Greater Columbia
Accountable Communities of Health
Leadership Council Meeting Minutes

Thursday, November 19th, 2015, 9:00AM-11:30AM
Greater Columbia Behavioral Health
101 N. Edison Street, Kennewick, WA 99336

Participants	**In person:** Jorge Rivera (Molina Healthcare), Rhonda Hauff (YNHS), Kat Ferguson-Mahan Latet (Community Health Plan of Washington), Sandra Aguilar (CCHS), Bertha Lopez (Yakima Valley Memorial Hospital), Marcy Durbin (People for People), Wes Luckey (TCCH), Brisa Guajardo (CHPW), Corrie Blythe (SE WA ALTC), Jeri Williams (Yakima Regional Medical and Cardiac Center), Stan Ledington (The Health Center), Larry Jecha (Walla Walla Health District/Kadlec Board), Delphine Bailey (Columbia County Public Health), Martha Lanman (Columbia County Public Health Department), Susan Campbell (Washington State University College of Nursing), Stein Karspeck (Richland Fire Dept.), Amy Person (BFHD), Reneé Biles (People for People), Suzy Diaz, (YUCF), Grant Baynes (Senior Life Resources), Shawnie Haas (Signal Health), Linda Mayovsky (Washington State University College of Nursing, Nursing Pathways HRSA WFD Grant), Cindy Mackay-Neorr (WSU), Ed Thornbrugh (Central Washington Comprehensive Mental Health) **Phone Participants:** Verni Jogaratnam (UnitedHealthcare), Sandra Suarez (Yakima Valley Farm Workers Clinic), Robin Read (Kittitas County Public Health Dept), Lindsey Ruivivar (Community Health Association of Spokane).
Backbone Support	Patrick Jones (Eastern WA State University, Facilitator), Carol Moser (BFCHA), Aisling Fernandez (BFCHA), Julie LaPierre (GCBH), Sue Jetter (Sue Jetter Consulting, Prosser Economic Development Association),
Guests	Lena Nachand (HCA), Mark Baker (Lifelong in Seattle)
Special Thanks	☐ Thank you to Greater Columbia Behavioral Health, especially Julie LaPierre, for letting us use your facility, morning refreshments and call-in capabilities. ☐ Thank you to HCA representative Lena Nachand for your support. ☐ Thank you Patrick Jones for facilitating the meeting.
Welcome & Introductions (Patrick Jones)	Meeting began at 9AM. Facilitator Patrick Jones, of Eastern Washington University, thanked everyone for coming to the meeting and asked each person to introduce themselves. There were self-introductions around the room and then Patrick reviewed the agenda.
Updates	**MINUTES**: Aisling briefly reviewed the minutes from the October Leadership Council Meeting and the minutes were approved by consensus. STATUS OF READINESS PROPOSAL (Sue Jetter): Sue Jetter, MPA, GPC, is a grants professional and owner of Sue Jetter Consulting Services. She was recently elected to the 2016 Board of Directors for the National Grant Professional Association. Sue helped to write the Initial Planning Grant, which we were awarded in 2014 that provided earlier funding for the GCACH. Since Blake's departure from PMH Medical Center, Sue is now the Project Director for the HRSA grant and will be providing some administrative and grant-related support to our group. During this meeting, she discussed her progress on the Readiness Proposal she is writing to submit to the HCA in order for GCACH to achieve official ACH designation. 1. Sue shared that she has been scouring the GCACH meeting minutes and other documentation to understand the progress we have made in recent month. There are six sections in the Readiness Proposal that she is preparing: Governance, Engagement, Backbone Organization,

Inventory, and Sustainability Planning. She joined the meeting to listen for updates and decisions on the Bylaws and to glean information for the sustainability component of the report. The report is due on Monday, November 30th. Sue asked the Leadership Council to discuss their thoughts on *sustainability*.

2. Sustainability Discussion: There was a group discussion about what GCACH participants envision that *sustainability* means for this group.
    a. WHAT ARE OTHER ACHs DOING TO ENSURE SUSTAINABILITY? WHAT CAN GCACH DO BETTER?
    b. Kat Latet mentioned that other ACHs in WA State address *sustainability* through membership dues, foundational support, and the CPAA ACH has developed a finance committee to discuss ways to bring in new sources of funding & the role of the Medicaid Waiver.
    c. Jorge Rivera mentioned that we have a backbone organization (the Benton-Franklin Community Health Alliance), which adds sustainability, whereas some other ACHs rely only on the Medicaid Waiver
    d. Lena Nachand said that we should think about *sustainability* in terms of financial and in terms of the sustaining the energy and duration of commitment from people who are involved.
    e. Carol Moser said that capacity that builds upon the work of the backbone will help with sustainability.
    f. Rhonda Hauff said that over time, you may lose momentum if all of the work falls to volunteers to expand the backbone. You need other ways to keep up the momentum and you need people to champion the work.
    g. Patrick Jones said that other ACHs have used loaned executives for a time.
    h. Wes Luckey agreed with Rhonda that you need strong support and infrastructure rather than volunteers when you're doing complex work such as estimating ROI, doing reporting, etc. Volunteers may not produce a sustainable framework.
    i. Bertha Lopez said that it will be important to have money in the budget for a grant writer if we will be seeking grants in the future for financial sustainability.
    j. Carol Moser shared that we are hiring Indira Pintak to do external communications and we have funds for a project coordinator once we have a first project in 2016. With the HRSA grant from PMH we have additional funds which will hopefully tide us over until we get to the Medicaid Waiver.
    k. Jeri Williams said that she is not clear on how to create a cohort of Yakima providers to work together within the context of the GCACH and how to share that information with the GCACH. Does it make sense to have people working together to consolidate resources for grant writing?
    l. Patrick Jones said in Spokane they use foundations to match when going after grants.
3. IS CURRENT FUNDING FOR BACKBONE SUSTAINABLE?
    a. Patrick Jones mentioned the ongoing discussion between the ACHs throughout WA State and the HCA about whether or not $660,000 for 3 year is adequate for the backbone organizations.
    b. Lena Nachand said that this discussion about the adequacy of funds for the ACHs is ongoing. If the ACHs feel that more funds are necessary, it would make a big difference when making this argument if ACHs can say, "If we have extra X amount, it would go toward X specific type of spending that we can't fully fund at this time with what we have. In other words, without this funding, it undermines our efforts to do X."
4. DO WE HAVE APPROPRIATE AND SUSTAINABLE CAPACITY FOR ANALYTICS?
5. Carol Moser: Providence Core has been hired to give us analytics at the Census Tract level and give us data we will need. Depending on what project(s) we choose, we should receive appropriate analytics to have the measures to meet performance guidelines.
6. Wes Luckey: Our data needs will depend on what our goals will be. We will need infrastructure internally or to contract with an outside organization (would make our internal needs simpler). Data is more than analytics. We also may need a website that can be used as a SharePoint site for different committees and groups to collaborate. We may need a virtual way to work. How do the 9 counties work together in a modern way?
7. Lena Nachand suggested that the GCACH members think about what data we will need to get the full picture. Providence Core is considered an interim solution not a long-term solution to data support. Ask ourselves, "How are we going to build something that goes beyond the initial grants to help the ACH(s) with sustainability?"
8. Bertha Lopez asked if Providence Core is providing models for predictability or raw data. (Lena says that it's neither, Providence Core will

share cleaned, accessible data to all the WA State ACHs). Bertha also said that right now we are talking about quantitative data, but we may need to consider qualitative data as well.

9. Jorge & Lena mentioned that the AIM Initiative within the HCA is ahead of other initiatives of Healthier WA. ACHs across WA are involved in the development of AIM so that it is in line with the needs of the ACHs. If we have data capacity/sustainability needs, we should work with AIM whenever possible so we don't need to set up independent capacity for everything.

DIRECTOR'S REPORT (Carol):

1. Goodbye to Blake Rose!
2. ACH & Managed Care Health System Meeting on Nov. 3rd, 2015:
   The Health Care Authority and the Managed Care Organizations sponsored a meeting at the Conference Center at SeaTac to develop a shared understanding of the roles of DSHS and HCA in the context of Medicaid. There was a great day of conversations between the BHOs and the MCOs.
   Words of wisdom given to Carol at this meeting: "Get started now on the integration effort!"
   Recognizing the responsibility for engagement for delivery systems around the table in order to have a shared understanding of how these systems operate. **In the near future, MCOs hope to give a PPT presentation to the GCACH to create a shared awareness of the goals and responsibilities of the MCOs,**
3. Medicaid Transformation Waiver:
   - The Health Care Authority is preparing for the Medicaid Waiver process and creating a **toolkit, a list of projects (update to minutes: toolkit called the *Medicaid Transformation Project List*)** that ACHs can select from to administer projects within the region. The HCA is releasing a **template** (**update to minutes: this document is called *Medicaid Transformation Waiver: Development of Transformation Project List. November 18, 2015*)** for ACHs suggest projects based on certain criteria that qualify them for inclusion in the Medicaid Transformation Project List.
   - There will be a webinar on December 8th to review the template to submit projects for the Medicaid Transformation Project List: To join this webinar, please register here: https://attendee.gotowebinar.com/register/2054476330064267521
   - Background on Medicaid Transformation, including periodic updates on the waiver, can be found on the Healthier Washington website.
   - Lena encouraged the LC to use the December and January meetings to think about what projects we would like to submit to the State for the toolkit that are in line with our ACH priorities.
4. Plan for Improving Population Health (P4IPH):
   The Washington State Department of Health (DOH) is inviting each ACH to provide a representative to the Plan for Improving Population Health (P4IPH) External Stakeholder Workgroup. **Update: Stan Ledington, PhD, MD will be our P4IHP representative.**
5. AIM (Analytics, Interoperability, & Measurement):
   There are two parallel initiatives happening at the state level. The Washington Health Alliance (WAHA) will be preparing clinic-level reporting for the Community Checkup and Common Measure Set for all counties in the state in 2016. On December 8th, they are releasing clinic-level results for 14 counties and in 2016 they plan to release clinic-level results for all 39 counties.
   The HCA recently signed a contract with Providence CORE (Center for Outcomes Research and Education) to develop the tools to define and track how the ACHs are progressing on key elements of the Healthier Washington initiative.

	Using Medicaid claims data, Behavioral Risk Factor Surveillance System data, Pregnancy Risk Assessment Monitoring System data, and Department of Health Immunization Information System data, CORE will be building regional dashboards for each ACH that will drill down to County level data on a beginning starter set of 7 measures, and add to this list every 6-8 weeks. A strong and unified desire to incorporate population health measures, specifically those that address social determinants of health, will be addressed through several potential avenues, such as syncing up with the PMCC workgroup (this is the group that set the 50+ measures in the Common Measure Set) and the emerging work of the "Plan for Improving Population Health" workgroup (building on the Prevention Framework). 6. Readiness Proposal Status: See "Status of Readiness Proposal" above. 7. Assessment & Planning Committee: • The A&P Committee is a subset of the Leadership Council and Governing Board membership. They have taken on the task of helping shape and develop meaningful agendas for the Priority Work Groups in order to facilitate the Regional Health Improvement Planning process. In order to be ready for ACH status, the GCACH must have an initial action plan implemented as part of the RHIP development to address "early wins" and other regional investments based on priority identification. This deliverable is due by January 31, 2016, and the work of this committee has enabled a smaller group to strategize between our monthly meetings. • A+P Report Out (Carol, Kat Latet, Rhonda Hauff & Jorge Rivera): There were two A+P Committee meetings between the November & December Leadership Council Meetings and discussed how to assess and filter the inventory of projects into a manageable number to consider for the RHIP. Shawnie Haas suggested avoidable ED visits as an issue in Yakima that may be a measure/aim for the entire region, and today we are asking each priority work group to use the North Sound Criteria Tool as a test for considering projects. The A&P committee looked at criteria put together by other ACHs, but landed on the North Sound tool as a first step to assess and filter a list of projects. How do all of the Priority Groups buy in to common aims? Important to say that the A+P group helps to provide structure for the LC meetings. The discussions, decisions and analysis still happen in the LC meetings. The A+P Committee tries to "keep the train running" and to make the most of the LC meeting time.
PRIORITY GROUP WORK	We broke into 4 smaller groups: Care Coordination, Behavioral Health, Obesity/Diabetes, Healthy Youth & Equitable Communities The aims of the Priority Workgroups at this meeting (as suggested by the A+P Committee) were to: 1. **Review the North Sound ACH's Criteria Tool** for Considering "Early Win" for Project Proposals.' What changes would you suggest to this tool to customize it for our ACH? Could this be an appropriate tool for us to pick out "early win" projects, given some editing? 2. Find one or more projects/services in the Regional Inventory that aims to reduce "avoidable ED usage" and see how that project or projects scores using this tool. Wes Luckey & Susan Campbell gave a brief explanation of the work of the Benton-Franklin Community Healthy Alliance's subcommittee, the Health Access Team. One of the goals of this subcommittee to make sure that patients receive the right care at the right time, in the right place, to the right end point. Wes said that, conservatively speaking, nationwide, 40% of those in the ER don't have to be there. Make sure people get access to preventive care. ER is focused on intense, acute care. This committee has employed several strategies such as Rack Cards which have been distributed to ERs and other places that give information on alternative places to receive care. Great data from local hospitals to monitor trends over time. Susan said that BF counties have made actionable progress: Urgent Care Centers were actually closing earlier than their posted hours. This group encouraged the Urgent Care Centers to stay open for longer hours, especially to be open during peak ER usage hours. There is also a Health Literacy Aspect in conjunction with local hospitals on what to do when your child is sick for young moms and dads. There is a strong tie between avoidable ED use and BH.
PRIORITY WORKGROUP	Priority Group Report Out: • BEHAVIORAL HEALTH SUMMARY (Report by Rhonda):

REPORT OUTS	○ BH Participants: Rhonda Hauff (Holding Place for BH Chair), Ed Thornbrugh, & Kat Latet. ○ The BH Priority Group began by looking at the list of projects on the regional inventory & lumped projects together. They noticed two different kinds of projects related to BH. The first is Mental Health integration program highlighted by several groups in the inventory, this is through UW and Harvard (evidence-based model). The second is supportive housing for families with mental illness. The supportive housing benefit focuses on individuals rather than families, but this hasn't been highlighted in any GCACH discussions previously. Those two projects could impact avoidable ED visits. Only time to score one project so they used the MH integration program to assess the North Sound criteria set. Bottom line was that the North Sound ACH criteria set worked well for this Priority Group in their discussions. The tool helped facilitate the discussion. ▪ The BH Group had several questions about tool/criteria set: 1. On Pg. 3, 3B for Outcomes: They looked at evaluation measures from a MH integration program. They were hard pressed to tie scores to reduced avoidable ED visits need to do more homework on this. 2. Under Readiness on section 4E: This group felt this section was hard to score. In the North Sound Criteria, three points are given if "project is currently underway and can easily move under the ACH." They not sure what this means or that this is what they want. Desire for clarification of this criterion. Overall, thought tool was useful. ▪ Ed Thornbrugh: When talking about scaling up a project that is already in place, there may become a conflict about creating another layer of governance. Maybe not as much of an issue with a new project. This could be a question to add to the GCACH's criteria, "Is your project a new service or are you expanding an existing model?" ▪ Kat: How does the ACH act as the convener and promoter of the initiative while other entities are carrying out the project? DIABETES/OBESITY SUMMARY (Report by Bertha): ○ D/O Participants: Marcy Durbin, Martha Lanman, Delphine Bailey, Dr. Larry Jecha, Dr. Amy Person, Bertha Lopez (D/O Chair) & Aisling Fernandez ○ Many of the projects in the inventory we knew very little about, which made the exercise challenging. For the exercise of evaluating the N Sound Criteria set, they chose a project related to ED that had enough info to answer some of the questions. They worked the Chronic Disease Self-Management program, a Stanford curriculum applied in multiple locations across the USA and has been around a long time. ▪ Some problems with the scoring tool including that you can score the program based on current outcomes in Yakima, but perhaps doesn't talk about challenges of doing this curriculum in other smaller counties with fewer resources or fewer people. ▪ Some questions about Equity question (1B), which seemed like a confusing question. ▪ Tool pretty good and walked us through some of the challenges and opportunities we need to talk about to look at a program. Criteria set was easy to use and flowed well. ▪ Martha Lanman: Brought up the regional scalability question: Can this be easily scaled to 7/10 counties in the GCACH- this is a good but tough question to reach the majority of the counties. Scalability from a financial standpoint. Important to discuss the role of the ACH in terms of funding, for example to finance training. The CDSM program is expensive and not covered by insurance. It is prescriptive in terms of requiring 2 educators, x people in classroom, which may pose challenges in smaller communities. CARE COORDINATION SUMMARY (Report by Jorge):

- CC Participants: Jorge Rivera (CC Chair), Carol Moser, Corrie Blythe, Susan Campbell, Shawnie Haas, Stein Karspeck, Brisa Guajardo, Wes Luckey, Jeri Williams, Grant Baynes, Reneé Biles
- They chose the Yakima Hot Spotter Program to review the N Sound Criteria and the "Avoidable ED Use" aim. They also had the challenge of not having all of the information about the program for the exercise.
  - They had many questions on the grading and the weighting. Some of the questions don't really apply to us, questions on data sharing. Questions about providing information vs. providing information in a timely manner. Even if you have a loose project statement would not be noted, lost in the project scale. In the end, liked the tool and most of the tool applied to them, but suggest that this tool be taken to the A+P Committee to work on the right grading and ranking over two sessions, then bring full documentation to next LC meeting to work on applying the revised tool to candidate projects again in December.

- HEALTHY YOUTH & EQUITABLE COMMUNITIES SUMMARY (Report by Cindy):
  - HYEC Participants: Cindy Mackay-Neorr (HYEC Chair), Stan Ledington, Linda Mayovsky, Suzy Diaz, Sandra Aguilar
  - The HYEC group went through the tool/criteria and selected the only project currently on the inventory, which is the grant project that Cindy currently manages.
    - It was difficult to determine if this group should be evaluating the project OR attempting meet the goal of avoidable ED visits. The grant project that Cindy manages is for workforce diversity in nursing and work with students to become registered nurses. There are no specific goal or guidelines to report on in terms of avoidable ED visits.
    - Gap in questions in terms of being able to evaluate on the project's ability to align with larger region, not just scalability, but whether or not project is in silo within just one priority group or if it applies to whole GCACH and all priority groups.
    - In general, because of dissonance between project and avoidable Ed visits, it was a major flaw to the exercise, as if they had skipped idea of logic model. There is a logic model for this grant project but how does it fit in with avoidable ED visits? Need a logic model to evaluate projects within the GCACH for all four priority groups.
    - Because this is a grant project, this could project score really well because you need to meet a lot of these indicators
    - In terms of data sharing: (criteria 3C) – Is the project "able to share data AND results AND indicates a willingness to do so frequently." The criteria needs to be revised define what *frequently* means, especially related to data and putting together reports. How often would you share data? Would everyone in the GCACH be able to share data at the same time so it can be compared and would the data be available for all of the counties?

FINAL COMMENTS:

- How can Backbone help HYEC section expanded in template??
- Carol mentioned that this is tough. We all have projects we really believe in and at some point it's instrumental for us to use this criteria tool to evaluate for the results that we want for the whole GCACH. It's not easy to evaluate your own project objectively and have it compared to other projects. Everyone will be in the same situation and everyone should be honest when scoring projects.
- Lena asked the group to think about, "How do you align multiple projects, some of which are already in place? For example, if you want to reduce avoidable ED visits, for each program that was talked about, are there elements of that

	project that could be tweaked that could contribute to another project? One project will likely not win overall, but instead, how do you tweak individual projects that already exist to complement one another? ▪ Maybe this idea needs to be added to scoring in the criteria set used by the GCACH. How can this project be used in collaboration with other projects already in place? - Rhonda: For the HYEC section of the inventory, there have been inventories taken by inter-professional workforce groups through Heritage and through Pacific NW University. - Bertha said she already feels informed about avoidable ED visits. If you don't have this background, it could be hard to apply that lens if you don't already know about that work and those issues. For example, she knows to ask questions such as, "Are we talking about high utilizers or those going in for colds?" - LC decided as a group that between this LC meeting and the next one, the Priority Workgroups will talk about projects and the A+P Committee will revise the North Sound Criteria set to fit the needs of the GCACH.
ADJOURNMENT	The meeting was adjourned at approximately 12PM.

Announcements	At the last Leadership Council and Board of Directors meetings we discussed the schedule for 2016. We conveyed the results of the Survey Monkey, which 43 answered, and the vast majority of respondents indicated that the 3rd Thursday of the month was best for their schedules. It was also determined that a central location was best, and that Kennewick was the most centrally located for our regional service area. We also discussed ways for GCACH members to be involved outside of the regularly scheduled meetings, so we will continue to include you in all distributions for Priority Work Group meetings, Assessment & Planning meetings, and other opportunities for engagement. Based on the feedback, here is the following schedule for 2016 (the Third Thursday of each month): - Location: Greater Columbia Behavioral Health, 101 N Edison St, Kennewick **Update: We have confirmed this schedule with Julie LaPierre from Greater Columbia Behavioral Health.** - Time: Leadership Council: 9-11:30; Governing Board: 12-2:30 (working lunch) o Thursday, January 21st, 2016 o Thursday, February 18th, 2016 o Thursday, March 17th, 2016 o Thursday, April 21st, 2016 o Thursday, May 19th, 2016 o Thursday, June 16th, 2016 o Thursday, July 21st, 2016 o Thursday, August 18th, 2016 o Thursday, September 15th, 2016 o Thursday, October 20th, 2016 o Thursday, November 17th, 2016 o Thursday, December 15th, 2016

	Please note, the final meeting of 2015 will be on Tuesday, December 15th, 2015. Thank you for your continued time and engagement with the Greater Columbia ACH!