Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

Board Minutes
November 16, 2017 | 12:00 pm – 2:30 pm
Columbia Basin College, L102

ATTENDANCE		Action Items
Participants:	**Board Members Present (* denotes they called in):** John Sinclair, Les Stahlnecker, Martin Valadez, Dan Ferguson, Amina Suchoski, Ed Thornbrugh, Lori Brown, Eddie Miles, Ronni Batchelor, Madelyn Carlson, Darlene Darnell*, Meghan DeBolt* **Guests in Person:** Sarah Bollig Dorn, Sandra Suarez, Jorge Rivera, Jac Davies, Miguel Messina, Shawnie Haas **Guests on the Phone:** Cathy Homkey	
Backbone:	Carol Moser, Patrick Jones, Megan Kummer, Wes Luckey	
Special Thanks:	Thank you, Columbia Basin College for today's facility. Thank you, UnitedHealthcare, for sponsoring the refreshments.	

Welcome & Introductions:	• **Martin –**
	  ○ Review of conflict of interest statement
	  ○ Review of self-dealings transactions statement.
	• **Patrick –** At the LC meeting, we broke up into groups based on the LHINs (Local Health Improvement Networks) that you established. Some organizations were missing from our LOI list, and these groups helped us identify them. This will help us moving forward as we gather our partnering providers/organizations.
	• **Megan –** The Project Plan Application has been posted on our website now, if any of you would like to download and view our submission. This includes all our attachments as well. The assessment team also confirmed this morning that they received all the required sections of the application, so now they will begin the review process.
	• **Patrick –** Our staff has done a phenomenal job with this application, and their work is much appreciated.	

MINUTES & REPORTS		**Action Items**
Consent Calendar	• October 26th, 2017 Board Minutes	• Motion by John to approve the consent agenda. Seconded by Amina, abstention from Lori. Motion passes.

Director's Report & Updates	• **Carol** – I just wanted to start out with thanking HMA. You all have been so amazing and helpful in this process. Many other ACHs followed in our footsteps in hiring them. We see this as a bridge to collaboration with the other ACHs in the future as well.
	  ○ Project Application Timeframe – We submitted our application last night (11/15), and the minimum qualifications review has already happened. Meyers & Stauffer then gives the ACHs the opportunity for writebacks to improve their scores. This allows the ACHs to adjust their plans up until January 30th.
	  ○ Theory of Action – This is our new and revamped Theory of Action that's been adapted from the RWJF Culture of Health Model, our staff ideas, and other models we've come across. What we're trying to do is bring systems integration, care coordination, and health equity together while engaging the community. Our mission and	

	values are also taken into account in this model and heavily incorporated. ○ **Wes** - Social Determinants of Health (Health Equity) – This relates to the tool we brought up about a month ago. This tool stratifies neighborhoods based on SDoH and socioeconomic factors that are gathered from census data. There are correlations between this index and the health care/mortality rates. ▪ **Eddie** – Can you clarify the key? ▪ **Wes** - Blue is low areas of deprivation, and those with red are at the bottom of this index and have the biggest issues. We did a presentation to VMM, and Farm Workers; and both commented that the indexing seems to be accurate for their communities. We are trying to take a broader look at effects health outcomes. This is a tool that can guide us. ▪ **Eddie –** This indexing looks similar to the hot spotting program for ER usage. ▪ **John –** How granular can this get? ▪ **Wes –** We can get down to the neighborhood level. We can do this county by county and then drill down. ▪ **John –** We could possibly overlay this is other data to help fill in the gaps. ▪ **Carol –** Shawnie, you've been able to impact utilization quite a bit using similar tools correct? ▪ **Shawnie –** Yes. In large part we relate it back to addressing the SDoH. In our program that handed out booklets "how to take care of my sick child" we've seen a large reduction. ○ **Wes –** Care Coordination (Addressing Upstream & Downstream Needs) - This model comes from an article in Health Affairs. They did targeted interventions on frequent flyers. They had a SDoH survey, and where possible they did care coordination. They had dramatic results. This diagram shows a bell curve that relates to the distribution of the population with the percentage of cost of healthcare. The concentric circles show intensive case management, focus of care coordination, and focus of community engagement/education.	

	▪ Carol – The community engagement piece is very important, and we need a multi-pronged strategic approach that will change the habits of generations. For example, when we went and talked to the Columbia Long Term Planning Association, we learned that if you get a job through WorkSource, you are required to get a doctor's excuse for a 3-day absence. If people can't get into their doctor, they go to the ED for the note. o Top 30 Providers List – This list still had some old organization names on it, so we can eliminate Adventist. This list is based on Medicaid claims. As you can see we did a pretty good job at engaging these providers and getting LOIs from them. We need to continue engaging them and connecting them together to eliminate duplication of efforts. This will also help with VBP (Value Based Payments). ▪ (Note – Triumph is not the same organization as Yakima Council on Alcoholism). o Building a Care Coordination Network - This shows what we're trying to do: integrate primary care with behavioral health and connect it to all of these other areas of service. ▪ **Carol –** We need to add the Tribes to this diagram as well. We specifically called this a network because a network becomes a catalyst for action. We have witnessed this at the BFCHA; the act of people coming together to share a common agenda creates action. ▪ **John –** I will provide some suggestions for more connections on this. o HCA Responds to ACHs Requested Project Scoring Methodologies – The last month the Board took a risk and made the hard decision of going from 6 projects to 4. They made this decision not knowing if we would receive full funding for only moving forward with 4 projects or not. Since then, we have heard back from HCA and learned that we will still be eligible for full funding at 4 projects! They will also no longer be rounding down with project plan	

application scores. More details on these changes are included in the Director's Report.

- Project Plan Application Submitted – We are almost at the end of creating our RFPs for the project areas. This will be our work in December. (Update, this work will be moved into January-February). Our new Contracts & Finance Manager, Kylee Spence, starts 11/27. I wanted to bring her on after this application was submitted so that we could focus on writing contracts for the LHINs and the RFPs. She was a grant and contracts manager for WSU Tri-Cities and had amazing reviews from her boss.
- Miscellaneous Items not in the Director's Report
  - Letter of Support from Yakama Nation – We have been working really hard to develop this relationship. From what we understand, it is not easy to earn the trust of the Tribes; and we should feel very proud that we've reached this level of collaboration. We've dedicated major resources to the Yakama Nation. This is a population we can move the needle on, perhaps with the help of Toppenish Hospital.
    - **Jorge -** Our numbers are usually managed-care maintained enrollment, which don't include fee for service. Your numbers include fee for service. Right now, Tribal populations don't engage much in managed care. Because of this, most of the tribal population is not counted. The plans would not be able to be delivered through MCOs.
    - **Eddie -** They need basic infrastructure help, for example access to transportation, or urgent care infrastructure or other provider services. This might be a way to help them. It's very basic stuff that they need.
    - **Dan –** Even an expanded paramedic role could have a big impact on their health.
    - **Ed –** Direct care and case management on the reservations are very tough.

	• **Wes –** Is that because of just lack of organization and coordination? • **Ed –** Violence, drug dealers, threats, intoxication in the homes that you're going into… weapons. Often times when you're doing behavioral health support, you're having 2 people go instead of 1. So your travel time and staff time counts are much higher. I was out there from 1992-1999. • **Ronni -** When you go as someone who as an agency behind you it may be off-putting to them.... But if you had known community members that are skilled to handle those things that aren't coming with a badge- what do you think, how would that be perceived? • **Ed -** Most of my successful encounters involved having a family member facilitate. • **Ronni -** CHWs within their community could be helpful. • **Darlene -** We helped with BH there for about 10 or 12 years. I think that this question of involving their community members in this work is one that we need to ask of the Tribe. One of the reasons they asked us to take that on was capacity, but they were involved in the hires of our staff for that. They also wanted to hire outside of the tribe to help with confidentiality. • **Carol -** That's a good point. We will help and support them, but they will develop their own plan. • **Madelyn -** We are actively working on reimbursement with the Yakama Nation for medical transportation. • **Darlene –** In the Catholic Charities Services Program, we actually have a tribal member that is operating out of the ALTC office down there. They do a lot of rides for medical appointments for Tribal Members. It's all free to folks that are Tribal Members, but most	

	of these rides are provided by volunteers on the reservation. • **Eddie** - Another striking example is infant mortality. The infant mortality is huge compared to other ethnicities. If they put an experienced mom/child care person in the house it drops off. Not even a medical provider, just someone with experience in infant and child care. It's little things that help.	
ACTION ITEMS		**Action Items**
Financial Reports	• **Carol -** Walkthrough of financials. These were reviewed with the Finance Committee which includes Brian, John, and Martin. o Statement of Activity – We are authorized to spend down the SIM grant, so we are allocating most of our expenses to this. o Phase 1 and 2 Design Funds – The RFPs and contracts will be using these funds until we find out our funding next year. ▪ **Ed** – I see that the Pathways HUB is still listed under the IT section. Does this need to be updated? ▪ **Carol** - We haven't ruled it out entirely, but yes, we can update that line item to be more generic. We can also use the FIMC funding for IT needs as well. ▪ **Les –** Perhaps we call it technology information? ▪ **Cathy H** - As we look ahead in the next 3 months, we'll be looking at the ACH administration budget, the Domain 1 budget which will incorporate the IT component...I would imagine this will be recapped in the next 3 months. ▪ **John** - Do we have audit costs/requirements for the grant? ▪ **Carol -** Yes. We have an annual audit cost. It's probably factored in under administration costs right now. The board has the latitude of switching the funding too. • **Martin** – I think as we get further along these financials will move into the consent calendar.	• Motion by John to approve the October Financial Reports. Seconded by Dan. Motion passes.
NEW BUSINESS		**Action Items**
Committee Updates	• **John/Megan – Communications Committee** o We've signed the contract with the website vendor SightWorks, and have a meeting with them next week to kick off the project.	

	• **Dan - Workforce Committee**
	  ○ We did have a meeting this last month. Carol led a broad discussion about the process of workforce planning and how important this is across all project areas.
	  ○ **Carol –** We have a very large committee. This is an issue that touches a lot of different sectors. Right now, nurses are a top need for most areas, but they also have a high turnover rate. We also have large mental health needs that we need to fill. We still see CHWs/Navigators as critical for carrying out these projects and improving healthcare. In our discussion this month, we talked a lot about what we put into our project plan application and used that as a springboard for further discussion. Wes and I also had a great conversation with Dr. Farion Williams (Medical Dean) from WSU Tri-Cities. They have intersessions for their residency students and are incorporating place-based screenings and assessments into the program. He is currently working with Broetje Orchards for a Spring intercession on site.
	  ○ **Ronni –** I've talked to Debbie Spink, and we discussed the trainings for CHWs and Peer Support for mental health, and how those 2 things interlock. I think that several people from the mission want to become involved in the leadership council. I also spoke to some people at Goodwill, and they were also excited about these trainings and that people could do them online for college credit.
	  ○ **Lori –** With the workforce committee… have they sent out any surveys? Have we thought about doing a survey to our distribution list that asks organizations what their workforce needs are?
	  ○ **Madelyn –** I would like to be included in this survey, Jack Fitzgerald (in Yakima), and Justin Merrill should also be included.
	  ○ **Dan –** By the way, I went to a special session on supportive employment services. There was a gentleman there from Clark County, and he gave an outstanding presentation on the effects of unemployment on Mental Health. I can share this presentation with you all if you'd like.
	  ○ **Lori –** One of the problems with practicums is that they want the MSW directly supervising, and we don't have a lot of MSWs. We	

	have a lot of people with great experience with bachelor's degrees, but this can often be a barrier. • **Wes - Data HIE/HIE Committee** ○ Our committee met at the beginning of the month and talked about priorities. We also discussed distributing a survey that would serve as an environmental assessment. Providence Core was included in the first part of our meeting as well. We are thinking that we will need to hire one IT Integrator. We still have questions surrounding HER, EDIE, Premanage, and Population Health Management.	

Bylaws Discussion	• **Martin** – As we've grown as an organization we've come across some Bylaws that need to be altered or updated. We will take the next month to review these and clarify them (Les, Rhonda, and Martin are on the Bylaws committee). If anyone else would like to join this committee, please let me know.
	  ○ **Les** – This means that in December we will vote on these new Bylaws.
	  ○ **Martin –** I will be rotating off as the sector representative next year. I will be nominating Sandra to represent the FQHCs. I will continue to help as the past president, and will also continue to be involved in the leadership council.
	  ○ **Les –** Can we clarify the section surrounding budget approval? It says two different things… to approve it by September/October, but it also says to approve it by December 31st.
	  ▪ **Martin –** This will be clarified as well in the updated Bylaws as well. The nominating committee will also bring a slate in December for new executive positions (Rhonda will be proposed as the chair, John as vice chair, Brian will continue as treasurer, Madelyn as secretary if she accepts, and I will be on the executive committee as the past chair).	

FIMC Interlocal Leadership Council Discussion	• **Carol –** Some of the people that wanted to talk about this aren't here today… but I think that we need to let everyone know that with the Greater Columbia Behavioral Health Organization voting to be Mid-Adopter, a couple of things have come up. Being a Mid-Adopter allows the counties to have more input on what the behavioral health system looks like under	

	managed care. Although the legislation didn't pass (ESB 1388) it established some policy direction to create "Inter-local Leadership Structures" jointly administered by the County Authorities, the HCA, and the five MCOs. The Leadership Structure would coordinate the planning for the transition to fully integrated care, including weighing in on the number of MCOs for the region, services that should be provided under MCO contracts, and forwarding an additional set of questions to the HCA that are region specific for the RFP. • We recently received a letter from MaryAnne Lindeblad that laid out how many MCOs will be in each region. For the largest regions (King, Greater Columbia, and North Sound) we would get 5 MCOs. I thought this was a good thing, and sent out an email to those involved in both the BHO and GCACH (Ed T, Mike Berney, and Barbara Mead). This group was divided on whether 5 MCOs was a good idea or not, so we have varying opinions. This will be a decision for the interlocal-council to make. However, I've been told that our BHO doesn't want the ACH as part of this group, which is concerning to me. We are doing a lot with bi-directional integration, so it's important that we have this connection to the transitional planning. Recently, Meghan DeBolt contacted me to offer the services of Walla Walla County to step in to start the planning since we haven't had any luck in trying to get the GCBHO to initiate the planning effort. ○ **Ed –** So who would Walla Walla County want to contract with? Directly with the ACH? ○ **Carol –** The idea was should we step into this, and offer some leadership in trying to bring this group together? I've been trying to communicate with Troy Wilson, but have been unable to reach him at all. ○ **Eddie –** My initial reaction would be to weigh any relationships like these against our mission statement. How does it help us achieve our mission? If they don't want to include the ACHs… I'm not sure that it will be helpful. ○ **Carol –** To me, it would mean more network adequacy if we had more MCOs, but maybe Amina and Jorge can speak to this.	

	Whereas Ed's comment brought up having to manage more contracts and more management and more reporting. ○ **Jorge –** What will happen is that the providers will want less MCOs because it's more work, whereas everyone else will want more. Most regions agree that the ACH should be included in these interlocal-councils. In the current legislation that is passed, it's not a requirement however. ○ **Amina –** Yes, the language in that paper is dated. ACHs didn't exist yet when it was written. So far, there hasn't been a uniform opinion on this yet (ACH involvement). ○ **Jorge –** Perhaps the ACH needs to consider writing a letter to HCA to ask them to make it a requirement that ACHs be included. ○ *(clarification that we the BHO would be doing FIMC, fully integrated managed care, by 2019)* ○ **Lori** – What is the role of the interlocal council and our ACH? ○ **Carol** – The crossover I see is that we have a work team dedicated to bi-directional integration that came together for this work, and this work should be considered when we are planning a new behavioral health system for our region. The inter-local council should have broad representation. We need to find a way to work together. ○ **Amina -** Maybe there is some approach that could bring us together. Perhaps if the MCOs threw their implicit support of the bi-directional project and explained this to HCA. ○ **Ed -** I've consistently said that I believe bi-directional is important work. Historically the BHOs and RSNs have served a narrow population. There is a persistent concern about moving BH into primary care that we would lose the most vulnerable people because you've taken that carve out for them and pushed it into the general medical community. There will be some anxiety surrounding this. Rather than a forceful letter through HCA, I would try and address their concerns. ○ **Les –** Maybe it should also include the other providers going out to those locations (like the MH providers). We should integrate in multiple spaces.	

	○ **Carol –** The 9 counties voted for Mid-Adoption, and I feel like with that decision comes the responsibility to reach out to your partners to start that process. I feel that the ACH should be heard in this conversation. ○ **Meghan –** We need to be thoughtful about the process moving forward. Emotions are high. People will lose their jobs. The reason I reached to out Carol was because other regions have already started convening their interlocal councils. It is my feeling that we are behind in getting this started. ○ **Lori –** Who do we have for our local government sector representative? ○ **Carol –** It's currently unfilled, but we've asked county commissioners to fill it. ○ **Lori & Ed –** Could we ask someone on the BHO board (or a designee for them) to serve on our board? ○ **Carol –** I've been trying to offer that. ○ **Lori** – Maybe they would be more interested in joining now that they've voted for mid adoption. ○ **Darlene** – The ASO application up in Chelan was very competitive. Do we foresee the same thing happening here? ○ **Meghan** – Not necessarily. It depends on what the BHO board decides. ○ **Jorge –** The link between this interlocal council and the ACH is very clear, because they should be helping to manage that transition. ○ **Wes –** We've intentionally focused our target populations around those high risk/needs patients. ○ **Ed –** But our pattern of behavior has been to drop projects because it would be too difficult. It's a hard sell for me, because right now we've written in those populations because it looks nice- but if they aren't going to move the needle I worry about them being dropped. ○ **Wes -** At this point, we can't drop anymore projects/areas; we are at the limit. We've also committed to integrate the other projects that we've let go, but under a model that we think may have more flexibility.	

	○ **Dan –** What I hear is Ed's fear of abandonment around those services. We need to look at supporting what's been provided in the past, as well as looking into innovation to improve and expand those services regarding integration with primary care. ○ **Ed –** I volunteer to help with this conversation. ○ **Martin –** How can we move forward and have that conversation with the BHO? Thank you for volunteering Ed, I know that there is a lot of uncertainty around these changes. ○ **Les –** It sounds like we need to really make sure that we continue these services. It's not an either/or, but instead a way to pick up these services and make sure that the new system addresses them. ○ *(Ed clarified that he was speaking on his behalf, not for the BHO)* ○ **Martin** – We just want to make sure that the ACH is involved somehow moving forward. Can we set up a conference call to address next steps with myself, Ed, Carol and Meghan*?* ○ **Ed** – In my mind, part of this is that the BHO has a responsibility to explain what makes them different from other BHOs. They've been very successful in places where other BHOs have failed. If they can articulate that, and help this group understand what they're protecting so fiercely- then we have a dialogue. ○ **Wes** – I'm curious to see these statistics as well. We want to understand what separates our BHO from the rest of them. ○ **Ed** – I'll tell you off the record, we have the statistics. ○ **Martin** – Rhonda suggested that I reach out to the BHO chair to initiate this relationship too, but we can talk more about this on the call. We just need to show them that we are there to help.	
2018 Board Membership Discussion & Lottery	• **Martin** – We are going to draw for term years (one or two) by sector today. This doesn't mean that if you draw a one-year term you can't stay on the following year. ○ **Ed –** We use the term "3 terms" in the Bylaws… where does this come into the 1 vs 2-year terms? ○ **Martin –** That's a good point. We have it on the agenda to discuss the Bylaws today too.	

	○ **Carol** – As I recall, we didn't do this last year because we were just getting our feet off the ground. So, it would be starting this next year. ○ **Martin –** And we can put that in our Bylaws, that these terms began January of 2018. ○ Lottery Outcome: ▪ Consumer – 2 years ▪ Transportation – 1 year ▪ FQHCs – 2 years ▪ Behavioral Health Provider – 1 years ▪ Workforce Development – 2 years ▪ Hospitals – 2 years ▪ Public Safety – 2 years ▪ Social Services – 1 year ▪ Healthcare Provider – 1 year ▪ CBOs/FBOs – 2 years ▪ Housing – 2 years ▪ Public Health – 1 year ▪ Philanthropy – 2 years ▪ Local Government – 1 year ▪ Education – 1 year ▪ Tribes & MCOs are on their own rotation schedules. ▪ As a clarification – this does not mean that the sector representatives are forced to end their membership, only that they are up for reelection.	
Path Forward with Implementation Planning, Provider Incentives	• **Cathy** – The budget and funds flow committee met on Monday, and the focus of the discussion was finalizing the narrative for the project plan application. We reviewed the funds distribution allocation definitions, as well as the recommended distribution by organization type. I wanted to note that in the application (based on the board discussion) we said that there were reservations surrounding the distribution by organization type as the agreements with the partnering organizations have not been formalized. And due to the uncertainty of the funds, the board did approve the recommended concept of distribution. The goal would be to align our distribution of funds with project goals and transformation efforts. We also	

	discussed a potential methodology for distributing engagement funds. The goal of these funds is to incentivize the GCACH partners to continue participating in our work. This methodology discussion included ways to cover cross sector collaboration, recommended criteria (which could be resource commitments, survey participation, target populations… etc.), and flat fees vs percentages. • **Carol** – To recap – you all approved the budget and funds flow allocation methodology at the last board meeting. That is what we put into the application. We circled back with the budget and funds flow committee to show them what we put together to make sure they were still comfortable with it. We just wanted to bring this back to the board to be transparent about the process. We also talked about this with the finance committee.	
December 2017 Meetings	• **Martin –** The Leadership Council has decided to not have a December meeting, so we've moved the time of our meeting up to 9:00 am, and it will go to 11:30 (still on 12/21). We will have this meeting at the new Tri-Cities Community Health Building at 800 W. Court Street. • *(Confirmed that everyone would like to continue to have meetings on the 3rd Thursday of the month in 2018. Megan will send out invites for these upcoming meetings).*	
ADJOURNMENT		**Action Items**
	Meeting was adjourned at 2:17 pm. Minutes taken by Megan Kummer.	
	Thank you for your time and engagement with the Greater Columbia Accountable Community of Health! The regular Board meetings will be from 12-2:30 p.m. on the following dates: • December 21st, Tri-Cities Community Health – 800 W. Court St., Pasco • January 18, 2018, CBC L102 • February 15, 2018, CBC L102 • March 15, 2018 CBC L102 • April 19, 2018 CBC L102 • May 17, 2018 CBC L102 • June 21, 2018 CBC L102 • July 19, 2018 CBC L102	