Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

Leadership Council Minutes
7/20 9:00 am – 12:00 pm
Columbia Basin College, L102

ATTENDANCE	
Participants:	**In Person:** Kat Latet, Rhonda Hauff, Chuck Eaton, Kathy Homkey, Cathy K, Kevin Martin, Lisa Hefner, Michelle Sullivan, Rob Watilo, Sierra Barrett, Sam Lidel, Rick Helms, Marcy Durbon, Sarah Bollig Dorn, Cendra Clark, Jessalyn, Jody, Doug Logan, Kayla Down, Molly, Carol Mann, Darin Neven, Michelle Gardner, Becky Gross, Madelyn Carlson, Virgina Janin, Susan Campbell, Andy Nyberg, Kurt Williamson, Michele Roth, Sue Jetter, Mike Benetta, Nicole Austin, Ed Thornbrugh, Karla Prock, Becca Sutherland, Jorge, Patrick Jones, Don Ashley, Stan Ledington, Gail Fast, Amy Norton, Tim Anderson, Heidi Desmarias, Barbara Mead, Nicole Austin, Corrie Blythe, Les Stahlnecker, Rebecca Sutherland, Ronni Batchelor, Mary Franzen, Angelina Thomas, Susann Bassham, Delphine Bailey, Carla Prock, Shelley Little, John Christenson, LoAnn Ayers, Fenice, Matt Davy, Dan Ferguson, Lee Murdock **One the Phone:** Sandra. Janet Johnson, Abby Dumont, Everett Maroon, Ferguson, Lindsey, Tina, Nicola, Jim Jackson
Backbone:	Carol Moser, Aisling Fernandez, Megan Kummer, Patrick Jones, William Van Noy
Special Thanks:	Thank you to … • Columbia Basin College (CBC), for today's facility and outstanding Information Services support • CG Catering, for providing the refreshments. • HMA (Cathy Kaufmann and Cathy Homkey) for facilitating the alignment discussion

Welcome & Introductions:	• We've been having trouble with emails, getting emails bounced back. If you aren't getting emails, please mark us as safe. Please look in your spam for our messages. We are looking into other solutions as well. • June 22nd minutes
MINUTES & REPORTS	
Director's Report	• Director's report o Broad overview of the timeline. ▪ Four major blocks: Planning, Project Implementation, Reporting and Results. ▪ Right now, we're in the Planning phase ▪ If you look at the chevrons at the bottom you can see what the funding we're getting now is going toward, which is Pay-for-Planning (i.e. the $1million we just received). ▪ The next big thing is Phase II Certification, a $5 million payment. That's why we've brought on HMA, to ensure that we get as much of that planning money as possible. ▪ Next year is Project Implementation and Planning ▪ In 2019, we start reporting on what we've done. o Table- summary of what timeline says. ▪ Phases 1, 2, right now we're at select target population and evidence based approach. o High level timeline of deliverables ▪ The swim lanes show the different levels of planning going on simultaneously • Swim lanes: project initiative flow, participating provider RFQ/LOI flow, phase II certification flow, project plan flow, and then program consultant activity. o When we start putting these projects together, some are more defined than others. Because of this, some of them require certain activities before we get to implementation. Some of these activities fit better with RFQ's rather than LOI's (i.e. with 2A). ▪ With other activities, we'll have lots of vendors that will be able to deliver these projects in their own counties. o The LOI/RFQ's will go out at the end of August. ▪ After we get the LOI/RFQ's back and our project plan application, we'll know how much funding we'll receive. o 2A and 2B will require more assessment and planning up front before getting to implementation. o Vendor = participating provider, we've included a glossary in the back to keep everyone up to date on all of the terms and acronyms. • **Jorge –** Can you explain what an RFQ is and the process around it? o **Carol** – Yes. The next piece is the "Steps toward project and participating provider contracts" ▪ We're currently at "develop project selection criteria", this will be covered later today (in the back of the handout) ▪ We'll also be creating criteria for each of the participating providers in each category. o **Cathy H –** We will put together RFQ/LOI's to be posted at the end of August. We will include descriptions of both. o **Carol** – We'll also be assembling a TAC (technical advisory committee) to evaluate the projects that you are developing as well as the LOI/RFQ's.

	• **Carol** – Spoke about Consumer/Public Engagement. Aisling is now our Director of Community Engagement. We're currently setting up meetings with our stakeholders, as well as community forums/focus groups. This feedback will play into the decision that the board will make at the 8/17 meeting. • **Carol –** Project Teams- We've brought in more subject matter experts. We have 8 project areas with initiatives in each project areas, sometimes a few initiatives per project categories. We're trying to look at all 8 of these together, and see how they align as a whole-person care model. • **Carol –** The next section talks about the funding and the way it's split up. Domain 2 (care delivery redesign) has the bulk of the weighting for funding. Domain 3 focuses on prevention. It will be up to the board if they want to go after all 8 projects, and how we will meet all those metrics. o If we decide to not go after a project area, what would happen in Y2, is that the funding would be rebalanced to the other project areas. • **Carol –** Project Selection Criteria – This is based on the project plan application, and we will be discussing this draft of criteria in the board meeting today. Mike Bonetto, Wes Luckey, Patrick Jones and Cathy Homkey helped create this draft. • **Carol** - Glossary of Terms – We tried to include all of the terms we could think of to keep everyone on the same page when talk about these different terms and acronyms.
Alignment across GCACH Demonstration Projects Presentation	• **Cathy K -** o The conversation we'd like to have today is about the project portfolio as a whole, and not the individual project areas. o **[Slide 2]** Overview of our discussion today: the importance of alignment, review where see alignment already (outcomes, target populations, metrics/strategies), breakout session to brainstorm how to increase alignment in these areas, identify backbone supports, and then look at our next steps. o **[Slide 3]** Project Evaluation Criteria – Alignment is underpinning a lot of the evaluation criteria. With strong alignment, we get high scores in support/collaboration (linkages), impact, sustainability, ROI and workforce. o **[Slide 4]** Why Alignment Matters - Not only does it make a strong portfolio, but it makes a stronger plan for the community. ▪ It gives you a more cohesive project portfolio. This helps with our application to the state to draw maximum funding available to us. ▪ Targeted resources. Focus our resources rather than a scatter shot approach. This makes implementation easier and more successful. • **Cathy H** - Health system transformation is no easy task. ▪ We wanted to create alignment across the projects, reduce redundancies, and change our care delivery. ▪ Overlaps in resources are an opportunity to leverage resources. ▪ Important to leverage backbone organizations ▪ As you think about outcome metrics, sustainability, it's the preparation to move to a value based payment system. That's the end game. ▪ What does it mean to create value in the services you provide? ▪ Outcome metrics. Aligning along populations and metrics increases the likelihood GCACH will meet the performance targets in later years. ▪ Sustainability. Strong alignment builds a strong foundation for sustainability in year 6.

- **[Slide 5-6]** Rowboat analogy- We all need to row in the same direction. If some projects don't work out as planned, it effects other projects. They are all connected. We win and lose together.
- **[Slide 7]** Alignment Questions in the Project Plan template
  - How has GCACH leveraged whole-population vision for health system transformation to inform its project selection & planning?
  - Which interventions, resources and infrastructure will be shared across its portfolio of projects, and how will they be shared?
  - Describe how, through these projects, the ACH plans to improve region-wide health outcomes for Medicaid and non-Medicaid populations.
  - Describe how, through these projects, the ACH plans to improve region-wide quality, efficiency and effectiveness of care processes.
  - Describe how, through these projects, the ACH plans to demonstrate a role and business model for a structured community collaboration and action mechanism (i.e., ACH) as an integral sustainable part of the regional health system.
- **[Slide 8] -** GCACH mission and vision
  - Keep it in your minds for the conversations today.
- **[Slide 9] -** Assessment Findings (high level assessment)
  - Please capture any missing sections in the breakout session. We will make those corrections after this.
- **[Slide 10] -** Commonalities across projects (based on Project Reports)
  - We already see a lot of alignment across the teams.
    - All projects focus on all counties
      - We need to make sure that all projects that say they will be serving the whole region will truly be serving the whole region.
    - Some alignment on target populations
    - Limited alignment on outcomes
    - Some shared tactics/strategies
  - Opportunity to build a strong, unifying framework for the project portfolio.
- **[Slide 11]** Target Populations
  - Children/teens most common target population (5 projects)
    - Some projects mentioned possibility of targeting or inclusion of including children/teens with other populations.
  - General Medicaid population (4 projects)
    - Not identified as the sole target population for any project
  - Beneficiaries with complex health needs (high risk/high utilizers)
  - People living with chronic disease (3 projects)
  - American Indian/Alaskan Native, Latino/Hispanic and Women also included in target populations of more than one project, but not more than 2 projects.
    - In thinking about equity, this is something we'll want to look at
- **[Slide 12]** Target Populations Matrix
  - This is a visual aid in seeing commonalities, sorted in order of the most frequently sited target population

- When you have your breakout discussion, you'll have a print out of this to add corrections to
- SPMI = serious and persistent mental illness

- **[Slide 13]** Outcome Metrics
  - Substance use disorder (SUD) treatment penetration (adults) identified by 4 of 9 project initiatives
  - Outpatient ED Visits (3 projects)
  - Follow-up after discharge from ED for MH or SUD (3 projects)
  - MH Treatment penetration - broad (3 projects)
  - All other metrics identified are shared by 2 projects or only identified for one project
- **[Slide 14]** Outcome Metrics Matrix
  - You'll have this handout as well as Wes's (has all of the metrics included) to go through and make corrections.
- **[Slide 15]** Strategies and tactics (this is only looking at the commonalities with the project areas, we didn't list every strategy each group mentioned)
  - 6 projects call for use of Community Health Workers as a key strategy
    - Strong alignment! But need for coordination here is critical
  - Projects call out need for cultural competency training
  - 5 projects identify health homes or PCPs as part of intervention
  - 4 projects identify care coordination as part of intervention
  - 4 projects identify hospitals as part of intervention
  - 4 projects mention screening for social determinants of health
- **[Slide 16]** Strategies Matrix
  - In your discussion groups, please tell us what we missed and what we got wrong. We want to capture that information.
  - **Rhonda** – Where does workforce development come into these discussions?
    - **Cathy K** – Workforce is part of domain 1. We found it difficult to get an accurate assessment of the commonalities with all the groups regarding this topic. We've included it in the discussion guide as bonus question.
- **[Slide 18]** Breakout Discussion Questions
  - What areas of alignment did this analysis miss?
  - How can projects increase alignment on target populations?
  - How can projects increase alignment on metrics?
  - How can projects increase alignment on strategies/tactics?
  - Discussion should be specific and concrete
- Recap with all groups:
  - **Phone Group (Nicola):**
    - Target Populations: Given the diversity of this region, and diversity of needs of each county, it's hard to think about alignment around target populations. There may be more in terms of alignment with outcomes and strategies
    - Metrics: This will differ from community to community. Performance in each county will vary. Think about prioritizing some of the outcomes shared most commonly across the counties, and those that are available in the RHIP (regional health improvement plan). Think about common

outcomes and the region as a whole. We should look at room and potential for a deeper analysis of metrics across the projects. Some could be more deeply explored, for example the opioid project. We should consider doing a deeper dive of the metrics that each PT could impact.
    - Strategies and Tactics: Generally, we should do a deeper look at strategies and tactics that each project is employing (thinking of community health workers as common strategy or tactic). You can start to think about how each project is using CHW's. We need to define more specifically what we're talking about with the roles of the CHWs in each project, the training that will required, how the CHW strategy is shared across the state, and leveraged across ACHs.
        - **Deb** - Identifying outcomes across most if not all counties- if we were to identify those outcomes, we can think about different approaches in different communities. In the aggregate, the sum of those approaches will move the needle on those outcomes.
- **Group 1 (Angelina):**
    - The opioid project area is really a chronic disease.
    - Should there be a target population for underserved oral health?
        - The outcome metrics give us an opportunity to thing about outcomes in that way.
    - 2A: We thought that chronic disease was missing. There's a need to be cognizant of the American Indian/Alaskan Native population.
    - 2B: We also thought that the American Indian/Alaskan Native population was missing from this area as well.
    - 2C: We added high risk/high utilizers
    - 2D: We added the American Indian/Alaskan Native population again, based on data that we have from Yakama.
    - 3A: We added high risk/high utilizers and people with SPMI
    - 3B: We added high risk/high utilizers
    - 3C: We added high risk/high utilizers, people with chronic disease, Latino, women in maternal health and American Indian/Alaskan Native
    - 3D: We added people with SPMI, as they should be included as people with chronic diseases.
    - It was useful to mix in with all of the other project areas to help us see the overlap.
- **Group 2 (Jorge)**
    - We mostly focused on the target populations. We also asked, will these populations remain the same over the whole 5 years, or will this change?
    - It would probably be beneficial to explain that these are our initial target populations, but that we have goals to reach other groups.
    - Some of these populations were assumed, but just not explicitly named in the reports. i.e. The Medicaid population. Our funding is Medicaid dollars, so of course we will all be working with this population.
    - 2A: We added high risk/high utilizers, chronic disease
    - 2B: We added high risk/high utilizers, chronic disease
    - For most groups, we added chronic disease (except for 3A)
    - Most groups should overlap with SUD individuals

- **Group 3 (Kat/Susan)**
  - We discussed Prevention and SDH (social determinants of health) and the way in which projects limit that focus.
  - Funds flow allocation with savings - Some ACH's are investigating carving off a small percentage around project dollars into a general wellness fund.
  - We also had a discussion around the Latino population
  - Susan - Make sure that upstream thinking was not left off to make a difference in the long run. We need to make a commitment to look at the long term.
    - Some linkages we saw were CHWs, substance abuse, mental health, ED readmittance and dental.
    - Importance of keeping the community engaged
    - It may be beneficial to take a deeper dive into the data that's been compiled by Wes (actual numbers, and not just percentages to get an idea of the number of people).
- **Group 4 (Dr. Kevin Martin)**
  - Target Populations
    - We added every identified population to 2A and 2B
    - We didn't add anything to 2C because by definition, its situational rather than demographic
    - 2D: we added children/teens, at risk/at transition and SUD.
    - 3A: added children/teens, general Medicaid population, high risk, chronic disease, and people with SMPI's.
    - 3C: added all except at risk transition, and high risk
    - 3D: added all except maternal health
  - A lot of these are aimed at fixing disasters, rather than prevention. This brought up the idea of a health fund for prevention.
  - Lots of overlap, easy to find alignment
  - Metrics conversation: do these metrics touch on each projects vs does this project primarily impact that metric?
    - Some metrics are specific to a given intervention
    - i.e. Are avoidable ED visits really a good way to measure the impact of Oral health intervention?
  - Transportation is huge, we should consider integrating that into the PTs
- **Rhonda** – CHW are often seen as the solution to the workforce problem. We need to come up with a definition of what that is, and what skills and training they will need. Will these CHW's be more social services or clinical positions? As this develops, we need to come to agreement.
- **Dr**. **Martin** – Our group also discussed the need for standardization in the training and deployment of CHWs. Perhaps we need different types of CHWs.
- **Susan** – How do we put them into a sustainable pipeline as a workforce? Currently, we are putting a lot our outcomes into a workforce that doesn't exist yet.

- **Ed** – We call them Case Managers in behavioral health. Why are we trying to duplicate this with CHWs?
- **Rhonda** – We all have people that do similar things; we need standardization. If we see them as part of solution we need to come together and standardize it.
- **Cathy K** – I think I'm hearing that there is a need for a committee to talk about CHWs (their definition, training, deployment etc.) This committee would need representation across all of the PTs as well as across all of the workforces that are close to CHWs.
- **Jim Jackson** – The CHW model varies from county to county. We should include the path and training for this that is currently being used. Peer support specialists are being used in behavioral health.
- **Les/Cathy K** – We need to see what resources/models are already being used in positions like CHWs. We need to look at the vacancies in those current systems and fill them in.
- **Ronni Batchelor** – I'm a CHW and also peer counselor. I work with Lutheran Community services now. Prior to that I was "boots-on-the-ground" outreach to homelessness. When I first started, my main focus was directing people into the services they needed. These services were lacking (housing, health, preventative medicine). This was frustrating and upsetting, so I became more involved. The further I got involved, the more I recognized this void that the professionals on one end couldn't reach, and the focus of the need couldn't reach over. I was then told about CHW's, and I decided that was what I wanted to do. I wanted to use that role as a catalyst to help me assist the population I was already aiding.

  In 2012, I put my career on hold. I was one of those people that didn't have a home at one point; I was transitioning from one couch to another. I found no work; I found no support. I knew that there were other people struggling in the same ways that I was, and my involvement was very powerful and passionate. Putting myself together was important, but also being able to help other people along the way.

  Housing, health/preventative medicine were necessary pieces of this process. Just talking with people, and letting them see that somebody *did* care and give them the framework of "I feel human right now". Often times we dismiss what we don't understand. Asking for help, holding up a sign, and hoping that someone would show a little bit grace and give you that help.

  When I lost my son to suicide, there was no one there to help overcome that; I had to find my way. Many people that I've met along the way have suffered the same things. Losing their jobs, not being able to care for their children and work because of mental health issues. Not being able to access medical help, because there was no healthcare.

  One of the people I met and helped was a gentleman that was discharged from the hospital right after a colon resection from stage 4 cancer. Looking for a place for him to go, or respite care- but there was no respite care. Where do you go? What do you do? I decided to help him figure it out. Finding attorneys to help them with their social security and expedite something like that is unheard of.

  I'm knocking on doors and figuring it out, and I'm getting some results. But I was only able to do that because I was only helping one person. There was no agency to go to. I knew I had to make it happen; because I didn't want them to go through what I had went through for so many years.

So these 2 things came out of the health department: which is the CHW, and the peer counseling. It helps support you and empower you; that you can get to the same place as these other people. I'm living proof that there is a possibility and probability that you can make it on the other side. Most people stop here, because they've been turned down. They won't go any farther.

Every person, no matter their circumstance- deserves to have the same as anyone else, and the same opportunity. Those disparities and those barriers, and the unknown with Medicaid/Medicare makes it so uncertain. They don't know, and they're scared, because what is tomorrow going to bring? When they're battling cancer, when social security is being threatened? I'm no more able now than I was, when I was on disability. But at least I was given an opportunity to go into the workforce again.

And that's the other piece. When you have a job where you can be proud of what you do, it gives you the opportunity to move forward and elevate up. I went from paying a rent, to actually owning a house this year.

- **Dan Ferguson** - CHWs are a great concept. I think we need to build up from just a CHW certification into different specialties. We need to develop it into a solid career path. We want to create a CHW workforce not only from our community, but one that will help our community.
    - Volunteered to chair this committee (include Susan and Ronni in this committee).
- **Cathy K** - (recapping Ronni's statement) - The CHW model is powerful, but you put a lot of weight on their shoulders if the resources aren't there for them to connect people to.
- **Ronni** – Yes, CHWs are often the voice for the people they serve. It's a navigation tool. We need to give the ability to the CHW to do the work. When you shackle the possibilities, you narrow that role.
- **Deb Gauck (phone)** - If we're wanting to include CHWs, it could be a nice fit for local coalitions to think about spearheading this.
    - **Rhonda** – Specific to the CHW, we need to stay at a regional level to help with a regional approach.
    - **Deb Gauck (phone)** – I agree that it should stay regional. My comment was more surrounding implementation, and including local coalitions to help with that process.
- **Les** – This is an opportunity to look at the entire community, rather than just healthcare. There are already people in other places (i.e. education) that are already reaching the populations we want to.
    - **Rhonda** - To me CHWs include housing case managers and other social services workers as well. It's bigger than just the health sector.
    - **Cathy K** – Make sure you have concurrent paths. Recognize that there needs to be a process. There will need to be concrete planning for the state.
- **Cathy H** – This proposed workforce committee can assess gaps and leverage CHWs and other existing workers.
- **Dan Ferguson** -This conversation helps the state. I meet with state/HCA in a couple weeks to help create a template for workforce.
- **Cathy K** – Next Steps
    - Capture this conversation
        - Please send feedback to us on our web survey to make sure that we are getting you the information that you need
        - We will synthesize the written feedback as well
    - Work with PT's to convene the cross-project work and figure out alignment

	• **Carol** – Please don't forget to fill out/turn in your attestations
ADJOURNMENT	
	Meeting was adjourned at 11:50 a.m. Minutes taken by Megan Kummer and Aisling Fernandez
	Thank you for your time and engagement with the Greater Columbia Accountable Community of Health! The regular Leadership Council meetings for 2017 will be from 9-11:30 a.m. on the following dates: • August 17th (UnitedWay, Kennewick) • September 21st (Columbia Basin College, Pasco) • October 19th • November 16th • December 21st