duties for 25+ provider clinic.
- Bridged the divided between providers and administration.
- Helped coordinate and problem solve space, productivity and patient satisfaction issues for site-based and visiting providers.
- Successfully involved in helping to recruit and expand rural clinic from 12 to 25+ providers.

Family Physician, Moses Lake Clinic, Branch of Wenatchee Valley Clinic, 1991-2016

- Provided full range of family practice care including outpatient, inpatient, and obstetrics.
- Consistently have exceeded MGMA productivity averages while achieving high scores on patient satisfaction surveys.

Salary Committee, Wenatchee Valley Medical Center, 2005--2016

Finance Committee, Wenatchee Valley Medical Center, 1999—2001

President, Grant-Adams County Medical Society. 1996.

Department Head, Family Practice, Samaritan Hospital, Moses Lake, WA. 1993--1994.

REFERENCES: Available upon request.

# Dr. Doug Wilson, MD

## **Confluence Health**

Specialty: Family Medicine; Location(s): Oroville Clinic, Tonasket Clinic

- Practices family medicine, hospital medicine and obstetrics in Tonasket since 2004.
- Clinical Assistant Professor in the Department of Family Medicine at the University of Washington, Seattle, WA.

#### **Education & Certifications:**

- BS, University of Washington, Seattle, Washington, 1991
- MD, University of Washington, Seattle, Washington, 2001

#### Advanced Education:

 Internship and residency, Family Medicine, Ventura County Medical Center, Ventura, California, 2001–2004

## **Board Certification(s):**

Family medicine, American Board of Family Medicine: 2004

## **Special Interests:**

- Family medicine
- Obstetrics
- Speaks Spanish

## Language(s):

- English
- Spanish

# HIGHLIGHT OF QUALIFICATIONS:

Experienced healthcare executive with a background in overall hospital operations, clinic management, physician recruitment & contracting, human resource management, and marketing. Proven track record of successful leadership and collaboration with board, physicians, staff, organization partners, and the community to advance the mission and vision of an organization

## PROFESSIONAL EXPERIENCE:

SAMARITAN HEALTHCARE, Moses Lake, WA

2014 – PRESENT

Chief Executive Officer, September 2015 - Present

## Chief Operating Officer, October 2014 - September 2015

 Reporting to the CEO, provided executive leadership in an administrative/physician dyad leadership model with responsibility for Samaritan Clinics, Imaging, Laboratory, and Rehabilitation Services. Oversaw development and implementation of community outreach and community wellness programming.

## CUYUNA REGIONAL MEDICAL CENTER, Crosby, MN

1992 - 2013

# Chief Operating Officer - Hospital, April 2009 - October 2013

- Responsible for Hospital Nursing (ICU, Med/Surg, OB, ED, Infusion Services), Surgery,
   Radiology, Lab, Rehabilitation, Pharmacy, Ambulance, Facilities Management, and Quality.
- Fiscal responsibility for \$48 million expense budget, \$2 million capital budget and 320 FTE's.
- Regularly involved in engaging the Board of Directors in strategic planning as well as supporting the CEO in various aspects of engaging and communicating with the Board.
- Engaged and collaborated with the Medical Staff leaders to conduct the business of the medical staff and to facilitate changes through the Medical Staff to ensure high quality care and service.
- Part of the team that consistently achieved an HCAHPS overall hospital rating in the 90<sup>th</sup> to 99<sup>th</sup> percentile in both state and national Press Ganey ranking.
- Attained employee engagement survey results in the 84<sup>th</sup> percentile for overall engagement for direct reports.
- Nutured an atmosphere of open communication, active problem-solving, and a focus on working together to accomplish organization goals.
- Planned and oversaw updating and remodeling projects.
- Actively built relationships to assist in establishing, operationalizing, and maintining various
  partnerships with a neighboring hospital, various physician groups, and other health care
  organizations.

# Resource Partners Administrator, September 2000 - April 2009

- As a member of the senior leadership team, provided leadership to the Resource Partners
  Business Unit including Human Resources, Education, Occupational Health & Safety, and
  Marketing Departments.
- On behalf of CRMC, developed strategic partnerships with chamber of commerce, local high schools and college as a key workforce development and recruitment strategy.
- Worked with the senior leadership team and the Board of Directors in the development of the overall medical center strategic plan.
- Developed and implemented successful marketing plans and strategies which contributed to a significant increase in overall market share.
- Part of the team to negotiate union contracts and to engage RN committee to update policies governing compensation and benefits.
- Acted as the communications officer for the medical center.
- Worked as a part of construction teams on multiple building projects to manage various aspects
  of new construction and renovation projects such as providing communication to staff and the
  community, plan for traffic flow, signage, and wayfinding.

# Chief Executive Officer - Longville Lakes Clinic, September 2000 - January 2013

- Planned and implemented strategic, financial, marketing and programmatic initiatives.
- Engaged a 9-member board of directors to provide strategic direction and leadership.

# Director, Northern HealthCare Partnership, September 1997 - September 2000

- Managed the daily operations of Northern HealthCare Partnership, a Physician-Hospital Organization (PHO) involving 3 hospitals and 10 clinics including Riverwood Healthcare Center
- Reported to the Northern HealthCare Partnership Board of Directors.
- Developed and implemented policies and infrastructure for the Partnership to function as a PHO.
- Developed a physician provider network of over 150 physicians.

# Director of Physician Recruitment & Personnel Coordinator, August 1993 – September 1997

**EDUCATION:** 

University of St. Thomas, Minneapolis, MN MBA in Medical Group Management - December 2001

Concordia College, Saint Paul, MN. B. A., Organizational Management and Communication - May 1994.

Brainerd Community College A.A. - May 1993 Phi Theta Kappa OTHER:

AWPHD Board of Directors (10/2016 - Present)

WHS Board of Directors (1/2016 - Present)

WSHA Strategic Planning Committee (1/2016 – Present) Grant County EDC Board of Directors (9/2015 – Present) Moses Lake Area Chamber of Commerce (11/2016 – Present)

American College of Healthcare Executives (ACHE) member (7/2010)

ACHE-MN Chapter Board of Directors (2011-2014)

FACHE designate (FACHE -7/2013)
MHA Patient Safety Committee (2010-2011)

Grant Reviewer - MN Dept. of Health (2001 to present)

Brainerd Lakes Chamber of Commerce - Bridges Academy & Workplace Connection

Advisory Board (2005 to present) - Chairperson (9/2007 to 2009)

Church Leadership & Volunteer

REFERENCES:

References or letters of recommendation are available upon request.

# Kevin Abel

725 Golf Course Drive ♦ Chelan, WA 98816 ♦ (509) 433-8586 ♦ abelkevin3@yahoo.com

#### EXECUTIVE PROFILE

Healthcare executive with eighteen years experience leading people, building teams, improving operating revenues, and expanding healthcare programs in integrated healthcare systems. Expertise spans healthcare finance, quality, facilities, human resources, marketing, contract negotiations, board relations, and strategic planning. Fosters an environment of respect and collaboration by developing positive relationships with providers, caregivers and business partners.

### PROFESSIONAL EXPERIENCE

# Lake Chelan Community Hospital and Clinics - Chelan, WA

2009 - Present

**Chief Executive Officer** 

Chief Administrative Officer reporting directly to five elected commissioners of 2,200 square mile public hospital district that serves Chelan, Manson, and Chelan Falls. Services include critical access acute care hospital, dual diagnosis chemical dependency, primary care clinic, specialty care clinics, EMS agency, rehabilitation services and mental health. The health system consists of five locations and 284 caregivers.

- Built a top-performing team of healthcare professionals and instilled a shared commitment to quality patient-centered care.
- Maintained positive board relations and directed the strategic planning process.
- Merged Lake Chelan Community Hospital with Lake Chelan Clinic.
- Created an orthopedic specialty clinic.
- Expanded rehabilitation facility and services increasing PT and OT visits by 485% over four years.
- Reorganized foundation increasing annual revenues 52%.
- Implemented a self insurance plan reducing medical insurance expense.
- Conducted a successful EMS levy campaign winning 68% yes vote.
- Won the Most Wired award every year from 2010 to 2016 as recognized in the American Hospital Association Hospitals & Health Networks magazine. Achieved EHR meaningful use for Medicare and Medicaid stages.
- Divested HUD subsidized senior apartments to Chelan County Housing Authority.
- Emphasized community relations holding regular speaking engagements with community organizations, media, and educational forums.
- Restructured organization with a greater emphasis on quality and the integration of clinic and hospital
- Chief Financial Officer February to June 2009.

# St. Charles Health System - Bend, OR

1999 - 2009

Controller 2005 - 2009

Controller for a three hospital system with home health, inpatient mental health, air ambulance, regional laboratory, clinics and joint ventures in orthopedic, imaging, and heart centers with an annual operating budget of \$419 million. Direct reports include Director of Finance, Director of Materials Management, Biomedical Services Manager, Decision Support Manager, Budget Manager and Director of Revenue Cycle.

- Staff member of St. Charles Health System Strategy and Finance Board Committee.
- Staff member of St. Charles Medical Center Foundation Board.
- Responsible for over 200 employees.
- Developed strategy and provided system oversight as a board member of Central Oregon MRI, Cascade Medical Imaging, and Cascade Surgicenter.
- Developed construction budget process for \$122 million expansion at Bend and Redmond campuses.
- Directed annual budget process and variance reporting.

- Issued \$50 million and \$103 million in hospital revenue bonds. Implemented debt compliance monitoring system.
- Implemented McKesson system conversion for material services, patient accounts, finance, and decision support.
- Built positive relationships with direct reports, caregivers and executive team.

#### Director of Material and Biomedical Services 2001-2005

Responsible for supply logistics, equipment maintenance, contracting and supply chain strategy for healthcare system.

- Responsible for supply costs of over \$87 million.
- Chaired system capital committee for three years with annual budgets of \$11 to \$17 million.
- Managed material and biomedical services consolidation process with merger of Bend and Redmond hospitals.
- Implemented Value Analysis Committee with surgeons, cardiologists and staff to address implant quality and costs.
- Managed cost reduction process that produced over \$3 million in savings.

#### Compliance Officer / Charge Master Manager 1999 - 2001

Compliance Officer managing team responsible for compliance strategy, board reporting, coding, procedure pricing, contracting and education.

- Created compliance program based on Office of Inspector General's guidance.
- Developed charge capture procedures and established formal charging methodology for medical center.
- Negotiated physician and insurance contracts. Created standard contract for medical director agreements.

#### Other Employment

Seattle University Controller's Office – Seattle, WA 1994 – 1998 Comerica / Hibernia Bank – Austin, TX 1992 – 1994

#### **EDUCATION / CERTIFICATION**

Master of Business Administration, Concentration in Accounting – Seattle University, Seattle, WA Master of Education, Curriculum and Instruction – Seattle University, Seattle, WA Bachelor of Arts, Communications – University of Illinois, Urbana-Champaign, IL Certified Public Accountant, Registered – Illinois (239.007436)

#### **BOARD / PROFESSIONAL ASSOCIATONS**

Washington State Hospital Association – Board Member, 2011 – 2014, 2017 - Present
Washington State Hospital Association Public Policy Committee – Board Member, 2011 – 2014,
Association of Washington Public Hospital Districts – Board President, Vice President, 2014 – Present
Public Hospital District Unemployment Compensation Trust – Board Member, Vice President, 2016 – Present
North Central Accountable Community of Health – Board Member, 2016 - Present
Lake Chelan Rotary – Member, Vice President, President 2009 – Present
Continuum of Care – Board Member, Treasurer, 2011 – 2016
Bend Park and Recreation District Budget Committee – Board Member, 2006 – 2008
American College of Healthcare Executives – Member
Healthcare Financial Management Association – Member
American Institute of Certified Public Accountants - Member

# Sheila Chilson Moses Lake Community Health Center

**Education:** 

Gonzaga University, May 1990, Bachelor of Business Administration -

Accounting

Experience:

2008 - Present Chief Executive Officer, Moses Lake Community Health Center

2002 - 2008 Chief Financial Officer, Moses Lake Community Health Center

2000 - 2002 Controller, Piston Service of Wenatchee, Inc.

1998 - 2000 Executive Director Financial Services, Richland School District

1992 - 1998 Business Manager, Ephrata School District

Affiliations:

Board member, Boys & Girls Club of the Columbia Basin

Chair, Homeless Taskforce of Grant County

Board chair, Community Health Plan and Community Health network of

Washington

Sheila Chilson

Chief Executive Officer
Moses Lake Community Health Center
605 Coolidge Street
Moses Lake, WA 98837
(509)766-8971

# Winnie Adams

2620 Golf Drive, Malaga, WA 98828 • Cell: 5096682942 • jjchadbeau@hotmail.com

# **Professional Summary**

Innovative, customer-oriented healthcare leader with background in hospital and clinical services. Strong background in quality assurance, fiscal accountability and management principles and practices. Seeking an executive leadership role within Lake Chelan Community Hospital. Skilled at communicating, organizing and solving problems to build lasting relationships.

## Skills

- Operations and finance expert
- Operations management
- Strategic objective execution
- Process improvement
- Financial management

- Quality improvement competency
- Budgeting proficiency
- Strategic planning capability
- Project management experience
- Knowledge of Medicaid statutes and regulations

# Work History

School Nurse Corps Director, 06/2014 to Current

North Central Educational Service District - 430 Olds Station Road, Wenatchee, WA 98801

- Confidently managed the overall operation of nursing services and patient care, including financial management, quality assurance, patient care, safety risk management, teammate satisfaction, quality index scores and facility maintenance.
- Educated school nurses on state and federal statutes, rules and regulations governing home care services.
- Developed a system of staff communication that ensured proper implementation of health care plans while maintaining students health and safety.
- Appointed North Central Accountable Community of Health (NCACH) Governing Board member and Secretary
- NCACH Governing Board appointed to lead a population health initiative workgroup focusing on childhood obesity

# Lead Registered Nurse, 08/2013 to 06/2014

Columbia Valley Community Health - 317 E. Johnson, Chelan, WA 98816

- Manage schedules, patient flow, no-show back fill within the clinic.
- Strong leader for nursing personnel assigned to the clinic.
- Collaborate with providers and organization to meet or exceed sustainability goals.
- Used LEAN methodology to assess patient access and flow throughout the clinic.

# Senior Consultant, 06/2012 to 03/2013

Innovative Consulting Group – 9210 Petersburg Rd, Evansville, IN 47725

- Maintenance and upgrade implementation of GE's Centricity Perinatal system for Alegent Health Services
- Maintained high departmental standards for quality and productivity metrics.
- Collaborated and coordinated with organizations Administration and nursing staff to configure changes to reflect standards of practice and organizational workflow.
- Coordination of system downtimes.
- Developed quality reports within the system that complied with organizational quality indicators.

# Director of Women's & Children's Services, 12/2002 to 03/2012

Central Washington Hospital - 1201 S. Miller St., Wenatchee, WA 98801

- Responsible and accountable for five nursing departments with approximately 44 FTE's.
- Knowledgeable in departmental budget activities to include the capital budget process, variance reports and combining two departments into one cost center.
- Implemented Lactation and pre-operative outpatient services.
- Knowledgeable with the JCAHO survey process.
- On the leadership building project team to include design, evidence based practice, workflow, security, physician and staff adoption.
- Empowered nursing staff in implementation of LEAN workflow and process improvement.
- Maintained quality of safe patient and family-centered care.

#### Education

MBA: Nursing Administration, Current

Grand Canyon University - Phoenix, AZ

- Coursework in Health Services Administration and Business.
- Coursework in Business Management.
- Coursework in Accounting Practices and Finance Principles.
- Coursework in Ethics, Policy, and Finance in the Health Care System.

Master of Science: Nursing Leadership, Current

Grand Canyon University - Phoenix, AZ

- Coursework in Organizational Behavior.
- Coursework in Leadership Styles and Development.
- Coursework in Strategic Management.
- Coursework in Operations Management.
- Coursework in Health Care Research Analysis and Utilization.

Bachelor of Science: Nursing Leadership, 2008 Washington State University - Spokane, WA

Associate of Science: Nursing, 1995

Wenatchee Valley Community College - Wenatchee, WA

## **Professional Memberships**

- Association of Nurse Executives (AONE)
- North Central Accountable Community of Health Governing Board member and Secretary
- Healthy Living Wenatchee Valley Coalition co-chair member
   Teen Pregnancy Prevention Coalition member

# Raymon John Eickmeyer 219 E Franklin Chelan WA 98816 509-670-2441 email-stingray@nwl.net

#### **EDUCATION**

- Diploma, June 1991- Shadle Park High School- Spokane, WA with Honors
- AA Liberal Arts, June 1994- Spokane Falls Community College, Spokane, WA with prerequisites in Nursing&Chemistry
- Bachelors of Science in Paramedic, June 1997- Central Washington University, Ellensburg, WA

#### CERTIFICATIONS

- Washington State Emergency Medical Technician-1992 to 1996
- Washington State Certified Paramedic and National Registered Paramedic-1996 to Present.
- IAFF Fire Fighter I- 1995-present
- Nursing Assistant Registrant- 2000 to present ٥
- Car Seat Safety Technician-2001-present
- Registered Healthcare Safety Officer- 2004 to present ٥
- Hazardous Material Technician- 2004 to present
- Hospital Decontamination Technician -2003 to present ٥
- Washington State Hospital Decontamination Instructor 2003 to present ٥
- ACLS, PALS, PHTLS, BLS, NRP Provider current
- ACLS, PHTLS, EMS, BLS, SafeSitter, GEMS, Instructor
- Patient Handling Specialist- 2006 to present
- Bomb Making Awareness Program Instructor- 6-2012 to present ٥
- Firefighter Rehab Instructor- 6-2013 to present
- BDLS- Basic Disaster Life Support Certified 6/2013 to present
- Community Healthcare Worker (CHW) certified-3/2015 to present
- Numerous other specialized certifications in Preparedness, EMS, Cardiac /Stroke Care, Hazmat, and Safety. (A few noted below)
  - ACF training (Texas A&M University)
  - Mass fatality (Kirkwood Community College) O
  - Emergency Operations Center Training (Texas A&M University)
  - PIO training (Texas A&M University)
  - NBC Domestic Preparedness Training (Jacksonville State University-2000)
  - WMD Emergency Medical Services Training Course (CDP- Anniston, Alabama-2006)
  - Methamphetamine Lab Recognition and Identification training (WA state DOE)
  - PCEP- Perinatal Course (67 hour course by National Association of Neonatal Nurses)
  - NIMS- IS 100, 106.1, 200, 300, 400, 700, 701, 702, 703, 704, 800, AWR 160 certified

#### EXPERIENCE

- EMS Operations Manager- Lake Chelan Community Hospital EMS from 2010 to present- managing 40 EMS employees
- Committee member for several DOH/Washington State committees:
  - WA State EMS Preparedness workgroup- December 2015 to present
    - WA state Prehospital TAC June 2015 to present
    - WA state Ebola Committee member (2015)
    - Washington State ACF Standardization Committee- 2010 to 2013
    - LEPC (local emergency preparedness committee) 2008- present
    - WA state Healthcare Coalition leadership committee 2008-present
    - Regional EM committee (Emergency Management) 2008 to present
    - Helped author the DOH EMS All hazards Protocol for all EMS providers in WA state (2003)
    - Homeland Security EMS preparedness workgroup (2003)
    - Chelan County Pediatric domestic abuse committee (2001)
- Speaker / Educator-
  - Speaker at Washington State Preparedness Conference June 2016 (on the 2015 wildfires)
  - Speaker at Washington State Preparedness Conference May 2015 (on the 2014 wildfires)
  - Educator for Region 7 Public Health & North Central Emergency Care Council-June 2015 (on Ebola and PPE)
  - Speaker at Christian Workers Conference-May 1998 (on young adult ministries)
- Governing Board Voting Member- North Central Washington Accountable Communities of Health for healthcare revision (October 2015- present)
- Chairman Greater Wenatchee EMS council- for all EMS agencies in South Douglas and Chelan Counties. April 2010 to present. I also participate in several sub-committees within the council.
- Program administrator- Regional PAD (public access to defibrillation) for Chelan, Douglas, Okanogan, and Grant Counties- April 2010 to present.
- Council member- Washington State Stroke Council- 2010 to 2013
- Graduate of Resuscitation Academy-March 2010
- Chairman-Washington State Region 7 HealthCare Coalition-Washington State DOH- June 2015 to Present
- Vice Chairman-Washington State Region 7 Healthcare Care Coalition-Washington State DOH- 2008 to June 2015, in addition I participate in several various sub-committees within the Coalition.
- EMS and Trauma Technical Advisory Committee- for Cardiac and Stroke systems to Washington State Governor- 2004 to Present, I also participate on several subcommittees within the TAC.
- Committee Member- Chelan County Child Abuse and Neglect Investigation Protocol revision committee 2008
- Preparedness Coordinator- Lake Chelan Community Hospital- 2008 to present
- Committee Member- EMS Homeland Security Skills Panel- 2005
- Paramedic, Safety, Hazmat Tech, ACLS/BLS Instructor, Hospital Decontamination coordinator, Lake Chelan Community Hospital / Lake Chelan Valley EMS from 1999 to present
- Safety Officer- Safety trainer Lake Chelan Community Hospital (Managing 220 employees in safety)- 2002 to present
- Safety Committee Chairman/Safety Program Lead-Lake Chelan Community Hospital-2002 to Present
- Nuclear Paramedic-Spokane Cardiology, Spokane WA, from 2004 to 2014
- Paramedic-Ephrata Ambulance, Ephrata WA, from 2001 to 2006
- Prevention Mentor/Instructor- for "Minors in Prevention" program (for Spokane County) 1998 to 2001
- Paramedic-Spokane Ambulance / American Medical Response, Spokane WA, from 1996 to 2003

- American Heart Association- BLS instructor (1995-present)
- Biological Infectious and Hazardous Waste Technician- Medical Resource Recycling Systems Inc, Spokane WA from 1993 to 2000.
- Fire Fighter / EMT- Spokane County Fire District 9, Spokane WA, from 1992 to 1995
- American Red Cross CPR/ First Aid Instructor- (1992 to 2000)
- Board Member and Committee member in many positions at Grace Baptist Church, Spokane WA, and Little Stone Church, Chelan, WA.
  - o Christian Education/Missions/ Deacon/-Board member- Grace Baptist Church, Spokane, WA- 1988 to
  - Christian Education Committee Chairman- Little Stone Church, Chelan WA. 2008-2010, 2012 -2013.
  - o Church Board Member- Little Stone Church, Chelan WA. 2008 to 12-2012.
  - Christian Education Committee Secretary- Little Stone Church, Chelan WA. 2010 to 12-2012.
- Youth Director- Little Stone Church, Chelan, WA, 2008 to 2010, and again from March 2012 to October 2012.
- VBS Director- Little Stone Church, Chelan, WA, 2008, 2009, 2010, 2011, 2012, 2013, 2014.
- Youth Pastor- Central Baptist Church, Spokane WA 1999 to 2000
- Vouth Pastor- Grace Baptist Church, Spokane WA 1993 to 1995
- Voung Adult Ministry Executive Director- for Exodus -American Baptist Churches- Spokane, WA 1998 to 2000
- Youth Camp Director and Counselor and Camp Nurse- Ross Point Baptist Camp, Post Falls ID 1992 to present

#### **AWARDS**

- Lake Chelan Valley EMS- Administrator's Award 2005- "for dedication and service"
- Lake Chelan Valley EMS- Director's Award 2005- "for going above and beyond the call of duty"
- Lake Chelan Community Hospital 2005-"Commitment to Care" Award
- ♦ Lake Chelan Community Hospital 2006- "You make the difference" Award
- ♦ Lake Chelan Valley EMS- Personnel of the year- 2007
- Lake Chelan Valley EMS- Administrator's Award 2008- "for dedication and service"
- Lake Chelan Valley EMS- Personnel of the year- 2009
- ♦ Lake Chelan Community Hospital- Employee of the Quarter- March 2009
- ♦ Lake Chelan Community Hospital-Employee of the Year- 2009
- Excellence in Safety Award for top safety results in 2009 (out of 33 Hospital group)
- O Top Performer Award from Washington Hospitals Worker's Compensation- 2009
- Safety Appreciation Award from Washington Hospitals Worker's Compensation- 2009
- Washington State Emergency Cardiac and Stroke TAC-Award for helping implement the state's first ECS system-2010
- Life Saving Award-from Chelan County Fire District #7, January 2011
- Vou're making a difference Award- Planetree recognition Coin, 2011
- American Red Cross Hometown Hero Award, March-2012
- ♦ Lake Chelan Valley EMS- Personnel of the Year Award- 2012
- ♦ Lake Chelan Valley EMS- Director's Award 2012-"for Sacrifices far above and beyond the call of duty"
- Outstanding Safety Leadership Award 2012- by Washington Hospitals Worker Compensation Trust, only one awarded from the 33 member hospitals.
- Administrator of the Year 2012 Award- from Greater Wenatchee EMS Council for all of Chelan and South Douglas counties
- Life Saving Award- from LCCH and Chelan County Fire District #7, February 2013
- Nominated as Administrator of the Year for- 2013 from Greater Wenatchee EMS Council for all of Chelan and South Douglas counties
- O 2013 EMS Agency of the Year -from Greater Wenatchee EMS Council for all of Chelan and South Douglas counties
- ◊ 2014 LCCH Employee of the 4th Quarter
- ♦ 2014 Nominate for LCCH/LCC Employee of the year (2<sup>nd</sup> place)
- ♦ 2014 Nominate for Administrator of the year for Chelan/Douglas County- Greater Wenatchee EMS Council
- 2015 Nominate for Administrator of the year for Chelan/Douglas County- Greater Wenatchee EMS Council
- ♦ 2016 Nominate for Administrator of the year for Chelan/Douglas County- Greater Wenatchee EMS Council
- Currently in my career I have 6 Out of Hospital Cardiac Arrest Saves, 10 In-Hospital Saves, and 5 successful Out of Hospital Infant Vaginal Deliveries

# **Peter Morgan**

# Community Member, Retired from Group Health Cooperative

Peter Morgan is the Board Chair for the Family Health Centers (Okanogan), a Community and Migrant Health Center operating 6 medical and 5 dental clinics in Okanogan County. Peter retired from Group Health Cooperative in 2010 after 18 years in various financial and operational management roles. Most recently he served as Executive Vice President where he was responsible Group Health's Clinical Operations from 2005 -2010. Peter has a BA in History and an MBA in Finance. He became C.P.A. and worked for Arthur Young & Co (now EY) for 7 years as a health care consultant before starting his own consulting company. He has served on the boards of a number of health care organizations including the Health Care Financial Management Assn., The Washington State Hospital Assn., King County Project Access, and the Country Doctor Community Health Centers.

Peter and his wife Raleigh Bowden, a retired physician, live in Twisp, Washington where they own and operate the Methow Valley Inn and participate in a number of local health-related projects.

# Jesús Hernández, MPA

## 804 Surry Road Wenatchee, WA 98801

509-322-2209 (cell) 509-422-7601 (w) jhernandez@myfamilyhealth.org

## LEADERSHIP & ADMINISTRATION

Overview: Proven leadership and planning abilities in multiple settings. Over twenty years of progressive responsibility areas of leadership in workforce development, education, healthcare and finance. Effective management through team leadership development, goal-oriented and proactive visioning. A proud student of Leadership with Lou Tice, Pacific Institute. My leadership skills have been enhanced through experience, civic involvement and practice of leadership principles in both the education and healthcare sectors.

*Healthcare:* As CEO at Family Health Centers and previously for Community Choice Healthcare Network, I have led numerous undertakings to move the organization's goals forward. Reorganized Bylaws, led network strategic planning, lead grant writer in securing over eight million in federal grants for network development and Health Information Technology. Directed start-up projects in health information and education for health care consumers and professionals.

-Led the research and development of consumer directed healthcare benefit options for small employers with the focus on reducing the uninsured through alternative ways to provide employee benefits. Consequently, Health Savings Accounts (HSAs) and other products are now available to consumers.

-Supported six rural hospitals with credentialing of their physicians with eight insurers with whom we contracted with for the regional PHCO provider membership.

-Responsible for primary application and grant administration/project coordination responsibilities for numerous state and federal HRSA and USDA grants over ten years.

-Planned, developed and implemented a four county Regional Access Program for five Public District Hospitals and one private non-profit hospital.

-Led a four county, comprehensive Community Health Needs Assessment that will lead to further change and focus of healthcare services and transformative system change in the region.

Education: Co-developed a Family Advocate intervention program that was implemented in ten schools in the Wenatchee School District. This program is ongoing and focused on building capacity with parents by helping parents know how to advocate for their students and exercise their parental responsibilities with the support of appropriate community resources supporting a stable, healthy home environment.

- Have had extensive experience in policy development, employee grievance and union negotiations as a school board member and in administrative roles over a period of fifteen years.
- Championed organizational culture changes for the whole district with collaboration of several employee unions that helped move an 8000-plus student district to a higher level of performance and excellence.
- Governor Appointments: Served nine years as a governor appointee to the Higher Education Coordinating Board, charged with statewide coordination of the entire Higher Education System in the state of Washington. I championed cost savings and outcome based policies for higher education in the state of Washington. Served two terms as Chairman of the HECB.
- Speaker/Consultant: Motivational speaker at numerous events including parent and student leadership conferences (K-12 and Higher Education), speaker on Cultural Fluency in the Workforce including consultation to healthcare providers, public education, human resource and community development organizations.

### SYSTEMS ANALYSIS, DESIGN AND INTEGRATION

Healthcare: Worked with a team that envisioned, coordinated and developed a medical Wide-Area-Network (WAN), reaching four counties with 7 hospitals, 16 clinics, 2 county community health centers and 2 public health jurisdictions. Helped coordinate efforts of four county Public Utilities Districts and local internet services provider to utilize existing fiber-optic systems to provide a high-speed, HIPAA-compliant, electronic communications infrastructure for rural the NCW healthcare delivery system. Together, we successfully established a robust, cutting-edge HIT network linked to hubs in Seattle and Spokane that has supported introduction of Tele-radiology, Telepharmacy, Tele-interpreting and other forms of health information modalities.

- 2007- Appointed by the state Health Care Authority to serve on the Health Information Infrastructure Advisory Board (HIIAB) to help design a new level of Patient Health Information Exchange in Washington State. Project included: Policy, Organization & Governance; Technical & Infrastructure Development; Consumer & Provider Engagement; Privacy, Security & Confidentiality and Finance & Sustainability.
- As the lead grant writer for Community Choice, I secured over eight million dollars in state and federal grants that funded regional healthcare delivery systems addressing quality of care, healthcare access and cost savings.

Education: As a Board Member in the Wenatchee School District, championed systems improvements incorporating vertical and horizontal alignment of educational practices to reach greater levels of efficiency and effectiveness. This included alignment of curriculum articulation, instructional strategies, professional development, data-driven decision-making, and outcome-driven intervention efforts for low-income and minority populations. With support of the whole board, championed introduction of ISO 9001 Continuous Improvement Processes and quality assurance. The Wenatchee School District became ISO 9001 certified for efficiency in operations. Most recently championed a comprehensive system transformation via an initiative named Wenatchee Learns.

#### **CONFLICT RESOLUTION**

*Healthcare:* Facilitating collaboration among regional, competing healthcare organizations for the purpose of achieving cross-sector system improvements is a major accomplishment that continues to be a work in progress. Despite the highly complex, competitive and ever changing regional healthcare landscape, we've managed to maintain robust regional collaborative relationships.

*Education:* Have served as liaison between groups in the Latino Community and the Wenatchee School District. Helped avoid critical conflicts with parents and restored confidence with the Latino Community avoiding district liability.

- Championed interest-based bargaining and shared decision-making between the Wenatchee School District and our teacher's union greatly improving a collaborative culture in our district.
- Assumed lead mediator role in finding consensus between parents, educators, and students concerned with the direction and growth of the Mariachi music program at Wenatchee High School following extremely stressful situations and restored teamwork within tight time frames.
- I am a Certified Mediator and a Founder Board Member of the Wenatchee Valley Dispute Resolution Center...insuring bilingual/bicultural mediation services in North Central Washington.

### PROFESSIONAL WORK EXPERIENCE

#### March 2016 - Present: CEO, Family Health Centers, Okanogan, WA

Lead the strategic and operational direction of a county wide system of medical, dental, behavioral and WIC services with six medical clinics, five dental clinics and supportive outreach programs across a large rural county.

August 2001 - March 2016: CEO, Community Choice, Wenatchee/Cashmere, WA.

Before being promoted to Executive Director/CEO in 2006, I held the position of Director of Programs & Marketing at Community Choice. As CEO, I am responsible for the overall leadership and administration of Community Choice, oversight and leadership on multiple grant projects, membership expansion and reorganization. As CEO of the regional collaborative, I often advocate for the needs of the four county region including the consumers and providers of healthcare in a rural setting. I lead an effective team of staff members, over 20 community volunteers and numerous committees and other functions.

#### HITECH Initiatives:

- Led the development and introduction of one of the first patient-centric Health Record Banks in the nation that included enrolling, training and supporting consumers and providers in the use of this system.
- As a sub-awardee and technical partner with the Washington/Idaho Regional Extension Center (WIREC) led by Qualis Health, I oversaw the delivery of WIREC services to over 200 providers.
- As a sub-awardee and technical partner with the Beacon Community Program of the Inland Northwest (BCIN), led by INHS, I oversaw the delivery of Beacon services to NCW providers.
- Community Choice initiated IT Consulting and Support Services to healthcare providers, non-profits and small business including developing Business Intelligence and network support.
- Developed and expanded a Spanish Radio Network from hosting a ½ hour live radio program on Spanish Radio to a network of affiliate stations reaching at least half the state of Washington covering various topics of healthcare including Medicare fraud prevention, navigating the healthcare system, chronic/complex health conditions, preventive healthcare and other aspects of social wellbeing and empowerment.
- Secured and initiated agency sponsorship of the Statewide Health Insurance Benefit Advisors (SHIBA) to ten counties for over eight years. Served as one of the top SHIBA sponsors with effective recruitment, training and coordination of more than 30 volunteers assisting consumers with Medicare, Medicaid, fraud prevention and outreach services.

July 1999 – Aug. 2001 Independent Representative/Financial Analyst, Primerica Financial Services, WA: Completed required training and professional development and acquired Securities Licenses for mutual fund investments, Life and Disability License in the state of Washington. Provided services in financial planning, education, debt elimination and life insurance. Recognized for leadership and production of business.

August 1995 – June 1999 Regional Office Director, WSMC Employment and Training, Wenatchee, WA. Initially hired to start-up a regional job-training and job development program serving four counties in North Central Washington. Led the top producing job development/job placement regional office in the state for four years running.

August 1992 – June 1996 Case Manager for At-Risk Youth, WSMC/Wenatchee School District, Wenatchee, WA. Responsible for services to at-risk students and families in three middle schools.

#### **EDUCATION**

MPA - Masters in Public Administration – 2006. University of Washington, Daniel Evans School of Public Affairs, Seattle, WA

**BA-Bachelor of Arts in Business Administration - 1992** 

Washington State University, Pullman, WA (First generation college graduate)

**Professional Development:** As part of my service in elected office, boards and commissions, I have benefited from high quality trainings, seminars, and conference speakers/trainers in the areas of Finance, Healthcare, K-12 Education, Higher Education, Economic Development and Community Development. The opportunity to apply much of this knowledge and leadership expertise through my civic involvement has been of great value and personally rewarding.

LANGUAGES Fluently Bilingual, Bi-literate and Bi-cultural in Spanish and English

## **CIVIC SERVICE**

Co-Founder/Lead Emerging Leaders Alliance, a civic and leadership development initiative

Member, Washington Rural Health Association - current

Member, Washington School Directors Association - current

Member, National School Board Association - current

Board Member, Chelan/Douglas Together! For Drug-Free Kids - current

Member, Wenatchee Rotary Club – 1999 to present/Board and President 2014-2015

Significant past civic involvement including-A few examples:

Board Member, Wenatchee Valley Farmers Market

Board Member, Campfire USA - NCW Council - four years

Founder/Board Member, Dispute Resolution Center – Wenatchee/Chelan County – two years

Recipient of various awards/recognitions over the years: 2015 State Jefferson Award, OIC Eagle Award,

Fiestas Mexicanas, Mariachi Festival, Financial Services, and numerous other recognitions.

#### ELECTED SERVICE

Elected School Board Member, Wenatchee School District, 1997 - 2016

- Have served in various leadership roles including Board Chair several times.

#### **Governor Appointments:**

Gov. Locke & Gov. Gregoire, WA Higher Education Coordinating Board (HECB) 2004–12

- Chair of the Board two terms 2009-2011
- Chaired the Student Financial Aid Committee involving annual reviews and legislative recommendations of the annual multi-billion dollar state financial aid program
- Analysis and approval of new degrees at public state universities
- Analysis and recommendation of higher education capital budget investments to the legislature
- Review and approval of State Need Grant eligibility by in-state higher education institutions
- Governor appointed to Governor's Taskforce on Funding Higher Education 2010/2011

**REFERENCES** Personal references available upon request.



#### WHOLE PERSON CARE VISION STATEMENT AND OVERVIEW (DRAFT):

#### **Vision Statement**

The vision of Whole Person Care is for a patient to reach a state of complete physical, mental, and social well-being by creating healthcare systems that will improve the patient experience of care, improve population health, and reduce the per capita cost of health care (The Triple Aim)

#### What is it?

The World Health Organization defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

Whole Person Care recognizes that a person's state of health is influenced by much more than the health care they receive. According to the Institute of Medicine, health is determined:

- 10% by health care
- 20% by genetics
- 30% by environmental factors, (such as housing, employment, etc.)
- 40% by personal behaviors, (such as diet, exercise, substance abuse, etc.)

Since health is affected by all of the factors above, Whole Person Care, to the extent possible, must address all of them. An important difference between Whole Person Care and other care is that Whole Person Care more effectively connects patients with resources outside the clinic which help address health-related social issues such as housing, education, and other social determinants of health. Whole Person Care also eliminates the divide between behavioral health and medical care.

How does it work? In a primary care setting, Whole Person Care involves a Primary Care Provider (PCP) acting as "quarterback" with a broad team of players who would help address the medical/behavioral issues as well as the health-related social issues affecting a patient. It has been shown that the key to success is resources, such as Care Coordinators, who contact and make arrangements for services at the direction of the PCP. It is important that all of this coordination is done in partnership with the patient to encourage patients to take ownership of their own health.

For patients receiving care mainly from specialists or others outside the framework of primary care, effective care coordination is a key element enabling patients to cope with multiple health care providers, while also connecting patients to community resources needed to address health related social issues.

What resources/services are required? The social determinants of health suggest the following resources/services should be part of the Whole Person Care toolkit available to providers, whether in the clinic itself or through care coordinators whom providers can call on to connect patients with community resources:



- Care Coordinators, often Community Health Workers but may be nurses or others with credentials needed for more complicated patients. Care coordination must itself be coordinated to avoid multiple silo-ed care coordinators attempting to help the same patient.
- Behavioral Health Counsellors and Prescribers, ideally co-located with medical providers.
- Patient consultations with Pharmacists
- Oral health resources
- Health Educators
- 24 hour/7days per week Nurse-staffed health information phone line
- Medical Interpreters
- Telehealth resources (especially important in rural areas)
- Housing specialists/resources
- Transportation services
- Nutrition education and access to healthy foods
- Employment Services
- ...and others depending on patient needs.

These resources would be linked together into a "system" through a combination of formal and informal agreements and proactively developed relationships.

Who would need which resources? The services required for a given person depend on their state of health. In primary care settings the PCP Team, led by the PCP as "quarterback", would identify gaps in needed services and connect the patient with the necessary resources in the clinic, or with care coordinators to meet needs addressed by community resources outside the clinic. Though the PCP will take a leadership role in this work, Whole Person Care is a team effort.

When presenting to the PCP Clinic, people generally fall into one of following three categories of health and therefore resource need:

- Healthy with no chronic conditions: This group typically needs care for acute conditions, preventive services for monitoring their continuing health, and review to ensure all their non-medical determinants of health are met.
- **Healthy with controlled chronic conditions:** This group typically needs preventive services/monitoring of their condition(s), education, prescription drugs and other services on an episodic basis. It is important to ensure all their non-medical determinants of health are met to avoid these individuals falling into the "chronic conditions" category of patient care.
- Chronic conditions: Uncontrolled or advanced: This group is the most resource intensive in terms of health care services, accounting for approximately 70% of total healthcare spend.
   It is also expected this group would have the greatest needs for other services over a long period of time as well. As a result, they are also the group where the largest potential for health care and other societal savings exist.



When Whole Person Care is fully developed and operational, patients in North Central Washington will experience the following:

- 1. Every patient who wants one will have a primary care provider (PCP) who knows the patient and his/her family, and is supported by a competent team of health professionals to assist the patient in developing a plan of care appropriate to each's health needs.
- 2. The PCP team coordinates the patient's care both within the clinic and wherever the patient is referred for services (e.g. specialty care, hospital care, or any number of community based non-medical services which support the patient in achieving his/her health goals).
- 3. In accordance with their care plan, patients will receive routine reminders about preventive screening and immunizations, which will prevent unnecessary illness and lead to early detection, cure, or appropriate management of more serious disease.
- 4. Patients will have online access to important health information in their medical record to assist in managing their own care. Patient Health Information comes from all sources (inside and outside the clinic) and is part of an integrated and comprehensive medical record accessible to all providers in the region authorized to care for the patient. (e.g. EMS, Emergency Room, Primary Care, Specialty Care, etc.)
- 5. Patients will be treated with respect, informed, cared for, and involved in decisions about their care at every step of the way. They will see themselves as an important members of their own health care team and the ultimate decision maker regarding their own care.
- 6. Patients will have same or next day access to an appointment with their primary care team if desired. They will also have the option to communicate with their PCP via e-mail or phone if more convenient than a face-to-face visit. In addition, they will be able to call a nurse advice line 24/7 which has access to their electronic health record to help them make important decisions about whether and where to seek care
- 7. In recognition of the additional expense incurred by Primary Care to implement a WPC model and of the value to the entire system in terms of improved quality, improved patient service and satisfaction, and lower costs for the system as a whole, new payment models will be in place that are consistent across all payer groups to ensure the financial viability of Whole Person Care.

## <u>Discussion Draft #2: Functions of the Whole Person Care Collaborative</u>

April 24, 2017

We need a framework that defines what the Whole Person Care Collaborative (WPCC) will do and the major steps that must be taken to do it. This is a discussion draft on those points.

<u>Primary Functions</u> The Whole Person Care Collaborative has several purposes related to the Triple Aim and other high level goals, but what is it supposed to <u>do</u>? Its primary functions are to:

- 1. Enable primary care and behavioral health providers in North Central Washington to better integrate BH and medical care, and;
- Enable them to adapt successfully to Value Based Payments, which will also help them with similar initiatives in Medicare such as MACRA. Successful adaptation means that the provider organizations are able to deliver effective Whole Person Care while surviving economically under the changing incentives created by changes in payment methods.

#### **Notes on Demonstration Funding**

The ACH will help define, allocate funding for and oversee Demonstration projects, but funding received for the projects will flow from the state's Financial Executor (an HCA contractor) directly to provider organizations, except for smaller amounts that go to the ACH for oversight functions.

HCA is expected to provide better information on Demonstration funding over the next two weeks, but we do have some hints. We have been informed that our region will receive incentive payments because we are a mid-adopter region and are taking on the challenges associated with that. We are told this incentive will total \$5.4M. Presumably, such an incentive would make up only a small part of our overall Demonstration funding. This suggests that during the 4 years of Demonstration implementation (2018-2021) the region will be eligible for several million dollars a year for projects – the bulk of which is expected to go to the care transformation effort.

Because Demonstration funds are expected to end in 4 years, the ACH's firm policy is to fund activities which create lasting changes in our regional health care system, as opposed to funding services that will fade away (or require rescue with new funding) at the end of the Demonstration.

#### **Steps for WPCC Member Organizations**

- 1. Behavioral Health provider organizations must become an integral part of WPCC as full members.
- Every WPCC member organization will conduct its own baseline assessment (using Qualis or the
  consultant of their choice) to establish a starting point and help define issues that must be
  addressed in the transition to Whole Person Care and Value Based Payment. Several of these
  assessments are under way now. The ACH may be able to provide help in paying for consultants if
  necessary.

- 3. Every WPCC member organization will work with the consultant of its choice (or its internal experts if available) to develop its own Transformation Plan. WPCC will provide a Transformation Plan template and will be able to help pay for outside consultants if needed, but each organization must develop its own internal plan. This plan should be as specific as possible in identifying necessary changes in arrangements for behavioral health integration, changes in staffing patterns, IT changes, care coordination arrangements and other measures that will be needed to provide Whole Person Care under Value Based Payment. The plan must explicitly address how the organization will engage front-line providers in the difficult process of bridging from today's configuration and practice patterns to those required for sustainability under Value Based Payment and other foreseeable changes. The plan should include a budget reflecting the costs of this transition and an implementation plan identifying who in the organization will be involved in shaping and implementing these changes. The Transformation Plan will be submitted to the WPCC. Medicaid Demonstration funds will be used to support the development of Transformation Plans.
- 4. WPCC will evaluate transformation plans and allocate Medicaid Demonstration funds to support the implementation of high quality plans. WPCC will work with organizations as needed to improve suboptimal plans, using Demonstration funds if needed to enable the organization to acquire needed consultations.
- 5. NC ACH performance on HCA's Demonstration metrics will determine the amount of Demonstration funding available. In early implementation years, funding will be earned by reporting on plans and other process indicators. In the middle years, actual achievements in implementing plans will be used as indicators. In the final year or two, transformation plan objectives, clinical metrics and other impact measures will be used.

#### **Related Regional Activities**

- 1. To support development of provider Transformation Plans, and in response to issues that emerge from the work to develop and implement those plans, the WPC Collaborative will function was a <u>learning collaborative</u> that enables sharing of expertise among participants and brings in relevant expertise from outside the region. One very helpful side effect of this activity would be to foster openness among provider organizations about successes and setbacks they encounter over the next few years. One role of the WPCC will be to organize and foster the learning collaborative.
- 2. This discussion assumes North Central ACH will develop a regional Pathways HUB to provide coherent and self-sustaining care coordination services available to all providers in the region. This will have to be done in a phased manner, but should eventually be available to any interested provider organization. (Note: selection of this project is still subject to Governing Board decisions based on partner input.)

- 3. North Central ACH may attempt to form a regional data repository or other mechanism to facilitate sharing of patient information among providers in the region. This is an ambitious goal at which others have failed before, and would require significant help from the IT effort at the state level, but Healthier Washington may create conditions in which this would be possible.
- 4. There may be need for a regional effort to help establish cooperatives of smaller providers to create a 24/7 nurse call line.
- 5. There may be a regional role to facilitate establishment of telehealth services, especially for behavioral health care. The issues with telehealth are no longer technical but revolve mainly around agreements among providers to provide, receive and pay for such services. For BH, this does not involve only telepsychiatry but, especially in small remote clinics, access to any credentialed mental health professionals. Other medical specialties (notably dermatology) have also demonstrated the effectiveness of telehealth in extending specialty care to very small communities.

#### **Operational Challenges**

There are many challenges involved, but some that stand out include:

- Establishment of a Pathways HUB that is self-sustaining will require financial agreements from the
  very beginning, in which parties which benefit economically from improved care coordination agree
  to share some of those benefits in the form of support for care coordination services and the HUB.
   Current revenue streams for care coordination could also support sustainable services.
- WPCC will be in the position of evaluating the Transformation Plans of member organizations and allocating funds in support of the transitional efforts. This will require a defensible and transparent evaluation and funding mechanism.
- A lot of "social determinants" service providers expect to share in revenues for their work on Whole Person Care. How would that happen? Will provider organizations or the HUB pay for the services of a housing specialist or for a transport service for one of their patients? Would MCOs create programs to pay for such services? Or is the provider's responsibility just to use the HUB to connect patients with whatever services already exist, and let those services fend for themselves (using whatever payment sources they have now)? The instability of our social services network suggests that the ACH should look for ways to support it as an integral part of Whole Person Care.

#### **Assumptions**

- WPCC membership must soon be more formalized, based on a written commitment to the steps described here.
- PCMH and similar approaches to advanced primary care are important starting places, but are in themselves insufficient to achieve sustainable Whole Person Care. ("PCMH" is used here as shorthand for the various approaches to optimal primary care, including "Advanced Primary Care.")
   It is not that optimal PCMH could not produce Whole Person Care, but it must be acknowledged

- after decades of work on PCMH and similar approaches that only a subset of organizations are able at any one time to achieve and sustain a high level of PCMH functioning (as distinct from certification or "checking the boxes"). The use of PCMH and comparable approaches does not by itself address the WPCC's function, although they have a place.
- Even practices that do not achieve a high level of PCMH functioning can provide better care through specific Whole Person Care measures (some of which are part of PCMH and some of which are community-based). These include:
  - o BH-medical integration. Patients of a less-than-stellar primary care office are still better off with telehealth links or other connections with behavioral health care, or co-located mental health providers who are used effectively by PCPs, even if the clinic never achieves PCMH excellence. No doubt PCMH excellence would enable the clinic to put these telehealth links to better use, but they would still have value to the patients in a less-stellar clinic.
  - Care Coordination. A person with diabetes and depression, who attends a primary care clinic that falls short of PCMH excellence, is still better off if he or she gets basic care coordination that connects the patient with mental health care, diabetes education (even at the simple level of instruction on how and when to monitor blood glucose and some basic nutrition advice) even if the clinic never achieves PCMH excellence. Similarly, a patient facing domestic abuse and the risk of homelessness will be better able to address medical issues if he or she has a Pathways HUB care coordinator who can help connect the patient with outside-the-clinic services to help address those social issues.
  - 24/7 Access to Health Advice. A patient attending a sub-optimal practice (in PCMH terms) is still better off if he or she has 24/7 access to a nurse and/or pharmacist who has access to the patient's records and can answer many of the patient's questions – even if the clinic never achieves PCMH excellence.
  - Ollt is not that principles of primary care excellence are unimportant. Many of them address Whole Person Care. The point is that in a region where levels of excellence must inevitably vary in PCMH terms, certain Whole Person Care measures can still meaningfully improve the overall care patients receive. It is not true that a high level of PCMH functioning must be achieved in a clinic <u>before</u> these and other Whole Person Care measures can have beneficial effects, though a clinic functioning at a high PCMH level would put those measures to better use.
- Clinical organizations in the region face a serious gap. Most practices still function to a significant extent in a fee-for-service payment environment. This dictates certain specific approaches to the staffing and organization of clinics, and to the operation of IT systems. These same arrangements, however, will be dysfunctional and financially unsustainable when Value Based Purchasing and capitation are the norm. New payment models create different economic incentives, but this does not magically produce changes on that ground. That takes long hard work. If clinics do not change, they will not survive the new regime. But if they change now, they will suffer financially in today's payment environment. Furthermore, it costs money to make the change from one system to the other. WPCC (in part by using Demonstration dollars) is meant to assist provider organizations in bridging this gap.

# North Central ACH Whole Person Care Workshop Friday, January 27 and Saturday, January 28, Campbell's Resort, Chelan, Washington Stehekin Ballroom

# **Friday Session**

AM

10:00 -- Coffee/Registration

## **Opening Session: Healthier Washington Overview**

10:30 - Welcome and Conference Overview

 Senator Linda Evans Parlette, Executive Director, North Central Accountable Community of Health

10:45 -- Healthier Washington - How the Pieces Fit Together

• Nathan Johnson, Chief Policy Officer, Washington State Health Care Authority

11:45 - Luncheon - Stehekin Foyer

#### PM

### 12:45 -- Three Aspects of Whole Person Care

• **Barry Kling, MSPH**, Administrator, Chelan-Douglas Health District; Chair, North Central Accountable Community of Health

#### **Part One: Advanced Primary Care**

#### 12:55 - Advanced Primary Care: What Has Worked and What Has Not

 Michael Parchman, MD, MPH, Director, MacColl Center for Health Care Innovation, Group Health Research Institute

#### 1:45 - Round Table Discussions

How do the take-home points from Dr. Parchman's presentation apply to my work, my clinic and my community?

- What are the most significant challenges for us in moving further along the road to Advanced Primary Care?
- What resources or assistance would be most useful in moving further in that direction? Groups will be asked to report out at about 2:15PM.

2:40 - Break

### Part Two: BH/Medical Integration

## 3:00 - Behavioral Health/Medical Integration - In Both Directions

Katharine A. Bradley, MD, MPH, Senior Investigator, Group Health Research Institute

### 4:00 - Regional Panel and Group Discussion on BH-Medical Integration

Panelists each make brief (10 min) presentations, followed by an open discussion with workshop participants. Panelists include:

- Malcolm Butler, MD, Medical Director, Columbia Valley Community Health
- Gail Davis Goodwin, Director, Management Services, Grant Integrated Services
- Rob Justus, MD, Medical Director Primary Care, Confluence Health
- **B. Tenzin Denison, MS, LMHC, DMHP,** Director of Clinical Services, Okanogan Behavioral Healthcare

#### 5:00 - Preview of Saturday's Program

5:10 - Adjourn

# North Central ACH Whole Person Care Workshop Friday, January 27 and Saturday, January 28, Campbell's Resort, Chelan, Washington Stehekin Ballroom

# **Saturday Session**

Part Three: Connecting Patients with Community Resources

AM

8:00 - Breakfast - Stehekin Foyer

9:00 – Introduction: Better Tools for Providers and Patients

- Sheila Chilson, CEO, Moses Lake Community Health Center
- Peter Morgan, MBA, Board Member, Family Health Center, and former Executive Vice President, Group Health Cooperative of Puget Sound

9:30 – The Pathways Care Coordination Community HUB Model – Bridging the Gap Between the Clinic and the Social Determinants of Health

- Sarah Redding, MD, MPH, Co-Founder of the Pathways Model, Director of the Pathways Community HUB Institute
- 11:45 Beyond the HUB Other Elements of Whole Person Care
  - Barry Kling, MSPH, Administrator, Chelan-Douglas Health District, Chair, North Central ACH Governing Board

Noon - Box Lunch And Networking

12:30 -- Open Discussion with NC ACH Governing Board Members on What's Next for North Central ACH

1:30 -- Adjourn

Copies of speaker slides and notes from discussion sessions, along with a link to an evaluation questionnaire, will be emailed to participants after the workshop.