Greater Columbia Accountable Community of Health

Leadership Council

Thursday, October 20th, 2016
9:00AM-11:30AM Meeting
Greater Columbia Behavioral Health
101 N. Edison Street, Kennewick, WA 99336

Minutes

Participants	In Person: Gail Fast, Lana Stuart Eskeli, Janis Luvaas, Becky Grohs, Delphine Baily, Larry Jecha, Don Ashley, Gina Ord, Mark Koday, Jim Jackson, Susan Martin, Rebecca Sutherland, Corrie Blythe, Virginia Janin, Efrain Quiroz, Alex Howard, Shawnie Haas, Marcy Durbin, Joyce Newsom, Sue Jetter, Liz Whitaker, Deb Gauck, Eddie Miles, Wes Luckey, Lena Nachand, Suzy Diaz, Carla Prock, Heidi Desmarais, Matt Davy, Nicole Austin, LoAnn Ayers, Karla Greene, Sandra Aguilar, Susan Campbell, Bertha Lopez, _____, Meghan Debolt, Gina Ord, Jeff Schroeder (Key: highlighted text means unsure about the name)	
Backbone Support Present	Carol Moser, Executive Director, GCACH Aisling Fernandez, Communications Coordinator, GCACH Deb Gauck, Consultant	
Guests		
Special Thanks	• Thank you to Greater Columbia Behavioral Health for providing the facility that allows us to hold these meetings.	
TOPIC	NOTES	ACTIONS
Welcome & Introductions	• Carol facilitated and led introductions around the room, asking everyone to introduce their name and where they work.	•
Action: Approval of Minutes	• September 22nd minutes were approved by consensus with some corrections to the list of names of the participants.	•

Director's Report (Carol, Aisling)	• Carol & Aisling presented the Director's Report
	  • The biggest news was the preliminary approval of the Medicaid Waiver which was announced on October 3rd.
	  • Excerpt from the Medicaid Transformation Initiative 1 Fact Sheet:
	  ▪ *Community providers will be the foundation for Medicaid transformation. Initiative 1 is intended to build incentives for providers who are committed to changing how we deliver care. Primary care and behavioral health providers, hospitals, social service agencies, and*
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	other community partners all have a part to play in building a system that improves health outcomes. ▪ This section was included in the Director's Report and led to a conversation about What is a "Provider?" • There are different definitions. Lena said that the HCA intentionally didn't define this. • Eddie said he's not sure how WSHA defines providers. • Carol said that she believes that all of the partners in the room (in Leadership Council meeting) are providers, whether medical or provider of non-medical services. With the waiver, we need to leverage the dollars to benefit the entire population, not only the Medicaid population. • Lena said that reasons that ACHs are important and unique include that they have a local/regional flavor and include social determinants of health. • There was a discussion of what kind of risk ACHs bear for the Medicaid Waiver. The question came from this letter about ACHs. • ACHs are not risk-bearing entities. The "risk" is that an ACH doesn't reach a milestone (and you don't receive the payment for that milestone). ACHs are not at risk for giving back money. For the SIM project, we've been working with CCHE to come up with strong and practical process measures. MCOs do have risk. Here is the Medicaid Waiver FAQ document, see page 20 for information about risk.	
Draft WSHA Presentation (Edward Miles, VP Integration & Business Development, Memorial)	• Eddie Miles gave the Leadership Council (LC) the PowerPoint presentation that he had been developing for the Washington State Hospital Association (WSHA)'s Accountable Communities of Health Advisory Group Update to get feedback from the LC membership. The ACH Advisory Group is a subgroup of WSHA and Chelene Whiteaker convenes this subgroup. • Eddie said that his presentation is intended for the audience that wants the ACH 101 information. The presentation includes a brief overview of the Waiver and the ACH organizational structure. • Slide 5: The Health Care Authority (HCA) will issue two Requests for Proposals which includes an Independent Assessor & Financial Executor. The Independent Assessor is required in other states. It's intended to provide a neutral party for approving projects who is not involved in the incentive payments. It	•

	can be like technical assistance or working with content experts who can help up to optimize projects. The Financial Executor sends the money directly to the project participants while the ACH decides who the money goes to. The funds flow model still needs to be developed by the HCA. • VBP discussion: Lena- read HCP LAN white document- everyone should read this. Because she has a PH background, go to total pop VBP. But there are multiple models that fall into VBP. Don't just jump into last bucket of VBP with x dollars with x people. There was an RFI. • Carol said that the RHIP was done very carefully so we're in good shape. We should select projects • that fit within project priorities and within guiding principles. • Carol mentioned that there is as draft document in the LC packet that has ACH decision-making expectations which was modeled after New Hampshire's waiver. • Janis asked if we know what the allocation of the Medicaid funds are going to look like? Lena said that this will be based on project submissions, not necessarily a formula, but it's important that rural areas and Eastern WA gets recognized just as much as King County.	
Board Nominations & Call for Nominating Committee	• Carol said that there are expectations in the Bylaws about changes to the Board of Directors. She asked for volunteers for a Leadership Council-level Nominating Committee to work through the steps to confirm which current Board members will stay for 2017 and nominate from the LC to the Board where there is an open sector position. Rebecca Sutherland, Alex Howard, Delphine Bailey, Wes Luckey, Meghan Debolt, and Liz Whitaker volunteered.	•
Data *CORRECTIONS TO MINUTES MADE DURING DECEMBER 15, 2016 LC MEETING	• Deb talked about data about the regional health resources and needs. She has added data on Klickitat County, *Whitman County ~~Yakima County~~ and the Yakama Indian Nation. There are 4 measures for which all 10 counties in the region performed worse than the State (1. Access to exercise opportunities 2. Dental workforce 3. Median household income and 4. Ratio of population to mental health providers) and these line up well with our priority work groups (PWGs). Deb went through the matrix of services to identify gaps for each PWG.	•

Priority Workgroup Breakouts	• The 5 Priority Work Groups broke out to have small group discussions:
	  • Healthy Youth & Equitable Communities (HYEC)
	  • Oral Health
	  • Behavioral Health
	  • Care Coordination
	  • Diabetes & Obesity
		•

Priority Workgroup Report Outs	• The 5 Priority Work Groups gave report outs and some groups provided written notes:
	  • Healthy Youth & Equitable Communities (HYEC) (by Suzy)
	  ▪ One of the original HYEC goals was to improve outcomes for high school graduation since education is one of the primary social determinants of health. They want to partner and coordinate with other service providers and use a resilience model. There should be urban and rural scaling components. They want to focus on some of the outcomes, but if they focus too early (too short-term) vs, too late (too long-term), there are trade-offs. Use a train-the-trainer method. Use parenting programs. Have a menu of resilience-based practices and service models.
	  • Oral Health (by Mark)
	  ▪ There isn't enough money to expand oral health access. "Drill and bill" has been a failure. There are three missing pieces that oral health doesn't have: 1. Care coordination & case management to get high-risk individuals into care wherever they need it. 2. Community prevention to get dentistry outside the walls of the clinic. Fully integrated medical. Most likely a hygienist-driven model since they can currently do almost everything.
	  • Behavioral Health (by Janis)
	  ▪ Behavioral Health started out with the health improvement project of bi-directional behavioral health. Then they stepped back and realized that one of the biggest issues is presented in the document with the ratio of MH providers. Focus more on the capacity and increasing that capacity and increasing access to MH and substance use so it's equitable. The premise is that contact with a BH provider is going to increase health outcomes. Maybe 5 years down the road, it's a broad goal. Ideas were to look at providing assistance with
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recruitment- huge issue. Have this project look at recruitment, look at ways to increase the ability of any organization to hire these individuals who want to work within this industry. Programs to incentivize students. Big draws for some organizations is providing loan repayment. Use funds to provide that for organizations that hire. Need to go to individual areas to see what the main concerns and needs are and might be different with the whole gamut of mental health needs in a community. Not dictating any one approach to increase capacity.

- Jim Jackson said there are many ways you can increase capacity- some involve consultation, telehealth, pediatrician psychiatry. Increasing access can mean peer supports- peer mental health specialists to provide local care that don't have to have a doctorate.
- Sue Jetter - incentivize- open doors and make connections as new folks are introduced to the system and integration becomes more of a reality.

- Care Coordination (by Susan)
  - The Care Coordination group has the SIM project to address readmissions within 30 days. They also looked at the NY examples. They took a vote. The first suggestion was to expand hotspotting to a regional project that could be part of the process funding to inform other projects. The second suggestion was care transitions from skilled nursing, residential to decrease readmission. The third suggestion was community-based training for competency for people most at risk for navigating the system.
- Diabetes & Obesity (by Gina)
  - Project: Diabetes Prevention & Management
    - Idea would be to start with 2-3 pilot communities and expand to every county in the GCACH.
    - 3 aspects, which would be multi-dimensional and integrated in each community:
      - Diabetes Prevention (community-based)
      - screen for pre-diabetes at community locations that serve a high percentage of the Medicaid such as supermarkets, food banks and schools (aim is to find potential participants before they arrive at the clinic with medical complications)

		- teach the diabetes prevention program (CDC version) at community sites such as low-income housing, churches, schools, and community centers. - hire master trainers to train community-based trainers - offer bilingual community support systems such as buddies and support groups so graduates can maintain lifestyle changes post-graduation • Diabetes Management (clinic-based) - use ER hotspot diabetes data to focus targeted interventions on particular geographic areas that have a high diabetes rate - streamline protocol for all healthcare providers to refer diabetes patients into one diabetes management system - care coordination using cell phone technology/apps to increase the likelihood of referred patients managing their diabetes - increase the number of certified diabetes educators, especially bilingual educators - communities can choose to implement either CDC or Stanford model of the Diabetes Management program, depending on community needs • Physical Activity and Healthy Food Access (community-based) - support 1-2 no-cost exercise classes in each community, and market to the Medicaid population - hire a facilitator to form and maintain community coalitions comprised of key stakeholders from various sectors (elected officials, businesses, community organizations and advocacy groups) to improve access to physical activity at the policy, systems, and environmental levels. - this facilitator would lead coalitions through community assessment tools and action plans to increase resident access to safe walking, biking and other physical activity opportunities. This coalition work is evidence-based through NIH/Extension partnerships in multiple states - built environment	

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Closing discussions	• Lena emphasized that *social determinants* needs to be present in this room. What if you don't have transportation to get to great bi-directional care? Think about social determinants as they will become more and more important. Also, remember that this work is *participatory*. If you don't have the voice of community members, you don't know what their barriers are. ACHs need accountability and transparency, particularly at the board level. There needs to be flexibility on both ends for HCA and ACHs
	• Ed expressed concern about duplication of effort whereas existing regional and local organizations are financially efficient, managing workflow, years of experience. We're going to create a new system rather than expanding the knowledge of the existing system.
	  • Lena- it's up to ACH Board to decide to contract out. Other boards don't supersede.
	  • Ed- concerned that you lose some of the institutional memory and knowledge.
	  • Caitlin- We're not sunsetting other groups, rather bringing groups to a table and learning from what they're doing. No one could do this in a way that's going to touch all 10 counties. Intended to bring in the community element. There are hard discussions to have. What does it take to stand up a new organization? Who is the employer of record on taxes? If you are under People for People, for example, what are the conflicts? How does it affect policy? Why are people moving to independent organizations? Advocate how you need to for the region.
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Adjournment	• The meeting was adjourned at 11:30	•
2016 Meeting Schedule	The GCACH Leadership Council meets the Third Thursday of the month. • Location: Greater Columbia Behavioral Health, 101 N Edison St, Kennewick • Time: Leadership Council: 9-11:30 • Only one remaining meeting in 2016: **December 15, 2016** Thank you for your time and engagement with the Greater Columbia Accountable Community of Health!	

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