Greater Columbia Accountable Community of Health

Leadership Council

Thursday, April 21st, 2016
9:00AM-11:30AM Meeting
Greater Columbia Behavioral Health
101 N. Edison Street, Kennewick, WA 99336

Minutes

Participants	In Person: Rhonda Hauff, Jorge Rivera, Patrick Jones, Jac Davies, Stan Ledington, Bethany Osgood, Caitlin Safford, Janis Luvaas, Harvey Crowder, Larry Jecha, Delphine Bailey, Martha Lanman, Leta Travis, Karla Greene, Sue Jetter, Lisa Stoddard, Liz Whitaker, Daryl Edmonds, Andrea Tull, Dana Camarena, Mark Brault, Gail Fast, Jefferson Coulter, Eddie Miles, Alex Howard, Melet Whinston, Marcy Durbin, Bertha Lopez, Suzy Diaz, Becky Grohs, John Sinclair, Carmen Bowser, Nancy Leahy, Corrie Blythe, Susan Campbell, Martin Valadez, Called In: Sandra Aguilar, Deb Gauck, Everett Maroon, Kat Latet, Steve Burdick, Gina Ord, Brady Woodbury, Erin Hertel	
Backbone Support	Patrick Jones, Facilitator Carol Moser, Executive Director Aisling Fernandez, Communications Coordinator Julie LaPierre, Technology Support Sue Jetter, HRSA grant writer Deb Gauck, RHIP consultant (phone)	
Guests	Lena Nachand, Community Transformation Specialist, 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. He asked everyone to introduce themselves by saying their name, whether or not they received a tax rebate, and if so, how they spent the money.	•
Action: Approval of Minutes	• Two corrections to the April minutes (suggestions from Leta & Deb) and approved by consensus	• Aisling will make the 2 corrections to the minutes

Plan for Improving Population Health (Stan Ledington)	• The DOH & HCA have formed a partnership to develop a Prevention Framework, which addresses *what* we plan to do to improve population health. The Prevention Framework is the foundation for the Plan for Improving Population Health (P4IPH) (the *how* we will improve population health). • The plan is to coordinate the P4IPH with the waiver • P4IPH will provide a supplement to the ACHs. • On May 25th there will be a draft plan focused on equity and sustainability	•

Director's Report (Carol Moser)	• Health Management Associates (HMA) has been contracted to work with the HCA. Working with expectations of the ACHs being the coordinating entities (it has been determined that it will be the ACHs), they have specific recommendations (listed in the director's report).
	  ○ At a recent meeting that Carol attended with the Centers for Medicaid & Medicare (CMMI), HCA leaders reiterated what the goals of the ACH are. The state's efforts (i.e. Waiver submissions) must support delivery system transformation and projects that can show ROI. Also now talking about sustainability (ability to carry on and produce revenue beyond test period) and reducing costs to the system.
	• P4IPH fits into this work nicely with a focus on prevention and management of diabetes, substance use disorders, oral health, etc. that is coordinated and whole-person centered.
	• 4 domains from HCA: these are broad overall categories listed in the DR.
	• Timeline for project toolkit framework: March & April are the months where the HCA has been developing the project toolkit framework.
	  ○ The draft Medicaid waiver toolkit (Framework) for the Medicaid Transformation Waiver (Initiative 1) is available.
	• Webinar on the 26
	  ○ Next Medicaid Transformation waiver update webinar—Tuesday, April 26, 10 a.m. to 12 p.m.
		•

	○ During this webinar the HCA will: ▪ Provide updates on negotiations with CMS, Initiative 2 (Long-Term Services and Supports), and Initiative 3 (Supportive Housing and Supported Employment) ▪ Focus in detail on Initiative 1 and development of the Transformation Project Framework ▪ Here's the link: https://attendee.gotowebinar.com/register/4930634924190239748 • Right now we're paying fee for service in most of our medical services. • Providence CORE is designing the Healthier WA Data Dashboard, a data repository for the ACHs to access data about their populations. Just yesterday we got late-breaking news in terms of where the data is coming from and 2 new measures. This site will be beta tested. All ACHs will be given a user name and password. Very exciting to have this information! • Second iteration of measures… the ACHs will have direct input. Carol will come back to the LC to see what is missing. • RHIP: put together a schedule with HCA delivery deadlines. • Deb: Measures from state are so clinical, but the plans such as P4IPH are much broader than clinical. Has there been a discussion at the State level about broadening the measures beyond clinical? ○ That's what WHA has been working on, but eventually we'll get population health measures. • Providence Core vs. WHA: what's the difference? ○ They're working very closely together to provide data. The CORE team is using a repository of data. WHA website is very clinical and provides measures showing whether each ACH is above average, average, or below average compared to the whole State for each indicator. Core website can	

	show trends and more details of the WHA measures. Providence is the "mechanic" making the data accessible.	

Regional Health Improvement Plan (Deb Gauck)	• Deb led the Leadership Council through the document she prepared.
	  ○ The funnel diagram is from the MAPP process and is familiar to many in community health planning.
	  ○ The process is to go from comments of the priority workgroups to underlying themes to strategic issues, then from strategic issues then goals, then to strategies, objectives, measures, and beyond.
	  ○ The reason we have looked at this process and the importance of doing underlying themes that are cross-sector, cross-county and cross-priority, is that we know we have very finite resources and we're only going to be implementing a few strategies.
	  ○ Robert Wood Johnson Foundation's (RWJF) Culture of Health (COH) Framework is helpful for a cross-sector perspective.
	  ○ Deb did affinity diagraming, but did that electronically rather than with sticky notes to prepare for the LC meeting.
	  ○ Deb gave an example of what we're trying to do during the LC meeting during the small group work.
	• Carol described our strategy for breaking into groups. Each committee chair has fruit unique to that group CC=bananas, BH=strawberries, HYEC= oranges, O/D=apples, Oral Health=limes & we will break into 5 small groups that have balanced number of each type of fruit for balanced representation from each of the 5 priority workgroups that traditionally meet.
		•

Priority Workgroup Meetings (Break into small groups)	• Rhonda's Report Out for her "fruit salad" group. This group discussed 6 of the 12 drivers, focusing on total integration & increased access. Included some new themes under the drivers including legal issues, education sector, civic engagement (and how civic engagement has been lost from our education	•

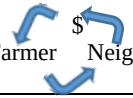
	system). *Empowerment* is a word we are missing. *Access* & *breaking sectors down* to take care of whole person health care. *More 211 and less 911.* • Patrick reported out: This group reviewed 10 of the drivers. Thought that Deb's underlying theme characterization was very good overall. They had some new ideas. Driver #5 investment in policy maybe should be under larger policy question #9. Deb captured those drivers well with the exception of investment. • Sue's Report Out: They added themes of *appropriate end of life* and *advanced care planning*. *Businesses investing in employment health*. *Funding for ACH*. *Health plans doing investments in programming*. Coalition participation. Programs like train the trainer and empowerment of the community. Fluoride in the water was not addressed. HIPPAA: understanding it and how it is a barrier. Overall, felt that the themes were generally right in line. • Lena's report out: This group felt that the economic drivers and financial incentives have to be present. Access not just about *getting to* care, but it's also about knowing *how* to use care. Care coordination is access and access is care coordination. Second only to financial alignment would be policy change across all the big institutions, employers, etc. • Carol's report out: This cross-priority group covered 6/12 drivers. They focused on community mindset with lots of discussion and agreed with underlying themes. They added a few. They talked a lot about access, which is more than just stable insurance, also needs to provide the services that you need. Policy suggestion: educational institutions need to remove the barriers to putting trainers in rural areas in terms of dental and oral health. Care coordination is missing transparency. Access: not just access to getting physicians, but the institutions. Important to creating our workforce by focusing on the disciplines lacking in our community. We need to be infusing and supplying our community with the professionals we need.	

Driver	New Influencing Factors Added During April 21st LC Small Group Session (all small groups' work combined)

Mindset & Expectations	• 911 is seen as part of the safety net and access to the public health system
	• 211 is under-accessed and under-resourced for prevention
	• Low-income believe they won't be treated fairly
	• Appropriate end of life expectations
	• Advanced care planning
	• Diverse communication methods
	  ○ Public discourse
	  ○ Radio, audio and print
	  ○ Disabled access to information
	  ○ Social media
	• Community mindset starting to coalesce around ACEs
	• Cultural barriers to seeing dentists preventive measure
	• Healthcare process should be more transparent
	• Next steps should be more apparent

Sense of Community	• Affordable, safe housing • Homeless people are part of the community too (even if their location is transient) • Safety in your neighborhood • In recent decades, the disconnect from neighbors and neighborhood (dissolution of trust) • People work and socialize in a different place than where they live • Labelling, reduce stigma (particularly asthma and diabetes) • Culturally appropriate inclusion • Social support like the Train the Trainer model to empower communities • Build capacity with social support • Successful diabetes/obesity programs include social support

	• Faith based and schools can be the center of social supports • Are we all on the same page around healthy eating? (messages) schools, churches, business
Civic Engagement	• Missing "empowerment" – both individual and group • Lack of understanding of how local, state government works- civics no longer taught in schools • Lack of understanding of how civic engagement work (leads to increased 911, decreased 211) • Equal access to legal support and legal services (particularly for those with mental health and for others to represent them well) • If someone ends up in the legal system, then civic engagement has failed them
Number & Quality of Partnerships	• Kids rely on schools for food. How do you get food to kids in an emergency? Emergency preparedness • All sectors involved • Health for youth- exercise
Investment in Cross-Sector Collaboration	• Funding for ACH • Business/investment in employee health • Health for investments • Coalition participation
Policies that Support Collaboration	• Supportive housing • Change policies that affect payment • Incentivize payment model on collaboration/talk policy –> collaboration (e.g. lawyers)
Built Environment/Physical Conditions	• Jail transitions – for housing • Gang violence. Theft. Meth • Transportation systems • Access to green space • Within walking distance, needs can be met, spot to do events • Multi-use for schools • Farmers market take EBT (federal policy stops this at times) • Pop-up farmers markets

		
Social and Economic Environment	• Address- monolingual. Spanish-speaking • Discrimination/fear • Promote equity in resources • Community fairs • Micro-local neighborhoods • Under resourced = lack of time = lack of relationships. Also means feelings of "do I deserve this?" • Economic environment → our environment means, right now, single means work 2 shifts, living wage jobs, what type of economic level?	
Policy and Governance	• Fluoride in water • ED usage driven by federal policy • Need to be sending health professionals to areas of need • Training institutions need barriers removed to increase supply of health professionals • Schools have policies to prohibit "bad" food • Policy is second to money • Schools: health literacy, first aid, what gets taught • Employers! • Mandatory sick-leave • We want others besides just D/O • Mental health implications ex. Recess, work place wellness • Health in all policies	
Access	• School based health services- on-site clinics, clinics nearby, nurses • Second to transportation! • Access=care coordination • Liability = urban myth • Clinical care focus on second shift ¾ to 11PM • FQHC don't connect to services as well • Diabetes/Obesity doesn't have access to services	

	Consumer Experience and Quality	• Understanding HIPAA barrier sometimes when it doesn't need to be • Behavioral health and substance use as well • All sorts of providers need to be part of the care coordination team • ED usage could be from lack of knowledge where to go • When you call, you reach a person • Care coordination = access • We say disconnect, somewhat (no the CHW) to the driver… belong somewhere else? • Care coordination as quality, but CC is after you're in • Partnership between clinic and social services (co-located?) ○ Issue with small clinics • Payment model that supports 15 or 30 minute visits	
	Balance and Integration	• Barriers to overcome silos in funding. Not whole person care. EMR different systems. Not compatible • Promote ACOs. Promote reform. • Promote integration of entire continuum: dental, pediatrics to geriatrics, ages and services • ED visits and intervention for 100% avoidable – good!!! (HIPAA/EMTOHLA) → The financial incentive has to change → reimbursement • Could be pared down/implicative • Missing: integration of social services and public health • Missing: integration of all • Population health drivers	
Next Steps	• Call for volunteer for the ad hoc Strategic Issues Committee SIC • Many members suggested 7AM as a meeting time • Composition of group would be cross-committee, cross-sector, cross-county • Committee to focus on strategic issues coming out of the with the new and existing underlying themes from today's work		•

	• Cross-representation is more important than the size of the committee. • Volunteers who raised their hands: Rhonda, Melet, Bertha, Corrie, Suzy, Gail, Jorge, Leta, Stein, Karla, Liz Whitaker, Bethany, John, Martin, Jac	
Adjournment	• The Leadership Council meeting was adjourned around 11:30 AM.	•

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:
	  ○ Thursday, May 19th, 2016
	  ○ Thursday, June 16th, 2016
	  ○ Thursday, July 21st, 2016
	  ○ Thursday, August 18th, 2016
	  ○ Thursday, September 15th, 2016
	  ○ Thursday, October 20th, 2016
	  ○ Thursday, November 17th, 2016
	  ○ Thursday, December 15th, 2016
	Thank you for your time and engagement with the Greater Columbia Accountable Community of Health!	