Greater Columbia Accountable Community of Health

Collaboration • Innovation • Engagement

Board Minutes
August 17, 2017 | 12:00 pm – 2:54 pm
Columbia Basin College, L102

ATTENDANCE		Action Items
Participants:	**Board Members In Person:** Lori Brown, Rhonda Hauff, Les Stahlnecker, Amina Suchoski, Ed Thornbrugh, Meghan Debolt, Carrie Green, Darlene Darnell, Martin Valadez, Tonya Kreis (for Frank Mesplie), Madelyn Carlson **On the Phone:** Dan Ferguson, Erin, Michelle, Chelsea, Nicola, Tina	
Backbone:	Carol Moser, Aisling Fernandez, Patrick Jones, William Van Noy, Megan Kummer, Wes Luckey	
Special Thanks:	Thank you, United Way for today's facility. Thank you, UnitedHealthcare, for sponsoring the refreshments. Thank you, Graze Catering, for providing the lunch.	
Welcome & Introductions:	• **Martin –** I was here for the last part of the discussion during the Leadership Council, which was great. There's been a lot of work done by the staff, our consultants, the Leadership Council and the Board. Thank you to all of you. It's positioning us well to move forward. • Martin read through the conflict of interest statement.	
MINUTES & REPORTS		**Action Items**

Consent Calendar	• Consent Calendar:
	  ○ 7-20-17 Board Minutes
	  ○ Finance Committee Charter
	  ○ TAC (Technical Advisory Committee Charter)
	• Les suggested that we specify that the Finance Committee Charter say "GCACH Board" on the bottom of page three.
	  ○ "Amendments to this charter will require the approval of the GCACH *board*."
		• Martin motioned to move the Finance Charter to the action items, seconded by Meghan. Motion passed.
		• Meghan motioned to accept the remaining consent calendar items, seconded by Ed. Motion passed.
		• Ed motioned to include the amendment suggested by Les in the Finance Committee Charter, seconded by Rhonda. Motion Passed.

Director's Report	• **Carol:**
	  ○ For this month's Director's Report, we wanted to give you an overview on the Certification Phase II submission that we turned in on Sunday.
	  ○ All ACH's are required to do 2 certifications. The first phase was due on May 15th. All the ACH's achieved a high enough score to get that initial $1 million for planning purposes.
	  ○ The Phase II certification is worth $5 million in design funds, and HMA helped us with this submission.
	  ○ We will hear in a month how we scored. If we get 90-100 points we get the full $5 million.
	  ○ Highlights
	    ▪ 46 pages
	    ▪ 27 attachments
	    ▪ 99 documents, the Bios alone were 11 pages!
	    ▪ 32 Megabytes
	  ○ Theory of Action & Alignment
	    ▪ Walkthrough of visuals we provided as attachments
	      • Theory of Action, Collective Impact, Project Team Report Template, Project Selection Flow, Project Selection Criteria
	  ○ Governance & Organizational Structure
	    ▪ Committee Charter documents (9), Conflict of Interest, Job Descriptions and Staff Bios (5), Sector Representation Policy,	

	GCACH Overview, New Organizational Chart (as we added new staff members- Megan and William). o Tribal Engagement and Collaboration ▪ The Yakama Nation is an essential partner to GCACH. Most ACH's have at least on Tribal Nation; we have the largest. It's been a joy to work with them. We've worked with them on our communication and collaboration model, and it's important for us to understand the programs they are currently utilizing there as well as their culture. ▪ Model GCACH Tribal Collaboration and Communication, Tribal Bios, Attestation of Participation o Community & Stakeholder Engagement ▪ A lot of this was showing how we distribute information to public (i.e. our website) ▪ GCACH Website Resources Overview, Board Meeting Minutes, Provider Engagement Schedule, Community Member and Partner Attestations (40) o Budget and funds flow ▪ William has established a finance committee with three board members. This helps inform what to do with design funds between now and 2020. ▪ Staff Bios, Financial Statement, Planned Design Funds Use o Clinical Capacity • This was an area that we received a lower score on in the first certification. This time around we added several attachments (including clinician bios) to showcase our clinical experts to help bump that score up. HCA wants to make sure that the process is driven by providers. • Clinical and Workforce Subject Matter Experts Bios, (49) Project Team and Team Facilitator Clinical Experts o Data and Analytic Capacity ▪ GCACH Comprehensive Data Analysis • The Christmas Tree chart. We've shared this analysis and some are beginning to use it for their own ACH's.	

      - ED diversion has the most number of shared metrics, second highest is inpatient hospital utilization.
    - Large data analysis that was sent out to the Project Team Facilitators.
- Transformation Project Planning
  - This section is asking "how are we going to do all of this?"
    - We'll accomplish this by aligning resources and partners, and going out to provider systems servicing our Medicaid beneficiaries.
    - We are finding out that some of the claims data may be off in some of these tables (which may be why Virginia Mason Memorial numbers may look low).
    - Do these claims number look about right to everyone?
      - **Ed** – Yes.
    - **Wes –** We decided to show claims rather than Medicaid beneficiaries because this would count duplicate beneficiaries.
    - **Rhonda -** Is this just claims that hit HCA? It wouldn't be claims that hit the MCO's?
      - **Wes –** They initially come through the MCO's. It includes both direct HCA claims, and indirect claims (MCO's). As Carol mentioned, these numbers may be slightly off. But for our purposes, we were just using this for directional guidance for who the top providers are.
  - "Top 30 Professional Services Providers List" that will provide path forward and how they fit into the process.
    - Comprehensive, YVFW, Kadlec, Lourdes, VMM (Virginia Mason), Community Health of Central Washington, Ideal Option, YNHS, Sunnyside Community Hospital… etc.
  - Partnering Provider List, Professional Services Summary, Collective Impact
- Thank you to the dozens of people who have:

	▪ Served as Facilitators, participated on the Project Teams, served on the Leadership Council and Board of Directors, returned their biographies and attestations, Served as consultants (HMA, Dr. Jones) and TAC advisors (Gov. Kitzhaber, Dr. Straley, Dr. Ostler, Bob Burden, Mike Bonetto) ▪ This great work could not have happened without your time, dedication and support. ▪ The report for Certification Phase II is available for you to look at online (link is on our website). o Timeline Overview: ▪ Phase II certification is now completed, and the next big deliverable is the Project Plan which is due November 16th. ▪ We should be getting the LOI's back at the beginning of October. ▪ **Rhonda –** Do we know which projects will go with LOIs and which ones will go with RFQs? • **Carol –** HMA will cover this later during their presentation. ▪ **Carla –** Do we have a list of who these LOIs will be sent out to? • **Carol –** Yes. All of you should have received a copy of our Phase II Certification which included this list (these documents are also available on our website).	
	ACTION ITEMS	**Action Items**
Project Selection Feedback & Action	• **Community & Stakeholder Engagement Presentation (Aisling)** o Aisling recently switched to the role of Director of Community Engagement for GCACH o Highlights ▪ The importance of Consumer & Stakeholder Engagement/Outreach, past activities, and our plan going forward. ▪ What can we do to fill in the gaps for consumers/community members? Some of these things include workforce, transportation, sustainability, and being proactive. o Why Consumer & Stakeholder Engagement? ▪ Ensuring bi-directional and timely communication between ACHs, the community and consumers and ACH stakeholders.	

	- Engaging community organizations, consumers – including hard-to-reach populations (e.g. homeless populations, people with substance-use disorders, Veterans, specific ethnic or cultural groups) – and other stakeholders through project selection and implementation.
	- Sustaining community and stakeholder participation and support beyond project selection and implementation.
	- Including the consumers in the decisions that will affect their lives.
	o Stakeholder Engagement to Date
	- Thank you to those of you that helped and participated in these calls.
	- 4 WA State Department of Social & Human Services (DSHS) conversations
	  - 3 Community Service Offices (CSOs)
	  - 1 Developmental Disabilities Administration (DDA)
	- **Carol –** The reason we chose DSHS was to get feedback from a social service that deals directly with Medicaid Clients.
	- 2 Managed Care Organization (MCO) conference calls
	- 1 Federally Qualified Health Center (FQHC) conference call
	- 1 Local Health Improvement Coalition (LHIC) meeting
	  - Thank you to Wes and Carol for participating in the Benton-Franklin Community Health Alliance (BFCHA) meetings.
	- 1 Benton-Franklin Oral Health Coalition meeting
	- 1 Tri-Cities Diabetes Coalition meeting
	o Community Engagement to Date: Lessons Learned
	- We're still new to a lot of this and learning some lessons on how to improve our engagement moving forward.
	- Considered hosting Health Fairs: We were advised to go instead to established events, farmers markets, or to call these *Resource Fairs* if we do them.
	- Tried hosting a Focus Group**:** We aimed for 6-8 participants, offered incentives, had 6 people sign up, but not one person attended.
	  - Lesson learned: Work with people who have already established trust in the community and try again.
	- Considered attending a Health Fair: This event was the day before our LC meeting (perhaps too tight a timeline) and a very busy environment.
	- "You have to go to people and not expect them to come to you" Oscar Olney, CSOA / Toppenish CSO / Economic Services Administration / *Washington State Department of Social and Health Services*
	o Community Engagement: Going Forward

	- We'll likely take a combination approach of going out and creating opportunities for the community to come to us.
	- Consumer Council: A council that meets regularly to provide an avenue for community members, Medicaid consumers and community/consumer advocates to collaborate with Greater Columbia ACH. Recruitment begins this year; council meetings will begin in 2018.
	- Communications Committee (Pending Board approval of the charter today): The Secretary of the Board shall chair a committee comprised of at least two (2) members of the Board to oversee the internal and external communications of the GCACH along with some members of the Leadership Council or subject matter experts to also serve on this committee with the President's authorization.
	- Please let us know if you would like to join or recommended people for either of these groups.
	o Unintended Consequences
	- Changes at DSHS in recent years since the Affordable Care Act & other regulation changes led to reduction in personnel and reduced ability to help.
	- Medicaid Enrollment: DSHS offices can't enroll people for Medicaid anymore. People must enroll through the Health Care Authority and they are having more difficulty doing so.
	- 211: CSO offices now restricted to providing information about resources in 211. No personal knowledge allowed to be shared.
	- DSHS can no longer contract with providers to take Medicaid clients for ABA therapy.
	  - This is negatively affecting well-child visits (EPSDT)
	  - Note that there are only 2 ABA therapists in the area
	- People fall through the cracks in the system.
	o Workforce Development
	- DSHS Conversations:
	  - CSOs need patient navigators in places where clients already go, to help them get enrolled and navigate the Medicaid system. Put navigators in:
	    o The Mission, food banks, churches, the health department.
	  - Need more Applied Behavioral Analysis (ABA) Therapists in the community- there are only 2.
	    o Need providers that take Medicaid
	  - Need psychologists in more CSO locations who will accept contracts to see Aging, Blind and Disabled (ABD). Save clients from having to travel all the way to Richland (many don't make it).
	  - Hard to get doctors to practice in rural areas.
	    o Previously a program at UW for medical and dental students to visit small rural towns such as Toppenish.
	- Benton-Franklin Community Health Alliance (BFCHA) meeting:

	- For Bi-directional integration of care, “you need to build up a workforce to support the system. You need Community Health Workers & telehealth (especially in rural settings).”
	- For social and medical care coordination:
	  - “clients need a coach or a case manager, need appointment reminders. There could be a people-solution.”
	  - Need to overcome the language barrier with effective interpreters. “Folks need to receive information from inside their own culture.”
	- Benton-Franklin Oral Health Coalition Meeting:
	  - Tele-dentistry “opens the door to a diagnosis”
	  - Oral Hygienists do assessment, education and some clinical services through mobile clinics
	o Transportation
	- I heard many times that people often lack access to a working vehicle, or a vehicle with gas.
	- MCO Conference Call: For 2A Bi-Directional Integration: Having co-location of services can help with compliance when transportation (having a vehicle, having gas) is an issue.
	- DSHS Conversations:
	  - Should give a navigator a van.
	  - Dial-a-Ride is overwhelmed and needs a better communication method. Can be life-or-death for someone to miss an appointment.
	  - “When they’re in your office they’re yours. Once they walk out the door, they’re gone” Toppenish CSO
	  - There’s a mobile CSO unit.
	  - Rather than having separate chronic disease education programs, it’s better to integrate education for chronic disease into physician visits because of transportation issues.
	- **Martin –** Is the main issue with Transportation the unavailability of resources for it, or that people are unaware of existing resources?
	  - **Aisling –** Both of those reasons were mentioned as contributing problems. People also mentioned that Dial-a-Ride needs a better communication system.
	  - **Les –** Within it, Medicaid has a transportation contractor that they can call for people that located rurally.
	  - **Rhonda –** Yes, the contractor is People for People, but they also come up against certain challenges. They require 72 hours’ notice; and sometimes some of our clients can’t plan that ahead. If they call the same day, it’s almost impossible for them to go within the same 24 hours of making the call. It’s a good system, but it’s not a perfect system.
	o Sustainability
	- Diabetes Coalition Meeting:

	- There was a successful diabetes-prevention program at CBRC (a gym in Richland) with scholarships, but the program ended when the scholarship ran out. This program was effective because it combined a teaching component with exercise.
	- FQHC Conference Call:
	  - Sustainability and comfort level are linked because people won't want to try these new programs if they won't be sticking around.
	  - For Bi-Directional Integration, Care Coordination and other Demonstration projects to succeed, the consumers need to be comfortable with the changes to the system.
	    - Some BH patients might not feel comfortable in a busy primary care setting.
	    - "It should be reassuring for the patient that the care coordinators are aware of each other and taking advantage of the resources"
	  - Access issues such as long waitlists and social determinant barriers can hinder success
	  - "It's paramount to have BH fully integrated into primary care or the Pathways HUB won't work."
	  - "Need to do better at tracking outcomes"
	- DSHS Conversations: Sustainability of Pilots:
	  - From Toppenish CSO: At one time, there were about 100 "assistors" from FQHCs in the CSOs who helped with paperwork for Medicaid, but that is now down to about 20. Would be great to have larger numbers again. The HCA paid for the assistors for about 3 years, then it was up to the hospitals and clinics to pay for these FTEs, and those with smaller budgets couldn't afford them.
	  - Business Tech Centers to give people access to computers. These computers were "hot cakes"! But these centers couldn't maintain 1-2 people to work there (salaries or insurance for them). The Yakama Nation kept up 4 of these centers. The Downtown Toppenish center closed.
	  - The DSHS office in Toppenish has a Parents as Teachers (PAT) program with YVFWC. It's a pilot that is limited to 12 families at a time, but it really works! There's a waiting list. Would love for this pilot to expand to more families.
	o Be Proactive
	- FQHC Conference Call:
	  - For Transitional Care and Diversion Interventions to succeed:
	    - Hospitals need to be able to see clinic records and visa versa.
	    - Have care coordinators available for when a patient is being discharged from the hospital
	    - Identify high-utilizers and better manage them at home (more frequent contact)
	    - Utilize technology for proactive follow-up. "Need technology to support workflow and visa versa"
	    - For 2D, focus on a small subset of the population and pilot multiple approaches.

	- MCO Conference Call:
	  - Transitional Care & Diversion Interventions: People don't like to go to the doctor and wait to go to the doctor until it hurts. Educate individuals about going to preventive
	- BFCHA Meeting:
	  - **"**Upfront screening by professionals [at primary care] is key"
	  - 5 years ago, the Grace Clinic started Patients with Diabetes. They have a required screening for depression for the diabetes patients. Starting January 1, 2017, started getting all patients to complete a PQH9, which can change the nature of the conversation with your PCP.
	- DSHS Conversations:
	  - In a CSO office, clients often give addresses and phone numbers that don't work.
	  - "Once they walk out the door, they're gone"
	  - Toppenish Community Service Office (CSO) used to have a person who did alcohol and substance use screenings before the ACA. He would give someone a ride that same day and not let them walk away.
	
	o Takeaways
	- Workforce development can mean *more* psychologists, doctors, hygienists, navigators. Can mean working in a *different location*. Can mean providers who *accept Medicaid*.
	- Sustainability can be financial, consumer trust, comfort and buy-in, partnerships with stakeholders and providers
	- Transportation can be addressed through mobile units, co-location, and building workforce in more communities.
	- Try to help people immediately when they are in your office (social service or medical). Try to do screenings and preventive care and education sooner than later.
	- Incentives can be very helpful for consumer engagement and for consumers showing up for appointments.
	- Barriers (and solution) to access lie on the provider side and the consumer side.
	- **Lori –** Looking at the needs under workforce development, we have a really hard time finding people with Social Service degrees and a couple years of experience (which is a requirement for Medicaid case management). This has been a real challenge.
	- **Meghan –** We face similar challenges with CHWs.
	
	• **Summary of Scoring & Comments by the GCACH TAC (Technical Advisory Committee) to the Project Area Proposals (Patrick)**
	o Overview of the presentation: why we're doing this (introduction to the process), quantitative summary from scorecards, presentation of qualitative summaries for each project, average score of the 8 project areas compared, and final comments.

	○ Overview of the evaluation process: ▪ The reason we are doing this is because the board voted at the July meeting to have an 'arm's length' group review the work that has been done so far. This is an objective assessment of where we are today. The TAC includes these members: ▪ Mike Bonnetto, MPH, PhD.: Partner at 10-Fold Health, former chief of staff & health policy advisor in office of the Oregon Governor ▪ Robert Burden: Retired Director, Group Health; 20 years in leadership with Benton/Franklin Community Health Alliance ▪ John Kitzhaber, MD: Former governor of the state of Oregon; founder, Center for Evidence-based Policy at OHSU founder of the Archimedes Group ▪ Lee Ostler, DDS: Richland-based; clinical instructor, Las Vegas Institute for Advanced Dental Studies ▪ Hugh Straley, MD: Past president, Group Health Cooperative; chair, The Robert Bree Collaborative ○ Overall Score of Project 2A: Bi-directional integration of physical and behavioral health ▪ Average score of 3.84 *(all scores are out of 5)* ▪ Summary comments on 2A: ▪ "This project has excellent community leadership & a well-developed assessment ongoing as well as a significant evidence base. Given the community needs …for interventions, this project has an excellent chance for success. It will require ongoing involvement & an infrastructure for information exchange which the plan implies will be available." ▪ … is the most transformational of all the projects. It is also the most difficult. Changing two cultures, asking groups who might be competitors, multiple governmental jurisdictions & literally hundreds of organizations to take on this kind of change & collaborate is daunting. The sheer size of the task is potentially overwhelming." ▪ "Overall, this is a strong beginning for this project - knowing that it should become the backbone for much of the other work. 2018 planning year will be essential to its success. This project has the potential to help GCACH generate the most revenue - so would be helpful to have a better sense of the likelihood of collecting & reporting the necessary data -- as well as actually improving the identified metrics….." ▪ "This project…. seems to be missing focus on the Physical Health side of the project. The stated focus is on behavioral / mental health issues w/o much mention of the cormid physical health challenges. Within the section mentioning diabetes monitoring, there is opportunity to include periodontal health due to its strong bi-directional relationship with systemic health." ▪ "Its goals are laudable…Developing standardized metrics and measurement-based treatment, as well as employing a registry driven process, are all very strong points.

        - At the same time, this approach is still fairly much "inside the box" with the focus on integration of mental health and physical health *within* the formal medical system. There does not appear to be much focus on the crucial clinical-community connections that are necessary for the long-term successful treatment of those with behavioral and chemical addiction issues…..
        - The proposal, as currently written, does not speak to the fact that rural & minority communities may be skeptical of this approach if it is perceived to be an "outside intervention." Trust at the community level (not just between mental health & physical health providers) is essential for success. *The strategy must include the development of relationships that are based on trust and inclusion, culturally relevant & local."*

- Overall score of project 2B: Community-based care coordination
    - Average score of 3.89
    - Summary comments on 2B:
        - "While this proposal is still 'a work in progress,' the involvement of broad leadership of providers, plans and community services, a well-developed Hub and spoke model suggest sustainability. The unanswered questions remain as to the social services that will be involved and how will interoperability of information be achieved."
        - "Care coordination is key to improving health outcomes it requires a level of communication, collaboration, agreement on process and standard data collection measurement which will be a challenge across nine counties with different population needs and resources. I believe that it is key to take small successful steps and not to make massive changes all at once. Getting agreement across so many agencies and jurisdictions on how and what to work on will be key."
        - "The initial assessment to identify the target population and the region's existing care coordination capabilities will be key in determining the right fit for where the HUB resides, the scope of the implementation plan and the ability to move the project metrics."
        - "There is opportunity to create a pathway for oral health management. Low birth weight problems are also intimately tied into periodontal health of the pregnant mother. Also, vertical transmission of bacteria that cause dental caries, from mother to child is well established. This could provide opportunity for the projects to inter-relate with oral health project. …Also include periodontal disease and obstructive sleep apnea in list of chronic disease conditions. Understand that even mild improvements in oral health leads to decreases in admission/readmission rates, and decreases health care expenses for several chronic health conditions."
        - "I find this project particularly strong, compelling and well written. The Pathways Community Hub model ensures individuals with the greatest risk are provided with a comprehensive assessment of all health, social and behavioral health risk factors, and then assigned to a specific pathway to

ensure that those factors are addressed with an evidence-based or best practices intervention (not limited to clinical care)……

- This project recognizes the importance of not trying to "boil the ocean" but rather will target 'candidate at risk populations'…….It directly recognizes the importance of not only health care coordination but the direct integration of social services — the direct connection between traditionally disconnected agencies………..
- The biggest challenge is agreeing on the approach to selecting an agency as the hub & in selecting the priority target populations. This involves engaging community leaders & community organizations which, while aligned around a common goal, are not aligned around how to get there.".

- **Cathy K –** We really need to start moving forward on the common denominators around performance metrics (to identify target populations). For example, if we need to move ED utilization, who is that we need to pay attention to? Ultimately your large target is all Medicaid beneficiaries, but that's not where you'll start. You'll focus on your complex care beneficiaries, high risk/high utilizers, where are they, what's driving them to the ED- getting tactical in your interventions. This is true for every project area.
  - **Lori –** Has this ED data been vetted?
  - **Cathy –** We do not currently have this data; it may help to have Jorge weigh in on this.
  - **Jorge –** With some ACH's, we've had conversations on data sharing. I'm not sure if it's the same for all MCO's, but this has been the case for us. We do send the same data to the state, but some of our reports may be different. Our metrics come from the needs of HEDIS (Healthcare Effectiveness Data & Information Set).
  - **Wes –** The ACH has realized this issue around data is a critical one. We're putting together a committee to come together and try to address some of these issues. We want to MCO involvement, hospital involvement; the committee hopes to look at this further.
  - **Rhonda –** At one of our last PAC meetings, we talked about the idea of crossing over all projects by looking at PRISM data. Is that information available, and have you had a chance to look at it?
  - **Wes –** We're getting PRISM data from the state. They're putting together a report for the ACH. We're hoping it's granular, but if it's not we can go back to them with specific requests.

- Overall score of project 2C: Transitional care
  - Average score of 3.93
  - Summary comments on 2C:
    - "Because this project is built on the success of existing programs in the region & b/c the models proposed have good evidence to support success, I believe this has a good chance for achieving the goals & sustainability. As with all the projects, the greatest challenge will be to identify and monitor the target population over time & to measure & report on outcomes."

	▪ "Transitional Care is another project that I think has a greater chance of success. The timing is right. Hospitals and other providers are under more and more pressure to do something about readmission rates and complications due to lack of coordination and communication. There is much in place that can be built on." ▪ "It appears that several of the identified interventions for this project are existing projects/programs and are unique to specific areas within GCACH. It would be helpful to have a better understanding of their current funding models & how each intervention could/should transition to other counties." ▪ "Opportunity to include hygiene or dental navigator in this project, and tie into the Oral Health Project - to help people presenting in ED with dental-related problems find access to care. This would also help improve the opioid use of pain meds for dental related problems." ▪ "This project acknowledges the importance of ensuring that the local community—& particularly the populations at risk—do not perceive GCACH as something being imposed from the outside. This requires interacting with, empowering & developing trusting relationships with local leadership, organizations and agencies. The fact that Health Homes and collaborative community paramedics currently have a significant footprint in some of the smallest communities means they should be relied upon to use that local knowledge & trust to help implement this. . ▪ The two biggest 'pain points' with this project are: 1)The need for committed engagement & cooperation with hospitals & MCOs. 2) The very real challenge of creating and maintaining robust interdisciplinary /inter-agency collaboration. The difficulty should not be underestimated. It requires skilled local trusted facilitators and an explicit commitment to the process by the key stakeholders.". o Overall score of project 2D: Diversion interventions ▪ Average score of 3.9 ▪ Summary comments on 2D: ▪ "Over all I think this project given its leadership and the well-developed model had the greatest chance for success of all the projects. Challenges will be information access, adequate hospital and EMS resources, and appropriate social services to address difficult psychosocial issues." ▪ "Diversion Interventions is the project with the greatest chance of success. In this case you have more to build on right away. CCS has several years of experience, has EDIE and CCS data & measurement capability already built, has relationships & a trust level with most of the major players. The "house" is already about half built. It might also be a template of sorts for some of the other projects. They have a lot of experience with what works & what does not. They also do not compete directly with the major players which takes some of the politics out of the equation."

	▪ "Much like project 2C, it appears that several of the identified interventions for this project are existing projects/programs and are unique to specific areas within GCACH. It would be helpful to have a better understanding of their current funding models and how each intervention could/should transition to other counties." ▪ "Opportunity to further consider the ED use for dental related problems, as well as to establish a navigator or continuing-care type coordinator that can help facilitate people finding access to care for acute dental needs, at least. " ▪ "This is a well-designed project with very clear goals and target populations & the potential for significant cost savings. Using CCS as the centralized referral center allows for intake from a wide range of sources & then assigning them one of three categories..... ▪ This project explicitly acknowledges the contradictory incentives between diversion from hospital admission and loss of hospital inpatient revenue. It seems to me that this issue needs to be placed squarely on the table because without the active participation of hospitals (& MCOs) this project has little hope for sustainability. It offers an opportunity to have a candid discussion about the current hospital business model (or the current healthcare industry business model) which pits short term revenue against long-term patient health." o Overall score of project 3A: Addressing Opioid Use ▪ Average score of 3.18 ▪ Summary comments on 3A: ▪ "I am not clear what the exact implementation plan will be, what is the monitoring and measurement plan, what is the ROI. Clearly this is a critical project with a core goal of saving lives. The project has a very general set of implementation strategies. Clearly there will be a need for additional resources of Care managers and CHWs. The proposal would be stronger if more detail were given to overcoming the implementation barriers." ▪ "The biggest problem with this issue is the prevalent belief in the community that this is an isolated issue that mainly effects the junkies and drug addicts. Many consumers and some providers believe that this is not their problem. There will be a need to educate the public about the size of the accidental overdose problem that touches every part of our society." ▪ "Even though this is a required project, it appeared to be one of the lightest proposals. I believe Olympic ACH is pursuing an evidence-based model (6 building block framework) that may be worth reviewing." ▪ "(There is an) opportunity to address the fact that dentists are also among the opioid prescribers within the community. Also, to address the Emergency Department use of Rx meds for unnecessary dental health issues."

	▪ "I realize that this is a mandatory project, but carving out opioid abuse from the larger problem of chemical addiction seems artificial at best. For example, creating a case management hub in each county seems redundant with the pathway hub concept which proposes a single hub for the 10-county region then contracting with care coordination agencies in the communities, which will allow the pathways to focus on each region's particular needs. Perhaps some thought should be given to partnering with Project 2B: Community-Based Care Coordination to do the case management through the care coordination agencies….. I understand that there is a natural inclination to apply these projects across the entire region from the beginning, but that may well not be practical or even desirable in a 'demonstration' project. We don't have to 'boil the ocean.' Project 2B: Community-Based Care Coordination clearly recognizes this and plans to start by implementing first for a small set of one or two target populations. " ▪ That's another issue for us: do we do all projects in all nine counties? o Overall score of project 3B: Reproductive & Maternal/Child Health ▪ Average score of 3.9 ▪ Summary comments on 3B: ▪ "This is an important project that needs investment. As with other projects, the infrastructure for monitoring and measurement is not developed. The 3-part intervention of LARC, NFP and PAT are strong & have a good chance for success if adequate staffing, good coordination, access to social services & monitoring & measurement are developed." ▪ "Maternal-Child Health has a couple of unique issues. There are the issues around contraception and some of the providers of contraception that require great care in the way it is presented and implemented. Cultural differences are always an issue in health care, they are even more sensitive around contraception and obstetrical care." ▪ "Much like projects 2C and 2D, it appears that several of the identified interventions for this project are existing projects/programs (NFP and PAC) and are unique to specific areas within GCACH. It would be helpful to have a better understanding of their current funding models and how each intervention could/should transition to other counties." ▪ "(There is an) opportunity to focus on children's fluoride varnish programs, oral health education, sealant programs, etc. Also, an opportunity to improve oral health focus of pregnant women (caries and periodontal disease). Also, an opportunity to address the linkage with and need for lactation counseling/training since this is a starting point for a child's airway development- which if not well established, results in increase in many behavioral problems as well as increase in infections, dental problems, and chronic illness later on."

	▪ "This is a well-designed project that relies on two well-documented approaches to home visitation: The Nurse Family Partnership; and Parents as Teachers….. The other goal of this program is to educate providers and consumers about LARC; to increase access these contraceptive options and decrease unintended teen pregnancies. You might want to consider incorporating the "One Key Question "approach into this aspect of the project, if it has not already been introduced in Washington State…… Primary challenges appear to be recruiting adequate numbers of culturally competent nurses; and in providing services in rural parts of the state where the caseload may not be large enough to justify the expense of the program." o Overall score of project 3C: Access to Oral Health ▪ Average score of 3.59 ▪ Summary comments on 3C: ▪ "The proposal could be improved with a more explicit plan such as an initial pilot program in several primary care sites with more exact estimates of costs and staffing requirements: 1. Breaking down the paradigm that oral health care must be delivered in the dental office. 2. The current dental law prohibits our ability to deliver all the preventative services we would like to. This is a limitation but not a barrier to the project. Our hope is that good outcomes will encourage a change in the dental WACs. 3. Data: Developing data sets that can be gathered by a disparate group of organizations scattered across a large area of the state. 4. Low Medicaid reimbursement for adult dental services 5. No Medicaid payment for oral health case management 6. Lack of medical/ dental integration" ▪ "Oral Health has three hurdles to deal with. Lack of access, current regulatory rules and lack of support/integration with medical community. Need to change WACs to allow more freedom for non-dentists to provide services under their own licensing and in other settings. Needs to educate the public more about the link between dental and "physical" health and convince the medical doctors to engage with the dental community." ▪ "There are 3 identified interventions for this project which will require additional project management resources. It would be helpful to have a better understanding of how the proposed interventions could/should be implemented within the 9 counties." ▪ "This project relies heavily on utilization of licensed registered dental hygienists, which itself imposes possible boundaries or limitations to the project, & hopes that upward pressures & evidence obtained can be utilized to effect change at the highest levels so that reimbursement levels for delivering care…. One opportunity would be to link this w/ the 2C Transitional project

	wherein a hygiene navigator may be of help in navigating people thru the "access-to-care" minefield. Such a provision may also help w/ follow up after field identification of dental needs.... The strongest part of this project is the clear articulation of the problem and the direct challenge to the notion that oral health must be delivered within a dental office......Major challenges, beyond breaking down that paradigm...................., is that it may require some statutory changes by the state legislature &that the workforce requirements for dental hygienists involves a minimum of 3 years training," o Overall score of project 3D: Chronic Disease Prevention & Control ▪ Average score of 3.65 ▪ Summary comments on 3D: ▪ "I found this proposal the most difficult to score since it is very broad in its goals and not specific in implementation. I would recommend that the proposal address each of the domains in the chronic care model. How will self-management programs be realized? What elements of practice redesign are doable and achievable? What are specific decision support tools that will be used? Importantly how will information systems be used or developed such as registries, monitoring and reporting? Given that this proposal like all others, is in the early stage of development, there is great potential for success. It is however in need of greater focus and more detail as to implementation plan." ▪ "Chronic Disease is an important subject. There are lots of people using different tactics to impact chronic disease. Some use registries; others do not. There is a lot that needs to be agreed on by a lot of providers. The data issues will be significant." ▪ "There are 3 identified interventions for this project which will require additional project management resources. It would be helpful to have a better understanding of how the proposed interventions could/should be implemented within the 9 counties." ▪ "This project is elegantly designed in that it addresses primary prevention (5-2-1-0 Let's Go program); secondary prevention (the Diabetes Prevention Program); and tertiary prevention (the Chronic Disease Self-Management Program). This has potential for significant long-term cost savings but, like the diversion interventions, could adversely impact hospital revenue…Obesity and diabetes have their roots in a number of social economic and environmental determinants and the modifiable risk factors involved are particularly prevalent in low income populations. For these reasons, this project squarely seeks to address some of the most significant social determinants of health." ▪ "There is a dramatic and well-established linkage between chronic diseases and the presence of poor oral health. ....Because of this, there is an immense opportunity in a bi-directional manner, to set the stage for both physicians and dentists to become better informed about these issues,

	as well as to improve the co-management of these health problems. There is a good opportunity to strengthen this and link projects by including conditions and metrics that bring focus on how medicine and dentistry can better work together to bring down chronic disease and reduce healthcare expenses by so doing. I would suggest adding "Sleep Apnea" and "Periodontal Disease" to the chart on pg 65 that outlines "Root Causes". Also - add "Diabetes - Medical attention to Perio & sleep" to the Evidences & Outcomes section. Add Periodontal Disease to "Comprehensive Care" on p. 67." o Overall scores of the 8 project area proposals: 3.73 o Overall summary remarks: ▪ "They seem to have a pretty good handle on what the challenges would be, but I am not sure they understand just how difficult some of them are. The very biggest obstacle in all of them is overcoming the resistance to change. The current system breeds unhealthy competition and duplication. Individuals and organizations tend to operate in their own self-interest and will need to be convinced that any change will not harm them…… Integration, communication and cooperation all require work and have some level of cost to them. Convincing or compelling people to change is never easy. Most providers, agencies and hospitals have their own ways of doing things and getting agreement across them all will take great patience. These things are present in all the projects ….." ▪ "The way to set GCACH apart from the pack in the project approval process is to demonstrate that you are not just after the money but, rather, that you have a constellation of projects that come together to create a holistic approach that is greater than the sum of its parts. This means that you must be disciplined in your approach to project selection….. ▪ A lot of good people put a lot of the time into each of these eight projects, but to start from the assumption that you need to move all eight forward, is more about politics than substance and confuses the objective from the very beginning. Your objective is to <u>demonstrate</u> ways in which we can transform our health care system to produce better value for less cost. The way this project has been set up means that, in order to achieve that objective, you need to move a set of metrics… ▪ This, in turn, means that you cannot view each project as a silo. You can't be successful in transforming our health care system using silos to break down the silos in the current system. You need to be open and flexible to incorporating some aspects of "project X" into "project Y" and not be afraid to drop one project while incorporating some of its key elements into another. ▪ "It is also worth noting that most of us (not all) who are engaged in this process are white and relatively privileged. Few of us have had direct experience of what it's like to live in deep poverty, to have no reliable access to medical care or to face food insecurity every day and not know where you'll be living tomorrow. We are developing policy for people, many of whom face these issues every day – and yet

	they are not at the table. It is also important to recognize that the formal medical system— and the very process in which we are participating—can be intimidating to many minority populations, including those from generational poverty. We are people from the 'outside' coming into 'help' those who are less fortunate…..It will be difficult to foster the kind of community collaboration that is envisioned in this demonstration project without honoring and relying on local knowledge and trusted local spokespersons and organizations that have been working in this space for years. Therefore, it is critical that we incorporate into this process the very people who are at risk. We cannot possibly craft interventions to help these populations without their input and participation." ▪ "It is important to remember that in the last years of the Demonstration Project, funding will be based on pay-for-performance – that is, on how well you actually move the metrics for which you are responsible (accountable). For that reason, you need to give serious thought to how you can maximize the funding for the projects you select, while being accountable for the fewest number of metrics…. ▪ Try to avoid "meeting fatigue" in the process of building collaborative relationships. For example, Project 3B: Addressing the Opioid Crisis, proposes to send a letter to agencies in all communities to gauge the interest and commitment to being involved in the opioid project. A subcommittee will define roles and responsibilities of the case management in each area. At the same time, Project 2A: Bi-Directional Integration proposes a community level engagement process, while Project 2C: Transitional Care will have to conduct extensive meetings to develop robust ID/IA collaboration. If all the meetings across all the projects areas are stand-alone events, you're going to burn out community members in short order." ▪ *"I cannot over-emphasize the importance of this (working with the MCOs)*. Unless you get buy-in from the MCO's, unless you develop true meaningful partnerships with them and can demonstrate the financial advantages of continuing these projects into the future, none of this goes anywhere beyond year five. You need to continue to push them hard about getting serious in addressing the social terms of health but, the way this project has been designed, you need their partnership <u>now</u> if all the hard work you have done to develop these projects is actually going to reduce costs and improve quality long-term." ▪ "I am impressed with the work that everyone has put into this. I also appreciate the fact that everyone has "day jobs" and that these are early proposals without exact implementation tactics or cost estimates. Common themes are: the evidence base is clear in all of the proposals; most have broad representation and relevant leadership; common weaknesses are the lack of clear implementation planning and the lack of infrastructure for monitoring, measuring, and reporting. These are frequent challenges in clinical proposals." ▪ "First let me start by saying it is evident that a lot of work and thought went into the development of each of the projects. They all would be improvements to our care system…..

DSRIP Calculator Review	• **William –** Most of the Board has seen this calculator already. It was developed by HCA, and I've made some slight modifications to it.
	  o The calculator is great tool for all organizations. It will help you see what the effects are of not meeting 100% of the metrics, and how that translates into your dollars.
	  o As we know, if we choose 6-8 projects, we still have the potential to earn up to the $119 million. If we go below that, we would lose money.
	  o Walkthrough of impacts of P4P and P4R
	  o Overview of Cashflow tool
	  o It's important to note that the calculator is just one tool for us to use, and it's not the end all be all.
	  o **Lori –** What I found the most helpful with the calculator is not necessarily the money, but being able to see the overlaps in metrics and the opportunities there.
	  o **William –** Yes exactly. Moving forward, this will be a great tool for CFO's and controllers for their budget processes. Please reach out to me with any questions.
	• **Wes –** I'd like to take some time to discuss some analysis that we've looked at and pulled from the Washington State Institutes for Public Policy. We've talked a couple times about our ROI for some of these project areas. During the July Leadership Council and Board meeting, I went to a meeting in Portland.
	  o At this meeting, they pointed us to a website that we can use for an online resource that has information about some of the project areas. We should take this information with a grain of salt, as it may not necessarily apply to the implementation of programs in our areas.
	  o We weren't able to find cost benefits for all of the areas, and some of these won't necessarily be apples to apples to our project areas. They apply dollars in terms of benefits, dollars in terms of cost, and they took the difference which is that "benefits minus costs".
	  o They also came up with an estimate of probability of achieving this outcome from 0-100%. 100% means they have a high deal of certainty that this will actually take place.
	  o The last column represents how many years it takes to get to a positive ROI. As I said, this shouldn't be taken as a direct comparison, but it may give us some directional guidance.
	• **Les –** We've been talking a lot about percentages. If I projected that we would meet the chance of benefit to exceed, then I would say if we hit 88% we're on the right path. What I mean to say is that we may not hit 100% right off the bat, and we may need to meet some milestones along the way (and still meet our % requirement to keep our funding).
	  o **Wes –** These percentages are based on a meta-analysis (a bunch of studies). So when they talk about these percentages, they're really a confidence interval.
	• **Rhonda –** Can you explain the first 2D metrics? According to this, there's a 44% chance that the benefit will exceed the cost, but it never achieves a positive ROI.

	○ **Wes –** When you look at the cost, it's expensive because it's home based (and it has a high cost per individual). These are just estimates to give us a sense of directionality between some of these project areas. • **Patrick –** I poked around on this site a bit, and I think it's important to keep in mind that these meta-analyses are based on prior studies (and in some cases, only 3 studies). Also, looking at 3D- there are many different approaches to this, so I wouldn't jump to conclusions. • **Rhonda –** I'm just trying to understand the logic- if it has a 44% chance of the benefits exceeding the cost, how could it never have a positive ROI? It seems to be contradictory. ○ **Wes -** I apologize if some of this is confusing. This is just another possible tool to inform the board to help them make these hard decisions. • **William –** I just have an observation to share. I come from the critical access hospitals, and I know that when we were working on ED intervention… I know it's not intentional, but it's a little misleading. When you're reducing your ED visits, you want to move them into clinics or urgent cares. So, you might lose revenue in your ED's, but it translates into your clinics. • **Lori –** If we're talking about ED visits, there is a need to really target your frequent fliers to make an impact. Another point is that we are supposed to be focusing on evidence-based programs, so if we are focusing on these programs, doesn't the evidence already say that there will be cost savings with those approaches (and better health outcomes)? ○ **Wes –** They should yes. There are some project teams however, not using approaches listed in the toolkit. There are some studies and trials behind those not in the toolkit though that do say they are effective. We do have to be careful about including these approaches though, as it may diminish the work that all of the teams have put in. • **Wes –** This was just an idea of where some these project areas could end up. Looking at 3D, programs that focus on wellness and obesity don't tend to work very well. Those that tend to focus on chronic disease following the chronic care model has become the gold standard of the industry. • **Les –** This is part of the problem with prevention; you're not showing a cost savings. You may have some cost savings, but overall, it's very hard to measure. • **Wes –** This is an important point, which also leads us to when we get to implementation. Where do we attribute success and failures where multiple project teams intersect?
HMA Project Feedback & Timeline of LOIs/RFQs	• **Cathy K, Cathy H, Dr. Bruce Goldberg** ○ Today's Discussion: HMA Feedback on Projects (What work needs to be done to develop a strong project application and project portfolio), strategic considerations for the selecting project portfolio, and next steps. ○ HMA's overall project feedback on the proposed projects ▪ All of these projects reflect the tremendous amount of work and collaboration that has gone into them.

    - All the proposed projects have real potential to improve the lives of people in the Greater Columbia region.
    - Every project needs more work to be ready for the November application:
      - Regional data
      - Interventions need to be able to move performance metrics
      - Identification of partnering providers and funds flow
      - Domain 1: What investments are needed across the portfolio in Workforce, VBP and HIT?
      - Alignment with other projects in the portfolio
      - Sustainability strategy
    - **Rhonda –** How much of our sustainability plan needs to go into the November application?
      - **Cathy K –** This will just be a very high level.
      - **Dr. Goldberg -**The ROI is less about the application, and more about a strategic decision. 5 years is such a short time to make a change. And as the community gets healthier, there is less utilization of healthcare.
      - **Les –** Which means a lot of these companies will lose money.
      - **Dr. Goldberg –** There are ways to share those wins and losses. But this is less about the state application, and more about the long-term success with alignment and sustainability.
      - **Cathy H –** And this is a conversation that will be happing in the Budget & Funds Flow committee.
  - Regional Data is a Critical need
    - Need to know where you are, and who and where to start with to move metrics
      - Need denominators – how many people need the intervention in order to hit performance targets?
      - Which sub-populations/ geographic targets? Every project right now says that it will serve all the Medicaid Beneficiaries in all nine counties. That is the right end goal for this, but it's a really difficult starting point.
        - As a starting point, all counties for all projects will undermine your ability to hit targets
        - Equity focus needs to be operationalized
    - **Rhonda –** Realistically we have to think about if we can hit those targets.
    - **Cathy K –** That's right. At the same time though, your organization holds these values to improve the healthy equity across the region. It's still important to think about how we will be including rural communities too.
    - **Dr. Goldberg –** All projects speak to population focus. But when it comes to these projects, the denominator in the data is Medicaid. The metric that needs to be moved is not population health, it's the Medicaid population health. The design needs to be sufficient enough to move this metric. There

	needs to be strategy around the projects to get you the $119 million so that it can be used to invest throughout the community. ▪ **Wes –** On our call with Manatt earlier this week with all of the ACHs, everyone is well aware that there are large deficits in the data. There are no baseline metrics or targets, which makes it really difficult for us to identify how to select projects. ▪ **Rhonda –** The state submitted an HIT plan to CMS. What's in that plan? ▪ **Jorge –** My personal opinion is that this plan doesn't really have a short-term solution for ACHs. There data strategy going forward doesn't have a solution for these immediate needs. ▪ **Cathy K –** This may be an opportunity to collaborate with other ACHs. If the state won't help you, do it without them. ▪ **Lori –** The data will show different things in different regions. Aren't the hospitals collecting some of this data? ▪ **Wes –** We had a conversation with them (specifically Kadlec). We're looking to form a data sharing agreement with them and VMMH, and possibly other hospitals. ▪ **Rhonda –** We had also talked about working with Providence Core. ▪ **Wes –** We had a conversation with Providence Core, and they are looking at the same data we have. ▪ **Rhonda –** Will the state accept the data we give them? ▪ **Cathy K –** Yes, they will. All of the ACH's are struggling with the same thing. ▪ **Les –** It's difficult for me to see how I can save money and sustain saving money in a rural community. Unless you add transportation and other costs into it, because you don't have the volume to show it. ▪ **Cathy K** – The DSRIP calculator is only a tool. We need to build something. A vision of a healthy regionwide community. Health equity is a clearly state value, and a GCACH value. ▪ **Jac –** It can also be easier to move the numbers for a small community, because they move quicker. ▪ **Lori –** We always know that that we will lose money in rural areas. You just don't have the economies of scale. When we take an RFP, we ask them to take all 8 counties and disperse the money throughout them. ▪ **Carol –** What you're also saying Lori is that you need to make the money first before we can ask them to distribute it. o Projects need to be able to move performance metrics ▪ Need for demonstration projects to "study to the test" ▪ This is a concrete step toward regional health system transformation, not just chasing dollars o Need to identify partnering providers and funds flow ▪ Where are we starting in our approach so that we can maximize the revenue in our communities? ▪ The focus on equity needs to be operationalized. ▪ **Dr. Goldberg –** You'll need data on race, ethnicity and geography to understand these disparities.

	▪ **Wes –** FQHCs are collecting this data. ▪ **Rhonda –** If we are going to move the needle, will we need to focus on one geographic area to focus on all projects? ▪ **Cathy K** – I don't think so. Your projects will probably all start in one area for an initial target with the goal of spreading to others. ▪ **Rhonda** – So if we're trying to improve health outcomes for homeless people in Walla Walla County, then everyone would focus on that and spread from there? ▪ **Cathy K** – Your metrics will inform your strategy. ▪ **Cathy H** – You can also map out the scale and speed how when you spread out based on quarters. ▪ **Wes** – We at least want county level data. ▪ **Amina** – If we take the approach to start out more targeted geographically and then spread, we need to communicate that to our partners where we'll be starting that we will reinvest our dollars to spread the programs. ▪ **Dr. Goldberg –** Strategically, you won't want to silo savings or projects. Behavioral Health Integration- many of those people have chronic diseases. If you balkanize people's bodies you balkanize the communities by chopping them up. You've got to think strategically on how to come together. The more you come together, the more likely you are to succeed. o Domain 1: Workforce, VBP and HIT ▪ GCACH will need to decide on anticipated allocations to Domain 1 investments. ▪ You're making investments that will outlast the life of the DSRIP demonstration, but they should also be part of your strategy to hit your performance metrics. ▪ Projects need a clearer articulation of needed Domain 1 investments. o Sustainability Strategy ▪ All of the projects need more work on potential paths toward sustainability ▪ Identify where savings will be accrued (for state, for MCO, etc.) ▪ Identify where revenue will be lost (Hospitals) ▪ Need to demonstrate stronger coordination with MCOs o Importance of Portfolio Alignment: We need to get laser-focused on project metrics and we need to have as much mutually enforcing activities across the projects as possible. o Project Feedback: ▪ 2A: ▪ Strengths: Clear plan to determine gaps and readiness, Addresses regional priority and strong potential for alignment ▪ Areas of improvement: Think about how this project will work in partnership with managed care, and more work to draw straighter lines to the physical health issues in 2A.

	- 2B:
	  - Strengths: Strong proposal with focused approach for selecting target population, MCOs are engaged in planning
	  - Areas of improvement: Some metrics very difficult to move (e.g., follow-up after discharge from ED for SUD or MH, % homeless). Will take a strong, focused effort and alignment with transitions projects and diversion projects.
	- 2C:
	  - Strengths: Strong proposal with clear target population and goals, Project can impact ED utilization and readmission rate
	  - Areas of improvement: Partnering providers: who are they, how will they be targeted, How will partnering providers be given training /tools needed for increased collaboration? and then linkages with other projects.
	- 2D:
	  - Strengths: Strong proposal that builds on existing efforts throughout region, Potential for strong alignment with other projects
	  - Areas of improvement: need to clarify potential partners with more specificity, need to clarify workforce needs, and looking at some of those more difficult metrics.
	- 3A:
	  - Strengths: Addresses key need in region, Identifies key gap in services
	  - Areas of improvement: Need more detail about project interventions and operationalizing them, making sure it meets the requirements of the project toolkit, and Stronger alignment with bi-directional integration, care coordination and diversion
	- 3B:
	  - Strengths: Builds on successful programs in the region and allows local flexibility, Identifies connections to other projects
	  - Areas of improvement: Metrics include childhood immunization status -- How will this intervention address that? contraceptive measures can also be challenging
	- 3C:
	  - Strengths: Strong proposal with innovative idea, Addresses identified regional health priority
	  - Areas of improvement: Consider implementation challenges and how they will be navigated, whether or not scale will be sufficient to impact performance metrics, many outlier metrics
	- 3D:
	  - Strengths: Reflects primary, secondary and tertiary prevention strategies, Builds on successful programs in the region

<table>
<tr><td></td><td colspan="2">

- Areas for improvement: Needs a stronger connection to performance metrics and target populations/ sub-regions that will be identified in 2A, Consider re-focusing efforts on chronic disease in office-based setting

</td></tr>
<tr><td>Board Discussion & Action on Project Selection</td><td>

- Strategic Considerations: These are the considerations for the board.
  - 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?
    - There's a strong argument for choosing 6 projects vs 8.
  - Consider the "leave-behinds," including Domain 1 investments
    - What investments will outlast this demonstration?
- **Lori –** Could you target one pathway as Maternal & Child Health?
  - **Cathy K –** Yes. HCA has loosened up the flexibility with the toolkit.
  - **Rhonda –** Another consideration to keep in mind is that we have to show the ROI in 3-5 years.
  - **Lori –** Is there the possibility that that we can rework the other projects to highlight the ones we leave out in other project areas?
    - **Carol –** There might need to be a change of focus in those. For example, with Chronic Disease. We may need to narrow our focus.
    - **Wes –** We will have more flexibility with the project areas we don't choose, as we won't be constrained by their metrics.
- Discussion for Rhonda's motion:
  - **Meghan –** We did this in Oregon. It's a good thing to focus on these 6 projects. This would give us the opportunity to regroup those remaining areas, and still make sure that we get what we want.
  - **Darlene –** I agree with the motion, but I want to make sure that we are focusing on integrating maternal and child health and oral health.
  - How will this motion function moving forward? Perhaps we need to attach a statement of accountability. We also need to make sure we clearly communicate our decision to the Leadership Council.
    - However these projects are integrated can also be reflected in the funds flow as well.
- Next Steps:

</td><td>

- Rhonda made a motion to move forward with 6 projects (excluding Maternal & Child Health and Oral health), with the intention to integrate these two project areas into other projects (such as Care Coordination/Pathways HUB). Seconded by Meghan. Opposed by Dan, Amina abstained, motion passed.

</td></tr>
</table>

	◦ Work with Patrick and the Project Teams on nailing down our alignment.	
Charter/Policy Approvals	• **Carol** - Some of these charters are in the bylaws, they haven't been enacted as charters yet. These charters help clarify the roles and responsibilities of these committees. It should also be noted that the Sector Representation document is a policy (rather than a charter). ◦ The only charter up for approval today that is not managed by board is the Data/HIE committee. It will have a much broader role now. • Does the Executive Committee usually approve the board agenda? It may make more sense just to work with the chair. ◦ **Rhonda** – The purpose of the Executive Committee is just to help guide the board and guide the agenda. ◦ **Carol** – We can strike the third bullet regarding drafting regular agendas (and just work with the chair on these). • Who are the members for these committees? ◦ Most of these have not yet been formed, so we don't know yet. • Sector Representation Policy ◦ There is a typo on page 2 (the top line in bold) ◦ Do we need to make sure our sector representatives are reaching out to their sectors and coming back? Perhaps this policy needs to be more specific and emphasize more responsibility. ◦ It would also be nice to have current information on who is in the sectors. ◦ This policy will help GCACH make the connections that are needed. We have great board participation, but our board members are involved in other activities that we aren't aware of. Having that information would be helpful to GCACH and reaching out to other organizations in the future. ◦ We will bring the sector policy back next month to have more time to discuss it, as well as a sector list for the board to have.	• Rhonda motioned to accept the proposed charters with the amendments prescribed, Lori seconded, motion passed.
Financial Reports	• These reports will eventually go into the consent agenda. • William walked through the July financial report. ◦ Food is not an approved expenditure from our SIM fund budget. • The finance committee meets and approves these reports before they come before the board.	

		• Darlene motioned to approved the financial reports, seconded by Les, motion passed.
NEW BUSINESS		**Action Items**
Discussion	• Reminder that the next Tribal Training will be held on October 18, from 12 pm – 4pm. ○ This location has since been determined to the Yakama Nation Corrections & Rehabilitation Facility. Megan has sent out a calendar invite for this event. • The board agreed that the October meeting can be moved to the 26th to avoid the Symposium on the 19th. Megan has sent out an updated event invite to reflect this new date. • Carol gave some updates regarding FMICs.	
ADJOURNMENT		**Action Items**
	Meeting was adjourned at 2:54 pm. Minutes taken by Megan Kummer & Aisling Fernandez	
	Thank you for your time and engagement with the Greater Columbia Accountable Community of Health! The regular Board meetings for 2017 will be from 12-2:30 p.m. on the following dates: • September 21st (Columbia Basin College in Pasco) • October 26th (Columbia Basin College in Pasco) • November 16th (Columbia Basin College in Pasco) • December 21st TBD	