Minutes of the Greater Columbia COH Steering Committee

December 19, 2014 RETREAT

10-3pm, Walter Clore Wine Center, Prosser

Present: Cindy Adams, Delphine Bailey, Blanche Barajas-Garcia, Carmen Bowser, Emily Buechler, Bob Burden, Tim Cooper, Al Cordova, Kathy Covey, Harvey Crowder, Andre Fresco, Erinn Gailey, Deb Gauck, Annie Goodwin, Sue Grinnell, Brisa Guajardo, Troy Henderson, Larry Jecha, Patrick Jones, Holly Kaiser, Kim Keltch, Kyle King, Linda Kirk, Monty Knittel, Julie LaPierre, Wes Luckey, Kevin Michelson, Carol Moser, Lena Nachand, Chase Napier, Ti Nelson, Dr. Amy Person, Bethany Phenix-Osgood, Carla Prock, Robin Read, Jorge Arturo Rivera, Blake Rose, Lane Savitch, Kathy Story, Sandra Suarez, Ed Thornbrugh

Welcome, Introductions

Blake Rose welcomed everyone to the retreat and asked them self-introductions. He thanked everyone for taking time out of their busy December schedules to attend the retreat.

Goals: Patrick asked Carol to state the purpose of the retreat.

Carol expressed that she really hoped that the participants would nail down the governance structure. She hoped that everyone could come to an agreement that fairly represents the nine counties and represents their priorities.

Chase (HCA) – Goals of their presentation: Increase understanding of the Healthier WA ACH Initiative, Increase understanding of Collective Impact and its potential role in the region, have opportunities for dialogue and discussion regarding the investments, provide a framework for our retreat.

Sue – Background of ACH. The Affordable Care Act created the CCMI, Centers for Medicare and Medicaid. Purpose of the center is to test innovative models to get to the Triple Aim (better health, better quality, and lower costs). WA received a pretest grant to write a plan. Two pieces of legislation supported the grant HB 6312 and HB 2572. 6312 legislates integrated whole-person care (behavioral and physical health by 2020) and 2572 legislates ACH testing. The state received notice on December 16th that they received $64.9 million. The Healthier Washington grant proposal aims to implement key elements of the state's five-year Health Care Innovation Plan, which was the result of a previous $1 million State Innovation Model grant from CMMI. It is a 4 year grant, and the first year is for planning, which Sue felt was advantageous in that it allows the state time to learn, explore, edit, and adapt.

Sue talked to the strategies, investments, and goals of the grant, and highlighted the work of the Accountable Communities of Health. The State has formed the Health Innovation Leadership Network from various cabinet level agencies to advise the work of the plan, and a subset of the HILN will act as the core project team: HCA, DOH, and DSHS. The idea of infusing Health in All Policies will be part of the work of the HILN group: Incorporating health, equity, and sustainability considerations into decision-making across sectors and policy areas. She then focused on Regional Service Areas, RSAs.

Goals of RSAs

•Align interests around a common population especially for individuals who have complex, high cost, multi-system service use and needs.

•Bring partners together for shared accountability and to meet the legislated outcome measures of SB 5732 and HB 1519

•Serve as a platform to expedite fully integrated managed care delivery systems by 2020, as directed by statute

•Provide a framework for the evolution of a community role in Medicaid purchasing through Accountable Communities of Health (ACHs)

Concerns regarding the RSAs and referral patterns were discussed. There are three Counties, Whitman, Asotin and Garfield whose referral patterns do not align with our RSA. Sue explained that Regional Service Areas and Provider Networks are different. Whereas a provider network ensures that there will be an adequate number of providers served by the health plan, the RSA will work with the MCOs to determine what services will be provided. Will the provider network influence referral patterns? The question of shared savings becomes important to this discussion that will have to be worked out. The reimbursement rates may be different between ACHs.

Chase – Health is more than Healthcare: The ACH Initiative

The state recognized the need to increase collaboration around health care initiatives that were already taking place in the state, so they looked to existing health collaboratives that could:

•Engage multiple sectors and organizations to create transformative, lasting change

•Increase coordination among clinical, community, and government

•Shift from the traditional outreach approach to authentically engaging communities

What is an ACH?

- Regionally governed public-private collaborative
- Representing a diverse coalition of participants
- Tailored by the region to align actions and initiatives
- Striving to achieve healthy communities and populations

What will ACHs do?

- Will serve as a regional forum for collaborative decision-making across multiple sectors and systems to align actions to achieve healthy communities and populations, improve quality and lower costs.
- Act as an accelerator, disseminator and collector of regional best practices, lessons learned and shared challenges to drive health systems transformation focusing on population health, social determinants of health, clinical-community linkages and whole person care.
- Collectively impact health through regional purchasing strategies, starting with Medicaid.

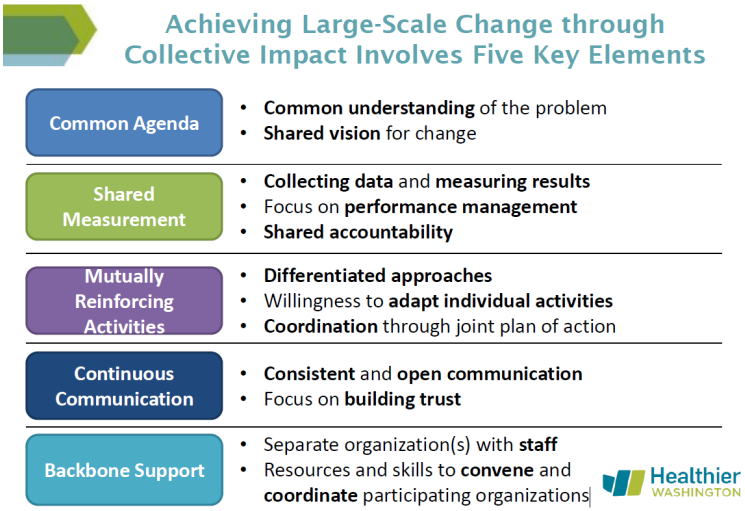
The State will support ACHs in each RSA as a partner in purchasing. Specifically, the "preliminary approach" proposes that 1) the ACHS will be active participants in the State's monitoring and evaluation of MCOs' performance 2) the State will partner with ACHs to develop contract

requirements, including the selection/planning for local transformation projects that are in line with the State's and Region's goals. It is intended to have fully functioning ACHS in every RSA by 2018.

Sue - The Promise of Collaboration

Collective Impact is the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem.

No single organization alone has the ability to solve the world's most challenging problems, especially with complex problem. We need to be adaptive to the problems of society.



The role of the backbone is to help provide a clear understanding of the problem, and to help drive the organization to work together to solve the issues.

Overview of County Health Rankings for 9 Counties

Patrick reviewed highlights from the CHR as a preface to the breakout exercise for the 3 top health priorities from each County. He noted that **shared measurement** (Collecting data and measuring results consistently across all participants) and **common agenda** (All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions) **were elements of the Collective Impact** model that Sue had just talked about. He picked 8 indicators using a couple of different filters: indicators that presented challenges to the 9 counties; and ones that highlighted a great deal of variety among the 9 county region. He reviewed measures in Health Outcomes: Premature death (potential years of life lost before age 75), Poor physical health days, Poor mental health days. Health Behaviors: Adult Obesity, Teen births. Health Access: Dentists to population ratio, Mental Health providers to population. Social & Economic Factors: High school graduation, Children in poverty (all counties are above the state average). People broke into groups by County to reflect on CHNAs, what has been eye opening during his presentation, prior work, County Health Rankings, and report out on top 3 issues.

Link to County Health Rankings: (for nine county comparison)

Although this will be an on-going discussion, this exercise will help jump-start the group in 2015.

Sue acknowledged that these are daunting issues with upstream problems. She suggested that we set boundaries and not get overwhelmed by some of the larger issues like poverty.

Top 3 issues by County & MCOs

Benton-Franklin: Obesity (all ages) linked to diabetes, Access to dental and behavioral health care, Inadequate social supports

Columbia County: Obesity and Nutrition (all ages), High diabetes, Mental Health and Substance Abuse (youth)

Kittitas: (All Youth) Mental health, Substance abuse, Obesity

Yakima: Obesity, Consumer education and engagement (health literacy) Culturally appropriate linguistic services, Educational attainment, ACES, Care coordination

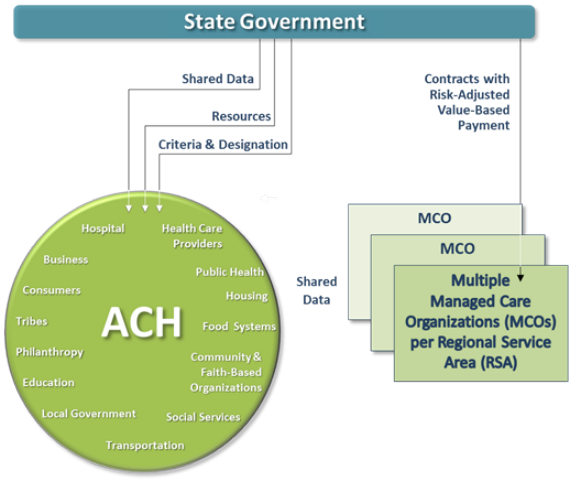
Walla Walla: Access to mental health services, Nutrition and physical activity, Combined mental health and CD treatment, Living Wage jobs (child poverty)

Whitman: Dental access, Childhood obesity, Access to social support programs

MCOs: Obesity, Health literacy and cultural diversity, Mental and behavioral health access, ER reduction

Role of ACH Governance & Backbone support

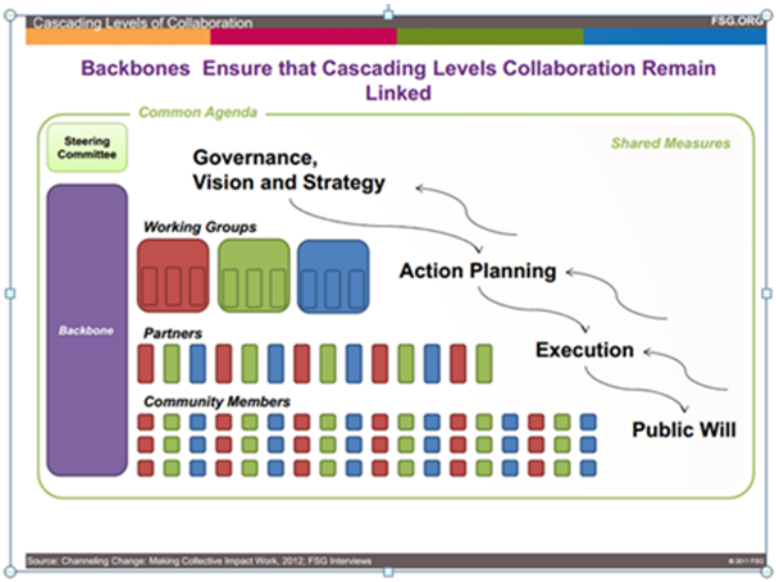
Carol referred to the models of governance in the packets that were emerging from two other COHs, the North Sound ACH Organizing Committee, and the Better Health Together Governing Board. Both boards included representation from cross sector organizations, and North Sound also had cross geographic representation. The task in front of the participants was to determine how to structure the Greater Columbia ACH, both for a governing board, and for the Leadership Council. She also referred to a white paper developed by Patrick called "Thoughts on Board Make-up for the SE & S. Central WA ACH" that was on the table. Deb asked Patrick to display a graphic representation of the Collective Impact governance model to assist the group in understanding what HCA expected in terms of representation. The group was also asked to identify what organizations exist in the 9 county region that could serve as the backbone support organization.



People broke into groups to discuss governance by county, function, and cross sector. Patrick also asked that the groups discuss the backbone support organization for the nine county region.

He reviewed the first proposed governing board that the committee had recommended, and then a model he had devised. **(Thoughts on Board Make-up)**. He tried to keep 12-15 as maximum on the Governing Board.

How to decide the representative groups?



Patrick displayed the above graphic to illustrate how the governance model looked like in Collective Impact. He asked for input on the model.

Thoughts on Board Make-up for the SE & S. Central WA ACH

Governing Board (12-15 members)

1. Representative from a large public health district
2. Representative from a small public health district
3. Representative from a large hospital
4. Representative from a small rural hospital
5. Representative from a multi-specialty clinic
6. Representative from a federally qualified health clinic
7. Representative from a regional mental health organization
8. Representative from a community action council
9. Representative from an education service district
10. Representative from a Medicaid plan provider
11. Representative from a Medicaid plan provider
12. Representative from a long-term care organization
13. Representative from a housing authority
14. Representative from a large agribusiness
15. At-large

Leadership Council (30-35 members)

A. A "general" approach – consisting of organizations not on the Governing board

1. Health districts (2)
2. Large hospital
3. Mid-sized hospital
4. Small hospital
5. Physicians' clinic
6. Oral health
7. Federally qualified health clinic
8. Community action council
9. Large school district
10. Small school district
11. Medicaid plan provider
12. Medicaid plan provider
13. Medicaid plan provider
14. Municipal governments – staff or elected (one for each county, or 9)
15. Community-based organizations (5)
16. Businesses (3)
17. At large (3)

B. A "Subject Expert" approach, as in Benton-Franklin's Health Alliance
Assuming 3-5 sub-committees, with 8-10 members each

D P Jones
12.14.14

Wes read his list for the **Partner** (Leadership Council) portion of the Diagram. A representative from that group would represent that entity.

County Representation
Public health

MCO - Medicaid
Private health care (Hospitals, clinics)
FQHCs
CBO (community based orgs, non-profits, Community Action Agency, World Relief; Ethnic Populations)
Schools – Higher ED, ESD
Criminal Justice
Transportation
Housing
Tribal
Business/ag business
Faith-based Organizations
Mental Health
Oral Health
Aging and Long-term Care
1-2 At large positions

This group would feed up recommendations to the Governing Body.

Patrick referred to the chart provided by the HCA and noted that most of Wes' list was on the chart. **Wes' list was accepted subject that it contained representatives from all nine counties.**

Harvey agreed with Wes' list. There needs to be a balance across the counties involved in the ACH. There was strong agreement with the addition of having "consumers" as opposed to "at large" positions.

Working Groups
The issues and community priorities should be represented by the Working groups in addition to the Leadership Council. The WG could also consist of outside experts, like NAMI, and not just by the partners. Harvey described that the Steering Committee could determine that a group needed to be formed (ad hoc) or be a standing committees. The number of Working groups could be numerous depending on the number of issues to be tackled.

Deb asked if the working groups be cross sector? Harvey suggested that it depended on the issue, like obesity would need to be cross sector. It was decided to determine the working groups in 2015.

Steering Board/Governing Board

12-15 people
Heavily driven by Health Districts?
Or more?

Harvey sees the Collective impact model working very well for the Governing Board, especially if they have the money to pay and the power to change policy. Harvey suggested a broad spectrum of healthcare, governance, consumer, business, social services representation. Ultimately, the GB determines what we should focus on. They also have the ability to change policy in their own organizations.

The distributed model of governance was preferred; many stakeholders and cross geographic. Intent for both Governing Board and Leadership Council to be cross geographic and cross sector.

There was a robust discussion regarding the MCOs. The group of MCOs did not feel that they should be represented on the Governing Board. Ed and Emily believed that it was not appropriate for MCOs to be on a committee where they were expected to monitor and evaluate their own performance. They felt that they would make great partners, but performance and contract discussions should be separated. Sandra referred to the round chart and agreed that they should not be on the SC. Bob disagreed.

Deb proposed that only one public health and one hospital be on the Steering Committee as opposed to two. Could we ask the professional associations of organizations to appoint a representative to the Governing Board?

Representation from each county; provider, social service agency, plus 2 at large consumers of health care: There were strong feelings that each county should be presented on the GB, and some concern of the type of slots each County may end up with. Dictating the positions for each county may inadvertently exclude the strengths of that County.

The Governing Board should have ability to take the information from the working groups and partners, be neutral, and help with the implementation of the priorities.

Is the position of the Governing Board to represent the issue or the County?
It was determined that the GB members should be representing the region, not their Counties.

It was suggested to ask the professional organizations to nominate 3-4 representatives on the Greater Columbia governing board.

It was determined to have One Leadership Council for the nine county area.
It was determined to have One Governing Board.

Backbone Organization: Two suggestions, BFCHA, or an Action Council Agency such as BMAC, or CAC.

Jorge felt that having a backbone organization that is already in place is advantageous in being able to respond quickly to the needs of the nine county region. He suggested that instead of creating a new backbone organization that we choose one that is already in place.

Andre felt that since the work of the ACH will be long-term, it needs a permanent staff as opposed to subcontracting. Having a structure in place to meet the needs of the organization will require permanent staff, and a backbone organization that can assist all of the counties in participating.

Deb moved the BFCHA be named as the interim backbone organization and be authorized to hire an interim director for the Greater Columbia ACH. The motion was seconded. The participants of the retreat named the Benton-Franklin Community Health Alliance as the 2015 interim backbone organization and authorized hiring an interim project director as needed to accomplish the work of the Greater Columbia COH with the caveat that BFCHA reach out and include all nine counties in developing the regional plan.

This arrangement with BFCHA will be subject to approval by the Executive Board. Currently, the Executive Director for the BFCHA is their only employee, although they subcontract with other entities and personnel to execute the various programs and administrative duties of the Alliance. It might be more practical at this point in the GC COH development to hire a position to take

over more administrative duties of the Executive Director of the BFCHA thereby freeing up the ED to implement the various milestones listed in the draft timeline.

Andre ended the discussion by emphasizing that the ACH needed to be inclusive, and that all counties needed to feel included in the process in order to have good representation of our ACH.

Design and HRSA Grant

Deb reviewed the elements of the HRSA and Design Grants. The HRSA grant was for rural planning, and the Design grant would be to carry forward the work of the ACH. Both grants are due January 9, 2015. Everyone was encouraged to supply letters of support for the HRSA grant. There are no letters of support required for the Design grant. Deb advised that the Design grant was fairly limited financially; probably enough funding to support a project manager and some project support.

Next Steps

There will be a meeting in January, probably towards the end of the month. Carol will send out a doodle poll to determine the best date.