Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

Leadership Council

Meeting Minutes

January 17, 2019 | 9:00 a.m. – 11:30 a.m.

ATTENDANCE	
Participants (*: called in, †: GCACH Board Member):	Jorge Rivera†*, Rhonda Hauff†, Sierra Foster, Stein Karspeck, Michelle Crowley, Marissa Ingalls, Bertha Lopez, Dr. Larry Jecha, Martha Lanman†, Corrie Blythe, Dana Oatis†, Susan Grindle†, Hayley Middleton, Martin Valadez, Jean Murrow, Susan Campbell, Holly Siler, Andy Nyberg, Jenny Krueger, Chuck Eaton, William Whealan, Bill Dunwoody, John Christianson, Ronni Batchelor†, Sandra Suarez†*, Sandy Quiroga*, Sue Jetter*, Virginia Janin*, Barbara Mead*, Mandee Olsen*, Lindsay Engh*, Kirk Williamson*, Ben Shearer, Karly Port*, Everett Maroon*, Jac Davies*, Joe Ketterer*, Diane Compos*, Deb Watson*, Cicily Zornes*, Cheri Snowhite*, Carla Prock*, Michelle Sullivan*, Kat Latet*, Caitlin Safford, Kelly Sanders*, Joyce Newsom*, Dave Wilson*, Adam Aaseby, Gena Morgan*
Staff (*: called in):	Carol Moser, Wes Luckey, Becky Kolln, Rubén Peralta, Lauren Johnson, Diane Halo, Jenna Shelton, Martin Sánchez, Dr. Patrick Jones, Aisling Fernandez, Rachael Guess, Sam Werdel*
MEETING PRESENTATIONS & REPORTS	

Welcome & Introductions (Dr. Patrick Jones, Our Fearless Facilitator): • **GCACH Report (GCACH Staff):** • **Brief & Sassy Updates from LC Participants (Dr. Patrick Jones):**	• SUMMARY OF THE LEADERSHIP COUNCIL MEETING: GCACH staff hosted the January Leadership Council Meeting at Columbia Basin College with over 60 people in attendance. The convening began with updates from each attendee to describe the work that will be done with each organization and GCACH. The attendees also enjoyed presentations from Adam Aaseby, Pierce County ACH, Gena Morgan, HealthierHere, Caitlin Safford, Amerigroup, and Kat Latet, Community Health Plan of Washington discussing the New York DSRIP Findings. To view the January Leadership Council meeting packet, click here! • GCACH REPORT: *The monthly GCACH Report provides great narratives on recent work, including more information about opportunities for webinars and trainings than previous reports, and staff ask that the Leadership Council members read the report independently in addition to hearing the meeting reports.* ○ GCACH Staff attended the most recent State of Reform (SOR) Conference on January 10th. One of the biggest takeaways was when DJ Wilson (Executive Director of State of Reform) talked about the Social Contract, the unwritten understanding that if you have wisdom, you ought to share it with others. The SOR is an opportunity for those who are in the field of health care to share that wisdom with others. This is called Social Capital, and it's a form of a wealth, in the form of information. Not sharing information and wisdom creates distrust. At GCACH we are trying to share information to build trust as well, such as information about Adverse Childhood Experiences (ACEs). ○ Financial Updates: Staff introduced GCACH's newest employee, Finance and Contracts Coordinator Rachael Guess. She also discussed this month's payments to Behavioral Health providers through the WAFE Portal, totaling $628,998. Last year, the payments totaled $3.7 million through the portal. We have the practice transformation contracts. ○ Everett Maroon of Blue Mountain Heart to Heart has reached out to say that naloxone is available in our region, and if you are interested, please contact him. ○ Staff introduced the new Board members for 2019: Susan Grindle (Social Services Sector), Jorge Rivera (MCO Sector), Dana Oatis (BH Sector), and Martha Lanman (Public Health Sector). Rhonda Hauff (Housing Sector) will continue this year as Board President, and Ronni Batchelor will continue as the Consumer representative. ○ Jenna Shelton and Martin Sánchez have been working on the Toolkit to make it useful and effective for Practice Transformation. They split the sites so they each have 22-24. It's going really well! ○ Diane recently participated in a webinar to learn about a program in Missouri called the "Medication First Model." This is a program in the ER providing Medication-Assistant Treatment (MAT) for people with Opiate Use Disorder (OUD) as quickly as possible in that setting. Click here for the article about the program. ▪ She also reported about Fully Integrated Managed Care (IMC): Behavioral Health (BH) Providers moved into Fully Integrated Managed Care (IMC) on January 1, 2019, and billing managed care organizations (MCOs). The Health Care Authority (HCA) has arranged IMC Implementation Check-In calls three days a week.

	○ In the 2019 budget, GCACH has set aside funds for LHIN participants to attend conferences and for sponsorships for events that align with GCACH's initiatives. Please contact Rubén for more information! ○ Diane Halo has been managing the IMC project but is now going to work as the Opioid Resource Network Specialist. GCACH is very excited to work on an Opioid Summit in June of this year and there will be a steering committee. We already have some incredible speakers lined up. ○ An IT update: GCACH has a unique Practice Transformation Toolkit and converting that into a web form (using the CSI Portal) will be challenging. People will receive secure messaging and Pre-Manage. We hope to have worked through many of the challenges by January or February. ○ The next Health Commons in the Tri-Cities, we hope to focus on a use case with an Opiate Use Disorder and incorporate some Social Determinants of Health. ○ Health Commons Update: Other ACHs have employed this and GCACH is part of an MOU with them to collaborate on Health Commons deployed throughout the State and IT-related costs for cloud storage. • BRIEF & SASSY UPDATES FROM LC PARTICIPANTS: Dr. Patrick Jones facilitated the day's convening, and he asked all participants to give their name, organization, and answer the following question, "His question for introductions is what does 2019 look like for the intersection of your organization with GCACH?" ○ Rhonda Hauff (GCACH Board President, Board Housing Sector Rep, Yakima Neighborhood Health Services): Rhonda wears the housing hat for the GCACH Board. At YNHS, they are waist deep in Practice Transformation. They have completed the PCMHA and the MEHAF. They are working on risk stratification, working from several rosters and working on a decision process to choose groups. Working on disease registries, care management software (starting with MAT populations). The other high-risk population is the homeless. They are 30 days away from opening a new place with 37 beds. Some of these people will also be the MAT population. ○ Sierra Foster (Astria Health): Excited to participate in the Practice Transformation Workgroup. Announced that they opened an in-patient psych unit. ○ Stein Karspeck (Richland Fire & Emergency Services): A big initiative for 2019 is to try to further understand what a community paramedic can look like. The goal is to dig down into the needs and how EMS can address those needs for people at risk. One of the other 2019 initiatives in Richland and Pasco is with Becky Grohs and Everett Maroon on getting medication and education out to the community for opioid use. ○ Michele Crowley (Pasco Fire Department): Pasco has a hot-spotter program. They see a lot of the same patients, the high-utilizer callers. Some of these people have help, and find out that these people are receiving help. They are trying to follow up with patients in the community so they get the care they need. Franklin County doesn't have a drug health court like Benton County does. Local fire departments will stock freezers with food so they can provide food on a temporary basis (the CRIMP program).

	○ Marissa Ingalls (Coordinated Care): Coordinated Care is in the deep end of integrated care and is fully invested in participating. ○ Bertha Lopez (Virginia Mason Memorial): They did an assessment to look for opportunities and goals, they are well on their way to looking at contracts and are partnering with GCACH on opportunities. ○ Dr. Larry Jecha (Walla Walla Department of Community Health & Columbia County Public Health): Defer to Martha ○ Martha Lanman (Columbia County Public Health, Garfield County Health District, SE Washington LHIN): Excited about the transformation dollars for hospitals to put those dollars into our community; it will be a real benefit. Also looking forward to the community health dollar. Have done some surveys and founds that transportation is a big issue. How do the additional family members get there when someone is taken to a distant hospital? Just getting people to appointments in Clarkston or Walla Walla is a real issue and cost. Something we can work on. ○ Corrie Blythe (Southeast Washington Aging & Long-Term Care): Our role is to remind folks that as we think about Social Determinants of Health, our agency focuses on SD's in these communities, we know what services people have, and in 2019, we will continue with partnering. The medical community doesn't have to do it all. We need to have warm handoffs and there are wonderful services outside the medical world. ○ Dana Oatis (Lourdes Counseling Center. GCACH Board Member, Behavioral Health Sector Rep): Lourdes Health is ramping up bi-directional care. Growing BH specialists and internal medicine. In 2019, we are bringing a primary care clinic to the counseling center. ○ Susan Grindle (CEO of HopeSource in Kittitas County, GCACH Board Member, Social Services Sector Rep): HopeSource works with homeless Vets in six eastern WA counties. We desire for recognition that Social Determinants are a real thing. Doctors asked us to give pocket size cards with information about topics medical care that they can give patients during a visit to help them find appropriate resources. ○ Hayley Middleton (Columbia Basin Health Association): Working in three ACH areas: GCACH, North Central ACH and Better Health Together. ○ Martin Valadez (Tri-Cities Community Health, Past President of GCACH Board): Working toward Behavioral Health Integration. They have a new director who is not from WA state. Fortunately, BH is right across the street from the main clinic. They revamping a building to physically integrate. ○ Jean Murrow (Family Learning Center): The Family Learning Center is an organization to help refugees arriving in the Tri-Cities become part of the community since 2009. Her background is in health care and she helps to educate children about. We are now teaching Health ESL to adults and trying to help adults on a one-on-one bases to navigate the health care system, particularly so they don't go to the ER with something like a cold. ○ Susan Campbell (Columbia Basin College Nursing Program Faculty, Union Gospel Mission Volunteer): At the CBC nursing program, she shares GCACH information about workforce needs with the dean. At the Union

	Gospel Mission, she helps to coordinate health and wellness services at the newer, bigger location. It's a great opportunity to serve those who are homeless. o Holly Siler (2nd Harvest): 2nd Harvest is working with two ACHs. They are learning about community-based organization. Transportation costs are growing and GCACH is one of the biggest areas to cover. o Andy Nyberg (Yakima Valley Farm Worker's Clinic): YVFWC is working with GCACH and has completed the MEHAF. They received a grant to integrate. EMR has a social determinants of health module and they are looking at individual patients. They are moving to EPIC for dental, medical and mental information to all be in the same system. o Bill Dunwoody (Kadlec): Working on integration for a year now. There are six case management RNs, some of whom are being oriented and there's one social worker. They are getting responses from primary care about warm handoffs. They are doing assessments and are "turning the battleship/aircraft carrier into the wind." o Chuck Eaton (Community Member): He feels that only those people are with organizations are welcomed, and he is hoping for something more inclusive and diverse, trying to bridge gaps more effectively in 2019. o John Christianson (Community Member): Just attended the local Democrats meeting last night. Wants community leaders give the message about the health care that is available. In WA State we have benefitted a lot from the Affordable Care Act, such as teachers get a better benefits package and the money has helped the WA State budget. We need to let our neighbors know what services are available to them including "community-based services." Hopefully GCACH can communicate effectively with people like him so he understands what is going on and he can tailor his messages better. o Ronni Batchelor (Lourdes. GCACH Board Member, Consumer Sector Rep): She is working with the True Blood program for crisis response for folks within the criminal system. She hopes diversion would come to this program. Folks who have suffered from severe MH challenges and housing and basic needs, when she meets them, she provides peer support. Hopefully in 2019, she can expand some of that outwardly. o Sue Jetter (speaking for PMH): Working on empanelment and risk-stratification. o Kelly Sanders (Pullman Family Medicine) o Deb Watson (Pullman Regional Hospital): Working for Pullman Regional Hospital and is working with Pullman Family Medicine clinic on Practice Transformation. Looking forward with 2019. There are eight metrics and milestones for the year. Just getting started. o Everett Maroon (Blue Mountain Heart to Heart): Blue Mountain Heart to Heart has expanded the mobile syringe exchange to Franklin county and to the Yakama Nation. There's a rapid response program in Walla Walla and possibly one with the corrections center. They're talking with people in Pasco and maybe there will be a rapid response program at the Pasco syringe exchange.

	○ Jac Davies (Northwest Rural Health Network): Diving in to opioids. They got a grant last year for opioid reduction and prevention strategy for Whitman, Asotin, Columbia, and Garfield counties. Southeast Washington Health partnership. ○ Cicily Zornes (Quality Behavioral Health): They are working with the Pomeroy hospital ○ Cheri Snowhite (Amerigroup): Addressing some of the social determinants like transportation. Obesity is a big issue, also adding some dietary and coaching issues. Addressing MH issues. A digital service to address mental health. ○ Barbara Mead (Lourdes): Working with BH and primary care, and also working with Becky Grohs to implement a service for MAT, peer counselors, beginning to form a theme. ○ Joyce Newsom (People for People/211): Working closely with GCACH to address Social Determinants of Health in 2019. WA State 211 is doing a lot of practice transformation. Locally there is a pilot project, hoping to expand this to a program, with a database to get more connected to vital resources. Working closely on the ACEs campaign. ○ Kirk Williamson (Benton Franklin Community Health Alliance): Decided last night at the BFCHA regular meeting on the three priority social determinants of health. They started on a Community Health Needs Assessment (CHNA) for 2019 for Benton and Franklin counties. There's a statewide tipline proposal for you that is a 24-7 tipline and our Republican Senator is championing this. Working with EMS to reduce ED visits, unfortunately right now we're number one. ○ Mandee Olsen (Kittitas Valley Healthcare): Along with Susan Grindle, working on practice transformation, on the Patient Centered Medical Home, also working with the Kittitas Health Network. Working with the Ellensburg School District. ○ Diane Compos (Yakima Health Neighborhood Services): Michelle Sullivan is there too. ○ Dave Wilson (Merit Resource Services): Worked with the ACH committee to enhance services they are providing, working to provide further collaborations. They provide BH services in Kittitas, Yakima and Benton and Franklin counties. ○ Jorge Rivera (Molina, GCACH Board Member, MCO Sector Rep): Molina is now seeing 600,000 members on integrated managed care. They picked up another 20,000 in the new year. The process has been working well across the state. Integrating care is the most important step for 2019 and making the transition seamlessly. It's harder than you think. There are big providers and very small ones and community health centers. Integrating all of those levels is a challenge but we seem to be in good shape.
New York DSRIP Findings Presentations:	• The first of three presentations for the Leadership Council on the topic of learnings from New York, was given by Adam Aaseby, Chief Information Officer at the Pierce County ACH, presented first, a talk called "Pierce County ACH, Population Health Strategy."

• **Adam Aaseby, Pierce County ACH:** • **Gena Morgan, HealthierHere:** • **Caitlin Safford, Amerigroup:** • **Kat Latet, Community Health Plan of Washington:**	○ Adam is studying the NY Staten Island Performing Provider System (PPS) to compare and contrast with the Pierce County ACH. ○ He advised to do what works for your region and to make things as simple as possible. ○ An overview of Pierce County: ▪ In 2017, there were about 203,000 Medicaid individuals. 31% of this population has an identified mental illness, 11% had received identified substance use disorder treatment, and 61% of 3-6 year-olds received well-child visits. ▪ Pierce County ACH formed a community resiliency fund (10%), has its own legal subsidiary, several endowments, and has its own board tied to the ACH. Pierce County ACH is one of the ACHs that is forming a Community HUB and they are about 10 months into the Pathways pilot, targeting the population of pregnant women at risk of a low-weight baby. They have generated 1,500 pathways, some clinical, some education, and some social services. They will be a Health Homes lead starting in March. ▪ Population health is related to data, analytics, evaluation, and strategic improvement. It's hard to get data from the HCA to community-based organizations like GCACH. ▪ The Staten Island PPS is very similar to the Pierce County ACH. • DATA: They're putting their data in a centralized data repository and this happened in only 2 months from the time they initiated the idea! Also going down that path on the Pierce County side. One example is a food-related project- Pierce County ACH wanted to work with local food services and provide free food, however none of those locations for food pick up were across from a health center. They used GIS location data to move food-pick up locations within one city block of a church or a community organization. Amazingly, it went from 5% to 95% of the food being picked up. • MONEY: NY has more money for their 1115 Waiver compared to WA. Pierce County has more lives than they do in Staten Island, however NY negotiated a better deal. High performance fund dollars earned by exceeding performance targets for 10 of 60 pay-for-performance measures. Additional High-Performance Payment (AHPP) Program dollars are distributed by a PPSs associated with the health plan for meeting 50% of 7 selected measures. NY Staten Island earned additional money this way with analytics. • Staten Island has trained 150 CHWs, paid for their first three months of salary, then a ramp-in as people get trained up. In Pierce County with Pathways, they pay for training and initial salary start-up. • Expanding Primary Care & Care Management Capacity: Staten Island PPS engaged 25 practices and 100+ PCPs in obtaining PCMH recognition.

- Community Based Organization Partnerships: They are being very creative with this work in Staten Island, actually very aggressive and progressive. There are a lot of creative opportunities. 21 organizations are sharing $6.4 million for CBO partnerships.
- Opioid Activities: Most of the focus has been on MAT treatment services in Pierce County. In Pierce County, there is a long lag between licensing for a MAT provider and their first prescription. About $6.8 million was allocated for data and analytics for Behavioral Health.

- Carol Moser asked about TA for PCMH. Is Pierce County doing PCMH?
  - Adam Aaseby: Feel frustrated about the changing narrative at the State level. At the ACH level there was a MeHAF focus but the preference was to do PCMH all along.
- Q: Can you talk about health equity trainings?
  - Adam Aaseby: We got speakers to give full day trainings on health equity using the IHI model, a national model for improvements. Will get more info to staff on that.
- PHMS Uses:
  - PHMS is used to implement a health management system.
  - Utilize PHMS for Value-Based Performance payments to providers and partners.
  - Staten Island PPS IT infrastructure: The slide shows the types of data and the sectors that are putting data in. UnitedHealthcare, EmblemHealth, and other MCOs. It's possible for a payer to get involved in this.
  - One of the key differences is that most states have Regional Health Information Organizations (RHIOs)- NY has six, but WA only has one, OneHealthPort which is a statewide information exchange.
  - You can see several dashboards for providers. They have roughly the same staff at their Staten Island PPS. They have three staff for the data work and to do official work back to partner organizations and determine payments based on analytics. There's a place you can go to get data. The organizations that are participating are also able to get access. They can segment 42 CFR Part 2 from HIPAA (42 CFR Part 2 prevents providers from sharing any information on a patient's substance abuse history unless the patient gives explicit consent), and protect business and personal data. This is an important part of the contract relationship.
  - Maps are used on the dashboards. You can make the dashboard public to providers for a competition.
  - The data contains all payer all types but the reimbursement options are only related to Medicaid DSRIP opportunities. It's easier for the data analysts to send the whole thing not just pull out Medicaid people.
  - You can click on a dot, demographics, and utilization trends over time.

- PPS sample dashboard. You can see the top pharmaceuticals for the population you narrow down to. Available at the population level for all providers with access.
- PHMS Considerations: Can be expanded to populations outside of DSRIP like for Medicare and Commercial Market Synergies.

▪ Q: If all the data was coming from local providers, how much value did you get from state data? Was it important for VBP if you already had provider and MCO data?
▪ Adam Aaseby: The next steps for Pierce include a contractual relationship with the Staten Island PPS- The nice thing about Pierce County is it is a small geographic area and you can do stakeholdering pretty quickly.
▪ Comment: I'm impressed with Staten Island's ability to pull groups together.
- Adam Aaseby: Both are Epic-based systems.

- The second presentation for the Leadership Council on the topic of learnings from New York was given by Gena Morgan, Chief Operating Officer at HealthierHere. Her talk was titled "New York Performing Provider Systems (PPS) Lessons Learned."
  - The NY Waiver was signed in April 2014 (the NY waiver is in the final quarter of year 4). NY had a year zero for planning. DSRIP Year 5 begins April 1, 2019. They received $8 Billion over the 5 years. NY State has 25 Performing Provider Systems (PPS) statewide, and an RFP process to decide, Multiple PPSs can be in a region.
  - Unlike in WA State, Most PPSs are hospital-based entities (each has an anchor public hospital with a network of partner providers –2 are FQHC based).
  - They visited 4 PPSs in NY during the week. It was a really great week and they had rich conversations. The 4 PPSs they visited are some of the highest performing PPS in NY and certainly on the short list of the very best 8-10.
  - Lessons learned from NY:
    - First, they had thoughtful staging and phasing of strategies. This applies to WA State because we ACHs are small organizations with small staff and we cannot do everything at once. Additionally, we are working with partners in communities who also can't do everything at once.
      - "WAVES AND SPRINTS" (a key takeaway):
        - A WAVE might be focusing on a system or infrastructure investment area, for example, PCMH for primary care and other areas.
        - A SPRINT could look like lifting up a couple of metrics that they need to move and organize their partners around "sprints" to move those metrics.

	○ Also recognizing because it's a performance-based contract we can't bring in the dollars unless we move metrics (the ED utilization metric for example) and we focus to organize activities specific to this metric. ▪ Second, you need to have access to the right data at the right time. Adam gave everyone information about Staten Island using data, essentially NY had access to the RHIOs, they spent a lot of time trying to figure out if and how the RHIOs could be helpful to them to measure progress. In the case of Staten Island, because RHIOs weren't nimble enough for them they created their own data repository. They also noticed how some of the top NY PPSs set up proxy measures for providers to perform better on their required measures. ▪ Third, workforce development is foundational. This was a big risk area for the PPSs. This is different from WA where we're expected to partner with the State but the PPSs were expected to go at it alone, so they did very robust work around workforce development. ▪ Fourth, involve the payers early and often. All the ACHs in WA have had MCOs at the table from the beginning, but in NY many of the PPSs didn't involve the MCOs until much later and this was a regret. They wish they had involved their payers earlier and more often in their planning especially with sustainability issues ahead of them now and the issues that are important to the MCO partners. ▪ Fifth, leverage other local initiatives. Another area our ACH is thinking about strongly is the ability to leverage other initiatives. In NY they did a lot of work with the health homes. The lesson is to understand your current environment and local work that is already seeded or in place or can be leveraged. ▪ Sixth, maintain flexibility and be nimble. If you overthink it and build too tight of a structure, you may have to rebuild it later. Do quick tests and change, takes risks. Create structures that allow you to be nimble and course corrections can be made to get better results. King County ACH is seriously considering an Innovation Fund. The Bronx PPS had this fund. There might be parameters such as demonstrating a project with community-clinical linkages, make up to x dollars available for each project, connect with a cohort of folks to test ideas. Develop an evaluation cycle to see how things are progressing, discover some innovative ideas. Develop different parameters each year and how and which ones to fund. ▪ Seventh, start community and CBO engagement early. In some cases, PPSs didn't pay out incentive dollars to CBOs or involve them until much later in the DSRIP. There was a certain amount of regret because of the limitations of involving them too late. In the Bronx, they gathered community feedback by recruiting high school students to gather data in the community about social determinants of health and they are using the findings from this research for the nonprofit organization that they're launching from the DSRIP.

        - Eighth, sustainability. A number of PPSs are planning the formation of an IPA-like structure post-DSRIP, some are considering consulting. There are some challenges from not bringing payers in early. There is more focus on the sustainability of the PPS itself than on the *activities* that the PPS was designed for. Lesson is to think about sustainability from the onset.
    - Adam Aaseby added here that at the Staten Island PPS, they are exploring the IPA side and their biggest regret was not getting MCOs involved from day one.
    - Dr. Patrick Jones asked Gena: Have they met some of those goals around cost savings? Are they measuring those goals in NY?
        - Gena: Their key successes have been around convening, laying infrastructure, and around getting diverse players together.

- The third talk for the Leadership Council on the topic of learnings from New York was co-presented by Caitlin Safford, Director of Government Relations, Anthem, Inc., and by Kat Latet, Manager of Health System Innovation, Community Health Plan of Washington. Their presentation was titled "Key Takeaways from NY State PPS Trip with Healthier Here
- MCO Perspective (Amerigroup and CHPW)."
    - Be aware of how states and marketplaces are different when comparing 1115 Waivers. This is an important point because it was startling being there to see how differently things are run there. There's a completely different structure there. For example, we think their impacts on behavioral health won't be as impactful as we think they will be here. We learned quite a bit.
    - Focus on primary care medical home. Important to recognize that to make changes in the community and ensure community-clinical linkages, the clinics themselves needs to need to be transformed to act as teams to look at population health (Clinical transformation). This speaks to the waves approach that Gena mentioned.
    - Sustainability. In NY they engaged MCOs and other payers too late. They began late in their attempts to support community-based providers to develop their capacity in demonstrating their value to more "traditional" medical providers, as well as to test innovations and partnerships to see what is sustainable. In NY the VBP movement is behind where we are in WA.
    - Roles and responsibilities. All PPSs spoke to this as a role to prepare providers to engage in; some PPS discussed their role in developing "roles and responsibilities" of providers; in a way entered into defining turf to facilitate further partnerships across providers. What position should primary care put themselves in for integration? What about owning a role vs. fighting over turf or money? We need to have those conversations in WA.
    - Leveraging existing partnerships, systems and services. Partnerships are very important for Health Homes, HIE/HIT, Supportive Housing and Employment, planning capacity, etc. Support capacity and connections to these existing services, before creating something new. For example, Health Homes is an existing contracted

	service so how do we build up this capacity? How do we maintain a caseload within Health Homes to move that forward? o Shared responsibility for sustainability. This does not rest solely on the payers and NY PPSs are trying to facilitate provider-to-provider partnerships as means of sustainability. o Use the PPS to promote public health initiative or crisis awareness. Example: Staten Island's Opioid Crisis and Response website; bringing attention and addressing stigma. This was fascinating and they leveraged a ton of data resources. Two non-traditional bedfellows. This NY works supports the work Rubén is doing around ACEs. o PPSs played a strong role in developing data and data analytic tools as well as workforce programs.
Facilitated Discussion (Dr. Patrick Jones):	• Patrick Jones facilitated a discussion with the audience and the presenters: o Q: Your presentation emphasized health homes. What you think the best approach to that is in our area? ▪ Caitlin Safford: When it comes to the health homes program that exists here, there are some clunky aspects to this transformation, for example, every MCO has to have a different platform. It's a contractual requirement that's really inefficient for providers and limits their ability to reach clients. It's an administrative burden. That conversation is a state-wide conversation we need to have and is important for GCACH. High levels of Medicaid lives in our region and connection to health homes. Process mapping hasn't been done recently related to health homes, and that's something we could take on over the next year or two. o Q: What about public health and academic institutions? ▪ Gena Morgan: NY PPSs that we met with didn't meet with any PH departments and they were not called out as a partner. ▪ Adam Aaseby: On the Staten Island side, they do have direct partnerships with PH and PH registries. Staten island has worked some with academic institutions as well. ▪ Kat Latet: Some PH initiatives are being leveraged. On the workforce side, they have leveraged teaching clinics and colleges. Workforce development was a huge component for PPSs we met with. o Q: You talked about sharing data. What about sharing client information across providers? ▪ Adam Aaseby: Different PPSs have done different things. A couple of the PPSs have done a "Unite Us" platform for what the physicians can see. • Wes Luckey announced a draft list for 2019 Leadership Council meeting topics (see the draft in the LC packet). In March we will do something around EMS and Care Coordination. We are looking for ideas from LC participants. • Patrick Jones said that there will be 8-10 LC Meetings this year, including one in February. • Ronni Batchelor, Board Member, talked about the challenges with the IMC transition with MCOs since United Health Care has exited from this area. We're challenged with trying to service those folks who have or had UHC, and some

	people are told to leave because they don't have the right insurance. Molina and Amerigroup are not being accepted at all pharmacies like Walgreens. • Jorge Rivera, Board Member, remarked that some people continue to be on United Health Care in other regions but seek care in the GCACH region. There are no members in GCACH region who have UHC. There are solutions to this.
ADJOURNMENT & MEETING SCHEDULE	
Adjourn:	• Minutes taken by Aisling G. Fernandez, MPH.

Thank you for your time and engagement with Greater Columbia Accountable Community of Health!

2019 Leadership Council Meetings will be held from 9 a.m. to 11:30 a.m.
at Columbia Basin College, Classroom L102 (2600 N 20th Ave, Pasco, WA 99301) on the following dates:

Thursday, February 21st Thursday, March 21st Thursday, April 18th Thursday, May 16th Thursday, June 20th July Meeting Cancelled
Thursday, August 15th Thursday, September 19th Thursday, October 17th Thursday, November 21st