Greater Columbia Accountable Community of Health

Board of Directors

Thursday, May 18th, 2017
12:00PM to 2:30PM
Regular meeting
Tri-Cities Community Health (TCCH)
715 W Court Street, Pasco, WA 99301

Minutes

Board Members:	Directors in-person: Les Stahlnecker, Madelyn Carlson, Martin Valadez, Meghan DeBolt, Rhonda Hauff, Tonya Kreis (Representative to the Yakama Nation), Ed Thornbrugh, Dan Ferguson, Eddie Miles Directors on the phone: Amina Suchoski We met quorum with a combined 9 directors in-person and on the phone.	
Backbone:	Carol Moser, Aisling Fernandez, Wes Luckey, Patrick Jones	
Guests:	Kayla Down, Sarah Bollig Dorn, Jordan Byers, Erin Hertel, Corrie Blythe, Kat Latet, Isabel Jones, Caitlin Safford, Deb Gauck*, Dan Vizzini*, Jorge Rivera, Grant Baynes, Dr. Darin Neven, Mandy McCollum, Becky Grohs, Ben Shearer * Called in	
Special Thanks:	Thank you to Tri-Cities Community Health for providing the facility and support that made it possible for us to hold these meetings. Thank you to United Healthcare for sponsoring lunch. Thank you to Graze for the sandwiches and salads.	
MINUTES, REPORTS & PRESENTATIONS		
Welcome & Introductions	• Martin facilitated the meeting & welcomed everyone to the meeting. There were self-introductions including name and your organization.	
Minutes (Action):	• Approval of April 20th, 2017 Retreat and Business minutes. No corrections.	Rhonda moved, Madelyn seconded. Motion passed.
SIM Project Report (Hospital Readmission	• Becky Grohs, RN, BSN, CCM, Mandy McCollum, RN, BSN, and Darin Neven, MD gave a presentation on the Readmission Avoidance Pilot (RAP), funded by the State Innovation Model (SIM) Grant through GCACH, to the GCACH Board. ○ The pilot started on November 7, 2016 and ended April 10, 2017.	

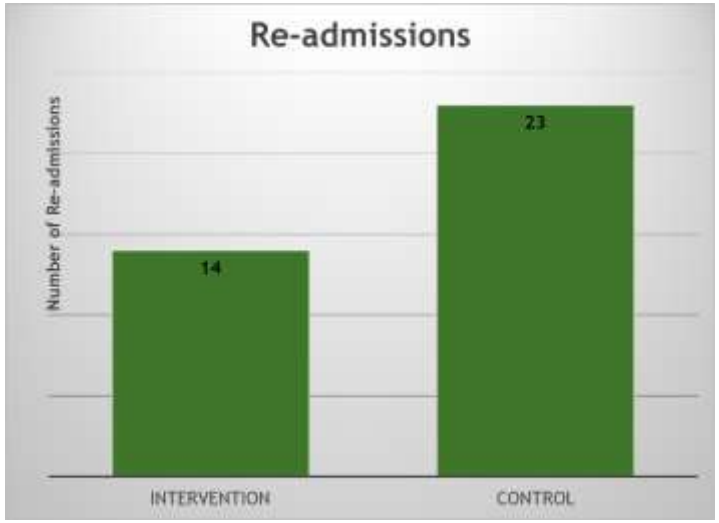
Avoidance Pilot) (Becky Grohs, Mandy McCollum, Darin Neven)	○ There were two hospitals that participated in the pilot – Trios and Kadlec. ○ RAP focused on Medicare patients that were discharging home ○ There were 40 patients in the control group and 40 in the intervention group (80 total). ○ Discharge planners in the hospital (hospital staff) used the adapted BOOST tool to pre-qualify patients and get their permission to be in the program. Then the RAP coordinator (Mandy) visited the patients in the hospital to establish rapport and explain expectations to the patient for after discharge. Once the patient was discharged, the RAP coordinator visited the patients in the home, where the full assessment was done including standardized tools for substance abuse, alcohol, anxiety/depression, pain, nutrition, cognition, etc. ○ Mandy did a complete medication review and other care coordination tasks including establishing a MD, or setting up MD appointments, providing education for disease processes, verifying orders, and connecting with community resources. Intensive in-home management continued for 30 days after discharge. ○ The BOOST tool was modified because the RAP team had trouble finding a tool that completely met the pilot's needs. The BOOST tool was adapted to include social determinants (e.g. mental health, substance abuse, transportation needs, financial needs, food insecurities, patient support and literacy). The BOOST tool was also modified to have a weighted scoring mechanism for the following 9 indicators: 1. **Problems with medications** – 30 people in both groups had 10+ medications 2. **Psychological/substance abuse** - 27 of the 40 in the intervention group and 31 of the 40 in the control group had some degree or suspicion of a mental health or substance use issue-equal to about 70% in both groups 3. **6 Principal diagnoses** (Cancer, Stroke/CVA, Diabetes mellitus, COPD, Heart Failure, and Pneumonia) – most people had at least 3 chronic conditions 4. **Physical limitations**- We found that once we got into the home and talked to the patient there actually were more chronic conditions present than what was accounted for in the BOOST tool before discharge. Of the 25% of patients who reported food insecurity, most were already in process of getting food assistance like food stamps, food banks, or needed help with the application process for food stamps

5. **Poor health literacy/Pattern of non-compliance:** 23/40 (58%) of patients that were referred to the RAP had some level of perceived non-compliance or poor health literacy by their discharge planner
6. **Patient support** – 2/3 patients had very little patient support
7. **Prior hospitalizations in last 6 months** - Most patients had at least 1 prior hospital stay in the last 6 months. 26 out of 80 referred to the program had 3 or more hospitalizations in the last 6 months (equal to 33%)
8. **Palliative/Hospice care** – The discharge planner was asked "Would you be surprised if this patient died in the next year?" We had 1 patient in the intervention group die within the first 30 days of discharge. She was getting treatment and not ready for hospice services. The control group had 2 patients pass away within 30 days, neither was on hospice services.
9. **Extra points for judgement "gut feeling",** Staff had a feeling there was something more to story – "Will this patient re-admit?" Staff instincts predicted that 95% of patients in the intervention group and 92% of patients in the control group would readmit in 30 days.

- Notable Cognitive Deficit findings:
  1. 30/36 **(83%) of patients** in the RAP pilot had some degree of a cognitive deficit based on standardized testing in the home after discharge.
- Notable Social Determinants Findings:
  1. For those patients that were enrolled in the RAP we found a high correlation between these issues and readmissions.
  2. Of note, 64% of the patients in the RAP pilot lived alone
  3. Patients with Medicaid coverage were more likely to re-admit, consistent between control and intervention groups
- Readmissions Results:
  1. Control:
     - 40 patients total
     - 23 re-admissions by 17 different patients
     - 43% of patients re-admitted
     - 4 patients accounted for 10 re-admissions

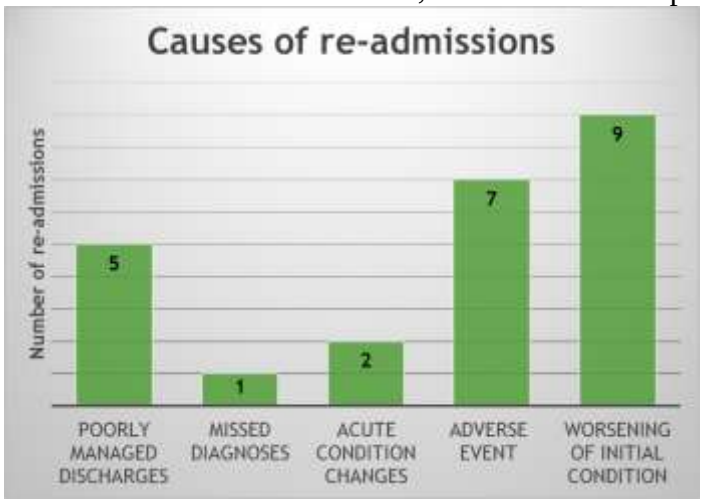
  2. Intervention:

- 36 patients total
- 14 re-admissions by 10 different patients
- 28 % of patients re-admitted
- 4 patients accounted for 8 re-admissions

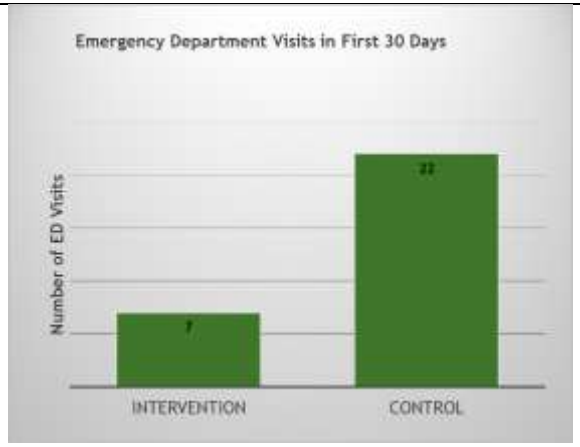


- Outcomes: Readmissions were attributed to 5 categories of causes
  1. Errors related to discharge planning (i.e. inappropriate level of care, lack of caregiver support, lack of education, poorly managed discharge)
  2. Missed diagnoses on initial hospital stay
  3. Acute condition changes after discharge
  4. Adverse events (i.e. fall, medication error by patient)

5. Recurrence of chronic condition; same as initial hospital stay



- Outcomes: Emergency Room visits NOT resulting in hospital readmissions
  1. RAP staff looked at ED visits in addition to re-admits. There were 22 additional ED visits that did not result in a readmission. **There was a statistically significant difference between the control and intervention group.** 76% of all patients in the control group went to the ED at least once.
  2. The control group had over three times more ED visits than those patients in the RAP intervention group.



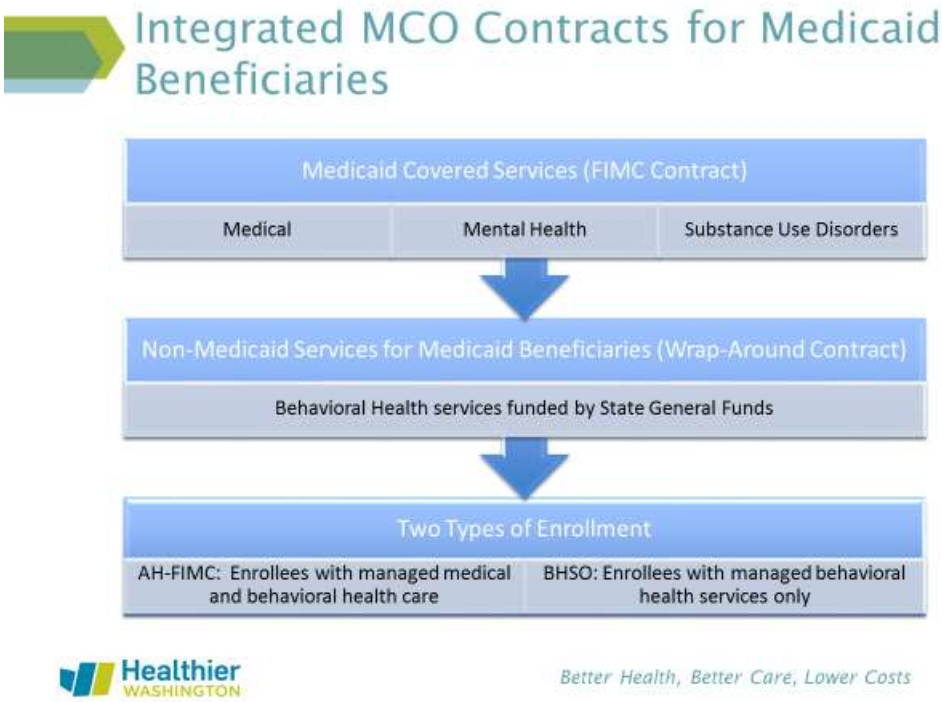
- Outcomes: Cost Avoidance = $3,248 per day
  1. Total # of hospital days attributed to a readmission stay:
     - Control: 137 days
     - Intervention: 89 days
  2. Difference of 48 days and a savings of $155,904 for 36 patients equals $4,330 per patient saved
- Patient Satisfaction: Overall everyone was satisfied with the program and felt it was very helpful. Patients trusted and appreciated Mandy and the RAP program.
- **Conclusions: How can we reduce readmissions?**
  1. Need for quicker access to provider visits post discharge
  2. Lack of communication between discharging hospital and the patients care team- Providers unaware of the admissions and new discharge plans
  3. Lack of understanding on the part of the patient regarding their instructions on discharge/medications
     - They verbalized understanding but on the home visit, evidence to the contrary
     - High percentage of patients we found to have a med-high cognitive deficit
       - How are we identifying this prior to discharge? – screening tools?
  4. Too much time elapsed between discharge and first Home Health visit

	• Provides a false sense of security on discharge planning & level of care patients receive post discharge 5. There was a correlation between SUD and higher ED visits • Are we capturing these SUD in the ED/IP with services like SBIRT, screening, etc.? 6. Correlation between those having unmet personal care needs, lack of transportation, and living alone with the # of re-admissions • What is the plan to address those that resist community help or other levels of care? 7. 64% of pilot patients had a mental health diagnosis before discharge. • What are we doing to provide these services to Medicare patients without coverage for mental health services? 8. Large number of ALTC referrals but low number accepting services. • Is this due to eligibility for services? • What about those patients that are receiving materials with med-high cognitive deficit and those that live alone? 9. Common feedback: appreciated having someone to call after discharge to help with issues. • What makes the RAP coordinator more accessible/responsive than the PCP? 10. Contact Information: • **Becky Grohs, RN, BSN, CCM** ○ Clinical Director (509) 392-6964 ○ becky@consistentcare.org • **Mandy McCollum, RN, BSN** ○ Case Manager (509) 392-4399 mandy@consistentcare.org
Fully Integrated Managed Care Presentation (Isabel Jones, HCA)	• Isabel Jones from the Health Care Authority (HCA) gave a presentation on Integrated Managed Care to the GCACH Board. ○ For over twenty years, HCA/DSHS have tried to make two distinct managed care systems work together so that care for clients can be delivered seamlessly. Clients still get caught between the systems. ○ Senate Bill 6312- Pathway to Integration: 1. Substitute Senate Bill (SSB) 6312 passed in 2014

	2. Changes how the state purchases mental health and substance use disorder services in the Medicaid program 3. Directs state to integrate the financing and delivery of physical health, mental health and substance use disorder services in the Medicaid program via managed care health system by 2020 4. Moves SUD Services into BHO structure as an interim step by April 2016 5. Directs the state to regionalize Medicaid purchase by April 2016 – 10 Regional Service Areas statewide ○ Currently, there are up to three siloed Medicaid provider systems that Medicaid beneficiaries must navigate to manage physical health, mental health, dental health and substance use disorder services. 1. Mental Health services for people who meet "Access to Care" Standards (ACS) are delivered through the Regional Support Network System, known here in Southwest as Southwest Behavioral Health. This system serves clients who have more chronic or serious mental health needs. 2. For clients who do not meet access to care standards but have lower-level mental health needs, HCA administers mental health benefits through our Apple Health managed care program today, or through a Fee-for-service program. HCA also administers medical benefits through Apple Health managed care, or the fee-for-service medical system. 3. Additionally, DSHS managed the substance use disorder system, through contracts with the counties for outpatient services and direct contracts with residential treatment providers. These services currently sit outside both the RSN or the Apple Health managed care system, and operate on a fee-for-service basis. ○ There is an opportunity to improve care coordination and ultimately improve health outcomes if we can integrate these services through managed care. 1. MCOs will provide all Medicaid physical, mental health, and substance use disorder (SUD) services. 2. MCOs will also provide services to Medicaid enrollees that complement the Medicaid benefit package, funded by general state funds and federal block grants (Examples of these services

include: recovery support services, community outreach, non-Medicaid UA's, authorizing Medicaid Personal Care, enhanced community services, non-Medicaid PACT team costs, etc.)

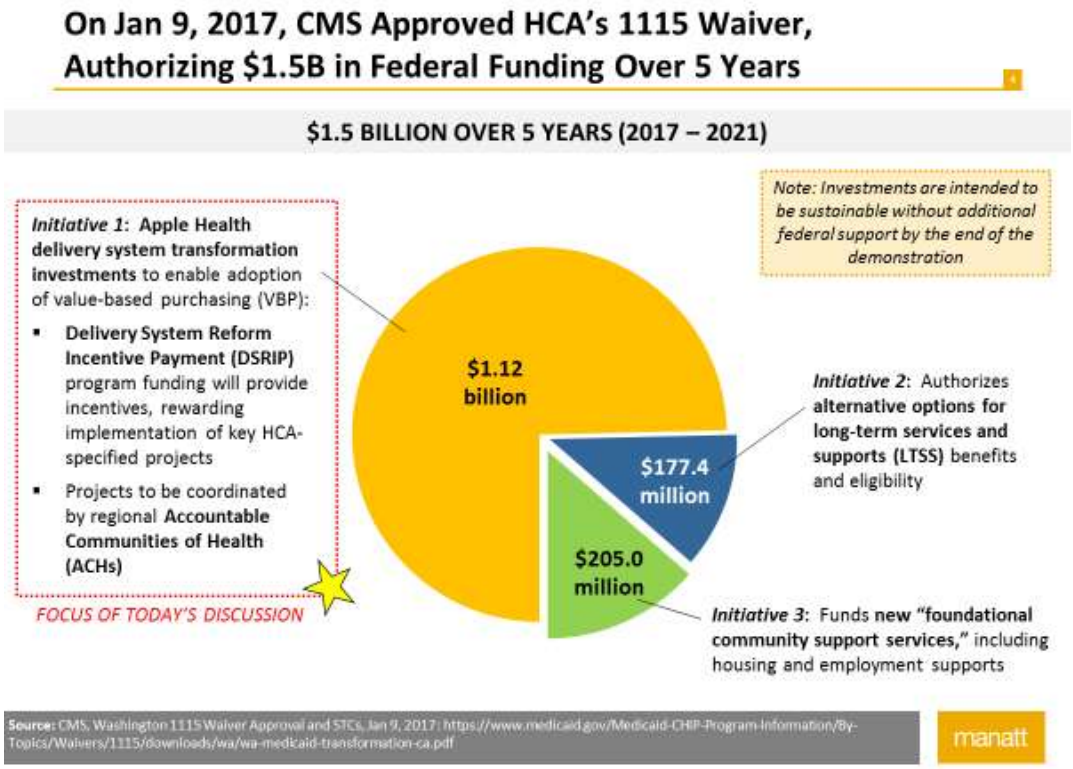
- Medicaid Transformation Demonstration Opportunities related to Integration:



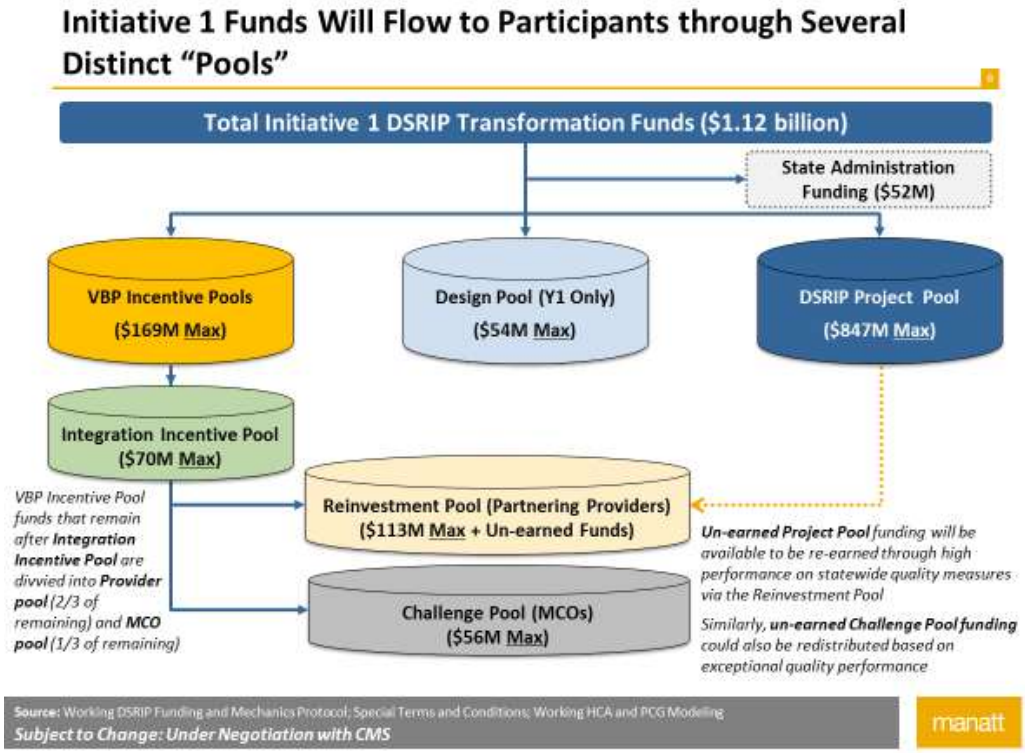
1. All ACH's are required to and will receive funding for clinical integration projects (see toolkit project 2A);
2. All regions with implementation dates prior to 2020 will receive incentives to support provider transition:
3. First incentive on receipt of binding letter: by 9/15/17
4. Second incentive on implementation date: 1/1/2019
5. The first incentive payment will be distributed upon approval of the ACH project plan – expected early 2018

6. Important note: it is the decision of the **county** authority to move forward earlier than 2020. The county authority should be defined in each county's charter. In a multi-county region, each county must agree to move forward before 2020 and each county must sign a binding letter of intent

- Integration Incentive Funds: Potential Uses:
  1. Can be used to assist providers in the region with the process of transitioning to an integrated managed care business model, such as:
     - Implementing new billing technology
     - Technical assistance to learn new billing/encounter submission/claims reconciliation methods and train staff on medical billing
     - Technical assistance in moving to value-based purchasing payment methods
     - Technical assistance to implement a new EHR
     - Technical assistance to implement an integrated clinical model
  2. Funds can also be used to further support implementation of transformation projects
- Next Steps:
  1. September 15, 2017: Binding Letters of Intent Due to be "mid-adopter"
  2. January 2019 – full integration, no transition
  3. January 2019 – MCOs assume risk, 1 year transition period
  4. Default: Full integration by January 2020 (no Demonstration incentives and no binding letter of intent due)
- Resources:
  1. **Accountable Communities of Health**
     https://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach
  2. **Practice Transformation Hub**
     https://www.hca.wa.gov/about-hca/healthier-washington/practice-transformation-support-hub
  3. **HCA Contacts**
     Isabel Jones
     360-725-0862
     Isabel.Jones@hca.wa.gov

Funds Flow and Mechanics Protocol Presentation (Dan Vizzini, Manatt)	• Dan Vizzini from Manatt gave a presentation about Delivery System Reform Incentive Payment (DSRIP) Program Funds Flow to the GCACH Board. ○ The Washington State Medicaid Waiver Demonstration total is $1.5 billion over 5 years. $1.12 billion of these funds are allocated for the DSRIP program for Initiative 1, coordinated by the 9 Accountable  Communities of Health (ACHs) in the State, including Greater Columbia ACH. ○ The Design Pool funds are available to ACHs this year (up to $54 million) for certification phases 1 and 2 (see the next box below about successful completion of Certification Phase 1!) The DSRIP Project Pool (up to $847 million) holds the majority of the funds available to ACHs for implementing various projects they are required to pick during the project planning efforts. Because this is not a

grant program, but rather a pay-for-performance waiver, anything that is not earned flows into a Reinvestment Pool which could be re-earned by ACHs based on high performance on statewide quality measures. Value-Based Payment (VBP) incentive pools (up to $169 million) include an Integration Incentive Pool for early integration (up to $70 million). What's left will be split into



Reinvestment Pool (for partnering providers) and a Challenge Pool (for MCOs) in a 2-1 ratio.

- The ACH is responsible for where investment decisions are being planned, prioritized, and made.
- MCO money comes through the Challenge Pool, but funding for everyone else (ACHs and implementation partners) receive funding based on plans submitted to state by October. ACHs do this in partnership with community, institutions, etc. and there are variety of ways to earn revenue to underwrite costs.

	○ Money will become available this year or early 2018. If you're successful in design phases you'll have money that is deposited throughout the 5-year program. ○ The project incentives are earned. The project plan GCACH submits in October (now November) will be evaluated by an independent assessor. The maximum amount is what we could get assuming no other changes to the pool. Numbers are likely overstated, looking at $19 million for Year 1 for GCACH. Would be evaluating in a couple of months following submission, likely in December or January we'll receive word that we've earned money up to $19 million based on the strength of the plan. The money doesn't come directly to ACH. Money is held in account managed by a financial executor. The executor sends money out based on requests in writing how much and for what reason. ○ In Years 2017 & 2018, money is based on process milestones (Pay for Reporting (P4R). In Years 2019 to 2021, money is based increasingly on performance outcomes (Pay for Performance (P4P)) that relate to our region. Any money we don't earn will go to reinvestment pool and become available to other regions showing higher performance. ○ Rhonda asked, "What do we have to prove by the end of the year to earn $19?" 1. Dan replied that what ACHs have right now is the toolkit, but there is no other guidance at this time for the targets that will be set in the region. We don't know what method the independent assessor is going to use to evaluate the plans. 2. In 2017, the $19 million is based entirely on the strength of the project plan. After that, the money is based on implementing the project plan. ○ Eddie asked, "What happens in 2022?" 1. Dan replied that the government is WA a chance to fundamentally change the system and to see if the new system will perpetuate itself with the engagement of patients, communities, etc. There's start-up money and a 5-year tranche of money. By the 5th year ACHs must be market-ready. 2. Caitlin replied that pieces of the ACH could be sustained not with demonstration dollars but with waiver authority to continue services. 3. Dan agreed that the State could provide regulatory relief to help perpetuate gains GCACH is making. He also stated that the VBP incentive portion of this is essential. The work of the ACH to support the transformation of the payment system is essential for sustainability of these reforms. Domain 1 items are absolutely critical and within that are the changes needed to support provider adoption of the VBP system.

	○ Slide 13 shows the purpose of the Design Pool Funds, which is to support ACH capacity, to support the capacity building that our partners are going to be invested in to ensure success of the projects. • Eddie asked, "Eddie- if you have an idea funded through fee-for-service and you want to turn that to a VB system and the state wants us to be self-sustaining. Would the fee-for-service piece be our self-sustaining piece?" ○ Dan disagreed, the game the State is setting up is intended for the region (the reason we have regions) to figure out payment mechanisms that will be most effective at moving the dial. The toolkit specifies what those targets might look like for a transformed system. Ed replied that we're talking about a change in the Medicaid system which allows us to spend money in a new way that we're now allowed to do currently and we'll achieve saving.	
UNFINISHED BUSINESS		
Employee Policies (Action)	• Board members deferred this to an online discussion and online vote. They need a week to review and want to vote in two weeks.	
NEW BUSINESS		
Board Member Resignations	• Resignation Letters from Jefferson Coulter & Ken Roughton	Dan moved, Meghan seconded. Motion passed.
Tribal Consultation Policy and Procedure (Carol)	• Carol began the discussion by introducing Tonya Kreis, who attended our Board meeting in person. She, along with Katherine Saluskin, is a designated Yakama nation representative to GCACH. Carol reminded the Board that the Yakama Nation is a sovereign nation. As representative, Tonya needs to take everything back to Frank Mesplie who is on the Tribal Council. • Madelyn asked, "Has the Tribe been able to review the policy and are there any concerns?" ○ Tonya replied that she has shared the policy with Frank but she didn't know if he had reviewed it. Frank must send documents through tribal attorneys because the priority of the Yakama Nation is its sovereignty and rights.	Rhonda motioned to allow the chair to sign and make minor changes based on Yakama

	• The Board approved the Tribal Collaboration Policy and the next step is for the Tribal Chair to sign and approve with any small changes. The Board will review the policy again if there are substantive changes.	Nation feedback. Madelyn seconded. Motion passed.

RFPs Discussion & Action	• Carol presented two RFPs to the Board:
	  ○ For a consultant to write Transformation Demonstration Project Plan
	  ○ For facilitation services for GCACH
	• Carol said that Patrick has done a wonderful job as a facilitator getting input and consensus. Carol likes the idea of having an outside facilitator. It would be great to have project and evaluative support, someone who is a good communicator, and if we need supporting documentation this person can help with those activities.
	• Rhonda suggested an RFQ rather than a RFP for simplicity.
	• There was discussion about whether there should be an attorney or CPA who should review the RFPs or RFQs.
	• Les suggested a minor edit where the RFP should say that is 15 days after the proposal deadline when it closes.
	• Ed said that he is becoming more and more concerned about the very fast-pace at which the Board is making motions. Also, there needs to be robust termination language in the contracts for consultants.
		Motion by Meghan. Seconded by Madelyn. Including edits. Motion passed.
		
		Carol will confirm with contracts and finance manager to follow super-circular information.

GCACH Staff Discussions	• Working CFO Discussion: ○ The current Finance Manager (Shannon Jones) is resigning for personal reasons. Carol will re-post the position with emphasis on a working financial manager since this person will have no staff working under them.	

	○ There was a discussion about whether this should be a full-time employee or contracted position. 1. Rhonda thinks that that is Carol's decision. 2. Madelyn suggested that this position is filled with someone who is savvy in the arenas of contracts and federal requirements. 3. The Board agreed that Carol should have the authority to make the management decision whether this should be contracted or full-time. • Administrative Assistant/Communications Coordinator & Director of Community Engagement Positions Discussion: ○ There was a discussion about hiring a 1.0 FTE Administrative Assistant/Communication Coordinator position (this is Aisling's current position, although she is .75 FTE). Aisling will be a program manager support employee with the title of Director of Community Engagement. Staff will post both job openings on Indeed.com soon	
Adjournment	Meeting was adjourned at 2:30PM. Minutes taken by Aisling.	
ANNOUNCEMENTS		
Remaining 2017 Meetings	**Thank you for your time and engagement with the Greater Columbia Accountable Community of Health!** The regular Board of Directors meetings for 2017 will be from 12-2:30PM on the following dates: June 22nd July 20th August 17th September 21st October 19th November 16th December 21st	