Minutes of the Greater Columbia COH Steering Committee

January 28, 2015, 9-11:30

Greater Columbia Behavioral Health, 101 N. Edison, Kennewick, WA

Present: Cindy Adams, Vonie Aeschliman, Delphine Bailey, Blanche Barajas-Garcia, Katherine Bell, Carmen Bowser, Emily Buechler, Harvey Crowder, Darleen Darnell, Susie Diaz, Anna Marie Dufault, Daryl Edmonds, Gail Fast, Dan Ferguson, Erinn Gailey, Mary Garza, Deb Gauck, Becky Grohs, Larry Jecha, Patrick Jones, Holly Kaiser, Kim Keltch, Julie LaPierre, Bertha Lopez, Martha Lanman, Wes Luckey, Carol Moser, Len Pavelka, Blake Rose, Ken Roughten, Sandra Suarez, Ed Thornbrugh, Martin Valadez

By phone: Cathy Bambrick, John Gallagher, Troy Henderson, Kevin Michelson, Chase Napier, Bethany Phenix-Osgood, Robin Read, Les Stahlnecker, Sara Needleman-Carlton

Welcome, Introductions

Patrick Jones welcomed everyone to the meeting and asked for self-introductions and to share anything else they might want the group to know. It is important to get to know each other!

Minutes: Carol asked everyone to review the December 19th, 2014 retreat minutes to ensure they accurately reflect people's comments. She explained that the reason the minutes were so detailed was to capture the discussions on governance, collective impact, community priorities, and backbone support. They will serve as a foundation for today's meeting.

SE WA and Yakima COH Overview: Deb Gauck reported that the Yakima COH started from ground zero not having an organization like the Health Alliance in place. They pulled together a cross sector group using the collective impact model and using the Yakima Health District as the backbone organization. Their group is on hiatus now since becoming a part of the Greater Columbia ACH. When the time comes, the group will be reinitiated, but for the time being, Yakima COH members will be active participants on the GC COH. She also explained why Yakima pursued their own COH grant given their demographics and health characteristics. She also acknowledged that SE WA and Yakima have had a close working relationship since the beginning of the grant cycle.

Carol briefly described the formation of the SE WA and how BFCHA and PMH Medical Center worked together to form the steering committee. She worked to bring in the Public Health officials while Blake worked the hospitals and clinical side. They then branched out using the collective impact model and suggestions from the Health Care Authority to be more inclusive of the social determinants of health. The group eventually outgrew the meeting space in Walla Walla, but was accommodated by the GCBH RSN who is providing conferencing and office support. The steering committee coalesced by learning about each County's characteristics and data. The discussion regarding governance didn't start until October, and with the announcement of the RSA boundaries which added Kittitas, Yakima, and Whitman to the COH, they had to reverse direction on governance and focus on bringing in the other three Counties. Blake and Carol decided the way to do that would be to have a retreat which was held on December 19th in Prosser. **Blake** added that the composition of the steering committee has greatly expanded, and that the group has accomplished a great deal in six months.

Robin said that the Kittitas, Chelan, Douglas, Grant, and Okanogan COH wanted to take advantage of the grant to build capacity and bring decision makers to the table. They identified the health issues important to the community but narrowed down to focus on mental

health for children and youth. They are currently working on a pilot project with one of the school districts to identify students at risk and make referrals. Cathy Bambrick reinterated that the issue wasn't the focus; what was important was establishing a process that brought the parties together. They are working on reducing the silos across organizations.

Whitman Troy Henderson said that there was concern from the providers from the larger facilities about the RSA/ACH designation from the HCA. The HCA was sent a letter from the County Commissioners asking for clarification on how ACHs will impact referrals. Would economics drive referrals away from Spokane? The HCA responded that it was not the intent of ACHs to drive business away from their providers. Their priority issues are childhood obesity in the rural areas, and access to dental care in Pullman and rural areas.

Patrick noted that we don't have anyone from Asotin or Garfield in attendance.

Design Grant Discussion: Deb used the collective impact model and ACH model for governance structure for the grant application. Backbone and applicant for the grant is the Health Alliance for 2015. By 2016 the group will transition into some type of entity. Carol is the interim director. What we submitted may change as we continue through the process. Deb identified 10 Working Groups for the grant which can change to accommodate the interests of the COH. Budget: The grant allocates .75 FTE for Carol's time and.5 FTE Admin Asst. Deb put travel expenses in the budget to facilitate moving the meeting locations around, and some funding for office supplies and materials. The HRSA grant was due the same day for $100,000 which is basically the same grant application as the HCA. The HRSA grant would cover a year of planning activities. Carol noted that a generous donation from Amerigroup gave us the ability to keep Patrick as our facilitator.

HCA Expectations: Chase reiterated that the intent of the Design Grant and the relationship between HCA and Health Plans is a progression of activities and learning priorities of the ACH. Deliverables in 2015 align with the process on getting the right people to the table before the ACH can accomplish specific tasks. 2015 considered the startup year but a lot of good ground work has been laid to make a good foundation. HCA recognizes that decisions and adjustments will have to be accommodated. The pathway to sustainability should be outlined by the end of 2015. Additional guidance regarding governance may be forth coming.

An update on funding: we must go through a prior approval process (30 day process) and are looking at the end of February to receive funding. More detail will follow in the contract regarding the milestones in becoming an ACH. ACH Readiness Proposal will detail milestones. Framework will be provided by HCA. Working with Pilots to establish. HCA is having a conversation in March with Pilots around what has been learned to date. Deliverables will mirror grant opportunity announcement. The agency will work with each COH on timelines, governance model and engagement strategy, backbone support to ensure administrative capacity, regional health needs inventory trends and priorities, resource inventory, initial plan and process for sustainability, ACH learning network to facilitate common approach to work.

Re: the MCO relationships and HCA. Chase referred to the circle graphic.

High level representation of entities involved in ACH. The schematic does not represent governing body, but refers to the County level engagement expectations. Since this version was published, MCOs (Medicaid) and commercial health plans would be a part of the ACH circle. There will be further clarity in 2015 regarding relationships with payors. There is a preliminary approach that HCA will be suggesting to help ACHs coordinate efforts with MCOs. It is important to have MCOs at the table, on not just at the contracting level.

Patrick asked Chase to start at the end goal for governance and work backwards to today.

Chase stated that the plan for improving population health (looked at prevention framework elements) is driven by ACHs. By 2019, these components should be well on their way with input from MCOs, social service agencies, housing, work force development. HCA expects increasing wellness within the communities. By 2019 there should be strong relationships between ACHS and commercial and MCOs, regionally based investments in upstream interventions (or investments getting at the front end of prevention). There is the potential for Medicaid waivers to contributie to investments. ACHs will have a strong voice in how existing resources and programs are coordinated and funded. An approach could be an 1115 waiver. Each ACH will be key component and aligned with priorities and needs of community. There is a rigorous process to allow for Medicaid waivers.

ACHs as a Risk Bearing Entity is not on the table now at the state level, or even by 2019. The conversation is more about how to leverage ACHs in cooperation with MCOs is the primary concern.

Chase cited two primary examples of governance with different methodologies: Leadership Council 10-20 individuals that don't directly represent their organization (BHT) or North Sound.

There also needs to be a way to engage the community, consumer, and customer. In another example (Cascade Pacific Action Alliance), the 2nd tier represents the decision making body; work groups, council, technical, subject matter experts. Everyone has voting ability. There are 44 voting members.

There will be different tiers. A cascading model makes sense. Provide organizations with opportunity for engagement.

It will be up to our group to define what the engagement looks like. As much as possible, get multiple sectors represented on the GB. Some challenges: Tribal engagement is very important But tribes need to be treated as independent governments. Re: the dynamic between ACH and MCOs. HCA wants them to be engaged to the fullest extent possible. State will set up appropriate firewalls to provide guidance around contracting.

Wes asked about IT and data support. Chase said that the SIM Round II grant is allowing for work to proceed around measurement infrastructure. Need to have a clear understanding of the statewide measurement set and IT. Do not have a core measure set for ACH. More about qualitative and process measures and infrastructure will follow.

ACH Governing Board Discussion: Top of the list of priorities for 2015 from HCA.

Started the discussion with a review the cascading levels of collaboration. A two Tiered level of governance came from the retreat.

The outline. A Steering committee (Governing Body) comprised of 12-15 people – neutral, take positions from Working Group level. Leadership Council broad based, around 35, allowing for more representation; this is where work gets done, as the LC takes up specific issues, form ad hoc associations with partners, report to and make recommendations to steering committee

Function of Steering Committee: Governance, vision, and strategy

Function of Backbone Organization: Guide vision and strategy, support aligned activities, establish shared measurement practices, build public will, advance policy and mobilize funding

Function of Working Groups: Action planning

Function of Partners: Execution

Wes reviewed the list that his group developed at the retreat for the Leadership Council or broader group.

County Representation
Public health
MCO - Medicaid
Private health care (Hospitals, large clinics)
FQHCs (TCCH, YVFWC)
CBO (community based orgs, non-profits, Community Action Agency, Blue Mountain) World Relief; Ethnic Populations)
Schools – Higher ED, ESD
Criminal Justice
Transportation
Housing (Housing Authorities)
Tribal
Business/ag business
Faith-based Organizations
Mental Health/Chemical Dependency (Behavioral Health)
Oral Health
Aging and Long-term Care
1-2 At large positions or consumers

This group would be around 30-35 members. Food systems (Food banks, 2nd Harvest) and Philanthropy was missing.

A brief introduction by the Yakima Valley Foundation: Suzy Diaz described the organization received $10 million grant when sisters of Prov sold to a for profit agency. A certain amount of proceeds must be distributed to health care. A theme: Wellness incorporates everyone and every institution. Use the resources to help further the work. The Foundation is restricted to Yakima County but includes out-of-county networks that are connected to other philanthropies.

It was agreed to add Food systems and Philanthropy to the list.

How to determine representation? Not determined by the group.

Blake suggested that the group attending the meeting could serve as the Leadership Council after filling in the other necessary positions. Harvey reiterated that while the Working groups can advise the LC, the Governing Board makes the ultimate decisions, and the Leadership Council advises the GB. GB and LC are classically separate. GB doesn't spend as much time as the LC in developing work plan. A strong LC is core to the success of the ACH, and could break into groups to tackle community priorities.

There was some concern that there is not enough county representation, and being more intentional about representation.

Thoughts on Board Make-up for the SE & S. Central WA ACH

Governing Board (from Patrick's Strawman) This was the list from the input of the retreat. A question: Do we need two health district and two hospitals?

Cross sector representation should drive the composition. Reproduce LC at the GB level; cross sector, cross county. Ideally all counties would be on the GB as their voices need to be heard. That is why Patrick included the large and small sectors for PH and Hospitals.

1. Representative from a large public health district
2. Representative from a small public health district (can represent all small public health districts)
3. Representative from a large hospital
4. Representative from a small rural hospital
5. Representative from a multi-specialty clinic (could this be handled by the hospitals?) Input and feedback would probably be different by providers compared to hospitals. Providers/physician groups provide different feedback than hospital organizations. That perspective is important.
6. Representative from a federally qualified health clinic
7. Representative from a regional mental health organization
8. Representative from a community action council
9. Representative from an education service district
10. ~~Representative from a Medicaid plan provider~~
11. ~~Representative from a Medicaid plan provider~~
12. Representative from a long-term care organization
13. Representative from a housing authority
14. Representative from a large agribusiness
15. Representative of consumers
16. Representative of consumers
17. At-large

***Ed felt that if the role of the Governing Board was to aid the framing of the contracts for MCOs, and provide a feedback loop on their performance that there should be a separation between them and the Governing Board. However, he acknowledged that the HCA seemed to be changing their opinion regarding the MCOs on the Governing Boards of the ACHs which was contrary to what they said in September.**

Patrick asked Daryl to weigh in on conversation. Daryl met with Mary Anne Lindeblad about what he had been hearing about the role of the MCOs.

He stated that if we are concerned about population health and how to improve the health of the communities that you can't do that with MCOs outside of the circle. Their priority is to improve the health of the population. Is there a fear that 1-2 MCOs will drive the agenda of the ACH in a body of 12? MCOs are already investing in the communities and want to come alongside to meet the priorities. We need to figure out how to work together as a community. Having the MCOs outside the circle does a disservice to the community.

How do we choose one MCO? That is separate decision and should not be a limiting factor. Presence on the GB are not lifelong positions; they can rotate in and out.

Another thought: the first nine positions could represent each county. But can each county make the financial commitment to be involved on the GB? How can the GC COH support each county? There are limitations given their size. A consideration: How many groups can touch multiple bodies like LT Care, BH, FQHCs? Based on a population basis, the ratio of representation on the GB is very difficult.

If the GB is a neutral body, there should not be a big concern about exact geographical representation except that people understand the issues. The LC group needs to be representative of areas of concern. The GB needs to have the expertise to understand and influence policy.

Need to get more clarification from Chase about this issue. Need more information and education. Ultimately the mission should be driving decision making. Need a mission statement for the GC ACH.

Patrick suggested that we make a commitment to resolve the governing and leadership council composition in February. Everyone agreed.

Carol highlighted the timeline for the **Interim Leadership Council**.

February finalize governance structure

Identify a governing board. GB meets every other month beginning in Feb.

By Feb/Mar will have Communications Coordinator on board to establish communications framework

Vision and Mission Statement work in Feb & March

Formalize stakeholder participation; working groups, identifying priority needs Feb-April

By April or May have a retreat with GB, LC, identification of priority issues

May-Sept form working groups to start work on Regional Health Improvement Plan; inventory assets,

RHIP has community outreach component in Sept & October

Last quarter of the year determine performance measurements – June - Dec

Expectation of this group is to meet monthly. Group liked to keep the meetings in a central location. Would like to set a calendar of dates. 3rd week better for health systems. Look at the difference between Wed and Thursdays.

Meeting adjourned