Greater Columbia Accountable Community of Health

Leadership Council

Thursday, September 22nd, 2016
9:00AM-11:30AM Meeting
Greater Columbia Behavioral Health
101 N. Edison Street, Kennewick, WA 99336

Minutes

Participants	In Person: Jorge Rivera, Andrea Tull, Sandra Suarez, Becky Grohs, Ed Thornbrugh, Les Stahlnecker, Larry Jecha, Meghan Debolt, Martha Lanman, Kevin Sliger, Suzy Diaz, Corrie Blythe, Virginia Janin, Fenice Fregoso, Marcy Durbin, Tracy Sloan, Rhonda Hauff, Erin Hertel, Eddie Miles, Susan Martin, Sue Jetter, Amy Person, Susan Campbell, Andy Nyberg, Stan Ledington, Lena Nachand, Wes Luckey, Darin Neven, Liz Whitaker, Gail Fast, Melet Winston, Efrain Quiroz, Bertha Lopez, Heidi Desmarais Called In: Everett Maroon, Dan Ferguson, Zosia Stanley, Jac Davies, Amy Boaro, Siobhan Brown, Lindsay Boswell, Stein Karspeck, Rebecca Sutherland, (Key: highlighted text means unsure about spelling/name)	
Backbone Support Present	Carol Moser, Executive Director, GCACH Patrick Jones, Facilitator, EWU Aisling Fernandez, Communications Coordinator, GCACH Deb Gauck, Consultant	
Guests	Kirsta Glenn, HCA	
Special Thanks	• Thank you to Greater Columbia Behavioral Health, especially Julie LaPierre, for providing the facility and support that allows us to hold these meetings. • Thank you Patrick Jones for facilitating the meeting.	
TOPIC	NOTES	ACTIONS
Welcome & Introductions	• Patrick led introductions around the room, asking everyone to introduce their name, where they work and if they have a bucket list item that they checked off this Summer.	•
Action: Approval of Minutes	• July 28th minutes were approved by Rhonda & by consensus, accepted as written.	•
Director's Report (Carol, Aisling, Sue)	• Carol, Aisling & Sue presented the Director's Report • Carol & Aisling attended the ACH Quarterly Convening on September 15-16 in Spokane. Some of their takeaways include looking at the high proportion of Medicaid	•

	lives in our region compared to the State and looking at some special populations that receive Medicaid benefits, for example persons with disabilities, populations that need care coordination, and adult caretakers within our region.
	• GCACH Region
	  ▪ Whitman is participating with Better Health Together, however it is still considered a member of GCACH.
	  ▪ Carol- Klickitat is back in our field of vision because they are not transitioning until 2020.
	• Another takeaway from the Quarterly Convening was to have a North Star and we believe that the Regional Health Improvement Plan (RHIP) is our north star. Having a north star is a good business practice. This is our RHIP and will guide our work in the next few years.
	• Aisling talked about the new monthly newsletter that she, Carol and the Communications Committee initiated in September. She also talked about outlook appointments.
	  ▪ Gail and others can help Aisling distribute the newsletter to a greater regional audience.
	  ▪ There was discussion around developing community engagement including the development of talking points and presentation.
	  ▪ Carol & Aisling will be looking for volunteers for the videos in the newsletters.
	• SIM Project Updated: Readmissions Avoidance Pilot (RAP)
	  ▪ The first SIM project work team meeting was held in the afternoon of July 28th. Still the pilot plan is still in draft form.
	  ▪ Expected sample size of 40, which is a small sample size. There will be ROI data from Qualis.
	• Sue presented results from the HRSA Sustainability Survey Results. GCACH has improved in every category.	

	• Rhonda observed that what used to be a challenge because of the disproportionate number of uninsured, now there are challenges because there are so many more on Medicaid (adults and patients). It's an access issue. • Bertha asked a question for the Board: Where are health equity and social determinants? How do we get to that level of training and who would fund it?	

RHIP Revisions and Discussion (Deb Gauck)	• Deb Gauck presented the updated RHIP document
	  • The SIC committee (now known as the RHIP Committee) met in September to discuss changes to the RHIP. When the RHIP Committee last met in July, the RHIP had two overarching strategies (1. SIM pilot and 2. training and technical assistance to communities)
	  • SUMMARY OF FEEDBACK ON RHIP DRAFT: The Board reviewed the plan in August. There were two primary concerns: 1. Format (not very accessible), 2. We are an ACH, we are a regional group and our projects should be regional. There is dissonance in providing tech assistance to communities because we don't know what they would implement.
	  • UPDATES: Now a completely different format. Hopefully it is now accessible to HCA and any community and organization in our region. It is now colorful with images and diagrams, has hyperlinks. The main content change was that the committee let go of technical assistance to communities and instead each priority workgroup will have a project. We'll continue to have training (on the RHIP, COH, etc.) We're trying to get communities to have a value around a Culture of Health and to understand who we are and what we're doing. Each PWG will have a project in the RHIP. For right now, there are placeholders for those projects. As we go out to the community, we'll have the PowerPoint that Deb is developing and we'll have the RHIP tables from the original RHIP.
	  • DISCUSSION:
	  ▪ Wes- thinks this new RHIP looks great
		•

	▪ Important that there is clinical-community linkage. We are so focused on population health. ▪ Gail: School-based health centers require a center population. Great to help broaden it to health services. Could include a school nurse to do care coordination. ▪ Lena- we're in uncharted territory, it's a learning process. HCA sees this as a process where we're learning together. Next iteration will reflect lessons learned. HCA wants to see the process. HCA wants to make the requirements (deliverables) comparable to the financing they are giving. Difficult to balance. A robust plan is a good idea. GCACH is leading the group of ACHs. She commends the work and the conversations that has gone in to this. GCACH is leading the edge. Pending if/when waiver comes, a robust plan will be part of those requirements. We have set ourselves up wonderfully to go forward into the next phase. • There was a group discussion on Medicaid dollars and distribution to each of the ACH regions, if the Waiver is approved by CMMS. • Lena- how money will be allotted to regions has not been figured out yet.	
HCA AIM Presentation (Kirsta Glenn) & Data Dashboard Demonstration via GoToMeeting (Providence CORE)	• Kirsta Glenn, HCA joined us in person and Providence CORE members joined us remotely via GoToMeeting to demonstrate AIM Data on the Data Dashboard using Tableau software. • Kirsta: In ACHs you're entrusted with population health measures, including utilization rates and prevalence rates. AIM is developing the Data Dashboard on a 3-4-month cycle. We are trying to add new functionality, for example we'd like to know trends, but we currently only have one year of data. If there are small samples sizes, data get suppressed. • Bertha: It's disappointing that the data does not include ethnicity information. We're really trying to look at health disparities.	•

	• Kirsta: We have some demographics, but if you had every measure and broke it down by ethnicities, the numbers might be too small. The Dashboard might not be the right place for that. • Lena: This is Medicaid data that is already collected • Chow Yu & other Providence CORE presenters joined the meeting we looked at their screen using GoToMeeting. • All the data is de-identified with some suppression. • They are using software that can display differently on different screens. They want to provide support to change settings so it displays well on different screens. • There are multiple tabs, and they opened the Medicaid Population Explorer tab to show us. • We are limited to selections • In terms of downloading Tableau on your own device, they said that they realize that it's currently a little clunky, but hopefully in the near future we will be able to look at it through the internet with a password. They're working on trying to make it easier to access. • In Measure Maps, you can explore by geography. You can see the range of percentages in the horizontal bar, by county on the map, and by county below. Or by zip code or other type of grouping. • Wes- what's the lag between this report and the actual data? • Providence CORE: Medicaid has 2015 data. You usually wait 3-6 months. We're looking at 2015 data. Hope in the future to roll forward the 12-month window. • Deb- can you show hotspots that don't fit these particular geographic regions (follow a different geographic shape/line)? • Megan: No, that hasn't been developed. Tableau requires boundaries, so it's hard to create hotspot maps without the political boundaries. You could create a layer, but we couldn't interact with it.	

	▪ Deb: Could I compare the rural non-contiguous counties within our region? • Megan: That might be something we could do in the future. • Providence CORE: Prevention and Access- this dashboard has a higher level picture in mind. There are five Medicaid measures and a visualization of each county's standardized core. Across the 5 Medicaid measures- you can see which counties are above, at or below average. • Patrick: how could we look at this in our offices? • Kirsta: We can send out the information including the password and instructions for downloading Tableau. The people at Providence CORE are interested in this group's feedback. • Les: It would be really nice to be able to select groups of counties/school districts, etc. • Kirsta: We will be adding well child visits, antidepressant medications, diagnosis rates and other measures. There will be more measures and info to see in late October and more improvements to user interface. • Please send feedback to Kirsta. Carol and Aisling will get Kirsta's contact info out. • Carol - Three ACH leads who are part of the AIM team are Elya, Marguerite, and Carol. They participate in phone calls every week. They have constant contact and get feedback from other ACHs about what data is needed. This will include hospital readmissions.	
Priority Workgroup Breakouts	• We didn't have time to breakout into small groups	•
Looking Ahead	• Carol laid out plans for the next few months. 1. Develop a project for each Priority Work Group (PWG). If we get PWGs to identify 1 project and look at Medicaid Waiver alignment, we can be ready with projects. This will give us a running start with implementing some of these projects. We were hoping we'd have time to talk about whether each PWG wants the current	•

project in the RHIP to be the one they want to go forward with, but this can be discussed when the PWGs meet next time.
2. Retreat in November with a World Café. Here's what we're doing: There are PWG projects to present, invite elected leaders. We would have a keynote speaker. The retreat would help us to understand 5 big projects.

- There was a group discussion around the retreat:
  - Rhonda: I think we should we do the retreat. How many projects per PWG?
  - Deb: We can create a portfolio of strategies and hit the issue in a number of different ways. There can be cross-pollination between PWGs during the retreat. For example, could we fold in concerns of the BH committee and also have training around ACEs?
  - Jorge: I like the idea. We could also have conference call times to meet before then.
  - Dr. Person: If we're inviting new people, it would be good to share this more broadly because there are a lot of people in the region who don't understand what the ACH is.
  - Sandra Suarez: The word "retreat" sounds more like a small group rather than an open forum for more people from the community.
  - Patrick- comments from the PWGs?
    - Bertha: Speaking for the Obes/Diab group, she thinks they can be ready to present a project and can meet between now and then. They can develop one or two projects.
  - Deb: We haven't talked about staffing yet. Do we have the capacity to have 5 concurrent projects led by the PWGs?
  - Lena: ACHs are set up as a public-private partnership and are intended to have braided funding.
  - Eddie: There should be a submission process to the board (a template).

	• Rhonda: It's not that hard to come up with a project or two • Suzy: Thinks HYEC can be ready • Heidi: Representing Oral Health. Thinks they can be ready • Patrick: Maybe call it an "open forum" or "community awareness meeting." Think about who's invited carefully. • Andrea: Is this different than a retreat for the Board? Think about the objectives. • Lena: Addressing an earlier question from Rhonda, there will be regionally allocated funding for Initiative 1. Lena will report back with more info next month. • Deb: There is a development grant that was just released that offers $300,000 per year for 3 years. It is developed for networks and looks at the strategies we've been talking about. You can only provide services in rural areas, that's the catch, but not necessarily a problem for many areas in GCACH. • Sue: As PWGs are thinking about projects, think about what it would look like in an urban setting and what it would look like in a rural setting. Then you can capture those rural pieces when going after that grant source. • Carol: That's the reason that Deb included those projects in the toolkit which are more likely to get funded if we have the criteria in mind. • Will put it forth to the board later today to pursue this grant.	
Adjournment	• The meeting was adjourned around 11:30	•
2016 Meeting Schedule	The GCACH Leadership Council meets the Third Thursday of the month. • Location: Greater Columbia Behavioral Health, 101 N Edison St, Kennewick • Time: Leadership Council: 9-11:30 • Dates: o Dates in November and December are to-be-decided Thank you for your time and engagement with the Greater Columbia Accountable Community of Health!	

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