Meeting Minutes
Greater Columbia Community of Health
Joint Retreat for the Leadership Council, Governing Board and new participants
August 20, 2015. 8:30 AM -1 PM. Walter Clore Wine & Culinary Center
2140A Wine Country Road, Prosser, WA 99350

Participants:	There were 71 participants! Amy Fuller, Amy Person, Ann Allen, Annette Rodriguez, Becky Grohs, Bertha Lopez, Bethany Phenix-Osgood, Blanche Barajas, Brady Woodbury, Brian Gibbons, Brisa Guajardo, Caitlin Safford, Carmen Bowser, Carrie Green, Cindy Mackay-Neorr, Corrie Blythe, Dan Ferguson, Darlene Darnell, Daryl Edmonds, Delphine Bailey, Doris Visaya, Ed Thornbrugh, Eric Nilson, Gail Fast, Glenn Baldwin, Grant Baynes, Harvey Crowder, Holly Kaiser, Indira Pintak, Jennifer Dorsett, Jorge Rivera, Katherine Bell, Kathy O'Meara-Wyman, Kathy Story, Kevin Barry, Kevin Bouchey, Kevin Michelson, Kim Keltch, Lane Savitch, Larry Jecha, Len Pavelka, Leonor Rico, Les Stalnecker, Linda Mayovsky, Lori Brown, Lowel Krueger, Madelyn Carlson, Marcy Durbin, Martin Valadez, Mike Maples, Monty Knittel, Philip Lemley, Rebecca Sutherland, Sandra Aguilar, Sandra Suarez, Shawn Conrad, Stan Ledington, Stein Karspeck, Suzy Diaz, Thomas Huntington, Ti Nelson, Tim Cooper, Tonya Kreis, Verni Jogaratnam
Backbone Support:	Dr. Patrick Jones, Eastern WA State University, Facilitator; Blake Rose, PMH; Carol Moser, BFCHA; Aisling Fernandez, BFCHA
Guests:	Craig Nolte, Federal Reserve Bank of San Francisco Lena Nachand, HCA Marc Provence, HCA, Medicaid Transformation Manager, speaker
Special Thanks	☐ Thank you to the Federal Reserve Bank of San Francisco for sponsoring the retreat, specifically the facility, morning refreshments, and a backup projector. ☐ Thank you to the Managed Care Organizations (Molina Healthcare, Amerigroup, United Healthcare, Community Health Plan of Washington, and Coordinated Care) for providing lunch. ☐ Thank you to Garcia's Tex Mex for the lunch buffet. ☐ Thank you to Walter Clore Wine and Culinary Center for letting us use your facility. ☐ Thank you to HCA representatives Marc Provence (for your presentation and answering questions on the 1115 Global Medicaid Waiver) and Lena Nachand for your support. ☐ Thank you Patrick Jones for facilitating the retreat.

Topic	**Findings and Discussion**
Welcome & Introductions (Patrick Jones)	Meeting began at 8:30AM. Flash drives were handed out for all participants to view documents pertaining to the retreat and background documents for their information. Facilitator Patrick Jones, of Eastern Washington University, thanked everyone for coming to the retreat and asked each person to introduce themselves. There were self-introductions with names and organizations around the room. Patrick said that the retreat's overall goal was to come up with definitive plan, projects issues, and priorities for the next year or two. He gave an overview of the content of the meeting. Patrick recognized the sponsor of the retreat, the Federal Reserve Bank of San Francisco.
1115 Global Medicaid Waiver Presentation and Q&A Session (Marc Provence, HCA, Medicaid	Marc gave an overview of the 1115 Global Medicaid Waiver. Presentation: This waiver gives permission to the state to be flexible about how the Medicaid program is administered going forward. The waiver is a commitment over the course of five years for services to Medicaid clients in WA state. The Healthier WA Initiative has three aims: Improved health, Improved care, & Control of Costs. Three initiatives outlined are in the waiver. Marc focused on Initiative 1. He said we are close to the end of the 30 day public comment period. The waiver is intended to continue the work of Healthier WA. For example, value-based purchasing is a goal of Healthier WA and this would promote

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Transformation Manager)	activities in the FQHCs, Rural Health Centers, etc. Role of the Accountable Communities of Health (ACH) in the Waiver. Coordinating entities and knowledge of local needs. Recommend to the state priorities needs related to Medicaid population. Toolkits provide two-way communication. Needs and input with regard to the types of initiatives that make sense to fund through the waiver. Accountability for performance. There will be a limited number and there will be consistency region-to-region so there will be projects and initiatives, some of which will be initiated by the state (e.g. behavioral health integration). There may be initiatives particular to this region. Resources on flash drive: Waiver FAQ doc Slideshow from Tri-Cities public forum Q&A Session: Submission of waiver is the beginning of a process. Input from the GC counties and sectors is very important at this stage. There was a previous 1115 Waiver, but this waiver expired and everyone suddenly had to go back to previous structures. There is a very heavy emphasis in this waiver on *sustainability*. *Performance measures* built in to determine if everything is on track over the next five years. Working closely with legislators in governor's office. Funding will come through the ACH. There is statutory authority but not fiscal authority for the ACHs to distribute funding. Discussion of silos: better integration opportunities for providers. Projects will be accountable for their own performance. The waiver has a five year timeline and there will be approximately $3 billion dollars available for the state, but it is unclear how that will be distributed to each ACH. The RHNI inventory is to fill in gaps. We tell the HCA that this is a real need for our region. The state will determine which projects will be funded through the waiver. Help the state formulate its goals toward which projects need to be funded in our region. There is a possibility that we won't get the waiver. However, it is still important to keep doing this work. Participant- If there are savings generated from the waiver. Portion of savings allocated back to the region. If the waiver is approved and went into place, then there is a delay of about a year. Marc- The allocation of funds is based on the achievement of milestones. Objective to establish projects that will create savings. We can beat federal trend line by 2%. Submission of waiver does not affect benefits of Medicaid enrollees. Stage 1: if waiver has been accepted. Fed has 15 days from whenever we submit the application. Then HCA will enter into negotiations with the feds.
Overview of Social Determinants of Health (10 Counties) & Discussion (Patrick)	Patrick Jones gave a PowerPoint presentation about the Social Determinants of Health and Proposed Priorities for the Greater Columbia ACH. How did this presentation relate to the retreat? ▪ At the retreat, the participants were tasked with arriving at, or re-confirming, priority areas to tackle as part of the ACH. ▪ Patrick's goal for the presentation: To give a snapshot of our region's upstream health measures and some health outcome measures of where our region's health is today. The ACH may want to prioritize some of the "upstream" measures affecting the outcomes or prioritize some of the health outcomes for change. ▪ He did not present clinical measures

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	▪ Presented data by county and compared to the measure for WA state Data sources: ▪ Census (American Community Survey, SAIPE, SAIHE) ▪ WA Department of Health's Local Public Health Indicators (CDC's BRFSS & WA's Healthy Youth Survey) ▪ University of Wisconsin & Robert Wood Johnson Foundation's *County Health Rankings*. (Recent snapshot of where we are as a 10 county region using the most recent data available. Looking at five years of data for most of the measures.) Background: According to the Robert Wood Johnson Foundation *County Health Rankings*, the **80/20 Rule** (including access to care and quality of care) states that **clinical care is only one-fifth of the factors determining health**. ▪ Healthy Behaviors (e.g. tobacco use, diet and exercise, alcohol and drug use, sexual activity) comprises 30% of factors determining good health. ▪ Social and Economic Behaviors (e.g. education, employment, income, family and social support, & community safety) comprise 40% of factors determining good health. ▪ Physical environment (e.g. air & water quality, housing & transit) comprises 10% of the factors determining good health. Key Social Determinants of Health from the CDC ▪ Poverty rates ▪ Median household income ▪ Population w/ no HS degree ▪ HS grad rate ▪ Vacant housing rates (will have 2 housing "distress" indicators) ▪ Rate of physicians by county At the December 2014 retreat, the GCACH participant voted on the following top priorities for our ACH: ▪ Reduce the incidence of diabetes ▪ Provide greater assistance to those with behavioral health problems ▪ Improve care coordination Results/Potential Priorities for GCACH: ▪ Social Determinants of Health ▪ Economic Conditions: on average, worse than WA state ▪ Nearly all ACH counties have a lower income, higher all-age poverty rates, & higher unemployment rates WA average. Yakima & Franklin counties, the biggest agricultural counties, have the worst economic measures in our region. Kittitas & Whitman, with higher college student populations, have higher all-age poverty rates compared to the state and the other counties. Benton County is the best off in our region. ▪ Education: most GC counties have high shares of the population without a high school degree & average HS graduation rates ▪ About the same public HS 5-year graduation rate as WA state ▪ Franklin, Yakima, Klickitat & Benton have highest proportions of young adults without a high school degree or equivalency ▪ Kittitas & Whitman have the best education measures ▪ Healthy People 2020 features On-Time High School Graduation Rate as its leading social determinant of health ▪ Housing: on average, better than WA state

Topic	Findings and Discussion
	▪ Yakima & Franklin have the most housing stress ▪ Kittitas & Whitman have housing stress due to student housing ▪ Social Support: ▪ Mixed results for householders living alone ▪ Relatively smaller portion of households than state: Yakima, Franklin, Benton ▪ Relatively more households than state: Whitman & Asotin ▪ About the same proportion of families of single families with children compared to WA state, with far higher proportions of families of single parents in Yakima & Franklin counties ▪ Crime: Overall better than WA state ▪ Majority of GC ACH counties have lower rates of property & violent crime. ▪ Health Status Measures by Priority ▪ **Diabetes**: generally worse than WA state ▪ Diabetes incidence higher in 5 of the 10 GC counties, especially in Yakima & Garfield ▪ Considerably less exercise among adults compared to WA state, except for Whitman and Kittitas which are better than state average ▪ **Behavioral Health**: generally better outcomes, but worse provider: client ratios compared to WA State. Data missing for youth measures. ▪ Adult mental health is about the same as WA state, but better in Klickitat county ▪ Less binge drinking among adults compared to state ▪ Access to mental health professionals considerably below WA average in all GC counties ▪ **Care Coordination**: (Patrick defined CC as the right care provided to the patient at the right time) ▪ Approximately the same proportion of adults who received dental care relative to state, but worse in Yakima county ▪ Approximately the same proportion of adults with a personal healthcare provider, but worse in Yakima county & better in Asotin county ▪ Rates of uninsured <65 worse than state in Yakima, Walla Walla, Klickitat, Kittitas & Franklin counties Group Comments: ▪ Violent crime under-reported for many reasons. ▪ Undocumented migrants are included in the measures of uninsured ▪ Mental health provider definition is broad and includes those who have a National Provider Identifier (NPI) ▪ Statutory authority for the backbone organization (BFCHA).
Report out on the Top 3 County Priorities	**Benton-Franklin:** Priorities: BEHAVIORAL HEALTH, CARE COORDINATION. Specifics: ▪ Focus on behavioral health in schools ▪ Want to focus on improving high school graduation rate. ▪ Diabetes is important but can be seen as a measure and an outcome to other intervention ▪ Education is an umbrella top over all other priorities ▪ Care Coordination: work more closely with fire department to identify patients of need Programs that are working: ▪ Tri-**Cities Community Health** is already focusing on behavioral health. ▪ **Prosser paramedic program** **Columbia:** Priorities: DIABETES, CARE COORDINATION, MENTAL HEALTH Specifics: reduce incidence of diabetes

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	Kittitas: Priorities: MENTAL HEALTH, CARE COORDINATION Specifics: ▪ Mental health & substance abuse are co-occurring disorders ▪ Diabetes not on the list Programs that are working: ▪ high schools with co-located care with providers onsite to identify mental health issues ▪ Care coordination (fire department working with frequent fliers, assist with weekly visits). **Walla Walla:** Priorities: BEHAVIORAL HEALTH, CARE COORDINATION, DIABETES Specifics: ▪ focus on rural access to care & services ▪ behavioral health (big shift needs to happen for addiction care) ▪ care coordination (look for a consensus model, it would be an early challenge to define CC) ▪ diabetes (move prevention efforts upstream to do more city planning, impact culture & prevention) **Yakima:** Priorities: DIABETES, CARE COORDINATION, BEHAVIORAL HEALTH Specifics: ▪ Need to work on root causes. ▪ Diabetes is a short-term strategy. There are a lot of intervention for all ages. ▪ Different definitions of care coordination (improve intensive care coordination for diabetes and other chronic disease, social determinants of health, focus on the uninsured & medically underserved (access issues). ▪ Maintain behavioral health as a priority (broader than just mental health, also focus on the high incidence of suicide rates and work to improve HS graduation rates). **COUNTY SUMMARY:** All 5 counties present at the retreat support **care coordination** and **behavioral health** as priorities. 3/5 counties present support **diabetes** as a priority.
Report out on Top 3 Priorities by Sector	Community Based Organizations: Priorities: EDUCATION, CARE COORDINATION, BEHAVIORAL HEALTH Specifics: ▪ Want ACH initiatives to be holistic and look outside of the silos we're currently working in. ▪ Meals on wheels is a program than can be more than just about nutrition. There can be education provided and pathway to get elders, disable, children and others connected with other resources ▪ Workforce training ▪ Community health workers- connections to vital resources for housing, mental health, prenatal ▪ Link services to help high risk populations get connected to services ▪ Behavioral health and substance use prevention is a huge priority. ▪ We need sustainability, parenting ▪ There are school-based programs that are being done but expanded and linked to other resources Public Health:

Topic	Findings and Discussion
	Priorities: BEHAVIORAL HEALTH, CARE COORDINATION Specifics: - Huge gap between what PH would like to do and is funded to do. - Behavioral interventions have been successful in the past, though focused more on the individual rather than broader community. e.g. change built environment. Need to change community infrastructure - How do we define care coordination? - Public health overlaps with many other sectors. They are great conveners. **Philanthropy & Social Services:** Priorities: EDUCATION, CARE COORDINATION, DIABETES, BEHAVIORAL HEALTH Specifics: - High school graduation rates and overall education. - Need to have *sustainability* on pilots Programs that are working: - One Voice for Education focuses on obtaining a high school degree and higher education. - ESD105 - Yakima Foundation focus on early learning and teen pregnancy issues - Catholic Child and Family Services provides one on one care to family, self-care and overall health - Tri-Cities Three Rivers Foundation provide transportation - Care Coordination: Health Homes have had very good results. Only funded through the end of the year. 5% reduction in smoking. Work with folks across BH, medical and long-term services and supports - Diabetes: chronic disease self-management program- provided by hospitals and FQHCs. - OIC connects master gardeners with schools in Yakima - Lourdes works with youth who are overweight. **MCOs:** Priorities: CARE COORDINATION, EDUCATION Specifics: - There are 6 MCO plans in region. - Need to have a large infrastructure to be able to do integrative care, and the payment is not there to do that as effectively as they want to. - MCOs would like to provide care coordination and work with housing providers, e.g. contract directly with housing providers to get supportive housing services to members. - Would like to do more education such as health literacy and health education for members to improve their health. MCO employees/individuals take that on an individual level **Education:** Priorities: EDUCATION, CARE COORDINATION Specifics: - Need preparation (higher education, community colleges) for people who will be working to be sure that programs have content that helps the graduates work in fields (e.g. Navigator programs, work in an agency). Need to build capacity. - Schools are a captive audience. Work with schools and work with teachers, go in to classrooms and do presentations. - Build *relationships* with school and teachers on behalf of the kids. (cited program in Baltimore, Police Athletic League)

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	▯ Have health centers in schools Behavioral Health: Priorities: CARE COORDINATION, BEHAVIORAL HEALTH, EDUCATION, DENTAL Specifics: ▯ Care Coordination happens through integration. BH tries to integrate with health clinics. ▯ Better accountability to people you are serving and better accountability between providers. Programs that are working: ▯ Yakima Neighborhood Health has a health clinic embedded within the BH center and a pharmacy onsite. (When someone has severe behavioral health issues or complex needs, all their needs can be met at one site, get a case manager involved, have better communication. We don't have to wait until 2020 to do that. Not the ideal model for everywhere, but works well for them. How did they do this? They went to 4 different providers- WW gen hospital, St Mary's, the medical group for each of those. Asked, "How can we help you? How do we work better together?") ▯ St. Mary's Medical Group- Chase clinic recently opened. There is a licensed clinic social worker 3 days a week. Direct hand-offs from clinicians. Do intake at that time. Communicate back and forth. Health records automatically sent to primary care physician. Keeps everyone current with meds, health concerns. Better integration of care. Work together, all orgs still keep their identity. ▯ Tri-City Community Health is implementing health clinics within schools, these are currently medical, hopefully will additional resources in the future to expand to add education, BH and dental care ▯ New Mental Health Court in BF county ▯ Lourdes will extend transition center so police officers bring people directly there for care Transportation: Priorities: CARE COORDINATION, BUILT ENVIRONMENT Specifics: ▯ Human service transportation plans are completed every four years- finds out where transportation services are available and where there are gaps. Helps to identify **severe access issues**, particularly in rural areas. Access to care affected by transportation! Sometimes 911 is called and an ambulance dispatched. If there had been transportation, perhaps 911 wouldn't have had to be called. ▯ Bring specialty care to our local communities. ▯ Complete streets and safe routes to schools- studies that ID that students who bike or walk to school have higher test scores and attendance. ▯ Work with hospitals for transportation options for discharges and for patients to access non-emergency room visits. Programs that are working: ▯ Special needs transportation & senior transportation through the WA state dept. of transportation. ▯ For Medicaid eligible- transportation to eligible appointments. ▯ Transportation outside of area to specialty care- some need to get specialty care in Seattle. ▯ 211: Coordination to know where transportation services are. There is a mobility coordinator who directs people throughout region to transportation options. FQHCs, school-based health centers: Priorities: DENTAL, BEHAVIORAL HEALTH, EDUCATION, CARE COORDINATION Specifics: ▯ There are five community health centers that serve the GCACH, four of them were represented at the retreat o Martin Valadez- TC Community Health in BF counties o Sandra Suarez- YV Farm Workers Clinic in Yak, BF & WW counties

Topic	Findings and Discussion

- Ann Allen- Yakima neighborhood health services, in Yakima, Sunnyside and soon to be in Grandview
- Mike Maples- Community Health of Central WA- Yakima, soon to be in Tieton, Kittitas

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- There is a dental only clinic in Asotin county
- Have a lot more in common than differences, but also different from provider community
- Career education
- Within GCACH, without Klickitat: GCACH 24% of land mass of state, 10% of pop of state, 14% of Medicaid pop. Of that pop 39% in 2014 had a primary care service at one of 5 community health centers. The fifth, not present, Columbia basin health associates full service clinic in Connell in Franklin County.
- Integrated behavioral health services- housing, transportation. Not a co-located model
- Partnership with MCOs
- Need from ACH to be allowed to experiment on the fringes with really innovative practices to get to root causes- education, poverty, not quick fixes even within 5-years. Focus on the long-term. *Allow us to be test beds*.

Programs:

- FQHCs provide comprehensive primary care services, dental services, WIC services & MSS services, case management
- Reaching out to Medicaid population that is enrolled but not engaged
- Neighborhood health does housing homeless services and vision
- Farm Workers clinic School vision and family medicine residency and other services
- Addiction services
- Caring for long-term care patients & 90% of Pediatric in-patient population in Yakima
- Reverse-integration model sending primary care provider to mental health center (neighborhood health in Yakima, Self-management education Outreach school and education services Already doing programs that are evidence-based and make sense) Partnership with MCOs.

Housing:

Priorities: CARE COORDINATION, BEHAVIORAL HEALTH, DIABETES, EDUCATION

Specifics:

- For people with drug or alcohol abuse- make sure people have these services are there once they have housing
- Provide wrap-around services. Talk with landlords, support of housing authority. They'll be a more stable tenant with those services. From a health standpoint, if someone becomes homeless again, their health risk increases.
- Behavioral Health: if a child has behavioral health issues, the schools may expel this child and prevent this child from graduating. How do we identify these kids and tie this in with housing needs?
- Care coordination: lack of communication among health care providers and those who provide housing. Improving and increasing communication. Housing and communication about circumstances can be central to health.
- Community gardens are not well-utilized space for the community in general
- Need education opportunities for people to learn to eat more healthfully
- Behavioral Health and care coordination: Many housing sites have space for classes to take place. Medical providers & counselors could provide/deliver services on site.
- Education & graduation rates: need policies and information in place for the kids who need supportive services for college-bound kids to help them complete all the requirements
- Section 8 voucher in connection with other services.

Providers:

Priorities: CARE COORDINATION, EDUCATION, DIABETES, DENTAL, BEHAVIORAL HEALTH

Specifics:

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	▯ Important to provide services for follow up after care focusing on complications and co-morbidities. Prevent readmissions at the State-wide level work. Programs that are working: ▯ Consistent Care: a case management company that contracts with hospitals and MCOs. Coordinate care- connect people with the appropriate resources. ▯ The fire department works with frequent fliers. ▯ Memorial hospital has a program where they do diabetic teaching. Uses evidence-based practices for the education program. Good outcomes. Ongoing follow-up at home for patients. ▯ Sunnyside has a grant program related to all three priorities- links people to a primary physician if they don't have one when they come in, also leads to connection with specialty care and other resources coordinated through the physician ▯ Pasco - Police department- connecting victims of crime with community resources. ▯ Home care association of Washington: partnering with WA Dental Foundation because oral health is connected with overall health including diabetes. Train primary care medical providers (40% now) in oral health for children in well-child visit and conversely train dental providers in diabetes. Network of interveners working on this together. ▯ (Prosser) PMH Medical Center's Community Paramedic Program through a CMS grant initially funded 3 years ago, provided training for medics and equipment. Saved $1.2 million dollars. Keeps people out of the ED, helps to avoid readmissions, ID social factors. Follow-up with patients after hospital stays and visit their homes. Very successful program. o Brief physical exams at food banks. Navigators to find insurance and a primary care physician. Visit kids post-surgery and patients who are in hospice. Very successful program. Sector Summary: 10/10 Sectors present reported that **care coordination** is a priority for their sector. 8/10 sectors reported that **education** is a priority. 7/10 sectors reported that **behavioral health** is a priority. 3/10 sectors reported that **diabetes** is a priority. 2/10 sectors reported that **dental health/care** is a priority. 1/10 sector reported that **built environment** is a priority.
Common Priorities between County and Sector groups	Summary: Care coordination was the common priority from all county and sector groups at the retreat. Behavioral health was also viewed as highly important. Diabetes was seen by some counties and sectors as a priority and not for others; some groups see it as an outcome rather than an upstream indicator to focus flexible Medicaid funding on. Education was an important priority that came out of the sector groups. Built environment and dental health were also discussed and are important factors in health.
Next Steps:	▯ **Future meeting dates for 2015:** o **Sept 24, October 22, Nov 19, and Dec 15** o All meetings at Greater Columbia Behavioral Health, 101 N Edison St, Kennewick o Leadership Council: 9-11:30; Governing Board: 12-2:30 (working lunch) ▯ Participants of the GC ACH should self-select into a Work Groups (by priority) & a Communications Committee (select a logo and other communications structures to help ACH become designated) ▯ BFCHA will use the template (the inventory of regional assets/programs/services/grants) that ACH participants have sent us to design a regional health improvement plan to give to the Health Care Authority (HCA). We must show the HCA that we have regional input of assets and needs, then we will work on interventions and programs for better health, better care, and lower costs.

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