Greater Columbia Accountable Community of Health

Board of Directors

Thursday, September 22nd, 2016
12:00PM to 2:30PM
Regular meeting
Greater Columbia Behavioral Health
101 N. Edison Street, Kennewick, WA 99336

Minutes

Participants	In Person: Rhonda Hauff (Vice President), Darlene Darnell, Les Stahlnecker, Lori Brown, Ed Thornbrugh, Andrea Tull, Eddie Miles, Jefferson Coulter, Martha Lanman, Julie LaPierre (for Ken Roughton) There was presence of a quorum because there were 9 or more directors present.	
Backbone Support Present	Carol Moser, Executive Director Aisling Fernandez, Communications Coordinator Deb Gauck, Consultant	
Guests	Bill Hinkle, Hinkle and Associates, LLC Erin Hertel, CCHE Efrain Quiroz, UnitedHealthcare Jorge Rivera, Molina Healthcare	
Special Thanks	• Thank you to Greater Columbia Behavioral Health, especially Julie LaPierre, for providing the facility and support that allows us to hold these meetings.	
TOPIC	NOTES	ACTIONS
Welcome & Introductions	• There were introductions around the room.	
Action: Approval of Minutes	• August 18th, 2016 minutes were approved with no corrections.	#1: Andrea moved to approve August 18th, 2016 minutes. Eddie seconded. Motion passed.

Director's Report: Carol, Aisling	Carol reviewed the items in the Director's report, highlighting the ACH Quarterly Convening, the GCACH Regional Health Improvement Plan (RHIP), the launch of GCACH's first monthly newsletter (this was done by Aisling), updates to the SIM Project (Readmissions Avoidance Pilot (RAP)), and results from the HRSA Sustainability Survey. On Thursday, September 15th & Friday, September 16th, Carol & Aisling met with ACH colleagues in Spokane who are from around the State for the ACH Quarterly convening. Two takeaways from this meeting were, first that Greater Columbia ACH has a high percentage of our total population which receives Medicaid Benefits (35% compared to 26.5 State-wide), and second that a good way to think about our RHIP is as the North Star of GCACH's work. Aisling noted that the GCACH newsletter was launched and talked about each of the sections of the newsletter, including a video, and plans for growing the distribution list for the newsletter to increase community outreach. Carol & Aisling asked for feedback on the newsletter. Carol reviewed the "spider web" graphic showing the results from the most recent survey that Sue Jetter took which compared members' view of different aspects of GCACH in February 2016 to August 2016. The survey is required for the grant. GCACH went up in all categories. Carol reviewed updates to the SIM Project and that there was to be a project meeting later that afternoon from 4-5PM in the Consistent Care office to discuss the project work team and other aspects.	
SIM Project Update & MOU Discussion	Carol described that the SIM Project is being called the Readmissions Avoidance Pilot or RAP for short. Erin Hertel and Carol worked to set up a logic model which is a one-page description of the project which includes Inputs, Activities, Short-term outcomes, Intermediate outcomes, and Long-term outcomes. Erin noted that this logic model is a tool for GCACH to further develop. It's helpful to put everything on one piece of paper to think about all of components together. The project team will need to collect data, some of which may come from the hospital. The team will need a way to track the data and ask questions such as: • Are they doing the processes we envisioned them doing? • Are they successful?	

	• Are the home visits being done? • Are they getting the services they should be linked to? Erin stated that part of the reason to do a project like this is to take a first crack at coming together as an organization and show value to the community. Plan, do, check, adjust. The data we are given would be more appropriate for long-term goals. As we think about spreading this project, we look at more aggregate data. We need to understand in real time if we're making changes whereas state-wide data has huge lags. Deb asked, what about following patients long-term? Erin believes it's hard to follow people long-term but it depends on the data agreements. That level of personal health information has a lot of concerns. Deb asked, what about value-based payment? Are these goals sufficient for the HCA to continue funding this kind of project? If you were doing this project under the waiver, you'd be working with a larger population and you do more tracking more easily. Starting smaller provides a wealth of benefits to understand what data capacity we have. Les noted that we'll pick individuals with a higher risk and then measure whether we're making an impact. The pilot will show us if we can help individuals and if we can do it in an efficient manner. A pilot project won't make a population change. The long-term outcomes might be 5 years out. Lori asked who was going to be on the project committee meeting later that day. Carol replied that it would be nurse case managers, Virginia Janin, Carol, Becky. Consistent Care will be running the project. Andrea asked if we expect any of the 40 in the pilot project would be Medicaid Beneficiaries. Lori noted that Qualis has a contract for Medicare and some are dual-eligible. Carol noted that Qualis produces a performance report for WA State and for 16 communities based on healthcare utilization patterns and Medicare beneficiaries' home ZIP codes. The Tri-Cities community includes Benton and Franklin Counties. This is how we found results on how we compare with the rest of the State. Erin said that there will be a data sharing agreement coming soon, not on the same cycle as the data dashboard, smaller than county but also not on an individual level. AIM will provide data. Les mentioned that the point is to enhance rather than to duplicate. Carol reiterated	

	that the point is not to duplicate. The Tri-Cities' hospitals are the worst in the State for 30-day readmissions. She explained about the process of talking to many agencies about their programs. The RAP partners are not set in stone but those on the MOU are the parties originally a part of this conversation. Consistent Care runs an emergency department diversion program with about 50% in terms of reducing avoidable ED use. Ed mentioned that Consistent Care excludes cancer patients which are a big subset of the hospital readmission group. Lori shared that she wrote an application to CMMS for care transitions in 2012 and was trying to build partnership with hospitals in multiple counties but lost that funding in 2014. Carol noted that medical transitions are not happening at the level that hospitals desire for people with complex medical conditions. Rhonda suggested that partners on the MOU be part of the steering committee. Ed suggested that part of the contracted deliverable be from Consistent Care, figure out the dollar amount, which relieves the ACH from figuring out how Consistent Care is going to operate. Carol noted that Consistent Care will responsible for executing the MOU and she brought it to the Board for comments. Jefferson suggested that Consistent Care identifies the players. There was no action on the MOU, just discussion. Martha suggested that on the top of page three, we add Klickitat County and Whitman County. Lena noted that it's the decision of the County Commissioners whether or not to be included in GCACH and they would have to send a letter to HCA.	
Contract with Consistent Care Services: Action	Carol introduced the document, Agreement for Services Between Greater Columbia Accountable Community of Health and Consistent Care Services, SPC. This project has a short 6-month window unless they are able to secure additional funding from the hospitals. There is a statement of work on the 6th page. Becky and Darin have qualifications with licenses to nursing and medicine, respectively. They are registered with Drug Enforcement Administration (DEA), have insurance. Larry Thompson was providing technical assistance (TA) last year and was helpful in writing the bylaws; Carol included his comments on this document in the back of the packet. Les commented that the agency should have credentials (added to the list of qualification). Lena mentioned that the goal is a flexible contract with a 3rd bucket for the work of the ACH to fall into that bucket. Lori suggested taking out "without cause" for a breach. Strike A and leave B & C.	#2: Ed moved to authorize Carol to execute contract with stated changes. Darlene seconded. Motion passed.

	We need to have cause factors for a breach. Put in a clause that gives contractual authority to pull their books and monitor records. A quality person or an accountant could inspect Consistent Care's records.	
Regional Health Improvement Plan Revisions: Deb	Deb introduced the new version of the RHIP into which she has incorporated feedback from the Board. The Board felt that the draft was not accessible to a wide audience and that the content should reflect that the GCACH is a regional organization. To address the accessibility, Deb moved the original RHIP draft (which she designed with the HCA as the audience and was aligned with collective impact) to the back of the document as a technical appendix and added a new section (the first 19 pages) which is designed to be accessible to a broader audience. When the RHIP draft was submitted to the HCA, the document included Training and Technical Assistance to communities, which Deb took out and put in that each Priority Workgroup will have a project in the RHIP. There were six measures for which all counties in the region had outcomes worse than the state: access to exercise opportunities, children in poverty, dental workforce, median household income, mental health provider workforce, and poor academic performance. The work has been guided by the population health model where clinical care determines only 20% of health outcomes. We decided to pair Robert Wood Johnson Foundation's Culture of Health (COH) Framework with this population health model, which broadened our understanding of determinants of health. Board members commented on the new version. Rhonda thought that the new document balanced the content and charts well. The big picture and the "What is the issue we're trying to solve?" will come out in the Executive Summary, which Deb will write last. Carol mentioned that she can see the data for why we have chosen the 5 priority issues and she appreciates that Deb added a definitions section. Board members discussed wording. Les suggested, "perhaps use *strategic concept* rather than *strategic issues*." Deb mentioned that RWJF uses *action areas*. Eddie asked about what happened with the idea of reducing ER usage. Jefferson suggested sending this back to the Leadership Council and the Priority Work Groups. Les observed that we are focusing on issues that are broader than a single community and advised not to go down to each community for a needs assessment, but find what are common needs between	

	communities. How would this shared, larger issue work for your community? Lori advised that we don't want to be as prescriptive as with the SIM project, that there should be goals strategies that can be adapted to different communities. Eddie said that he can bring this document back to people he works with to see if makes sense to others outside of this work.	
Executive Session on Executive Director	There was an Executive Session.	
Adjournment	Meeting was adjourned at 2:30PM. Minutes taken by Aisling & Carol	
Remaining 2016 Meetings	• Meeting dates for November and December are To-Be-Decided Thank you for your time and engagement with the Greater Columbia Accountable Community of Health!	