Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

Board Minutes
October 26, 2017 | 12:00 pm – 2:30 pm
Columbia Basin College, L102

ATTENDANCE		Action Items
Participants:	**Board Members Present (* denotes they called in):** Amina Suchoski*, Brian Gibbons, Carrie Green, Darlene Darnell*, Ed Thornbrugh, Eddie Miles, Les Stahlnecker, Madelyn Carlson, Martin Valadez, Meghan DeBolt, Rhonda Hauff, Ronni Batchelor, Jorge Rivera **Guests in Person:** Corrie Blythe, Kayla Down, Sierra Foster, Miguel Messina, Martha Lanman **Guests on the Phone:** Cathy Homkey	
Backbone:	Carol Moser, Patrick Jones, Megan Kummer, Wes Luckey, Cathy Kaufmann	
Special Thanks:	Thank you, Columbia Basin College for today's facility. Thank you, UnitedHealthcare, for sponsoring the refreshments.	

Welcome & Introductions:	• **Martin –**
	  ○ Review of conflict of interest statement
	  ○ Review of self-dealings transactions statement.	

MINUTES & REPORTS		**Action Items**

Consent Calendar	• Consent calendar was looked at after the Director's Report so that we had quorum.
	• This consent calendar included:
	  ○ 9/21/17 Board Meeting Minutes
	  ○ Sector Policy
	  ○ Budget and Funds Flow Charter
	  ○ 10/9/17 Budget and Funds Flow Committee Minutes
	  ○ 10/11/17 Executive Committee Minutes
	  ○ 10/19/17 Finance Committee Minutes
		• Motion to approve the consent calendar by Meghan. Seconded by Madelyn. 1 abstention (Ed). Motion passes.

Director's Report & Updates	**Carol –**
	• This is a very detailed report this month. I will just take you through the highlights, but I encourage you all to read it.
	  ○ Tribal Training - 6 board members attended (Martin, Ronni, Amina, Les, Dan, and Frank). We met with Frank Mesplie (who is our Tribal board member). Tanya Kreis, Arlen Washines (Director of Human Services) were also there. Overall it was a fascinating training and discussion that outlined some of the challenges that the Yakamas are facing in regard to health care. They are vastly underfunded (they received 1/3 of the funding that Medicaid does), and the suicide rates are also at very high levels. The training also included some of their history, and their governance structure. The Tribes are an important player in Washington state and have carved out funding in the demonstration. We need to continue to learn more about their healthcare delivery.
	  ▪ **Martin –** They really covered two big areas: the Yakama Nation itself, and then their healthcare system. One thing that I was unaware of what that they have to access their healthcare system first before accessing other ones. This adds another bureaucratic layer to what already exists.
	  ▪ **Ronni –** We learned a lot about their culture as well, and looked at the treaty and what that promised them. Their	

	healthcare is supposed to be high quality and free, but they are still required to pay premiums on Medicare. The people of the Tribe is what drives the council and their decision making. ▪ **Carol** – We also got to meet with Jay Sampson, who is the CEO of the Indian Health System, and we spoke with them about our ideas of incorporating a Dental Health Therapist there. We want to assure the board that we are not leaving behind these important project areas. o LOIs – We are up to about 68 LOIs now. We've organized these both by project area and county in the spread sheet we've shared with you all. We continue to have a few trickle in, but we may still need to reach out to other partners to submit. At the last meeting, the board approved a flexible timeline surrounding LOIs/RFPs. Contracting won't being until the spring of 2018, when we know our funding. Overall, we are very excited about the number and quality of LOIs that we've received. ▪ **Rhonda –** Will providers that submitted LOIs still need to respond to an RFP? ▪ **Cathy K –** The ACH will have to decide how they want to manage this process. The planning phase is about figuring out who is doing what for whom and where. It may vary for each project area also (for example the gap analysis for 2A). ▪ **Amina –** Are you saying there will be a range of LOIs/RFPs/RFQs? ▪ **Cathy K –** Yes, it will be a range. And you should have flexibility in your approach and do what it is needed/necessary. o Funding Cuts – We will be talking more about these cuts later today, and some strategies to mitigate the effect it will have on us. One of the ones that we should look at closely is to possibly move forward with 4 vs. 6 projects. The ACH leaders submitted a letter to HCA to allow us to move forward with 4 projects and not face a financial penalty. ▪ **Jorge –** Did all 9 ACHs sign the letter?	

- **Carol –** Not all ACHs were on board with moving from 6 to 4 projects, it's a tough decision for everyone.

- Myers & Stauffer – This will be the company scoring our project plan applications. If there are gaps in anything we submit, we can do write-backs and fill those in. This process lasts through February, so we may not know our total amount of money until then. They also currently have a score down process, which means if you get an 89%, they score you down to an 80% (this has been amended, and they will no longer be scoring down the applications).
  - **Ed** – Has there been push back on any of this by the HCA?
  - **Carol** – HCA is very willing to listen, but so far they have not been willing to change their methodology. We pushed back on the supplemental workbook. We were being asked to list funding for each of our providers from now until the end of the program, and we don't know any of that information yet (and we don't want to upset our providers). Now they are allowing us to put percentages for our allocations. We are still being held accountable for the same metrics, even with less funding.
  - **Ed** – Regarding the funding cuts, was this a miscalculation on their end?
  - **Cathy K** – Yes. It was a miscalculation on what match funds would be available.
- Greater Columbia BHO becomes a mid-adopter – We will receive $10 million in funding for this; which will help with training and infrastructure. We are very grateful for this decision, and for Rick Weavers help and guidance to the county commissioners. The option that the BHO chose was to have a transitional year (2019), and to become the BH-ASO (Administrative Service Organization) with an Interlocal Leadership Structure.
- Stakeholder & Community Engagement – We've really been taking to heart the idea that we need to get feedback from consumers without having a consumer council. So what we've tried to do is learn from the agencies that work directly with consumers. What's nice about working with these organizations is that they can really

	get to the root of why consumers are facing the challenges they are. I've included a list of some of these meetings we've attended in the director's report. We will be looking to our LHICs to engage the community in the future. ▪ **Wes –** We are starting to pick up on patterns with all of these meetings too. For example, most of them say that their clients need a lot of hand-holding and assistance to keep on track. ▪ **Rhonda –** We have our network retreat coming for Yakima County. I will send that information to you. ▪ **Carol –** That would be great. Another thing that we're hearing consistently across all of these groups is the idea of empowerment and utilizing the existing resources available in the community. ▪ **Meghan –** The LHICs will help with spreading the message too, and provide boots on the ground throughout our region. ▪ **Rhonda –** I agree, I also think it's important for our staff to have perspective outside of Benton/Franklin counties. ▪ **Meghan –** This should start to happen organically as we get into more planning and implementing. o Review of the Workflow Timelines, and the new Tribal Map.	
ACTION ITEMS		**Action Items**
HMA Presentation on 4 vs. 6 Projects	• **Cathy K-** Reconsidering the Greater Columbia ACH Project Portfolio o Today's Discussion ▪ Reminder of strategic considerations used in Project Portfolio decision in August ▪ Review budget cuts announced by HCA in September ▪ Discuss implication of cuts for GCACH ▪ Consider whether or not GCACH's Project Portfolio strategy should change based on new information ▪ Considering a 4-Project Portfolio ▪ Q & A / Discussion ▪ Next Steps o Importance of Portfolio Alignment: Review	

	▪ Cohesive Project Portfolio - Strongest applications will demonstrate alignment and shared framework ▪ Targeted Resources - Focused rather than scatter shot approach makes successful implementation easier to achieve ▪ Outcome Metrics - Aligning along populations and metrics increases likelihood GCACH will meet performance targets in later years ▪ Sustainability - Strong alignment builds strong foundation for sustainability in year 6 o Projects Need to be Able to Move All Performance Metrics ▪ Need for demonstration projects to "study to the test" • Dollars tied to performance on planning, reporting and then performance on metrics ▪ GCACH is accountable for all of the performance metrics in any project area • Each metric for each project area worth equal weight ▪ If project area is selected, GCACH must choose from set of evidence-based models in each project area (which aren't always well aligned with metrics) o Visual of table and overlap in metrics o Rationale for deciding on 6 Projects in August ▪ Project Portfolio that maximizes likelihood of success and leverages DSRIP funds effectively • Strategy regarding metrics – maximize region's ability to draw down DSRIP funds • Make investments that will be meaningful even when Medicaid Demonstration funds go away ▪ 6 Projects needed for ability to draw down 100% of available funds • Potential participation in high performance pool ▪ Recognition that important work could be done outside the projects • Commitment to oral health and reproductive & maternal child health even though those projects not selected	

	○ 6 Projects Selected for Project Portfolio in August ▪ 2A: Bi-directional Integration of Care (required), 2B: Community-Based Care Coordination, 2C: Transitional Care, 2D: Diversion, 3A: Opioid Crisis (required), 3D: Chronic Disease ○ Budget Cuts to Medicaid Demonstration Project Funds ▪ In late September, HCA identified an estimated 1/3 cut to the budget for DY2 funds • First was 36%, but now estimated to be 27%. I would guess that it will end somewhere between these two numbers. ▪ $1.5 billion DSRIP Waiver funds based on federal match of available state funds: Intergovernmental Transfers (IGTs) and Designated State Health Programs (DSHP) • Actual DSHP expenditures in state lower than anticipated ▪ Additional cuts in DY 3 – 5 expected though amounts uncertain, which means there could me more cuts later. • State is exploring additional DSHP sources and options for a revised IGT strategy for future Demonstration years ▪ **Ed –** Is there any forecasting that takes into account the pending lawsuits against the state that would affect those funds/intergovernmental transfers (i.e. Trueblood)? ▪ **Cathy K –** I don't have an answer to that question, although I think it's a good one. There's just a lot of uncertainty about what dollars are for certain, and what dollars are not. ○ What do budget cuts mean for GCACH? ▪ Cuts are significant enough that the Board should discuss implications and whether or not changes in strategy are warranted ▪ Before cut GCACH had potential for up to $118.6 million over 5 years with $19.3 million for first year	

	▪ Now, $14.1 million for first year of projects. And if cuts in remaining years are of similar size, would mean $86.6 million for 5 years instead. ▪ Although ACHs have fewer funds next year – and likely reductions in subsequent years – no changes in the required planning, reporting or performance metrics have been made ▪ ACHs need to achieve the same targets with less money and more uncertainty o Lessons learned from the New York Waiver ▪ In other states with DSRIP dollars, the maximum dollars that are available to you is not the same thing as the dollars you will actually get. ▪ When you move into the P4P years, (even though you'll do amazing work) you won't be able to hit 100% of your targets. Many of the PPSs in New York struggled to move their measures. ▪ **Cathy H –** As we look at the first couple years that are based on P4R, New York's PPSs only met about 90% of the targets. And as they're moving into the performance years, they are really struggling with hitting those measures, which will result in reduced funding. So as we look at our approach to P4P, we're looking at a target of about 70%. ▪ **Cathy K –** So 70% is probably pretty optimistic. You should feel good about yourselves if you hit 70%. ▪ **Eddie –** In the New York scenario, what year are you guys in? ▪ **Cathy H –** We are in year 3. ▪ **Eddie –** Do you get any indication on what will happen in year 6? ▪ **Cathy H –** They are looking at extending the waiver. ▪ **Carol –** When we went to the Healthier Washington Symposium, they thought this would be the last class of DSRIP funds. ▪ **Wes –** The state is pretty clear that by year 5, 90% of all services will be some form of Value Based Payments (VBP).	

	▪ **Eddie –** Won't these organizations struggle without making money with VBP? ▪ **Brian –** The state is working to try and create better efficiency, but they're still figuring out how to do that. It helped me to look at Medicare to understand how it will work with Medicaid. ▪ **Cathy K –** The reality is it's not sustainable, and it needs to change at some point. ▪ **Cathy H –** The overall goal of DSRIP is to catalyze the transition from fee for service to VBP. DSRIP only represents a small piece of that value. So when you think about the stand point of the ACH and your funding level, you're not going to cover the full cost, but your partners that participate in the project will help carry some of that financial responsibility. o Should GCACH Change its Project Portfolio? ▪ The size of the cuts do mean ACHs should pause to reconsider whether their strategies still make sense • Should use same strategic lens that was used in initial decision-making process, but consider the new information ▪ There is no one right path – as was the case before the cuts were announced, each ACH must decide for itself the right strategy for its region taking all factors into consideration • King County ACH has already decided to move forward with a Project Portfolio of 4 Projects, while others are still planning to move forward with 6 or even 8. o Strategic Lens ▪ What portfolio of projects has strongest potential for GCACH to draw down most funds in performance years? ▪ How likely is each project to meet performance measure targets? ▪ Consider the impact of projects and investments? • What investments will outlast this demonstration?	

	○ Strategy of 4 Projects rather than 6 ▪ Budget cut (and further cuts to come in the remaining years) means less money without fewer accountabilities • If funding same projects at a smaller scale, still accountable for moving same metrics as before the budget cut • One way to mitigate this is to do fewer projects (with aligned metrics) ▪ Deeper, target investments could allow for more strategic use of limited dollars • With smaller, more targeted portfolio, GCACH may have greater potential to meet reporting and performance metrics (which means more dollars in years 2-5) ○ Potential for more local control ▪ Project Portfolio is what GCACH is signing up to be accountable for to state • Project areas selected determine planning, reporting and performance requirements ▪ Project Portfolio does <u>not</u> need to reflect all of the interventions / strategies of an ACH • ACHs are responsible for achieving the metrics within their chosen Project Portfolio - but can choose to fund interventions and activities in all 8 project areas without selecting them all for the Project Portfolio • Investing in project areas outside the Portfolio allows an ACH more local control over which models to use ▪ **Ed –** It sounds like there is more leeway with the funding than I originally thought. ▪ **Meghan –** Yes, you can use those draw down dollars for other things. ▪ **Cathy K –** The projects you formally pick to move forward with do not have to be your only focus areas. For example, King County sees Care Coordination as their top priority, but	

	they are not moving forward with 2B because of how limiting the toolkit is. ▪ **Jorge –** Have you seen King County's plan for care coordination yet? ▪ **Cathy K –** They have not developed a plan yet. They are using the planning year to do an environmental scan and a needs gap assessment to help them decide. ▪ **Madelyn –** For King County, Eli Kern is working with WIN 211 to create a resource map with an overlay with population. He's using some already existing resources to help with some of that assessment work. ▪ **Cathy K –** So to sum up- the world is not your oyster (you can't do whatever you want with the funding), but you are not limited to the project portfolio as far as what your ACH decides to do with those dollars. ▪ **Ronni –** (asking for clarity) So the strategy with going with 4 projects would be to streamline those dollars into 4 projects vs. 6? ▪ **Cathy K –** Let's get more concrete with the implications of these choices, because there are tradeoffs for both scenarios. One option that I would suggest we take off the table is choosing 5 projects, because at 6 projects – you have access to 100% of the potential funds available to you. Anything less than 6, you don't. At 4 projects, you're leaving a little bit of money on the table, in the first project year but not in the later years. o Financial Considerations ▪ Reduction of $1.4 million out of $14.1 million (in first year only) • May ultimately be financial benefit if it makes it easier to meet more performance targets in later years ▪ Forego potential opportunity to earn dollars from high performance pool	

	▪ Unclear how much money would be in the pool or if GCACG would qualify • Given the budget cuts, state could even reduce or eliminate the pool • Many of the ACHs are pushing the state to change these restrictions so that neither of these limitations exist for Project Portfolios with 4 projects ▪ **Ed –** asked a question regarding the high-performance pool, and taking ourselves out of the running for it. ▪ **Wes –** To be honest, I don't think we should count on that pool anyway. They may use that pool to help make up those cuts. ▪ **Brian –** I imagine that the pool would have quite a bit of money in it, as no one will hit 100% on their metrics. ▪ **Wes –** In that scenario though, you'd have to bank on your ACH doing really well, and everyone else not doing well. ▪ **Rhonda –** Do we know if we have the option to go back to 6 projects in a year? ▪ **Cathy K –** No, you won't be able to do that. You can change your number of projects through January 30th of 2018 though. ▪ **Eddie –** With the King County scenario, in the unlikely event that they meet all of their metrics, can they go back in that scenario? ▪ **Cathy K –** No, your metrics are your metrics. There is a list of statewide metrics though, so for example if King didn't pay attention to well-child visits that would mess up everyone. ▪ **Eddie –** Would it make sense then to possibly support King with some financing to help them meet those measures. ▪ **Cathy K –** There will definitely be a lot of places for the ACHs to collaborate. o Example of Need for Local Control ▪ 2B: Community-Based Care Coordination	

	• Community-based care coordination is viewed as a critical, foundational component of health systems transformation in the Greater Columbia region • Pathways HUB is the only model in the toolkit ▪ Concerns have arisen since Project Portfolio decision made: • GCACH staff have learned that significant investment in IT and training will be needed • Questions about sustainability • Unclear if strong buy-in from communities across the region • GCACH has existing care coordination resources that most ACHs do not have ▪ **Wes –** We've received a contract from CCS (who does the pathways HUB). We're not allowed to say specifics in the pricing, but it is very expensive. It may be a good model, but it would be a large financial commitment. ▪ **Carrie –** I am also concerned about the sustainability of that. ▪ **Rhonda –** We do want some form of care coordination, but it doesn't need to be the HUB model. ▪ **Les –** So if we go with 2B, does it have to be the HUB model? ▪ **Wes –** Yes, it does. ▪ **Rhonda –** Care coordination is so essential. Probably the largest infrastructure that we currently have around care coordination right now is with health homes. Maybe one of our goals would be to get our health homes contractors together to agree on a model that would work for everyone. ▪ **Carol –** You make a good point. We received over 50 LOIs from care coordination organizations. We still need to talk to them and see what their thoughts are on this. We want our providers of this to have a say in it. ▪ **Wes –** We are trying to be thoughtful for this from a geographic perspective as well (what may work in Yakima, may not work in Benton/Franklin). ▪ **Ed –** In our current care coordination model, we have 3 different agreements. The interface with the MCOs is	

different for everyone. Is it less expensive to make modifications to our own system?
    - **Carol –** From what we know, yes. Elya's ACH is doing it for far less.
    - **Jorge –** There is a missing piece in the system. It will cost money to bridge that gap. We don't have enough information right now. We have no idea what the cost will be… we should push back on CCS to share that pricing information.
    - **Eddie –** I would be shocked if VMMH implemented the HUB as part of their care coordination.
    - **Rhonda –** I share the same reservations, but I know that if GCACH moves forward with the HUB, we would still participate.
    - **Carrie –** Who would pay for the maintenance of the HUB after year 5?
    - **Cathy K –** Hopefully it would prove its value so that someone would sustain it (since this is just a demonstration). The idea is that after the demonstration they will fund the things that have shown their value.
- Review of the financial implications of 4 vs 6 projects with tables.
- Which 4 Projects?
    - 2A: Bi-directional Integration of Care (required)
    - 2C: Transitional Care
    - Can incorporate Diversions work into this area
    - 3A: Opioid Crisis (required)
    - 3D: Chronic Disease
    - Development of GCACH Strategy for Community-Based Care Coordination
    - Investments in oral health and reproductive / maternal child health
- Review of table with performance measures of these 4 areas.
    - **Cathy K –** With 4 projects you help cut down on some of those more difficult metrics to move (i.e. percent arrested).

	▪ **Ed –** That may not be as difficult as we are thinking. Regarding the Trueblood lawsuit, there could be other organizations working on programs that would help us move that measure. ▪ **Jorge –** This needs more analysis. We are trying to align 3 things: the metrics of the tool kit, metrics of the MCOs and the metrics of the providers. ○ Improvement Target table – ED Reductions: 1,302 (Yakima County) ▪ **Carrie –** The objective of diversion can be folded into other areas. ▪ **Wes –** Yes. If we do a great job with 2A it will definitely affect diversions. ▪ **Meghan –** And also with 3A. ▪ **Ed –** One thing to consider is the option to change before January 30th. I would advocate to wait and use this option if necessary. ▪ **Carol –** The problem with waiting is that we would need to start acting now if we go with HUB. ▪ **Wes –** The training for the HUB alone takes 4 months. ▪ **Rhonda –** Just to clarify: this conversation is not about if we will be doing care coordination- just if we will be doing 2B in our portfolio. We will do care coordination no matter what. ▪ **Les –** Can we just hire an IT firm to help us come up with another option? ▪ **Jorge –** That is the route that Olympic is taking. ▪ **Rhonda –** There would need to be time dedicated to finding another system. ▪ **Ronni –** From what I've read, the history of the HUB is good, but the gag order on the talk of the price is alarming. I am worried that the money that would be going to the HUB would not be well spent. I am also worried that the toolkit is limiting us to that one option. We could utilize other systems already in place.	• Motion by Rhonda to move forward with the following 4 project areas: 2A Bi-Directional Integration of Care, 2C Transitional Care, 3A Opioid Crisis, and 3D Chronic Disease. Within this motion is the plan to work to include the other 4 projects (Maternal/Child Health, Oral Health, Care Coordination, and Diversion Interventions) in the remaining project areas as we move forward with our Project Portfolio. Seconded by Carrie. 7 in favor, abstentions from Madelyn, Darlene, Amina, and Les. Motion passes.

Financial Reports	• **Carol –**
	  ○ Walkthrough of the following reports:
	  ▪ Balance Sheet 10/15/17
	  ▪ SIM Funding, Statement of Activity
	  ▪ SIM Funding & Projected Spend Down
	  ▪ PHASE I Design Funding, Statement of Activity
	  ▪ Phase 2 Design Funding, Statement of Activity
	• **Cathy H** – Budget & Funds Flow Committee Presentation
	  ○ Finance Committee Recommendation
	  ▪ Overview of guiding principles
	  ▪ Definition of Use Categories
	  ▪ Projected percent funding of the Project Incentive funds by use category over the course of the demonstration
	  ▪ Distribution of Project Incentive funds by organization type for DY 1.
	  ○ Guiding Principles
	  ▪ Mission: The mission of the GCACH is to advance the health of our population by decreasing health disparities, improving efficiency of health care delivery, and empowering individuals and communities through collaboration, innovation, and community engagement.
	  ▪ Accountability
	  ▪ Transparency
	  ▪ Collaboration
	  ▪ Value-Driven
	  ▪ Flexibility
	  ○ Funds Flow – Greater Columbia ACH (visual)
	  ○ HCA Fixed Required Use Categories
	  ▪ *ACH Administration and Project Management;*
	  ▪ *Project Engagement, Participation and Implementation;*
	  ▪ *Provider Performance and Quality Incentive Payments;*
	  ▪ *Health System and Community Capacity (Domain 1)*
	  • Financial Stability Through Value Based Payment;
	  • Population Health Management;
	  • Workforce.
		• Motion to approve the financial reports for October 2017 by Brian. Seconded by Madelyn. Motion passes.

	○ Use Categories established by GCACH ▪ ***Integration*** recognizes that systems collaboration and integration is foundational to budget and funds flow. The fund will be designed to support improved population health, well-being and equity. Distribution methodology to be determined (possible RFP process) ▪ ***Contingency Fund*** for unanticipated events or costs, provide safeguards of resources for projects, administration and in consideration of cashflow needs. ○ Incentive funds allocation by use category – 4 projects selected (visual) ○ Distribution by Organization Type ▪ The ACH will allocate the payments to its participating providers/organizations based on a Funds Flow methodology determined by the appropriate governing body ▪ ACH Organization/ Sub-contractors ▪ Partnering Provider Organizations • Providers traditionally reimbursed by Medicaid: ○ Primary Care, Mental Health, SUD, Oral Health Providers ○ Hospitals ○ Health Systems ○ SNF • Providers not traditionally reimbursed by Medicaid: ○ Community Based Organizations ○ County Organizations, including Corrections Facilities ○ Tribes/Indian Health Services, Tribal or Urban Indian Health Programs ▪ Other ○ Distribution by Partner Organization	

GREATER COLUMBIA ACCOUNTABLE COMMUNITY OF HEALTH
DSRIP PROJECT FUNDS ALLOCATION

DY1-2017

	TOTAL	
GCACH	16.1%	2.21
Medicaid Providers	50.3%	6.90
Non-Medicaid Providers	33.5%	4.60
Tribes/ITU	0.8%	0.11
Other	0.0%	-
	100.0%	**13.72**

- **Carol –** We experienced a technical glitch, but these percentages reflect what the funds flow committee decided upon to the best of our recollection. These percentages are just tied to year 1.
- **Cathy H** – It's also important to note that the state is just looking for a high-level overview. This could change.
- **Eddie** – This looks like a proposed operational plan.
- **Ed** – I would feel more comfortable knowing what accountability is tied to each of these areas and their funding.
- **Carol** – I understand. Unfortunately, we were asked to make decisions when we weren't ready even after we pushed back on HCA. This is just a general direction. Does it look about right? It can always be tweaked in the future.
- **Ed** – I'm not seeing the logic model behind these decisions. How does this allocation help move the needle?
- **Carol** – The idea was to include the SDOH and CBOs/FBOs. None of this is cast in stone.

	▪ **Cathy H** – We also weren't sure if they would pull this requirement from the workbook or not when we had this retreat. ▪ **Eddie** – I like the idea of segregating and defining. Is it fair to say that we like the methodology? ▪ **Cathy K** – We need to include some numbers in the November application unfortunately. ▪ **Ed –** I would like to see what Ryan is saying he had down for the numbers, as well as the logic model behind this (Ed was not receiving our email with the meeting materials, which included the retreat minutes). ▪ **Carol –** We will send you the materials to look at Ed. • **Carol –** Amend professional services agreement with ProAccountant through 12/31. o **Ed –** Was this contract terminated when William was hired? o **Carol –** No, Shannon is technically still under contract. o **Brian –** We need that function regardless.	• Motion to approve the suggested allocation from the Budget & Funds Flow Committee. Seconded by Carrie. Abstention from Ed. Motion passes. • Motion to amend the professional services agreement with ProAccountant through 12/31 by Brian. Seconded by Ed. Motion passes.
Approval of Website Redesign Proposal	• **Megan –** o We received a lot of responses for website redesign RFP (10 proposals total), and many were from companies we'd never heard from. o I put together a quick comparison table that looked at our RFP requests, and what each company submitted. Some proposals did not mention all of our requested deliverables, and some were over budget (or very close). I also looked at the strength of their submitted portfolios (these grades were based on my thoughts). o Although only a few committee members were able to review the proposals, we were able to come to the consensus that we would like to recommend SightWorks (based in Portland) as the vendor to move forward with. o Rhonda has suggested that we also have another person formally review the proposals, which we can definitely do.	• Motion to approve the proposal from SightWorks and move forward with them as the vendor for our website redesign by Meghan. Seconded by Carrie. Motion passes.

NEW BUSINESS		Action Items

Discussion about Board Membership for 2018	• **Carol –**
	  ○ We need to have a rotation schedule for our membership (outside of the MCOs).
	  ○ We will send out an email to get a count of who would like to continue on the board next year, we just wanted to put this on your radar.
	  ○ Brian and Darlene mentioned they would like to continue, Martin will be stepping down.	

Discussion about December Board & Leadership Council Meetings	• **Carol –**
	  ○ We just wanted to ask if we needed or wanted a Leadership Council meeting in December.
	  ○ If we don't need a LC meeting, we could meet at a smaller venue like CAC or TCCH.
	  ○ The board recommended to let the LC decide via a poll on a December Meeting.
	  ○ We will send out a poll to them to figure this out.	

ADJOURNMENT		**Action Items**
	Meeting was adjourned at 2:45 pm. Minutes taken by Megan Kummer.	
	Thank you for your time and engagement with the Greater Columbia Accountable Community of Health! The regular Board meetings for 2017 will be from 12-2:30 p.m. on the following dates: • November 16th (Columbia Basin College, L102) • December 21st TBD	