Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

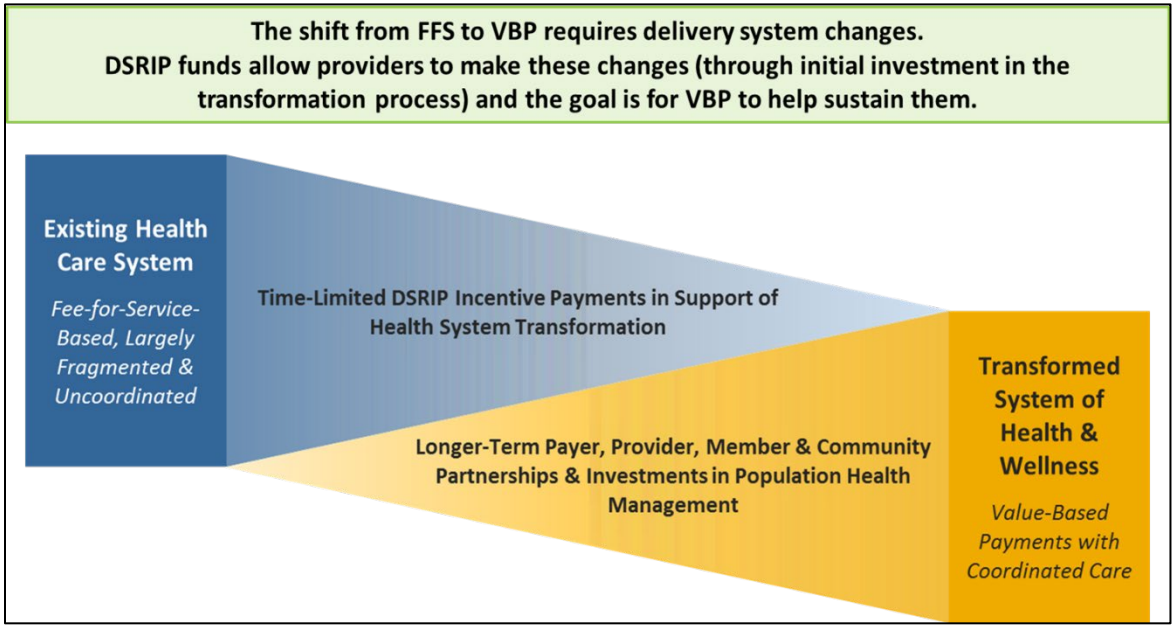
Meeting Minutes

November 15, 2018 | 9:00 a.m. – 11:30 a.m.
Columbia Basin College | L102, 2600 N 20th Ave, Pasco, WA 99301

ATTENDANCE	
Participants (* denotes they called in, † denotes a GCACH Board Member):	Dr. Amy Person, Shawnie Haas, Jac Davies, Marcy Durbin, Sierra Foster, Martin Valadez†, Andy Nyberg, Kat Latet, Susan Campbell, Dr. Larry Jecha, Rhonda Hauff†, Barbara Mead, Miguel Mesina, Julie Distel, Susan Sisson, Shelly little, Sue Jetter, LoAnn Ayers, Rick Ballard, Hayley Middleton, John Richardson, Dr. Antonio Gonzalez, Ronni Batchelor†, Chuck Eaton, Marissa Ingalls, Diane Campos, Lisa Hefner, Carmen Mendez, Ben Shearer, Caitlin Safford†, Carmen Bowser, Sandra Suarez†, Michelle Sullivan,
Staff/Contractors (* denotes they called in):	Carol Moser, Wes Luckey, Becky Kolln, Rubén Peralta, Lauren Johnson, Diane Halo, Jenna Shelton, Martin Sánchez, Patrick Jones, Aisling Fernandez
Special Thanks:	Thank you, Columbia Basin College, for use of the facility.
MEETING PRESENTATIONS & REPORTS	
Welcome & Introductions (GCACH Staff)	• Patrick Jones facilitated introductions by name and organization around the room and on the phone. • The November GCACH Report provided great narratives on recent work, including more information about opportunities for webinars and trainings than previous reports, and staff asked the Leadership Council members to read the report independently.
The What, Why, and How of Value-Based Purchasing (JD Fischer, Health Care Authority)	• JD Fischer is a Senior Health Policy Analyst at the Health Care Authority (HCA). His presentation focused on Value-Based Purchasing (VBP) from the HCAs perspective. • For all of the information, please view the full presentation here (credit for the images below goes to the HCA and JD Fischer's presentation). • The highlights of JD Fisher's presentation included: ○ The HCA Is the largest health care purchaser in Washington State, and this includes Medicaid, Public Employee Benefits, and will include School Employee Benefits starting in 2020.

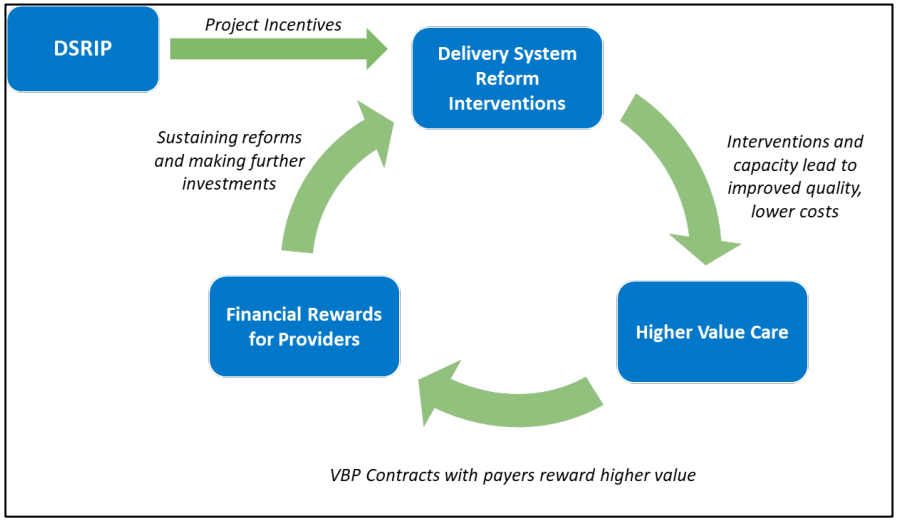
	○ *The HCA defines Value-Based Purchasing as*, "Contractual arrangements between a purchaser (e.g., Apple Health, PEBB, CMS) and its contractors and partners (e.g., managed care organizations, TPAs) that incentivize them to meet specified value-based targets that may include: quality, cost, access, patient and provider experience, and other value-based metrics." ○ The HCA is driving change through incentives and its *Guiding Principles*: ▪ Quadruple Aim (lower costs, better outcomes, better consumer and provider experience), ▪ Reward the delivery of person and family-centered high value care, ▪ Reward improved performance of HCA's Medicaid, PEBB, and SEBB health plans and their contracted health systems ▪ Align payment and delivery reform approaches with other purchasers and payers, where feasible, for greatest impact and to simplify implementation for providers, ▪ Drive standardization and care transformation based on evidence, and ▪ Increase the long-term financial sustainability of state health programs. ○ *Value-Based Payments* and *Value-Based Care* are other commonly used terms you might hear. *Value-Based Purchasing* is about providers assuming more accountability for the quality and cost of care, incentivizing higher-value care, and incentives can look like bonus payments or penalties. Payment drives system transformation. ○ HCA's ultimate vision is a healthier Washington, consistent with the Quadruple Aim, by containing cost growth while improving outcomes and both consumer and provider experience. ○ HCA will drive toward a healthier Washington by using the State's authority and purchasing power to advance value-based purchasing (VBP). HCA's key VBP goal is 90% in 2021. ○ Move from a fragmented approach to care to an integrated system. For the members who have previously been left out of their care decisions, the new system will be designed to empower them and improve shared decision making. Providers will feel supported in empowering patients, using decision aids and other resources. ○ System redesign means moving toward whole person care by focusing on social and behavioral health needs. This requires care coordination across sectors as well as financial flexibility. Data is at the heart of HCA's new models of care.

- VBP and the Medicaid Transformation: Essentially, the Demonstration provides resources to create new infrastructure to enable VBP, support building capabilities, test models, etc. Once a better system is created (higher value, better outcomes, etc.), VBP sustains that by supporting high-value whole-person care. Over the 5 years of the Demonstration, the new system gradually takes over from the old, with support for the transition through the Demonstration funds. Meantime providers and payers are learning what works and how to do it.



- Clinical integration is essential – patients experience a no-wrong door experience with healthcare, leading to more satisfaction, reduced stigma, and a greater likelihood of needs being met. Integrated care will improve clinical outcomes, reduce overall costs of care, and lead to higher clinician satisfaction in integrated settings. Aim to be fully integrated in WA state by 2020.
  - There is some evidence of this working in Southwest Washington region! The SW WA region (Clark and Skamania counties) is performing better than non-integrated regions in 10 of 19 measures, and statistically significant improvement for Medicaid beneficiaries includes Adults' access to preventive and ambulatory health services, percent homeless, percent arrested, and more!
- Addressing Social Determinants of Health: You're less likely to be healthy if you don't have a home, if you don't have food, and if you don't have a job. This includes support of:
  - Adverse Childhood Experiences (ACEs) Intervention,

	▪ Support of community health workers (CHWs), ▪ Diversion Intervention (% homeless, % arrested), ▪ Foundational community supports (housing and employment), and ▪ Long-term services and support (supporting unpaid family caregivers, supporting people who need long-term services to prevent impoverishment). o As providers consider VBP, HCA doesn't consider VBP to be a one-size-all proposition. Instead, the HCA recognizes that providers are uniquely situated and will be empowered to maximize their strengths and not pressured to do something that doesn't make sense to them. o Roles: ▪ HCA's role- very important to establish clear definitions across agencies, establish clear definitions, act as the lead agency for clinical data repository, have a role in training and TA, encouragement of contractors- getting beyond verbal encouragement. HCA's goal is to move the market- moving to VBP, aligning with the national movement away from fee-for-service to payments based on value. We are at 43% VBP now and still a long way to go. It might be increasingly difficult as we get closer to 90%, but HCA is looking to the future to better support our partners for TA and technical support. Will also lean on some federal or external partners to build capacity. Partners are counting on us, which translates to the programs the HCA operates and paying close attention to making stepwise annual improvements. ▪ MCO's are very important for VBP system transformation and contribute by taking on risks and incentives toward improved quality and lower costs, by taking on VBP contracts with payers rewarding higher value, and by sustaining reforms and making further investments. ▪ ACHs, including GCACH, are huge in terms of bringing partners together and connecting resources. *The goal of DSRIP is to provide investments in delivery system reform that enable these interventions and success in VBP.*



- Q&A session for JD Fischer, facilitated by Dr. Patrick Jones:
  - Q: Washington State has already surpassed 30% VBP and is aiming for 90% in a few years. How do you feel you're moving the market will impact the cost of healthcare in the United States? How do you think HCA's work will spill over to other payers for cost?
    - JD Fischer: One thing that gets lost in these discussions is that the cost continuum is a long-term proposition and goal for these payment models. The improvements we're making and the focus on prevention will have downstream effects on later utilization. In fact, we might see a short-term spike in costs as you see more appropriate utilization [of health care]. In the medium- and long-term focus, the on prevention will reduce long-term negative health outcomes. Much of this is unproven. We are trying to learn from other state agencies, other health plans, and trying to improve upon what's already been done. WA state is doing pretty well on the cost containment side considering all that. We are slightly ahead of the State trend, however it's a low bar considering the high costs of the system. The goal of 90% by 2021 isn't the end all be all, the ultimate goal is a healthier population and a better health care system. We have to do a lot to do to get there, including looking at waste and unnecessary spending. This is a great question. Hard to know how to bend the cost curve down rather than up at a slower pace.
  - Q: Regarding the social determinants of health, such as housing and employment, these are challenges in rural communities with no housing and no jobs. Is HCA working with state or federal agencies, for example grants for housing, to make sure these things are in fact available?

	▪ JD Fischer: Amerigroup is the contracted group on the network side. I don't have a better answer than that. We are not sure and not focused on that- when it comes to sustainability and making it a robust program, we must address this. o Q: Where does a patient play a role in all this and how is he/she on the hook for his/her own care? What about patients who aren't that cooperative? ▪ JD Fischer: This is a tough nut to crack, particularly in Medicaid. There are many external barriers to engaging in appropriate care. On the employee side, we are looking at how benefit design drives patients to preventive care and to utilizing high-quality providers. In Medicaid it gets down to health literacy efforts and the need to engage patients in their care. It also gets to the integration point. What are the factors preventing patients from engaging in their care? Do they not know where to go? Do they not have time to leave work? There is a myriad of challenges beyond any benefits structure. The struggle is understood, and we hear that from providers in different settings. Will hope to develop resources or outreach efforts to address those. o Q: If the CHWs are going to be implemented, is there funding set aside for that? Walking people through systems of care, getting people accustomed to going into an office, this takes time and energy. What about the roles of navigators, assistants and CHWs? ▪ JD Fischer: I cannot speak with any great confidence about the funding level for CHWs. The HCA is putting thought into workforce development and making sure to develop gaps in WF across the state. Can't speak to that but would have to follow up on that.
Value Based Payment Discussion (Partnering Providers and Managed Care Organizations (MCOs))	• At this point of the meeting, there was a panel on Value-Based Payment with the following guests: o Shawnie Haas, President and CEO of Signal Health o Rob Watilo, CSO, Southeast Washington Region at Providence Health & Services o Rhonda Hauff, Chief Operating Officer and Deputy CEO, Yakima Neighborhood Health Services o Caitlin Safford, Director of External Affairs and Community Development, Amerigroup Washington o Kat Latet, Manager of Health System Innovation, Community Health Plan of Washington • Shawnie Haas, President and CEO of Signal Health o Signal Health has Medicaid advantage as well as a partnership with Molina. Very proud of outcomes from clinical interventions. To prepare for risk, you must aggregate data for analytics. You can't move what you can't measure, and we have an unparalleled base for that work. Leverage those organizations, for example around risk assessment. Neighborhood Health is a leader in that. Performance is shared across the networks. We have many committees that are fully integrated. That's the work at hand, to be on the same sheet of music. Barriers and challenges are familiar to

me. I grew up on the reservation in Yakima county, with poverty, disparity, and social determinants. I see opportunities differently than others and can relate to our membership and community. There is a tremendous amount of poverty in the Medicaid population. Help those providers wrap around with supports. Having the providers deal with a challenging case- advance the work and not feeling like they're the only engineer on the boat, but also have a team- feel like those have been the barriers. The key is partnership where there are no silos on the horizon. Trust is need for Medicare and Medicaid.

- Rob Watilo, CSO, Southeast Washington Region at Providence Health & Services
    - Providence has 51 hospitals across 7 states. Locally there are about 300 providers here at Kadlec and providers in Walla Walla too. Need to get upstream of VBP, to create value, by looking at systems and data analytics. For a certain type of procedure, figure out which one of those has to happen to impact the other; you don't need to run this test and you'll achieve the same outcomes. It's a huge undertaking of the system. Really trying to improve continuity of care for patients, even across states. Looking at Medicare shared savings plans. Looking at bundled payment work and fixed rates. We have fee-for-service right now, but we're looking at migrating to VBP and also trying to stay afloat. Mark Wakai is talking about how to work on the St. Joseph side. Looking at that policy to expand across all systems. There are various markets in housing and other arenas. We partner with a number of other agencies locally for care coordination, behavioral health and mental health services. We are partnering with others because can't be all things to all people. There is some social reason they're coming to the ER for care- partnering with them to identify the top 50-100 patients, meeting with other agencies that care for that patient. We're trying to get them the care they need when they need it.
- Ronda Hauff, Chief Operating Officer and Deputy CEO, Yakima Neighborhood Health Services
    - I just came home from four-day conference about electronic health record systems, and there are two major things that stood out- 1. Interoperability (no longer "meaningful use", now "Promoting Interoperability," 2. VB Care and Contracting. In our region, there are four community health centers and about 20 sites total. We are preparing for contracting with the foundation for community health centers and VBC. We are working on the annual federal report to congress. Several years ago, we began looking at the info within our own systems to compare ourselves to national leaders and to ourselves in previous years. It's challenging to take all this info pouring in and figure out how to study it and understand what' the most meaningful. For almost all community health centers, social determinants of health are our mainstay, part of the civil rights movement. We're looking at how we're going to reduce the barriers, considered to be the major contributors of health- lots of screens- diagnostic Z codes built into diagnostic systems- put values on those at risk -

chronic condition codes to capture the complexity of the patient- at some point will put a value on them. Duff (mentioned in JD Fischer's presentation) was our client. We talk a lot about homeless clients. We see about 23,000 people per year and it's about 10% of our business but 90% of our time because of the complexity. We rely on our partners in MCO world because about 70% of clients are covered by Medicaid. We work with all of the MCO plans and MCOs are very involved. There's a medical respite program and housing. The MCOs are very supportive to reduce costs. Those people are going into the hospitals or being readmitted. Data info isn't sexy enough, however, data has become oxygen. We are working to find the most important info. We have come a long way. In the 90s VBP wasn't a concept. Trust is definitely important. We have to match up the cost of services more in real time with the outcomes we're seeing. 16 of the community health centers entered into an agreement with the HCA to move from encounter-based system to a value-based system.

- Caitlin Safford, Director of External Affairs and Community Development, Amerigroup Washington
    - Amerigroup is currently at almost 80% VBP, and we're feeling great about that. Though it's not easily achieved, it can be more easily achieved with larger health systems. Now we're working on the smaller groups where the population sizes are harder to manage. We put together registries to monitor the patients more closely. We meet with providers often to talk about patients, then dive deep into the metrics and HEDIS. We give them extra incentives. In the next couple of years there will be more advanced VB agreements as providers add BH services. There will be certain quality metrics. A primary care provider being at risk for that is challenging. We are working with some providers on what that looks like. Also working with more providers toward clinical integration, whether that's internal or maybe BH providers making better connections with primary care. The parent company Anthem is also looking at this. The providers are now more at risk and we help them manage the risk better. Providers are more hesitant to take bigger risks like MCOs, which are used to it. It's not just about getting providers into contracts, but about progressing along the spectrum of risk.
- Kat Latet, Manager of Health System Innovation, Community Health Plan of Washington
    - As CPHW thinks we think about value-based purchasing and care, we need to think about each of the roles and about building relationships. How is the MCO adapting to working with providers? How are we creating a cross-department multi-disciplinary team to meet the needs of providers and this needs to happen with the providers as well. We need acknowledgement and leadership about the change that's going to happen, we need continuous focus on quality. How do we bridge from the triple aim to the quadruple aim? We are thinking about how the allowance of a risk-based arrangement allows for people to serve at the top of their license and to engage in a multi-disciplinary team. We are looking at the national and state landscapes. WA State is progressive and

	aggressive, however is taking heat for what's happening at the federal level. What is CMS setting forth with their models? How are they looking at Medicare Advantage? As we move to the future, it's important to diversify our menu of options: VBP is not one-size fits all system. It's important to recognize where the strengths are, to focus on details of what you want to be good at and where you want to expand. What's the role of a network, of a provider, of a plan in disease management? These are set roles that plans have defined and are good at as you increase risk. There has to be ownership you have to build trust with providers. It's important to be honest about what the relationship is like and if that's going well. Data analytics and Quality Improvement are important, as well as having a tool that can combine claims data and clinical data, and creating incentives to using that tool effectively. We need a practice improvement team, a care improvement team, etc. We need technical assistance and data support. The NY waiver has Families USA which is looking at social determinants of health and equity. This is not a nut we've cracked yet. We want that to be at the top of everyone's minds. We could leave equity out, but we shouldn't.
Facilitated Discussion (Patrick Jones)	• Patrick Jones facilitated a discussion with the panel members and the audience. ○ Rhonda Hauff: Most of us have little to no reserves. ○ Q: Will coverage in WA be determined by the new rule allowing plans that do not adhere to or comply with the ACA, specifically the high-deductible plans? ▪ Caitlin Safford: Short-term limited duration plans won't affect Medicaid at all. We have a very robust Medicaid benefit. Most people are not in favor those plans in WA State. ○ Q: What are your thoughts about leveraging the EHR to document or communicate for those who are the boots on the ground? What about using the HER for community interoperability? ▪ Rhonda Hauff: We use the NextGen system. There were so many solutions that promoted the concept of a data hub where info could be uploaded. They have to be HIPAA compliant and able to share limited or unlimited info with providers. We already have one registry. Adding another registry helps us bring in the managed care rosters to bring them in to one place and to do more outreach to the many partners in Yakima valley. We use the registries for our own purposes, to find out what the additional needs are. One speaker at the conference made a comment that 2018 is the tipping point for interoperability between systems. With community health centers- there are 4-5 systems across the country. • Comment: That's a great next step. This is important for the follow-through for the social determinants and for whether CHWs are able to help a client. ○ Rhonda- Most centers have CHWs.

- Shawnie Haas: We do not have a systematic way to ID illiterate, homeless people where they interface with the HC system. We're not actively collecting SD information.

- Caitlin Safford: There's a huge gap in bidirectional communication. BH providers have had forever. Many places don't have protocols. We should standardize or get a platform to help with bidirectional referral communication. It's worth the cost to try it.
- Q: Thank you to Kat and Caitlin for bringing information about waiver efforts from NY State and for bringing uniformity and consistency to the message. I want to hear more about equity, the care manager model, stratification, investing resources without discrimination, and moving resources. When we talk about integration, the pool of resources shifts to primary care. When you speak to equity, is a displacement of resources or a shift of resources?
  - Kat Latet: This is a great question. One, in general, the way that VBP operates in a BH setting is nascent, models haven't been built. WA is leading the way. Much of the way VBP is designed is around centricity; Primary care is the quarterback and provides the whole-person care for that individual. Some of that model is based on the gap in the way we measure the system. We must tie quality to cost as we drive quality. Measures sit with primary and physical care space. Regarding equity and the BH diagnosis of an individual, one of the core challenges with the way the state has built expectations for a measure related to diabetes. Studies show that it's harder move around a metric for an individual within a certain race or ethnicity, and as we consider equity, we must be cognizant to incorporate that information. We must measure and reward success for the BH component and those individuals will be more complex and need more intervention. How we are equitably measuring as well?
  - Comment: One is rewarded by outcomes. If there's no equity in how outcomes are measured, then there's no equity in resources.
- Caitlin Safford: Measures were held to in HEDIS or actually getting to a doctor and that alone is an equity problem. If you can't see one face to face a provider it doesn't count. It's incumbent on a patient to travel to get care to get the access they need.
- Kat Latet: One piece of relationship building and working with BH is to make sure this is a relationship. BH providers are entering into arrangements and it's important to understand what your capacities are.
- Carol Moser: We talk about housing as a foundation. Housing is controlled by county government. County government has the funding to allow communities to building housing that supports people with MH. But we come into conflict with what the counties want and what neighborhoods want.

	Putting Rhonda on the spot, how are you so successful at getting respite care? It seems the dynamics are similar in Yakima and the TCs. ▪ Rhonda Hauff: The cities do it: Ellensburg, Olympia, and Tacoma have passed the 1/10th of 1% initiative. The homeless network of Yakima county is part of it. Medical respite is short-term but not really considered housing. We don't have a lot of housing so master leasers take on the risk, they are actually the tenant- with the new landlord mitigation fund. With the passage of the new landlord mitigation fund, if they rent to low-income individuals, they can apply for funds to help if there's damage then they can get money from the state. This removes some of the risk for the landlords and can help get people into housing.
ADJOURNMENT	
Adjournment	• Meeting adjourned early at 11:35 a.m. • Minutes taken by Aisling Fernandez.

Thank you for your time and engagement with Greater Columbia Accountable Community of Health!

2019 LEADERSHIP COUNCIL SCHEDULE:

2019 Leadership Council Meetings will be held from 9 a.m. to 11:30 a.m.

at Columbia Basin College, Classroom L102 (2600 N 20th Ave, Pasco, WA 99301) on the following dates:

January 17th, 2019

February 21st, 2019