Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

Leadership Council Minutes
9/21/17 9:00 am – 11:30 pm
Columbia Basin College, L102

ATTENDANCE	
Participants:	**In Person:** Carla Prock, Kevin Martin, Rhonda Hauff, Shannon Jones, Patrick Jones, Michelle Sullivan, Lisa Hefner, Jocelyn Pedrosa, Sarah Bollig Dorn, John Christenson, Bill Dunwoody, Erin Hertel, Kathryn Weiss, Dan Ferguson, Sierra Barrett, Chase Foster, Jim Jackson, Barbara Mead, Ronnie Batchelor, Amanda Hinrichs, Jessalyn Bruce, Jodi Ferguson, Susan Bassham, Morgan Lindor, Virginia Janin, Corrie Blythe, Becky Grohs, Mandy McCollum, Reese Holford, Tim Anderson, Jean Murrow, Heidi Desmarais, Sue Jetter, Jac Davies, Martha Lanman, Marcy Durbin, Joyce Newsom, Don Ashley, Andy Nyberg, Angelina Thomas, Miguel Messina, Meghan DeBolt, Amy Person, Susan Campbell, Ryan Lantz, Elissa Southward, Bertha Lopez, Gail Brown, Jennifer Felicitas, Larry Jecha, Tim Anderson, Lillian Bravo, Marie Reddert, Carmen Bowser, Les Stahlnecker, Michelle Chapelle, Lauren Baba **One the Phone:** Jorge Rivera, Sandy Corrollo, Laura Sim, Sandra Suarez, Mike Maples, Brian Sandoval, Leta Travis, Debbie Dumont, John Raymond, Liz Whitaker, Bethany Osgood, Kayla Down, Sam Werdell, Kat Latet, Jason Zaccaria
Backbone/and HMA	Carol Moser, Megan Kummer, Patrick Jones, William Van Noy, Wes Luckey, Cathy Kaufmann

Special Thanks:	**Thank you to …** • Columbia Basin College for providing the space today, and to CG catering for the refreshments.
MINUTES & REPORTS	

Director's Report	• **Carol:**
	  ○ All ACH's all scored in the highest tier, which yields them all $5 million. We had a lot of hard work that was put into phase 2, and now we gear up for the project plan application in November. Phase 2 Certification was the foundation for that application. We find out tomorrow what our scores were, and we also get an individual interview with Manatt to see our deficiencies. This will help us score as high as possible in November.
	  ○ LOIs went out on 9/5 on the website and via email. The LOI is to collect potential partners in doing this work. It's not binding. If you haven't received an LOI, you can find it on our website. We also have an FAQ document on the website for the LOI. Please email us with any questions that you have.
	• **William** - Design 1 Funding Allocations
	  ○ This has been approved by the board. Going through the process of expending these funds, some of the monies shifted within the 6 categories (which were set by HCA).
	  ▪ ACH Project Plan Development ~ $185,000. This includes the monies set aside for HMA, and other consultants.
	  ▪ Engagement ~ $243,000. This includes monies for travel, food, funding for Local Health Improvement Coalitions (LHICs), Tribal consultation, and marketing and outreach.
	  ▪ ACH Administration / Project Management ~ $78,000. This includes monies for the TAC (technical advisory committee), additional consultant support, and legal fees.
	  ▪ Information Technology ~$372,000. This is the biggest category. This includes HIE/HIT, data capacity for the ACH and providers, and the pathways HUB.
	  ▪ Health Systems & Community Capacity Building $78,000. This is set aside for developing and maintaining our website.
	  ▪ Other ~$42,000. This is for upfront program investments to help offset some expenses that our partner organizations might have.
	  ○ I'll develop another budget for the $5 million. The first $1 million does not need to be spent or encumbered this year, it can be spent throughout the 5-year period.
	• **Carol:**
	  ○ Greater Columbia BHO Discusses Mid Adoption – The local BHO is the same regional service area as GCACH. In order to become a mid-adopter (which means they would agree to go to a fully managed care contract by 2019), all 9 counties' commissioners have to agree. This is a difficult discussion for the BHOs to have, because this shortens the BHO's lifespan. The state is requiring them to be integrated by 2020, though. Rick Weaver and MaryAnne Lindeblad came and talked to the BHO and it was a positive experience. The commissioners gained a much better

	understanding of the advantages of being a mid-adopter. We will find out shortly if all of the GCACH counties want to become mid-adopters. If they do, it means that mid-adoption allows us to obtain $10 million in incentive funding. This incentive funding would help provide the infrastructure and training needed to do this. There are more details in the Director's Report about this. o Participating Provider Workflow – The struggle with this type of program is that things move so fast. This shows where we are in the process. LOI's are due back on 10/5, and the TAC will score them with GCACH and HMA. After we receive them, we will review them to assess which gaps we have with our partnering providers. After the review, we will compile a list that will go to the board. That list will also go into our project plan application. After we know how much money we have, we go into contracting in 2018.
Project Advisory Committee (PAC) Retreat Update	• **Wes –** Data Presentation o The retreat on Tuesday included a really great discussion on target population, which focused in on high cost/high utilizer patients. o Population health management starts with flagging high costs ▪ Most effective health management programs start by identifying these high cost/high utilizing patients. ▪ Top half of users account for $1.2 trillion in spending, while the bottom half only account for $36 billion in spending. ▪ Bottom 15% of users use no money. ▪ The ACA is struggling because the federal government was relying on the low users to subsidize the high users, and this hasn't necessarily come about. ▪ The top 1% of users use 20% of all healthcare funds. The top 5% of users use almost half of the funds. o Defining the high cost patient ▪ Around 45% of people in the Top 10% spender tier in one year remain in the Top 10% the following year. ▪ The top 5% individual spender tier in the GCACH would include around 12,750 and represents a reasonable target for population health improvement. Using national figures, the top 5% of users average $43,000 in expenditures per person. If we use this amount and multiply that by our estimated population, it's a little over half a billion dollars ($548,734,500). ▪ A single, monolithic care management strategy is rarely successful in addressing the entire high cost population. ▪ Segmenting this population is an important first step. o Stratifying the high cost population ▪ Patients with Advanced Illness • These patients are often nearing end-of-life and responsible for some of the highest costs. Most of these patients often die within 1-2 years. • Opportunities to provide home and community-based services can cut down on unnecessary hospitalizations.

	• Care management involving informed choice and other support can optimize the use of hospice and other palliative care services to redirect end-of-life care from hospital to home and community. • Not only is this in the best interest of the patient, recognizing that most patients would prefer not to die in the hospital, but the potential for savings from such strategies is high. • Clinical characteristics: Diagnoses include heart failure, COPD, cancer, coronary disease, diabetes, etc. They also have increasingly frequent hospitalizations and increasingly frequent ED visits. • We are looking to put together a small workgroup that focuses on this population (end of life care). Please reach out to Megan or myself if you would like to participate. ▪ Patients with persistent high spending patterns (from year 1- year 2) • Characterized by multiple chronic conditions. • Many face psychological and social barriers to care. • Many are good candidates for care management and social support services. • Concentration of spending is particularly significant in Medicaid, where 60% of patients in the Top 10% Spender Tier in any given year remain in that tier the following year. • Medical conditions for this group vary depending on patient age. • It is useful to distinguish common diagnoses (e.g. hypertension, hyperlipidemia) from diagnoses that drive spending (e.g. congestive heart failure, COPD). • Persistence of high spending in 45-64 years old • Complex patients with low patient activation—as measured by the Patient Activation Measure (PAM)—are at particular risk due to the inability to perform adequate self-care to manage their condition. • Serious mental health and substance use diagnoses are among the most significant drivers of cost. o Per capita costs are double or triple for Medicaid patients with a co-morbid mental health diagnosis or with evidence of substance abuse. o These diagnoses are especially prevalent in Medicaid high cost populations and care management programs need to address these underlying drivers of utilization ▪ Patients with episodic high spending patterns • This is usually due to a sudden event. Their cost decreases as the issue resolves. • Complex patients with low patient activation—as measured by the Patient Activation Measure (PAM)—are at particular risk due to the inability to perform adequate self-care to manage their condition. • Serious mental health and substance use diagnoses are among the most significant drivers of cost. o Per capita costs are double or triple for Medicaid patients with a co-morbid mental health diagnosis or with evidence of substance abuse.

- These diagnoses are especially prevalent in Medicaid high cost populations and care management programs need to address these underlying drivers of utilization
- Have increased costs due to a sudden event, but costs decrease as the condition resolves.
- These acute temporary spenders tend to be younger with good or excellent self-reported health status.
- Difficult to target proactively because cost spikes are usually not predictable.
- There may be educational opportunities for this sub-group through our work.

▪ Identifying the high cost population
- Quantitative Methods: Claims-based Algorithms
  - In the absence of prospective risk modeling software, claims-based algorithms can be used to identify potential persistently high cost individuals.
  - For Medicaid populations, the presence of alcohol/drug use and severe mental health diagnoses are strong predictors of patterns of high spending and should be added to claims-based algorithms.
  - Alternatively, patients could be sorted by total aggregated costs. The top 5% or 10% for consecutive calendar years could be identified and targeted.
  - **Rhonda** - Can we get this information through PRISM (a risk index program)?
    - **Jim Jackson** -Yes, but only certain agencies can access it. There is a great deal of detail in the PRISM reports.
    - **Rhonda** - Could the ACH access it?
    - **Jim** – I think that's a discussion needs to happen with HCA. There would need to be tight controls on it because of the sensitive information that's in the reports.
    - **Don** - I wouldn't count on it being your main source.
  - Drawbacks:
    - Sensitivity: These algorithms miss about half of potential enrollees. The remainder of enrollees would need to be referred through utilization or case management.
    - Limited Clinical Data: Many good metrics of illness progression and mortality are not routinely gathered in the traditional medical record (e.g., functional status).
    - Time Delay: Collection, aggregation, and reporting of insurance claims take time. When they finally become available to individuals, illnesses may have progressed significantly and preventable utilization or death may have already occurred.
- Qualitative Methods
  - Factors not captured in claims or EHR data can be the best predictors of advanced illness or persistent spending. Patient-based self-reporting and engagement can be useful for targeting:

	○ Patients with Advanced Illness: Vulnerable Elders Survey (VES-13), indications of active functional and/or nutritional decline (Karnovsky performance status, ADLs, involuntary weight loss, reduced intake, cachexia, etc.) and more. ○ Patients with Persistent High Spending: PHQ-2 or PHQ-9, Veterans RAND 12 (VR-12), Patient Activation Measure (PAM), homelessness, physician referral and more. ▪ Characteristics of ED super utilizers • ED Super-Utilizer (EDSU): Defined as six or more visits for Medicaid patients aged 1-64 years-of-age within a twelve-month period. • Age/Gender: EDSUs averaged around 32 years-of-age (older than non-EDSUs) and 69% female (a greater proportion than non-EDSUs). • Chronic Illness: Almost 40% of EDSUs have one or more chronic conditions, a higher percentage than non-EDSUs. Three times as many EDSUs had three or more chronic conditions compared to non-EDSUs. • Unfavorable Discharge: A greater share of EDSUs were discharged against medical advice than non-EDSUs. • Mental Health: EDSUs, proportionally, had more mental health or maternal/neonatal types of ED visits. • Diagnoses: The top first-listed ED diagnoses for EDSUs: Abdominal pain, other complications of pregnancy, back problems, upper respiratory, and headache. ▪ Social Determinants, Health, and Health Outcomes: The Area Deprivation Index (ADI) • Strong causal link between individual socio-economic status and the neighborhood we live in. • Neighborhood-level contextual exposures have an independent effect on health. High degree of persistence in neighborhood deprivation exposure over time despite mobility. • Predictor: Living within a disadvantaged U.S. neighborhood (high ADI) is a re-hospitalization predictor of magnitude similar to chronic pulmonary disease. • Outcome: For Heart Failure patients, ADI was significantly associated with 6-month all-cause readmission even after adjusting for other patient-level factors. • This map that shows the top 15% of the ADI, or the most disadvantaged neighborhoods. There is one area that looks like it might be part of either Yakima or Franklin County. ○ Stratifying the data, darker is the highest ADI • Graphs of utilization vs the type of neighborhood you live in: What these show is that if you live in these disadvantaged neighborhoods, you have significant first and subsequent inpatient and ED visits. Where you live affects your utilization of healthcare resources. ▪ What role does community and faith play? • If you're a rural resident it effects your health a great deal.

	• Your degree of faith identity also has a protective effect (across all settings). This probably has to do with the availability of social services in your faith organization, and also that social contact helps your health. • **Don** - Can we target closer? Walla Walla has a wide range of communities in the same census block. • **Wes** - This will just be an aid in our process, we can do zip code +4. • **Don** - We can also be a resource to help you classify these areas • **Wes** – We'd like to put together a multilayer map with social determinants, demographics of race/ethnicity, and healthcare organizations. • **Kevin** - Census blocks are smaller than census tracks • **Bertha** -The hot spotter program does overlay some of that information, and we can add a social determinants layer as well. ▪ P4P metrics and scoring methodology (Christmas tree visual) • Gap to goal and improvement over self o Improvement over self looks at your current baseline, and adds 2%. Your goal is to meet 102%. o Gap to goal looks at national Medicaid benchmark data for NCQA HEDIS measures. They look at where you're at plus that 10% toward that 90th percentile. That is your target. • These are modified to include gap to goal/improvement over self (+2%), start year. • They reset the target every year, so we need to continue to build. • Tableau Walkthrough • https://public.tableau.com/profile/apde.datarequest#!/vizhome/GC_PerformanceGapAnalysis/Readme • When we look at our baseline, it's not just a number, it's a rate. There's a numerator and a denominator. The denominator is the eligible patient population (i.e. all of those that have diabetes that are eligible for that measurement, like eye exams). The numerator is the number of people that actually received it. And this is your baseline. • Initial target tab walkthrough • ED visit reduction targets walkthrough • The reason for the visits will be diagnosis driven, when we're looking to identify this. • We have some data on acute vs. chronic conditions, but we could use more.
Pac Retreat Discussion	• **Cathy K –** PAC Retreat Overview o The PAC members (project team facilitators) and invited guests were brought together to work on: ▪ Review of Regional Data ▪ Refining project target populations ▪ Addressing oral and maternal child health ▪ Alignment across projects

	▪ Equity o Oral & Maternal Child Health ▪ PAC shared Board's commitment to addressing oral health and maternal child health even though those areas are not moving forward in the Project Portfolio: ▪ 2B (Care Coordination) seen as a key project for addressing these needs with pathways for each ▪ 2A (Bi-directional Integration) and 3A (Opioids) see oral health interventions as important services for their target populations. ▪ 3A will also include pregnant women as a target population. ▪ 2D (Diversion) will look at diverting people who got to ED for oral health needs ▪ Oral Health and Maternal Child Health subject matter experts will be pulled into project implementation planning in 2018 ▪ GCACH planning additional investments outside the projects o Target Populations ▪ Participants actively engaged in discussion of target populations for each project and shared populations across projects. ▪ Key target populations for the project portfolio: • Medicaid beneficiaries with Severe Persistent Mental Illness (SPMI) and other co-morbidities (for example, diabetes) • Medicaid beneficiaries with 6 or more ED visits in past 12 months • Medicaid beneficiaries with an ED visit and a MH, ETOH (alcohol) or Drug abuse diagnosis ▪ Important to target Medicaid beneficiaries with preventable ED visits even if they don't have 6 or more in a year (3D will address patient education) ▪ Important to identify people with social determinant needs across projects ▪ Developing a visual of target populations and how they enter the system / 6 GCACH projects o Project Portfolio Alignment Questions ▪ Rich discussion of Project Portfolio Alignment in answer to these questions: ▪ What will the shared interventions, resources and infrastructure be across projects? ▪ How will the projects advance equity in the Greater Columbia region? ▪ How will the projects be sustainable after the Medicaid Demonstration ends? o Project Portfolio Alignment Discussion ▪ Key areas of alignment include: ▪ Information sharing (HIT/HIE) and work force (esp. CHWs) foundational across projects ▪ Pathways as a connection point across projects ▪ Screening for social determinants, behavioral health needs as well as patient engagement (Patient Activation Measure)

	▪ Trauma Informed Care ▪ Equity needs to be meaningful consideration in project planning and projects need common means of defining, measuring and tracking race/ethnicity and language. ▪ Suggestion: Ask project teams to use King County Equity Tool for each project during planning phase. ▪ Projects need GCACH to provide a shared infrastructure /TA for building business case and measuring ROI ▪ Suggestion: Sustainability Task Force to begin this work across projects now. ▪ **Wes –** part of our evolving philosophy is a system that we're calling 'no wrong door'. This means that regardless of how you enter the system, you will receive the same consistent care across the board. o Next Steps ▪ HMA is starting to draft project section of Project Application due Nov. 16th ▪ Will work through PAC to gather further information as needed and get input on drafts ▪ All projects will go through a planning phase in 2018 – this is really when all of the project implementation is worked out • Discussion & Questions: o **Kevin –** One thing that wasn't called out in this summary is that transitions represent a critical event for all of the at-risk populations. o **Ronnie –** Have you thought about the utilization of CHW's with all of this? For mental health care, we use peer support as well, and a CHW is not a peer support specialist. ▪ **Carol –** We use the CHW term very broadly. Ronnie, you are right- there are different levels of CHWs. We know that they are navigators to help people along the path to wellness. Certain projects will call for different kinds of navigators, so we will have our workforce group look into this and try and propose specific needs for each area. o **Patrick –** Can you give more details on what will happen in 2018? ▪ **Cathy K –** I would point everyone to the timeline included in Carol's Director's Report. The short of it is that we expect that the state will make funding decisions in December or January. That will enable all of the ACHs to move forward with a procurement process (with RFPs for each of the project areas). There would be some more intensive planning in the first half of 2018. If you look at the project tool kit and look at the implementation for each of the projects, you can see how the state is thinking about how timelines work. ▪ **Carol –** Cathy we actually didn't include that timeline in the director's report, because we want the opportunity for the board to look at it and tweak it. As soon as they approve it, we can get it out on the web. In the provider/contracting workflow, we did provide the highlights through the end of the year.
Financial Sustainability through VBP	• Note – William gave a presentation on the Value Based Payment model that raised some concerns among our MCO partners. In lieu of including his presentation, below is a link to several resources that our partners recommended: o VBP Resources • Announcement – We have put up the new DSRIP calculator on our website for you all to access.

	• **Patrick** – I know that Heidi and others expressed some concerns at the last meeting about being sure to include Oral Health and Maternal Child Health going forward. How are those concerns looking now?
	  ○ **Heidi –** One thing you can do across all projects (if you look at the triple aim), there is a model for how you can ask more of medicine to take on more of oral health (i.e. education and training). Look at how much of that education and prevention is still going on across the projects. In terms of getting out in the Yakama Nation, we have an idea for that we will work on (a dental therapist). I think it would really help to have a dental hygienist in your hospitals. This will help draw your numbers down.
	• **Patrick –** The staff wanted to be sure to double back and get more feedback on these areas, since we voted to move on without them in a formal sense, although we will still be including work in those areas as we move forward. Any other comments before we end the meeting?
	  ○ **Rhonda** – It seems that this body could do a lot in our communities. We've only received 3 LOIs, and it seems that this body could do a lot by just taking this back to our colleagues and encourage them to complete one. They are not binding, and they don't take long to fill out.
	• **Wes –** I mentioned before we're trying to put together an End of Life Workgroup. It's near to myself and Kevin, and others as well. Please let us know if you are interested in joining that.
	  ○ Also, we are reforming the DATA/HIE committee. Please let me know if you are interested in joining that as well.
	• **William** – We are also starting to meet with the Budget & Funds Flow committee. They are in charge of developing the methodology of allocating incentive monies. Please let me know if you would like to join, or if you have ideas or suggestions. We want to make this process as transparent as possible.

ADJOURNMENT	
	Meeting was adjourned at 11:15 a.m. Minutes taken by Megan Kummer.
	Thank you for your time and engagement with the Greater Columbia Accountable Community of Health! The regular Leadership Council meetings for 2017 will be from 9-11:30 a.m. on the following dates: • October 26th (Columbia Basin College, Pasco) • November 16th (Columbia Basin College, Pasco) • December 21st TBD