Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

Leadership Council Minutes
10/26/17 9:00 am – 11:30 pm
Columbia Basin College, L102

ATTENDANCE	
Participants:	**In Person:** Shawnie Haas, Rhonda Hauff, Susan Campbell, Martha Lanman, Chuck Eaton, Caitlin Safford, Michele Roth, Robert _____, Kevin Martin, Jocelyn Pedrosa, Michelle Sullivan, Becky Grohs, Sharon Gentry, Ronni Batchelor, Larry Jecha, Sierra Foster, Darin Chase Foster, Ashley Nelson, Morgan Linder, Angelina Thomas, Amy Person, Jessalyn Bruce, Jodi Ferguson, Mandy McCollum, Kayla Down, Lillian Bravo, Carmen Mendez, Andy Nyberg, Tim Anderson, Corrie Blythe, Dan Stone, Jean Murrow, Wally Lee, Fenice Fergoso, Martin Valadez, Bill Dunwoody, Cathy Neiman, Sue Jetter, Ron Jetter, Jorge Rivera, John Lobdell, Michelle Gardner, Denice Clapp, John Christenson, Lupe, Miguel Messina **One the Phone:** Cathy Homkey, Ryan Lantz, Lara Sim, Amina Suchoski, Elissa Southward, Sandra Aguilar, Kirk Williamson, Stein Karspeck, Jim Jackson
Backbone/and HMA	Carol Moser, Megan Kummer, Patrick Jones, 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 –** • This is a very detailed report this month. I will just take you through the highlights, but I encourage you all to read it. o Tribal Training - 6 board members attended (Martin, Ronni, Amina, Les, Dan, and Frank). We met with Frank Mesplie (who is our Tribal board member). Tonya Kreis, Arlen Washines (Director of Human Services) were also there. Overall it was a fascinating training and discussion that outlined some of the challenges that the Yakamas are facing in regard to health care. They are vastly underfunded (they received 1/3 of the funding per capita than Medicaid), and the suicide rates are also at very high levels. The training also included some of their history, and their governance structure. The Tribes are an important player in Washington state and have carved out funding in the demonstration. We need to continue to learn more about their healthcare delivery system. o LOIs – We are up to about 68 LOIs now. We've organized these both by project area and county in the spread sheet we've shared with you all. We continue to have a few trickle in, but we may still need to reach out to other partners to submit. At the last meeting, the board approved a flexible timeline surrounding LOIs/RFPs. Contracting won't being until the spring of 2018, when we know our funding. Overall, we are very excited about the number and quality of LOIs that we've received. o Funding Cuts – We will be talking more about these cuts later today, and some strategies to mitigate the effect it will have on us. One of the ones that we should look at closely is to possibly move forward with 4 vs. 6 projects. The ACH leaders submitted a letter to HCA to allow us to move forward with 4 projects and not face a financial penalty. o Myers & Stauffer – This will be the company scoring our project plan applications. If there are gaps in anything we submit, we can do write-backs and fill those in. This process lasts through February, so we may not know our total amount of money until then. They also currently have a score down process, which means if you get an 89%, they score you down to an 80% (this has been amended, and they will no longer be scoring down the applications). o Greater Columbia BHO becomes a mid-adopter – We will receive $10 million in funding for this; which will help with training and infrastructure. We are very grateful for this decision, and for Rick Weaver's help and guidance to the County Commissioners. The option that the BHO chose was to have a transitional year (2019), and to become the BH-ASO (Administrative Service Organization) with an Interlocal Leadership Structure. o Stakeholder & Community Engagement – We've really been taking to heart the idea that we need to get feedback from consumers, but we currently don't have a Consumer Council. So what we've tried to do is learn from the agencies that work directly with consumers. What's nice about working with these organizations is that they can really get to the root of why consumers are facing the challenges they are. I've included a list of some of these meetings we've attended in the Director's Report. We will be looking to our LHICs to engage the community in the future. o Review of the Workflow Timelines, and the new Tribal Map.

Project Plan Application Presentation	• **Cathy K-** Reconsidering the Greater Columbia ACH Project Portfolio o Today's Discussion ▪ Reminder of strategic considerations used in Project Portfolio decision in August ▪ Review budget cuts announced by HCA in September ▪ Discuss implication of cuts for GCACH ▪ Consider whether or not GCACH's Project Portfolio strategy should change based on new information ▪ Considering a 4-Project Portfolio ▪ Q & A / Discussion ▪ Next Steps o Importance of Portfolio Alignment: Review ▪ Cohesive Project Portfolio - Strongest applications will demonstrate alignment and shared framework ▪ Targeted Resources - Focused rather than scatter shot approach makes successful implementation easier to achieve ▪ Outcome Metrics - Aligning along populations and metrics increases likelihood GCACH will meet performance targets in later years ▪ Sustainability - Strong alignment builds strong foundation for sustainability in year 6 o Projects Need to be Able to Move All Performance Metrics ▪ Need for demonstration projects to "study to the test" • Dollars tied to performance on planning, reporting and then performance on metrics ▪ GCACH is accountable for all of the performance metrics in any project area • Each metric for each project area worth equal weight ▪ If project area is selected, GCACH must choose from set of evidence-based models in each project area (which aren't always well aligned with metrics) o Visual of table and overlap in metrics o Rationale for deciding on 6 Projects in August ▪ Project Portfolio that maximizes likelihood of success and leverages DSRIP funds effectively • Strategy regarding metrics – maximize region's ability to draw down DSRIP funds • Make investments that will be meaningful even when Medicaid Demonstration funds go away ▪ 6 Projects needed for ability to draw down 100% of available funds • Potential participation in high performance pool ▪ Recognition that important work could be done outside the projects • Commitment to oral health and reproductive & maternal child health even though those projects not selected o 6 Projects Selected for Project Portfolio in August

- 2A: Bi-directional Integration of Care (required), 2B: Community-Based Care Coordination, 2C: Transitional Care, 2D: Diversion, 3A: Opioid Crisis (required), 3D: Chronic Disease

- Budget Cuts to Medicaid Demonstration Project Funds
  - In late September, HCA identified an estimated 1/3 cut to the budget for DY2 funds
    - First was 36%, but now estimated to be 27%. I would guess that it will end somewhere between these two numbers.
  - $1.5 billion DSRIP Waiver funds based on federal match of available state funds: Intergovernmental Transfers (IGTs) and Designated State Health Programs (DSHP)
    - Actual DSHP expenditures in state lower than anticipated
  - Additional cuts in DY 3 – 5 expected though amounts uncertain, which means there could me more cuts later.
    - State is exploring additional DSHP sources and options for a revised IGT strategy for future Demonstration years
- What do budget cuts mean for GCACH?
  - Cuts are significant enough that the Board should discuss implications and whether or not changes in strategy are warranted
  - Before cut GCACH had potential for up to $118.6 million over 5 years with $19.3 million for first year
  - Now, $14.1 million for first year of projects. And if cuts in remaining years are of similar size, would mean $86.6 million for 5 years instead.
  - Although ACHs have fewer funds next year – and likely reductions in subsequent years – no changes in the required planning, reporting or performance metrics have been made
  - ACHs need to achieve the same targets with less money and more uncertainty
- Lessons learned from the New York Waiver
  - In other states with DSRIP dollars, the maximum dollars that are available to you is not the same thing as the dollars you will actually get.
  - When you move into the P4P years, (even though you'll do amazing work) you won't be able to hit 100% of your targets. Many of the PPSs in New York struggled to move their measures.
- Should GCACH Change its Project Portfolio?
  - The size of the cuts do mean ACHs should pause to reconsider whether their strategies still make sense
    - Should use same strategic lens that was used in initial decision-making process, but consider the new information
  - There is no one right path – as was the case before the cuts were announced, each ACH must decide for itself the right strategy for its region taking all factors into consideration
    - King County ACH has already decided to move forward with a Project Portfolio of 4 Projects, while others are still planning to move forward with 6 or even 8.

- Strategic Lens
  - What portfolio of projects has strongest potential for GCACH to draw down most funds in performance years?
  - How likely is each project to meet performance measure targets?
  - Consider the impact of projects and investments?
    - What investments will outlast this demonstration?
- Strategy of 4 Projects rather than 6
  - Budget cut (and further cuts to come in the remaining years) means less money without fewer accountabilities
    - If funding same projects at a smaller scale, still accountable for moving same metrics as before the budget cut
    - One way to mitigate this is to do fewer projects (with aligned metrics)
  - Deeper, target investments could allow for more strategic use of limited dollars
    - With smaller, more targeted portfolio, GCACH may have greater potential to meet reporting and performance metrics (which means more dollars in years 2-5)
- Potential for more local control
  - Project Portfolio is what GCACH is signing up to be accountable for to state
    - Project areas selected determine planning, reporting and performance requirements
  - Project Portfolio does <u>not</u> need to reflect all of the interventions / strategies of an ACH
    - ACHs are responsible for achieving the metrics within their chosen Project Portfolio - but can choose to fund interventions and activities in all 8 project areas without selecting them all for the Project Portfolio
    - Investing in project areas outside the Portfolio allows an ACH more local control over which models to use
- Financial Considerations
  - Reduction of $1.4 million out of $14.1 million (in first year only)
    - May ultimately be financial benefit if it makes it easier to meet more performance targets in later years
  - Forego potential opportunity to earn dollars from high performance pool
  - Unclear how much money would be in the pool or if GCACG would qualify
    - Given the budget cuts, state could even reduce or eliminate the pool
    - Many of the ACHs are pushing the state to change these restrictions so that neither of these limitations exist for Project Portfolios with 4 projects
- Example of Need for Local Control
  - 2B: Community-Based Care Coordination

	• Community-based care coordination is viewed as a critical, foundational component of health systems transformation in the Greater Columbia region • Pathways HUB is the only model in the toolkit ▪ Concerns have arisen since Project Portfolio decision made: • GCACH staff have learned that significant investment in IT and training will be needed • Questions about sustainability • Unclear if strong buy-in from communities across the region • GCACH has existing care coordination resources that most ACHs do not have o Review of the financial implications of 4 vs 6 projects with tables. o Which 4 Projects? ▪ 2A: Bi-directional Integration of Care (required) ▪ 2C: Transitional Care ▪ Can incorporate Diversions work into this area ▪ 3A: Opioid Crisis (required) ▪ 3D: Chronic Disease ▪ Development of GCACH Strategy for Community-Based Care Coordination ▪ Investments in oral health and reproductive / maternal child health ▪ **Rhonda –** If we narrow our target populations, the metrics would still cover the full population correct? ▪ **Cathy K –** Yes on the overall population. It might be effective, but we might get a better draw in years 3-5 with 4 projects. o Review of table with performance measures of these 4 areas.
Project Team Breakouts	• **Breakout questions:** o What is your initial reaction to the idea of 4 rather than 6 projects? o What would you like the board to consider when they hear this presentation alter today? o If the board decides to move forward with 4 projects, what does GCACH need to do in order to assures Care Coordination and Diversions (along with Reproductive and Oral Health) are adequately addressed? ▪ **Caitlin –** I just want to clarify that you would still get partial credit for the tough measures you effect (i.e. percent arrested). It's not all or nothing if you don't hit the target. ▪ **Susan –** King County went down to 4 projects (the same ones being recommended today). ▪ **Cathy K –** CPAA will most likely stick with 6 projects (they are not doing diversions). ▪ **Jim –** I just want to point out that the state has challenges around forensic units, but have partners around jail diversion and are trying to help with that as well. ▪ **Shawnie –** For the percent arrested… I'm having a hard time wrapping my head around what that high rate looks like. What percent reduction does that look like? ▪ **Carol –** For 2019, we would need 134 arrests fewer in Yakima county (to give you an idea).

	▪ **Corrie –** One of the strategies we've talked about has been using what we already have. I don't recall seeing targeted efforts for arrest rates. ▪ **Carol –** Becky has a hot spotting program in Pasco, but we've never really brought it into the equation. Spokane has built their program all around jail diversions. When we first started planning and looking at our projects, we already had a strong infrastructure around care coordination, so we've focused on that a lot. We just haven't focused on jail diversion yet, although I think if we wanted to beef that up we could. ▪ **Rhonda –** Yakima is currently implementing the Trueblood Jail Diversion program too. This is an initiative that could be leveraged. Helping with mental health and homelessness can also help move this metric. It's also important to consider that we can still work on this metric without being accountable for it if we move forward with 4 projects. ▪ **Jim –** For the 134 arrests, is that duplicated or unduplicated arrests? ▪ **Patrick –** Typically it's unduplicated, but the state hasn't operationalized yet. ▪ **Jim –** So if we address high utilizers of the jails, we may be able to address this. ▪ **Ronni –** Focusing on mental health court programs will also help with arrest rates. ▪ **Carol –** I think I know about the program you're talking about Ronni, and it's a great program- they just don't have a lot of resources (cap out at 40 people). ▪ **Corrie –** Can I ask about the logic of choosing 4 vs. 5 projects? ▪ **Cathy K –** 6 or 4 make the most sense. Our guidance would be to go with 4. 6 projects makes sense if you don't want to sacrifice any money, but 4 makes the most sense if you want to narrow your focus. ▪ **Susan –** I am in favor of going with 4 projects. We aren't dropping these other areas, and it will allow us to deal with them without our hands tied by the metrics. ▪ **Cathy K –** Exactly. For King County, their board didn't like the pathways HUB model, but coordinated care is still their top priority. You can have a high priority area focus and not have it be in your portfolio. ▪ _____ **-** It's important to also think about the cost of the pathways HUB. That cost mitigates the benefits of those dollars. We should take that savings from that area and use it elsewhere. ▪ **Wes –** If we don't move forward with 2B, it also carries a little risk, in that the onus is on us to come together and find another model to go with. ▪ **Carol –** We are looking at other platforms for care management, but even if we don't move forward with 2B- that doesn't mean we can't still pick the HUB. I would like to ask the providers using the system and get their input. ▪ **Sue –** I also think it makes sense to bring it down to 4 projects. I just think we would need to be very intentional about including those groups left out in our remaining areas. ▪ **Patrick –** Do we all agree with what Sue just said? ▪ **Kevin –** My only concern is that if we work to keep all 8 projects included with a budget that only supports 4 projects we will be stretched thin.

	▪ _____ **-** We need to look at the threshold on where the HUB becomes more of a benefit. The question is, do we have a replacement that beats the cost threshold? We just need to make sure we are covered with a replacement. ▪ **Rhonda –** We will do care coordination with or without 2B, but we would just need to look at other models. ▪ **Caitlin –** We can still eliminate projects in January, is that correct? ▪ **Cathy K –** Yes, we can still adjust the portfolio before January 30th. ▪ **Shawnie –** Up to this point, there have been many conversations about strategy and how our 8 and then 6 projects align and overlap. My concern is that these strategies would need to be adjusted if we move down to 4 projects. ▪ **Wes –** The PAC team could help refocus this is we move to 4 projects. We know that care coordination would still be foundational. ▪ **Corrie –** We need clear care coordination protocols in place for each of the counties. ▪ **Amina –** If we go down to 4 projects, we need a clear plan in place to incorporate the other 2. Realistically, you can't do 6 or 8 projects with funding for 4 projects. I am concerned about being able to develop this plan with the short time frame. Some things may fall off the table. ▪ **Patrick –** Thank you all for this feedback. We will pass it onto the board.
Budget & Funds Flow Presentation	• **Cathy H** – Budget & Funds Flow Committee Presentation o Finance Committee Recommendation ▪ Overview of guiding principles ▪ Definition of Use Categories ▪ Projected percent funding of the Project Incentive funds by use category over the course of the demonstration ▪ Distribution of Project Incentive funds by organization type for DY 1. o Guiding Principles ▪ Mission: The mission of the GCACH is to advance the health of our population by decreasing health disparities, improving efficiency of health care delivery, and empowering individuals and communities through collaboration, innovation, and community engagement. ▪ Accountability ▪ Transparency ▪ Collaboration ▪ Value-Driven ▪ Flexibility o Funds Flow – Greater Columbia ACH (visual) o HCA Fixed Required Use Categories

	▪ *ACH Administration and Project Management;* ▪ *Project Engagement, Participation and Implementation;* ▪ *Provider Performance and Quality Incentive Payments;* ▪ *Health System and Community Capacity (Domain 1)* • Financial Stability Through Value Based Payment; • Population Health Management; • Workforce. o Use Categories established by GCACH ▪ ***Integration*** recognizes that systems collaboration and integration is foundational to budget and funds flow. The fund will be designed to support improved population health, well-being and equity. Distribution methodology to be determined (possible RFP process) ▪ ***Contingency Fund*** for unanticipated events or costs, provide safeguards of resources for projects, administration and in consideration of cashflow needs. o Incentive funds allocation by use category – 4 projects selected (visual) o Distribution by Organization Type ▪ The ACH will allocate the payments to its participating providers/organizations based on a Funds Flow methodology determined by the appropriate governing body ▪ ACH Organization/ Sub-contractors ▪ Partnering Provider Organizations • Providers traditionally reimbursed by Medicaid: o Primary Care, Mental Health, SUD, Oral Health Providers o Hospitals o Health Systems o SNF • Providers not traditionally reimbursed by Medicaid: o Community Based Organizations o County Organizations, including Corrections Facilities o Tribes/Indian Health Services, Tribal or Urban Indian Health Programs ▪ Other o Distribution by Partner Organization

GREATER COLUMBIA ACCOUNTABLE COMMUNITY OF HEALTH
DSRIP PROJECT FUNDS ALLOCATION

DY1-2017

	TOTAL	
GCACH	16.1%	2.21
Medicaid Providers	50.3%	6.90
Non-Medicaid Providers	33.5%	4.60
Tribes/ITU	0.8%	0.11
Other	0.0%	-
	100.0%	**13.72**

- **Rhonda** – Just to clarify, the actual incentive dollars… will those flow through the ACH, and if so are they represented here?
- **Cathy H** – Yes those are represented here.
- **Carol** – This is the work of the Budget & Funds Flow committee (which has about 13 members, including 2 board members). This was the recommendation to the finance committee, but it is still a work in progress. I just want to highlight the huge commitment to our CBOs. This very important in delivering whole person health.

Domain 1 Breakouts

- Population health management/Data/HIE Committee (Wes)
- Workforce Committee (Carol)
- VBP (Rhonda)

ADJOURNMENT

Meeting was adjourned at 11:30 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:

- November 16th (Columbia Basin College, Pasco)
- December 21st TBD