Leadership Council

Thursday, February 18th, 2016
9:00AM-11:30AM Regular Meeting
(11:30-12:00PM Press Conference)
Greater Columbia Behavioral Health
101 N. Edison Street, Kennewick, WA 99336

Greater Columbia Accountable Community of Health

Minutes

Participants	IN PERSON: Christy Ivy, Delphine Bailey, Bethany Osgood, Jeri Williams, Eddie Miles, Carla Green, Liz Whitaker, Robert Garza, Janis Luvaas, Andy Nyberg, Stan Ledington, Kathy Anderson (Columbia County), Lindsey Anderson, Susan Campbell, Sandra Aguilar, Bertha Lopez, Suzy Diaz, Rhonda Hauff*, Joyce Newsom, Brisa Guajardo, Gina Ord, Amy Person, Susan Campbell, Becky Grohs, Efrain Quiroz, John Sinclair, Rebecca Sutherland, Kathy Story, Lauren Spills, Jorge Rivera, Caitlin Safford*, Jeanette Filan PHONE PARTICIPANTS: Kim Keltch, Kat Latet, Martha Lanman, Mike Maples, Deb Gauck (Backbone), Amina Suchoski, Shawnie Haas, Brady Woodbury	
Backbone Support	Patrick Jones, Facilitator Carol Moser, Executive Director Aisling Fernandez, Communications Coordinator Julie LaPierre, Technology Support Sue Jetter, HRSA grant writer	
Guests	Lena Nachand, Community Transformation Specialist, HCA	
Special Thanks	• Thank you to Greater Columbia Behavioral Health, especially Julie LaPierre, for providing support that allows us to hold these meetings. • Thank you Patrick Jones for facilitating the meeting.	
TOPIC	**NOTES**	**ACTIONS**
Welcome & Introductions	• There were introductions around the room. Then Patrick led an icebreaker themed on the Chinese New Year, Year of the Monkey. Patrick asked us to think about traits that would serve the GCACH well for 2016. We went around the room and each person chose one characteristic of the monkey that the GCACH should strive for this year and one characteristic of the monkey to avoid this year. The top two positive traits were being **adaptable** and capable of **problem solving**, while the top two negative traits to avoid were being **unwilling to listen to others** or being **short-sighted**. Julie kept score as we went around the room.	•

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Action: Approval of Minutes	• Those present at the meeting were given an opportunity to review the minutes from the Leadership Council meeting on January 21st.	• The Leadership Council Meeting minutes from January 21st were approved by consensus.
Director's Report (Carol Moser)	• State of Reform 2016 on January 7th at the Hilton Hotel at SeaTac. o DJ Wilson, President of Wilson Strategic and the host of State of Reform meetings each year is the facilitator and attracts insightful speakers. o This year the first panel included Dorothy Teeter, Jeff White, David Snodgrass, and Alex Rule. The SOR theme was *Purchasers Accelerating Value in their Health Care Spend*. ▪ Jeff White, Director of Health Strategy of Boeing, talked about how Boeing (as a very large employer) has their own health program now. He said that the key to health care transformation is getting the consumer engaged and to align insurance policies with what will incentivize people to change health behaviors. ▪ Dorothy Teeter, Director of the Health Care Authority, talked about how WA spends $10 billion per year in Medicaid purchasing for 2 million people. The HCA wants to focus on the Triple Aim. Good advice for us. It's the HCA's role to help others understand how you form these kinds of contracts. ▪ David Snodgrass, the President/CEO of Healthcare Management Administrators, Inc., said that there is an opportunity for our communities where we have big employers that are big enough (2,000 or more employees) to have their own health care system (like Boeing does). Important to meet the needs of employers. Help to control health care costs for their companies. ▪ Alex Rule, VP, Sales, Northwest Region said that employers need to be better informed about healthcare costs. Relatively little engagement with employers who don't really understand health care coverage. o Recently, BFCHA heard a presentation by Kelly Harnish on the remarkably poor health of the employees on the Hanford worksite. Tax payer money is being spent. There are opportunities in our region to improve the health of populations!	•

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	• Medicaid Transformation Waiver Update Webinar on February 4th, 2016
	  ○ Compressed timeline: Implementation of the Regional Health Improvement Plan projects starts as soon as we can, as soon as we have a RHIP developed. CMS requires adherence to 5-year period with project ramp-up in year 1 (this Summer).
	  ○ 180 projects were submitted to the HCA, who is reviewing them and coming to understand key ideas to apply to our HC needs.
	  ○ Don't expect $3 billion from the fed government (CMS)
	  ○ Linkages to the clinical care system are key
	  ○ 80% of waste comes from overlap of systems that could be addressed through integration of systems that improves efficiencies.
	  ○ Today's discussion of root causes for each of the priority workgroups relates to the WA Medicaid Transformation Goals. Focus on prevention, smoking, pediatric, mental illness, accelerating the transition to value-based payment, and ensuring that the Medicaid per-capita cost growth is 2% lower than national trends.
	  ○ How do we get ready at the board level? If we incorporate, what's the timeline? It could take 4-18 months depending on staff and attorney time we use.
	  ○ Communications update. We now have a live GCACH website! Go to greatercolumbiaach.org
	  ▪ We still need bios from Board and other resources on our new website.
	• Discussion #1: Are we focusing on Medicaid waiver interventions or something else? Are we doing both if we get the Medicaid funding?
	  ○ Carol: according to Mark Provence, the guiding star needs to be what is more important for the health of our community. You will find money if that's what's important. That's what will be sustainable for us.
	  ○ Rhonda: Do we lead with the Medicaid population and use criteria from the recent waiver webinar? If we do something for the Medicaid population, this should also help the larger population.
	  ○ Caitlin: We don't have a choice, with SIM grant that might diverge a little from the waiver, disseminating waiver dollars. The Medicaid waiver will take up a lot of our resources. We may not be as successful under the waiver unless we live up to it. Still need guiding star of population health. How do we straddle both while focusing on the	

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	waiver? There is no year 0 so we may have 4 years rather than five. She agrees we should lead with the Medicaid population. ○ Carol: 35% of our population receives Medicaid benefits and the state percentage is only 14%. We are doing a service for our community by focusing on the Medicaid population and gives us an opportunity for funding. We do want to keep the whole population in mind. ○ Caitlin: HCA will whittle down the list of projects for the toolkit. ○ Jorge: The project ideas submitted to the HCA seems like a common sense list of what we should be doing. ○ Lena: Keep a balance with the Medicaid waiver. An ACH is about the total population. How do you balance the miniscule funding of the SIM grant with the huge Waiver funding? In terms of the projects and toolkit: Lena found **slide 17** of the webinar the most helpful. What does *care coordination* mean in our region and what does that mean for us? What falls into the project domain of CC (should work with the HCA on this)? How do we pull out the themes and concepts to submit to CMS?	
HRSA Sustainability Survey (Sue Jetter)	• One of the requirements is that we show progress putting together a health network that we will be sustainable for the long-run. Sue put together a survey based on the Georgia health policy center. Sue will send this out via survey monkey to everyone on the LC. Aisling will send out to everyone in the LC Update: Aisling emailed the survey to the LC on 2/23/2016. • Hope that the survey will gauge the strengths and what we need to work on. We'll be doing this survey again in July or August and hopefully we'll be able to see improvement. Hope for a highly functioning and sustainable network. Deadline for survey is 2 weeks and Sue will provide a brief summary next month. • Discussion: ○ Patrick: Any questions for HRSA grant? ○ Sue: Applied for a second grant- hopefully another $100,000. Providing a framework to get feedback from some of the smallest communities in the 10-county region- hear from their voices. ○ This grant has a rural emphasis? Yes, Rural health network development planning.	•
Medicaid Transformation Waiver:	• Webinar Slide 17 ○ Lena reminded everyone of what **DSRIP** is: Delivery System Reform Incentive Payment. An incentive-based program, not a grant, must have infrastructure to begin with. Slowly transition to health outcome measures.	•

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Webinar Review	Start making money for health progress. A hard idea to wrap your head around. Many ideas fall into the project categories. ○ The *thousand flowers blooming* approach, like what has happened in Texas, creates problems where you can't keep track of the programs or see what makes a difference. How do we see themes, allow regional flexibility (because each region has its own challenges, political scene, and infrastructure)? Something like CC. What is CC and how do we do that? This is incentive based. ○ Eddie Miles: Here's a scenario, real life scenario in Yakima, where memorial hospital in Yakima has the distinction of being the busiest ER in state. The lion's share of the ER visits are level 4 and 5- low acuity visits- and many of those patients are Medicaid patients. They're trying to use their own capitol and strategic planning to find a lower-cost alternative. The beneficiary is the State, but can't get the State to help them. ▪ Les: Yes, these are primarily infrastructure- building funds ▪ Eddie: We already know if the same number of people go to another lower-cost-of-care facility then it's a lower cost to the State. Why wouldn't the State help them build this infrastructure? ▪ Lena: Getting a Waiver gives us flexibility in how we spend Medicaid dollars. These are different Medicaid dollars, not the current Medicaid dollars. We have federal regulations right now on how we can spend Medicaid dollars, and hopefully we can spend the new Medicaid dollars differently to divert people from the ED to save the State money. This allows us to do that so we see that ROI. ▪ Rhonda: Does that waiver allow us to change policy such as EMTALA laws? • Caitlin – probably not • Eddie- We already know what they are, we just need to build infrastructure to get ROI for the state • Caitlin: The ACH is responsible for recognizing where these barriers are, whether state or federal, and informing the state of these. If these barriers are state-wide, then at least at the state level we should be able to make real change ○ Jorge: There is a lot of alignment between the criteria from the HCA and the GCACH. The timeline is similar, some of the initiatives that are	

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	already here could be in alignment. We could be heading in the right direction. ○ Lena: Is this delivery system incentive based? How would that look to be a DSRIP project? The way to make significant changes is how we implement it. We implement it through the ACHs and this is different than any other state. ○ Carol: One take-away is that we have to think outside the box. The projects we submitted are informing the themes, which could change the dynamics of how health care is being delivered. How other businesses are doing this (like how Boeing requires certain things from their consumer because they shaped their health plan). Carol wants us to be bold, willing to listen to one another. If we had an opportunity what would it be. Themes: care delivered to the person. State is giving an opportunity to do something differently. ○ Rhonda: her interpretation is different- we looking for projects that are small and scalable. ○ Carol- The HCA is primarily looking for new projects. ○ Lena- Acknowledges that it's a contradictory request for evidence-based (as well as evidence of what doesn't work) and promising practices. Not everything has to have years of trials and literature. Trying new things that won't have supporting literature. ○ This region can implement a project from another region ▪ Lena- this is a state-wide list. CMS has the final say. There may be 1-2 projects required for any region and some flexibility.	
Medicaid Waiver Project Review & Regional Health Improvement Plan (Deb Gauck)	• Carol introduced what Deb's topic • Deb Gauck (over the phone): ○ The Priority Workgroups should have a discussion about the r**oot causes** of their problems. Discuss a few things impacting your ability to overcome the barriers that currently exist. ○ While developing the RHIP, at some point Deb will be working with all the committees/workgroups to develop goal statements and strategies. The concern is that without identifying the root cause, the goal statement would be different. For example, for diabetes. If the understanding of the root problem of diabetes is because of lack of physical activity, then the strategies need to be about physical activities. But if you dig deeper, then you ask, why is there low physical activity? Why aren't there facilities at schools? Because schools are concerned about liability. Why are schools concerned about liability? Schools are concerned with liability because of	•

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	high crime rates. Then you form strategy around high crime rates rather than around low physical activity. • It is important to find the common thread(s) between all of the priorities that rises above a one-project solution. • Discussion about whether the LC would for longer in March (9-1).	
Priority Workgroup Meetings (Break into small groups)	• The LC broke into 4 groups: Care Coordination, Behavioral Health, Obesity/Diabetes, Healthy Youth & Equitable Communities. Oral Health did not meet today. There were no report outs today.	•
Adjournment	• The Leadership Council meeting was adjourned at 11:30 AM. • From 11:30 to Noon there was a press conference to announce designation status of GCACH. The Leadership Council and Board members were invited to stay for the press conference, lunch, and cake.	•

2016 Meeting Schedule	**The GCACH Leadership Council meets the Third Thursday of the month.**
	• Location: Greater Columbia Behavioral Health, 101 N Edison St, Kennewick
	• Time: Leadership Council: 9-11:30
	• Dates:
	  ○ Thursday, March 17th, 2016 (This meeting will be longer, from 9:30-1).
	  ○ Thursday, April 21st, 2016
	  ○ Thursday, May 19th, 2016
	  ○ Thursday, June 16th, 2016
	  ○ Thursday, July 21st, 2016
	  ○ Thursday, August 18th, 2016
	  ○ Thursday, September 15th, 2016
	  ○ Thursday, October 20th, 2016
	  ○ Thursday, November 17th, 2016
	  ○ Thursday, December 15th, 2016
	Thank you for your time and engagement with the Greater Columbia Accountable Community of Health!	

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