SE WA COH Steering Committee
Thursday, Nov 13, 2014
Minutes

Present: D. Patrick Jones, Mary Garza, Dr. Amy Person, Vonie Aeschliman, Ed Thornbrugh, Ken Roughten, Jim Bell, Lynn Moate, Carol Moser, Blake Rose, Brisa Guajardo, Wes Luckey, Bethany Phenix-Osgood, Dr. Larry Jecha, Delphine Bailey, Martha Lanman, Emily Buechler, Blanche Barajas, Daryl Edmonds, Randy Hartman, Hollie Kaiser, Jorge Rivera, Kathy Olson, Laurel Lee, Troy Wilson (call ins: Troy Henderson, Tim Meliah, Brady Woodbury, Deb Gauck)

Welcome, Introductions

Update on RSA Designations, GOA Pilot

Carol - reported that the official RSA designations had been announced through an email by Dorothy Teeter on 11/4/2014. The Greater Columbia RSA includes a nine county region including: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield, Whitman and Asotin Counties. She referred to the map and the criteria used in determining RSA boundaries. There are 3 counties in the RSA who are currently not a part of our COH: Kittitas, Yakima and Whitman Counties, although several of the COH committee members have been meeting with the Yakima leadership to discuss combining the COHs.

Ken described his understanding of the purchasing authority of the RSA designations. Behavioral health services (chemical dependency and mental health services) will be purchased by the RSA for services in the RSA under a capitated model. Medical services will have a much broader footprint than the BHOs with more choices. The real question will be how the services will be delivered: in an integrated system with behavioral & medical services provided within the same clinic, or MCOs contracting for all of the services within the RSA? This seems to be the battle between DSHS and HCA. Hospitals being pushed by Managed Care to cut costs and do population health management. Can't ignore the BH and Medical aspects of a patient's care.

Blake asked what the Plans think MH, CD, PH integration looks like by 2020?

Amerigroup-HCA wants to blend MH and CD services by 2016. By 2020 they pay MCOs for all CD & MH services so health plans will need to work with BHOs .

They will pay the plans the capitation and be responsible for all the services. By 2020 the State will contract with the MCOs for all services: CD, MH, PH. The Plans will then do one of 3 things:

- Contract with the BHO for MHCD services
- Contract with 3rdC party company (like Magellan) to do manage services
- Plan will have direct contracts with each provider

Molina-(Laurel Lee) Molina has been reorganizing to align with the ACHs. 2016 each RSA will move forward as an early adopter or under BHO model. Need to partner to ensure there is integrated care.

Daryl and Ken do not see that the ACHs will be risk bearing entities, nor contracting entities.

Guidelines for ACH Governance

- **Principles – Dr. Person, Dr. Jecha & Blake Rose**
- **Structure – Ken Roughten & Carol Moser**

Dr. Person-Purposes and Aims that came from the NSACH group revolve around the planning process as opposed to the aims of a governance structure and whole ACH, so they are not translatable. Tried to capture ideas around looking at more than just what happens in the health care system, like incorporating other aspects of the community in order to capture the social determinants of health, planning to have the appropriate infrastructure, trying to build on small local success, use what has been successful rather than try new things, but it needs more work to create a "Planning to Act" document. Ed believes that the MCOs will ultimately be responsible for developing infrastructure and being a risk bearing entity for the ACH so wondered if bullet items 4 & 7 should be a part of the document. Bethany felt that we needed to make a statement about health literacy a

part of the purpose statement.
Jim Bell-Created a template based on the style of governance at GCBH for a set of Bylaws and an Interlocal Agreement. The Interlocal binds people together, the Bylaws instruct how the people will function. Most of the work done through GCBH is through the committee structure with a strong board of directors to oversee the RSN. We should think about the committee structure and if it might be organized around geography, subject matter, etc. Bylaws are more specific, and the Interlocal is more general. **Patrick** - Spokane's COH has an overall advisory board similar to the description in the Interlocal, but hasn't established the committee structure yet. **Ed** - likes the structure similar to BFCHA with an overall board of directors but has several strong committees focused around subject area. **Jim** - The Board could be organized by geography with representation coming from each County, and the committees could be populated by subject matter experts. This structure would allow subcommittees to meet without violating open meetings act especially if the committee included a number of elected officials. **Blake** - pointed out that the "ideal" governance and organizational structure mentioned in the GOA was a centralized governance model with "aim" focused subcommittees; **"The ACH will have county level sub-committees to reflect the needs of each county."** He recommended that what we are talking about is what the state is considering "ideal". **Ed** - felt that subcommittees organized by subject area may encourage more collaboration. What is important is that each county feel represented at the Board level and that their needs are being met. In some counties, there are established committees or coalitions that are already involved in health issues. **Emily** - thought it may be more difficult in the larger counties to have one board to represent the interests of the whole county. **Carol -** suggested that services or agencies that cross our 9 County region may be better placed on the Board. The communities of health need to represent a cross sector approach to health. It's also possible to create sub-committees that have subject matter expertise.

It was agreed that the governance structure would include at least one representative from each Health Department (Administrator/Designee) with a possibility of giving Benton-Franklin 2 votes on the Board of Directors, and include leadership from a few other sectors representing population health. Jim suggested that we could decide to have 2 representatives from each County to broaden the expertise of the Board.

Blake, Bethany, Ken, Martha, and representatives from Yakima, and Walla Walla were suggested to work on a governance structure for the committee's consideration for December 8th.

Request for Backbone Support – Blake/Carol
Carol presented a revised budget that reallocated the expenses to include more compensation for backbone support, reduced the compensation for the facilitator, reflected more accurate expenses for committee travel and food, and absorbed the contingency funds. The training funds for Community Health Workers and IPAs would need to be authorized by the Health Care Authority.

A	B	C	D	E	F	G	H	I	J	K	L
SE WA ACH BUDGET											
Budget Line Item	Contract Budget	Cumulative Expenses	Remaining Funds Available	% Spent		Proposed Revised Budget Line Item	Revised Budget	Difference	In-Kind Contributions	Notes	
Facilitator Expenses	$ 15,000	$ 882.76	$14,117.24	5.9%		Facilitator Expenses	$ 8,000	$ 7,000		Have recv'd two invoices to date	
Facilitator Travel	$ 2,000		$ 2,000	0.0%		Facilitator Travel	$ 1,500	$ 500			
Planning Committee Travel	$ 3,686	$ 142.80	$ 3,543	3.9%		Planning Committee Travel	$ 1,000	$ 2,686		Committee members have been offered reim for travel, but most have not submitted invoices	
Planning Committee Meeting Food	$ 2,500	$ 270.73	$ 2,229	10.8%		Planning Committee Meeting Food	$ 1,026	$ 1,474		October and November food provided by GCBH	
Planning Committee Materials	$ 1,000	$ 12.39	$ 988	1.2%		Planning Committee Materials	$ 500	$ 500			
Backbone Organization Support	$ 2,640	$ -	$ 2,640	0.0%		Backbone Organization Support BFCHA	$ 12,000	$ (9,360)		Backbone support of BFCHA has been much more labor intensive that first estimates at 20 hours/month. Ex. Dir. expects to allocate at least 20-30 hours/week on COH activities through December.	
						Backbone Org Support PMH	$ 5,000	$ (5,000)		Would like to recognize the backbone support of PMH/Blake Rose	
Backbone Organization Travel	$ 200	$ 123.20	$ 77	61.6%		Backbone Org. Travel	$ 200	$ -			
Training Experts/Travel	$ 5,000		$ 5,000	0.0%		Retreat for 9 County ACH	$ 5,000	$ -		Approval rec'vd from J Cornell 11/18/2014	
Final Plan Preparation	$ 2,200		$ 2,077	5.6%		Final Plan Preparation	$ 2,000	$ 200			
Contingency	$ 2,000		$ 2,000	0.0%		Contingency	$ -	$ 2,000			
Walla Walla County Health Dept											
GCBH											
PMH Medical Center											
Total	**$ 36,226**	**$ 1,431.88**	**$34,670.92**	**4.0%**			$ 36,226	$ -			

Larry moved to approve the revised budget subject to approval by the state on the training funds; second, Bethany. Motion carried.

Carol will get back to the committee regarding the HCA's decision on CHW/IPA training.

Break

Discussion with Health Plans

- **Interventions with a high probability of success for SE WASH population**

Data Sharing

Amerigroup-Daryl Edmonds – Amerigroup became an MCO in July of 2012, so newer to WA State, operate in 20 states. Took a look at national, state, and zeroed in on Greater Columbia area. Spoke to three areas: Data, Utilization and Disease. Serving today a very different population compared to previous years which trended towards a much younger population. Patient 360 (web portal) allows PCPs to look at patient's data. Working with RSNs to share data with their members and identify populations to focus on. Reducing inappropriate ED use by partnering with PCPs, ED Providers, and Community Resources. Growing concern around diabetes and helping members manage their diabetes. Would like to get to the issue of obesity. Engaging with national sources to address obesity. It was noted that Washington state averages 2x the national average on prescribing psychiatric medications. Amerigroup is digging into the reasons why. Many members are getting the same prescriptions from several providers. Starting to work with the RSN to monitor drug usage.

Molina- Jorge Rivera – Molina has grown by 90,000 members statewide since January; over 500,000 members covered. Have over 34,000 members in the 6 County region. Largest provider of Medicaid services in our COH region. Automatic renewals working to improve continuous coverage. Molina is continually improving internal processes to provide quality service for all members like new authorization policies and prior authorizations for services. **Kathy –** Spoke about the Community Connectors program. Training developed by University of New Mexico. Their vision is to improve health outcomes and reduce unnecessary cost of utilization by offering face to face, community based care coordination and connections to community resources, health providers, and clinical teams. CC provide non-clinical assistance for up to 4 months through face to face contact, are embedded in community so they understand what resources are locally available, and serve as the "eyes and ears" of the clinical teams. Get referrals from the ED departments and go where the client is located. Try to get clients connected with housing, food, transportation, schedule appointments, fill out forms, referral to agencies, understanding medications, and

breaking down barriers to health care. 90% of their clients have some form of mental illness and CCs are appropriately trained to help them. How will shared savings be calculated and distributed?

Pilot or Design Designation Discussion

Two Pilot grants funded through legislation for $150K each. Design communities pending funding federal government approval of the SIM grant. Matching funds are desired for both Pilot and Design designations. Pilot application is due by December 8, Design application due by January 9. The Pilot ACHs will be funded through June 30, 2015, and the Design Communities will be funded through December 31, 2015. Pilots will serve as peer leaders for other ACHs. The application is the same for the Pilot or Design. Community Health Workers were mentioned as a theme that could be used across all nine Counties. Concerns were expressed as the Pilot needing more focus, with more deliverables in the grant application like governance needing to be in place to be competitive. **There was a consensus to move forward with a Pilot Application unless the governance issues proved to be too difficult to overcome.** Carol asked the Health Departments for their cooperation in determining their plans for Community Health Workers.

Wrap-up & Future Meeting Dates

Dec 8, 9-11:30am, GCBH

Drop Box: https://www.dropbox.com/home/Accountable%20Community%20of%20Health