Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

Leadership Council Minutes
8/17 9:00 am – 12:00 pm
United Way of Benton& Franklin Counties in Kennewick

ATTENDANCE	
Participants:	**In Person:** Les Stahlnecker, Sierra Barrett, Matt Davies, Chuck Eaton, Everett Maroon, Miguel Messina, Barbara Mead, Ed Thornbrugh, Doug Logan, Virginia Janin, Corrie Blythe, Shari Robinson, Mandee Olson, Michelle Sullivan, Mike Maples, Rhonda Hauff, Jocelyn Pedrosa, Lisa Hefner, Sam Werdel, Kindra Clark, Jodi Ferguson, Jessalyn Bruce, Rick Helms, Debbi Dumont, Heidi Desmarais, Lisa Campbell John, Sandra Suarez, Cindy Carroll, Tracie Hoppes, Elissa Southward, Bertha Lopez, Kirk Williamson, Michelle Gardner, Jac Davies, Amina Suchoski, Sarah Bollig Dorn, Kevin Martin, Dulcycorr Field, Mandy McCollum, Becky Grohs, Joyce Newsom, Stein Karspeck, Delphine Bailey, Martha Lanman, Shannon Jones, Michelle Roth, Bill Dunwoody, Robin Roderick, Aleah Bravo, Amy Person, Susan Campbell, Rebecca Sutherland, Meghan Debolt, Carla Prock, Caitlin Safford, Torri Canda, LoAnn Ayers, John Christenson, Liz Whitaker, Jorge Rivera, Kayla Down, Andy Nyberg, Dr. Don Ashley, Suzanne Swadener, Chase Foster, Reese Holford, Darlene Darnell, Angelina Thomas, Brian Sandoval, Ben Shearer, Marcy Durbin, Lilian Bravo, Millard McQuaid, Isabel Lin, Judi Ferguson, Susan Bassham **One the Phone:** Karla Greene, Dan Ferguson, Mark Koday, Bethany Osgood, Maria Courogen, Kathy Saluskin, John Raymond, Libby Watanabe, Craig Nolte, Michael Largent, Sue Jetter, Siobhan Brown, Lisa Gonzalez

Backbone/and HMA	Carol Moser, Aisling Fernandez, Megan Kummer, Patrick Jones, William Van Noy, Wes Luckey Dr. Bruce Goldberg, Cathy Kaufmann, Cathy Homkey
Special Thanks:	**Thank you to …** • United Way for providing the space for today. Thank you to Jo Brenneman and LoAnn Ayers for their help in coordinating the use of their space.
MINUTES & REPORTS	
Director's Report	• **Carol:** o For this month's Director's Report, we wanted to give you an overview on the Certification Phase II submission that we turned in on Sunday. o All ACH's are required to do 2 certifications. The first phase was due on May 15th. All the ACH's achieved a high enough score to get that initial $1 million for planning purposes. o The Phase II certification is worth $5 million in design funds, and HMA helped us with this submission. o We will hear in a month how we scored. If we get 90-100 points we get the full $5 million. o Highlights ▪ 46 pages ▪ 27 attachments ▪ 99 documents, the Bios alone were 11 pages! ▪ 32 Megabytes o Theory of Action & Alignment ▪ Walkthrough of visuals we provided as attachments • Theory of Action, Collective Impact, Project Team Report Template, Project Selection Flow, Project Selection Criteria o Governance & Organizational Structure ▪ Committee Charter documents (9), Conflict of Interest, Job Descriptions and Staff Bios (5), Sector Representation Policy, GCACH Overview, New Organizational Chart (as we added new staff members- Megan and William). o Tribal Engagement and Collaboration ▪ The Yakama Nation is an essential partner to GCACH. Most ACH's have at least on Tribal Nation; we have the largest. It's been a joy to work with them. We've worked with them on our communication and collaboration model, and it's important for us to understand the programs they are currently utilizing there as well as their culture. ▪ Model GCACH Tribal Collaboration and Communication, Tribal Bios, Attestation of Participation o Community & Stakeholder Engagement ▪ A lot of this was showing how we distribute information to public (i.e. our website)

	▪ GCACH Website Resources Overview, Board Meeting Minutes, Provider Engagement Schedule, Community Member and Partner Attestations (40) o Budget and funds flow ▪ William has established a finance committee with three board members. This helps inform what to do with design funds between now and 2020. ▪ Staff Bios, Financial Statement, Planned Design Funds Use o Clinical Capacity • This was an area that we received a lower score on in the first certification. This time around we added several attachments (including clinician bios) to showcase our clinical experts to help bump that score up. HCA wants to make sure that the process is driven by providers. • Clinical and Workforce Subject Matter Experts Bios, (49) Project Team and Team Facilitator Clinical Experts o Data and Analytic Capacity ▪ GCACH Comprehensive Data Analysis • The Christmas Tree chart. We've shared this analysis and some are beginning to use it for their own ACH's. • ED diversion has the most number of shared metrics, second highest is inpatient hospital utilization. • Large data analysis that was sent out to the Project Team Facilitators. o Transformation Project Planning ▪ This section is asking "how are we going to do all of this?" • We'll accomplish this by aligning resources and partners, and going out to provider systems servicing our Medicaid beneficiaries. ▪ "Top 30 Professional Services Providers List" that will provide path forward and how they fit into the process. • Comprehensive, YVFW, Kadlec, Lourdes, VMM (Virginia Mason), Community Health of Central Washington, Ideal Option, YNHS, Sunnyside Community Hospital… etc. ▪ Partnering Provider List, Professional Services Summary, Collective Impact o Thank you to the dozens of people who have: ▪ Served as Facilitators, participated on the Project Teams, served on the Leadership Council and Board of Directors, returned their biographies and attestations, Served as consultants (HMA, Dr. Jones) and TAC advisors (Gov. Kitzhaber, Dr. Straley, Dr. Ostler, Bob Burden, Mike Bonetto) ▪ This great work could not have happened without your time, dedication and support. ▪ The report for Certification Phase II is available for you to look at online (link is on our website). o **Patrick Jones** - What is the curve on the scoring for Certification Phase II? ▪ **Carol** – We expect to get 100 points, but if you achieve 90-100 points, you get the full $5 million

Presentation of Project Feedback	• **Community & Stakeholder Engagement Presentation (Aisling)** o Aisling recently switched to the role of Director of Community Engagement for GCACH o Highlights ▪ The importance of Consumer & Stakeholder Engagement/Outreach, past activities, and our plan going forward. ▪ What can we do to fill in the gaps for consumers/community members? Some of these things include workforce, transportation, sustainability, and being proactive. o Why Consumer & Stakeholder Engagement? ▪ Ensuring bi-directional and timely communication between ACHs, the community and consumers and ACH stakeholders. ▪ Engaging community organizations, consumers – including hard-to-reach populations (e.g. homeless populations, people with substance-use disorders, Veterans, specific ethnic or cultural groups) – and other stakeholders through project selection and implementation. ▪ Sustaining community and stakeholder participation and support beyond project selection and implementation. ▪ Including the consumers in the decisions that will affect their lives. o Stakeholder Engagement to Date ▪ Thank you to those of you that helped and participated in these calls. ▪ 4 WA State Department of Social & Human Services (DSHS) conversations • 3 Community Service Offices (CSOs) • 1 Developmental Disabilities Administration (DDA) ▪ 2 Managed Care Organization (MCO) conference calls ▪ 1 Federally Qualified Health Center (FQHC) conference call ▪ 1 Local Health Improvement Coalition (LHIC) meeting • Thank you to Wes and Carol for participating in the Benton-Franklin Community Health Alliance (BFCHA) meetings. ▪ 1 Benton-Franklin Oral Health Coalition meeting ▪ 1 Tri-Cities Diabetes Coalition meeting o Community Engagement to Date: Lessons Learned ▪ We're still new to a lot of this and learning some lessons on how to improve our engagement moving forward. ▪ Considered hosting Health Fairs: We were advised to go instead to established events, farmers markets, or to call these *Resource Fairs* if we do them. ▪ Tried hosting a Focus Group**:** We aimed for 6-8 participants, offered incentives, had 6 people sign up, but not one person attended.

	• Lesson learned: Work with people who have already established trust in the community and try again. ▪ Considered attending a Health Fair: This event was the day before our LC meeting (perhaps too tight a timeline) and a very busy environment. ▪ "You have to go to people and not expect them to come to you" Oscar Olney, CSOA / Toppenish CSO / Economic Services Administration / *Washington State Department of Social and Health Services* o Community Engagement: Going Forward ▪ We'll likely take a combination approach of going out and creating opportunities for the community to come to us. ▪ Consumer Council: A council that meets regularly to provide an avenue for community members, Medicaid consumers and community/consumer advocates to collaborate with Greater Columbia ACH. Recruitment begins this year; council meetings will begin in 2018. ▪ Communications Committee (Pending Board approval of the charter today): The Secretary of the Board shall chair a committee comprised of at least two (2) members of the Board to oversee the internal and external communications of the GCACH along with some members of the Leadership Council or subject matter experts to also serve on this committee with the President's authorization. ▪ Please let us know if you would like to join or recommended people for either of these groups. o Unintended Consequences ▪ Changes at DSHS in recent years since the Affordable Care Act & other regulation changes led to reduction in personnel and reduced ability to help. ▪ Medicaid Enrollment: DSHS offices can't enroll people for Medicaid anymore. People must enroll through the Health Care Authority and they are having more difficulty doing so. ▪ 211: CSO offices now restricted to providing information about resources in 211. No personal knowledge allowed to be shared. ▪ DSHS can no longer contract with providers to take Medicaid clients for ABA therapy. • This is negatively affecting well-child visits (EPSDT) • Note that there are only 2 ABA therapists in the area ▪ People fall through the cracks in the system. o Workforce Development ▪ DSHS Conversations: • CSOs need patient navigators in places where clients already go, to help them get enrolled and navigate the Medicaid system. Put navigators in: o The Mission, food banks, churches, the health department. • Need more Applied Behavioral Analysis (ABA) Therapists in the community- there are only 2. o Need providers that take Medicaid

	• Need psychologists in more CSO locations who will accept contracts to see Aging, Blind and Disabled (ABD). Save clients from having to travel all the way to Richland (many don't make it). • Hard to get doctors to practice in rural areas. o Previously a program at UW for medical and dental students to visit small rural towns such as Toppenish. ▪ Benton-Franklin Community Health Alliance (BFCHA) meeting: • For Bi-directional integration of care, "you need to build up a workforce to support the system. You need Community Health Workers & telehealth (especially in rural settings)." • For social and medical care coordination: o "clients need a coach or a case manager, need appointment reminders. There could be a people-solution." o Need to overcome the language barrier with effective interpreters. "Folks need to receive information from inside their own culture." ▪ Benton-Franklin Oral Health Coalition Meeting: • Tele-dentistry "opens the door to a diagnosis" • Oral Hygienists do assessment, education and some clinical services through mobile clinics o Transportation ▪ I heard many times that people often lack access to a working vehicle, or a vehicle with gas. ▪ MCO Conference Call: For 2A Bi-Directional Integration: Having co-location of services can help with compliance when transportation (having a vehicle, having gas) is an issue. ▪ DSHS Conversations: • Should give a navigator a van. • Dial-a-Ride is overwhelmed and needs a better communication method. Can be life-or-death for someone to miss an appointment. • "When they're in your office they're yours. Once they walk out the door, they're gone" Toppenish CSO • There's a mobile CSO unit. • Rather than having separate chronic disease education programs, it's better to integrate education for chronic disease into physician visits because of transportation issues. o Sustainability ▪ Diabetes Coalition Meeting: • There was a successful diabetes-prevention program at CBRC (a gym in Richland) with scholarships, but the program ended when the scholarship ran out. This program was effective because it combined a teaching component with exercise. ▪ FQHC Conference Call:

	• Sustainability and comfort level are linked because people won't want to try these new programs if they won't be sticking around. • For Bi-Directional Integration, Care Coordination and other Demonstration projects to succeed, the consumers need to be comfortable with the changes to the system. o Some BH patients might not feel comfortable in a busy primary care setting. o "It should be reassuring for the patient that the care coordinators are aware of each other and taking advantage of the resources" • Access issues such as long waitlists and social determinant barriers can hinder success • "It's paramount to have BH fully integrated into primary care or the Pathways HUB won't work." • "Need to do better at tracking outcomes" ▪ DSHS Conversations: Sustainability of Pilots: • From Toppenish CSO: At one time, there were about 100 "assistors" from FQHCs in the CSOs who helped with paperwork for Medicaid, but that is now down to about 20. Would be great to have larger numbers again. The HCA paid for the assistors for about 3 years, then it was up to the hospitals and clinics to pay for these FTEs, and those with smaller budgets couldn't afford them. • Business Tech Centers to give people access to computers. These computers were "hot cakes"! But these centers couldn't maintain 1-2 people to work there (salaries or insurance for them). The Yakama Nation kept up 4 of these centers. The Downtown Toppenish center closed. • The DSHS office in Toppenish has a Parents as Teachers (PAT) program with YVFWC. It's a pilot that is limited to 12 families at a time, but it really works! There's a waiting list. Would love for this pilot to expand to more families. o Be Proactive ▪ FQHC Conference Call: • For Transitional Care and Diversion Interventions to succeed: o Hospitals need to be able to see clinic records and visa versa. o Have care coordinators available for when a patient is being discharged from the hospital o Identify high-utilizers and better manage them at home (more frequent contact) o Utilize technology for proactive follow-up. "Need technology to support workflow and visa versa" o For 2D, focus on a small subset of the population and pilot multiple approaches. ▪ MCO Conference Call: • Transitional Care & Diversion Interventions: People don't like to go to the doctor and wait to go to the doctor until it hurts. Educate individuals about going to preventive ▪ BFCHA Meeting: • **"**Upfront screening by professionals [at primary care] is key"

	• 5 years ago, the Grace Clinic started Patients with Diabetes. They have a required screening for depression for the diabetes patients. Starting January 1, 2017, started getting all patients to complete a PQH9, which can change the nature of the conversation with your PCP. ▪ DSHS Conversations: • In a CSO office, clients often give addresses and phone numbers that don't work. • "Once they walk out the door, they're gone" • Toppenish Community Service Office (CSO) used to have a person who did alcohol and substance use screenings before the ACA. He would give someone a ride that same day and not let them walk away. o Takeaways ▪ Workforce development can mean *more* psychologists, doctors, hygienists, navigators. Can mean working in a *different location*. Can mean providers who *accept Medicaid*. ▪ Sustainability can be financial, consumer trust, comfort and buy-in, partnerships with stakeholders and providers ▪ Transportation can be addressed through mobile units, co-location, and building workforce in more communities. ▪ Try to help people immediately when they are in your office (social service or medical). Try to do screenings and preventive care and education sooner than later. ▪ Incentives can be very helpful for consumer engagement and for consumers showing up for appointments. ▪ Barriers (and solution) to access lie on the provider side and the consumer side. • **Summary of Scoring & Comments by the GCACH TAC (Technical Advisory Committee) to the Project Area Proposals (Patrick)** o Overview of the presentation: why we're doing this (introduction to the process), quantitative summary from scorecards, presentation of qualitative summaries for each project, average score of the 8 project areas compared, and final comments. o Overview of the evaluation process: ▪ The reason we are doing this is because the board voted at the July meeting to have an 'arm's length' group review the work that has been done so far. This is an objective assessment of where we are today. The TAC includes these members: ▪ Mike Bonnetto, MPH, PhD.: Partner at 10-Fold Health, former chief of staff & health policy advisor in office of the Oregon Governor ▪ Robert Burden: Retired Director, Group Health; 20 years in leadership with Benton/Franklin Community Health Alliance ▪ John Kitzhaber, MD: Former governor of the state of Oregon; founder, Center for Evidence-based Policy at OHSU founder of the Archimedes Group ▪ Lee Ostler, DDS: Richland-based; clinical instructor, Las Vegas Institute for Advanced Dental Studies

- Hugh Straley, MD: Past president, Group Health Cooperative; chair, The Robert Bree Collaborative

- Overall Score of Project 2A: Bi-directional integration of physical and behavioral health
  - Average score of 3.84 *(all scores are out of 5)*
  - Summary comments on 2A:
    - "This project has excellent community leadership & a well-developed assessment ongoing as well as a significant evidence base. Given the community needs …for interventions, this project has an excellent chance for success. It will require ongoing involvement & an infrastructure for information exchange which the plan implies will be available."
    - … is the most transformational of all the projects. It is also the most difficult. Changing two cultures, asking groups who might be competitors, multiple governmental jurisdictions & literally hundreds of organizations to take on this kind of change & collaborate is daunting. The sheer size of the task is potentially overwhelming."
    - "Overall, this is a strong beginning for this project - knowing that it should become the backbone for much of the other work. 2018 planning year will be essential to its success. This project has the potential to help GCACH generate the most revenue - so would be helpful to have a better sense of the likelihood of collecting & reporting the necessary data -- as well as actually improving the identified metrics….."
    - "This project…. seems to be missing focus on the Physical Health side of the project. The stated focus is on behavioral / mental health issues w/o much mention of the cormid physical health challenges. Within the section mentioning diabetes monitoring, there is opportunity to include periodontal health due to its strong bi-directional relationship with systemic health."
    - "Its goals are laudable…Developing standardized metrics and measurement-based treatment, as well as employing a registry driven process, are all very strong points.
    - At the same time, this approach is still fairly much "inside the box" with the focus on integration of mental health and physical health *within* the formal medical system. There does not appear to be much focus on the crucial clinical-community connections that are necessary for the long-term successful treatment of those with behavioral and chemical addiction issues…..
    - The proposal, as currently written, does not speak to the fact that rural & minority communities may be skeptical of this approach if it is perceived to be an "outside intervention." Trust at the community level (not just between mental health & physical health providers) is essential for success. *The strategy must include the development of relationships that are based on trust and inclusion, culturally relevant & local."*
- Overall score of project 2B: Community-based care coordination
  - Average score of 3.89
  - Summary comments on 2B:

- "While this proposal is still 'a work in progress,' the involvement of broad leadership of providers, plans and community services, a well-developed Hub and spoke model suggest sustainability. The unanswered questions remain as to the social services that will be involved and how will interoperability of information be achieved."
- "Care coordination is key to improving health outcomes it requires a level of communication, collaboration, agreement on process and standard data collection measurement which will be a challenge across nine counties with different population needs and resources. I believe that it is key to take small successful steps and not to make massive changes all at once. Getting agreement across so many agencies and jurisdictions on how and what to work on will be key."
- "The initial assessment to identify the target population and the region's existing care coordination capabilities will be key in determining the right fit for where the HUB resides, the scope of the implementation plan and the ability to move the project metrics."
- "There is opportunity to create a pathway for oral health management. Low birth weight problems are also intimately tied into periodontal health of the pregnant mother. Also, vertical transmission of bacteria that cause dental caries, from mother to child is well established. This could provide opportunity for the projects to inter-relate with oral health project. …Also include periodontal disease and obstructive sleep apnea in list of chronic disease conditions. Understand that even mild improvements in oral health leads to decreases in admission/readmission rates, and decreases health care expenses for several chronic health conditions."
- "I find this project particularly strong, compelling and well written. The Pathways Community Hub model ensures individuals with the greatest risk are provided with a comprehensive assessment of all health, social and behavioral health risk factors, and then assigned to a specific pathway to ensure that those factors are addressed with an evidence-based or best practices intervention (not limited to clinical care)……
- This project recognizes the importance of not trying to "boil the ocean" but rather will target 'candidate at risk populations'…….It directly recognizes the importance of not only health care coordination but the direct integration of social services — the direct connection between traditionally disconnected agencies……..
- The biggest challenge is agreeing on the approach to selecting an agency as the hub & in selecting the priority target populations. This involves engaging community leaders & community organizations which, while aligned around a common goal, are not aligned around how to get there.".

- Overall score of project 2C: Transitional care
  - Average score of 3.93
  - Summary comments on 2C:

- "Because this project is built on the success of existing programs in the region & b/c the models proposed have good evidence to support success, I believe this has a good chance for achieving the goals & sustainability. As with all the projects, the greatest challenge will be to identify and monitor the target population over time & to measure & report on outcomes."
- "Transitional Care is another project that I think has a greater chance of success. The timing is right. Hospitals and other providers are under more and more pressure to do something about readmission rates and complications due to lack of coordination and communication. There is much in place that can be built on."
- "It appears that several of the identified interventions for this project are existing projects/programs and are unique to specific areas within GCACH. It would be helpful to have a better understanding of their current funding models & how each intervention could/should transition to other counties."
- "Opportunity to include hygiene or dental navigator in this project, and tie into the Oral Health Project - to help people presenting in ED with dental-related problems find access to care. This would also help improve the opioid use of pain meds for dental related problems."
- "This project acknowledges the importance of ensuring that the local community—& particularly the populations at risk—do not perceive GCACH as something being imposed from the outside. This requires interacting with, empowering & developing trusting relationships with local leadership, organizations and agencies. The fact that Health Homes and collaborative community paramedics currently have a significant footprint in some of the smallest communities means they should be relied upon to use that local knowledge & trust to help implement this. .
- The two biggest 'pain points' with this project are:
  1)The need for committed engagement & cooperation with hospitals & MCOs.
  2) The very real challenge of creating and maintaining robust interdisciplinary /inter-agency collaboration. The difficulty should not be underestimated. It requires skilled local trusted facilitators and an explicit commitment to the process by the key stakeholders.".

- Overall score of project 2D: Diversion interventions
  - Average score of 3.9
  - Summary comments on 2D:
    - "Over all I think this project given its leadership and the well-developed model had the greatest chance for success of all the projects. Challenges will be information access, adequate hospital and EMS resources, and appropriate social services to address difficult psychosocial issues."
    - "Diversion Interventions is the project with the greatest chance of success. In this case you have more to build on right away. CCS has several years of experience, has EDIE and CCS data & measurement capability already built, has relationships & a trust level with most of the major players. The "house" is already about half built. It might also be a template of sorts for some of the other projects. They

	have a lot of experience with what works & what does not. They also do not compete directly with the major players which takes some of the politics out of the equation." • "Much like project 2C, it appears that several of the identified interventions for this project are existing projects/programs and are unique to specific areas within GCACH. It would be helpful to have a better understanding of their current funding models and how each intervention could/should transition to other counties." • "Opportunity to further consider the ED use for dental related problems, as well as to establish a navigator or continuing-care type coordinator that can help facilitate people finding access to care for acute dental needs, at least. " • "This is a well-designed project with very clear goals and target populations & the potential for significant cost savings. Using CCS as the centralized referral center allows for intake from a wide range of sources & then assigning them one of three categories….. • This project explicitly acknowledges the contradictory incentives between diversion from hospital admission and loss of hospital inpatient revenue. It seems to me that this issue needs to be placed squarely on the table because without the active participation of hospitals (& MCOs) this project has little hope for sustainability. It offers an opportunity to have a candid discussion about the current hospital business model (or the current healthcare industry business model) which pits short term revenue against long-term patient health." o Overall score of project 3A: Addressing Opioid Use ▪ Average score of 3.18 ▪ Summary comments on 3A: • "I am not clear what the exact implementation plan will be, what is the monitoring and measurement plan, what is the ROI. Clearly this is a critical project with a core goal of saving lives. The project has a very general set of implementation strategies. Clearly there will be a need for additional resources of Care managers and CHWs. The proposal would be stronger if more detail were given to overcoming the implementation barriers." • "The biggest problem with this issue is the prevalent belief in the community that this is an isolated issue that mainly effects the junkies and drug addicts. Many consumers and some providers believe that this is not their problem. There will be a need to educate the public about the size of the accidental overdose problem that touches every part of our society." • "Even though this is a required project, it appeared to be one of the lightest proposals. I believe Olympic ACH is pursuing an evidence-based model (6 building block framework) that may be worth reviewing."

- "(There is an) opportunity to address the fact that dentists are also among the opioid prescribers within the community. Also, to address the Emergency Department use of Rx meds for unnecessary dental health issues."
- "I realize that this is a mandatory project, but carving out opioid abuse from the larger problem of chemical addiction seems artificial at best. For example, creating a case management hub in each county seems redundant with the pathway hub concept which proposes a single hub for the 10-county region then contracting with care coordination agencies in the communities, which will allow the pathways to focus on each region's particular needs. Perhaps some thought should be given to partnering with Project 2B: Community-Based Care Coordination to do the case management through the care coordination agencies…..
  I understand that there is a natural inclination to apply these projects across the entire region from the beginning, but that may well not be practical or even desirable in a 'demonstration' project. We don't have to 'boil the ocean.' Project 2B: Community-Based Care Coordination clearly recognizes this and plans to start by implementing first for a small set of one or two target populations. "
- That's another issue for us: do we do all projects in all nine counties?

- Overall score of project 3B: Reproductive & Maternal/Child Health
  - Average score of 3.9
  - Summary comments on 3B:
    - "This is an important project that needs investment. As with other projects, the infrastructure for monitoring and measurement is not developed. The 3-part intervention of LARC, NFP and PAT are strong & have a good chance for success if adequate staffing, good coordination, access to social services & monitoring & measurement are developed."
    - "Maternal-Child Health has a couple of unique issues. There are the issues around contraception and some of the providers of contraception that require great care in the way it is presented and implemented. Cultural differences are always an issue in health care, they are even more sensitive around contraception and obstetrical care."
    - "Much like projects 2C and 2D, it appears that several of the identified interventions for this project are existing projects/programs (NFP and PAC) and are unique to specific areas within GCACH. It would be helpful to have a better understanding of their current funding models and how each intervention could/should transition to other counties."
    - "(There is an) opportunity to focus on children's fluoride varnish programs, oral health education, sealant programs, etc. Also, an opportunity to improve oral health focus of pregnant women (caries and periodontal disease). Also, an opportunity to address the linkage with and need for lactation counseling/training since this is a starting point for a child's airway development- which if not well

established, results in increase in many behavioral problems as well as increase in infections, dental problems, and chronic illness later on."

- "This is a well-designed project that relies on two well-documented approaches to home visitation: The Nurse Family Partnership; and Parents as Teachers…..
  The other goal of this program is to educate providers and consumers about LARC; to increase access these contraceptive options and decrease unintended teen pregnancies. You might want to consider incorporating the "One Key Question "approach into this aspect of the project, if it has not already been introduced in Washington State……
  Primary challenges appear to be recruiting adequate numbers of culturally competent nurses; and in providing services in rural parts of the state where the caseload may not be large enough to justify the expense of the program."

- Overall score of project 3C: Access to Oral Health
  - Average score of 3.59
  - Summary comments on 3C:
    - "The proposal could be improved with a more explicit plan such as an initial pilot program in several primary care sites with more exact estimates of costs and staffing requirements:
      1. Breaking down the paradigm that oral health care must be delivered in the dental office.
      2. The current dental law prohibits our ability to deliver all the preventative services we would like to. This is a limitation but not a barrier to the project. Our hope is that good outcomes will encourage a change in the dental WACs.
      3. Data: Developing data sets that can be gathered by a disparate group of organizations scattered across a large area of the state.
      4. Low Medicaid reimbursement for adult dental services
      5. No Medicaid payment for oral health case management
      6. Lack of medical/ dental integration"
    - "Oral Health has three hurdles to deal with. Lack of access, current regulatory rules and lack of support/integration with medical community. Need to change WACs to allow more freedom for non-dentists to provide services under their own licensing and in other settings. Needs to educate the public more about the link between dental and "physical" health and convince the medical doctors to engage with the dental community."
    - "There are 3 identified interventions for this project which will require additional project management resources. It would be helpful to have a better understanding of how the proposed interventions could/should be implemented within the 9 counties."
    - "This project relies heavily on utilization of licensed registered dental hygienists, which itself imposes possible boundaries or limitations to the project, & hopes that upward pressures & evidence

obtained can be utilized to effect change at the highest levels so that reimbursement levels for delivering care…. One opportunity would be to link this w/ the 2C Transitional project wherein a hygiene navigator may be of help in navigating people thru the "access-to-care" minefield. Such a provision may also help w/ follow up after field identification of dental needs….
The strongest part of this project is the clear articulation of the problem and the direct challenge to the notion that oral health must be delivered within a dental office……Major challenges, beyond breaking down that paradigm……., is that it may require some statutory changes by the state legislature &that the workforce requirements for dental hygienists involves a minimum of 3 years training,"

- Overall score of project 3D: Chronic Disease Prevention & Control
  - Average score of 3.65
  - Summary comments on 3D:
    - "I found this proposal the most difficult to score since it is very broad in its goals and not specific in implementation. I would recommend that the proposal address each of the domains in the chronic care model. How will self-management programs be realized? What elements of practice redesign are doable and achievable? What are specific decision support tools that will be used? Importantly how will information systems be used or developed such as registries, monitoring and reporting? Given that this proposal like all others, is in the early stage of development, there is great potential for success. It is however in need of greater focus and more detail as to implementation plan."
    - "Chronic Disease is an important subject. There are lots of people using different tactics to impact chronic disease. Some use registries; others do not. There is a lot that needs to be agreed on by a lot of providers. The data issues will be significant."
    - "There are 3 identified interventions for this project which will require additional project management resources. It would be helpful to have a better understanding of how the proposed interventions could/should be implemented within the 9 counties."
    - "This project is elegantly designed in that it addresses primary prevention (5-2-1-0 Let's Go program); secondary prevention (the Diabetes Prevention Program); and tertiary prevention (the Chronic Disease Self-Management Program). This has potential for significant long-term cost savings but, like the diversion interventions, could adversely impact hospital revenue…Obesity and diabetes have their roots in a number of social economic and environmental determinants and the modifiable risk factors involved are particularly prevalent in low income populations. For these reasons, this project squarely seeks to address some of the most significant social determinants of health."
    - "There is a dramatic and well-established linkage between chronic diseases and the presence of poor oral health. …….Because of this, there is an immense opportunity in a bi-directional manner, to set the stage for both physicians and dentists to become better informed about these issues, as well as to

improve the co-management of these health problems. There is a good opportunity to strengthen this and linked projects by including conditions and metrics that bring focus on how medicine and dentistry can better work together to bring down chronic disease and reduce healthcare expenses by so doing. I would suggest adding "Sleep Apnea" and "Periodontal Disease" to the chart on pg 65 that outlines "Root Causes". Also - add "Diabetes - Medical attention to Perio & sleep" to the Evidences & Outcomes section. Add Periodontal Disease to "Comprehensive Care" on p. 67."

- Overall scores of the 8 project area proposals: 3.73
- Overall summary remarks:
  - "They seem to have a pretty good handle on what the challenges would be, but I am not sure they understand just how difficult some of them are. The very biggest obstacle in all of them is overcoming the resistance to change. The current system breeds unhealthy competition and duplication. Individuals and organizations tend to operate in their own self-interest and will need to be convinced that any change will not harm them……
    Integration, communication and cooperation all require work and have some level of cost to them. Convincing or compelling people to change is never easy. Most providers, agencies and hospitals have their own ways of doing things and getting agreement across them all will take great patience. These things are present in all the projects ….."
  - "The way to set GCACH apart from the pack in the project approval process is to demonstrate that you are not just after the money but, rather, that you have a constellation of projects that come together to create a holistic approach that is greater than the sum of its parts. This means that you must be disciplined in your approach to project selection…..
  - A lot of good people put a lot of the time into each of these eight projects, but to start from the assumption that you need to move all eight forward, is more about politics than substance and confuses the objective from the very beginning. Your objective is to <u>demonstrate</u> ways in which we can transform our health care system to produce better value for less cost. The way this project has been set up means that, in order to achieve that objective, you need to move a set of metrics…
  - This, in turn, means that you cannot view each project as a silo. You can't be successful in transforming our health care system using silos to break down the silos in the current system. You need to be open and flexible to incorporating some aspects of "project X" into "project Y" and not be afraid to drop one project while incorporating some of its key elements into another.
  - "It is also worth noting that most of us (not all) who are engaged in this process are white and relatively privileged. Few of us have had direct experience of what it's like to live in deep poverty, to have no reliable access to medical care or to face food insecurity every day and not know where you'll be living tomorrow. We are developing policy for people, many of whom face these issues every day – and yet they are not at the

	table. It is also important to recognize that the formal medical system— and the very process in which we are participating—can be intimidating to many minority populations, including those from generational poverty. We are people from the 'outside' coming into 'help' those who are less fortunate…..It will be difficult to foster the kind of community collaboration that is envisioned in this demonstration project without honoring and relying on local knowledge and trusted local spokespersons and organizations that have been working in this space for years. Therefore, it is critical that we incorporate into this process the very people who are at risk. We cannot possibly craft interventions to help these populations without their input and participation." ▪ "It is important to remember that in the last years of the Demonstration Project, funding will be based on pay-for-performance – that is, on how well you actually move the metrics for which you are responsible (accountable). For that reason, you need to give serious thought to how you can maximize the funding for the projects you select, while being accountable for the fewest number of metrics…. ▪ Try to avoid "meeting fatigue" in the process of building collaborative relationships. For example, Project 3B: Addressing the Opioid Crisis, proposes to send a letter to agencies in all communities to gauge the interest and commitment to being involved in the opioid project. A subcommittee will define roles and responsibilities of the case management in each area. At the same time, Project 2A: Bi-Directional Integration proposes a community level engagement process, while Project 2C: Transitional Care will have to conduct extensive meetings to develop robust ID/IA collaboration. If all the meetings across all the projects areas are stand-alone events, you're going to burn out community members in short order." ▪ *"I cannot over-emphasize the importance of this (working with the MCOs)*. Unless you get buy-in from the MCO's, unless you develop true meaningful partnerships with them and can demonstrate the financial advantages of continuing these projects into the future, none of this goes anywhere beyond year five. You need to continue to push them hard about getting serious in addressing the social terms of health but, the way this project has been designed, you need their partnership <u>now</u> if all the hard work you have done to develop these projects is actually going to reduce costs and improve quality long-term." ▪ "I am impressed with the work that everyone has put into this. I also appreciate the fact that everyone has "day jobs" and that these are early proposals without exact implementation tactics or cost estimates. Common themes are: the evidence base is clear in all of the proposals; most have broad representation and relevant leadership; common weaknesses are the lack of clear implementation planning and the lack of infrastructure for monitoring, measuring, and reporting. These are frequent challenges in clinical proposals." ▪ "First let me start by saying it is evident that a lot of work and thought went into the development of each of the projects. They all would be improvements to our care system…..
DSRIP Calculator Discussion	• **William** o Delivery System Reform Incentive Program (DSRIP) Calculator

	○ Over the last couple of weeks, William has meet with most of the board members to walk them through how this calculator works. ○ The original calculator was put together and released by HCA, but William has made some slight updates/modifications. ○ In the first tab, dollars are associated with the Project Teams and their milestones ○ If 6, 7, or 8 projects are chosen, this will not diminish the $119 million, but if less than 6 programs are chosen, we lose some of that funding. ○ William walked through an example of decision making with project teams, and how the money reallocates with the remaining project teams. ○ $119 million is the full amount for all 5 years and is predicated on hitting 100% of our metrics for every year out. This is most likely not realistic. Manatt's average was hitting 80% of the required metrics. ○ William walked through example of percentage of metrics hit, and then P4P (pay for performance) and P4R (pay for reporting). ○ One of the changes William made was adding in the definition of the metrics as comments to provide more detail on what they are asking for. ○ If you are playing with the calculator and change each percentage in specific project team tabs, be sure to go back and change the values to what they were originally so that the calculator is still formula driven from the first tab. ○ What are the actual performance targets/baselines? ▪ **William** – On the call with Manatt – this question came up from all of the ACH's. Unfortunately, they don't have those right now. It's something that they are aware of and working on. Right now, we only know what metrics they'll be looking at, but we currently don't have the baseline numbers that we'll need to hit. This affects all the ACH's in Washington. ▪ **Wes** – Most of the measures are tied to the Healthcare Effectiveness Data and Information Set (HEDIS). Our belief is that at some point benchmarks that are tied to HEDIS will be adopted by HCA. They've talked about providing us with some of that baseline data by the end of the summer also. ○ Cash Flow Tab ▪ GCACH will receive money every six months. ▪ The draw down rate of funds effects the draw down projection (on the tab labeled "Revenue Drawdown 1"). ▪ The Revenue Drawdown II tab is just another look at what it will happen as we start to drawdown the money. ○ Funds Flow Tab ▪ This shows how the money is allocated by program. ○ Project incentive Pool Tab

	▪ This shows you how much of the total $847 million the GCACH has. As you can see, GCACH is 3rd highest for funding. ▪ We will put this on our website for everyone to download and look at. If you have any questions or concerns, please reach out to William. ▪ We hope that this is helpful not only in selection phase, but also in budget phase for your CFO's and Controllers. o Next steps ▪ William is assembling a project plan budget and funds flow committee. This committee will help come up with a process and methodology to distribute the funds. If you are interested in this committee or if you have recommendations of those who might be interested, please let us know. o **Cathy H** – The two main takeaways from the DSRIP calculator is that it's being used right now to help with project selection, and secondly that the funding is driven by performance. There's a lot of variation in terms of achievement for pay for reporting and for pay for performance. It won't be $119 million that will be down streamed to the partners; there are some budget considerations. As your looking at the project selection, you're looking at whether you can hit those targets or not. That's the important piece for financing these initiatives.
Presentation of HMA's Analysis of Projects/Portfolio Alignment	• **Cathy K, Cathy H, Dr. Bruce Goldberg** o Today's Discussion: HMA Feedback on Projects (What work needs to be done to develop a strong project application and project portfolio), strategic considerations for the selecting project portfolio, and next steps. o HMA's overall project feedback on the proposed projects ▪ All of these projects reflect the tremendous amount of work and collaboration that has gone into them. ▪ All the proposed projects have real potential to improve the lives of people in the Greater Columbia region. ▪ Every project needs more work to be ready for the November application: ▪ Regional data ▪ Interventions need to be able to move performance metrics ▪ Identification of partnering providers and funds flow ▪ Domain 1: What investments are needed across the portfolio in Workforce, VBP and HIT? ▪ Alignment with other projects in the portfolio ▪ Sustainability strategy o Regional Data is a Critical need ▪ Need to know where you are, and who and where to start with to move metrics ▪ Need denominators – how many people need the intervention in order to hit performance targets?

	▪ Which sub-populations/ geographic targets? Every project right now says that it will serve all the Medicaid Beneficiaries in all nine counties. That is the right end goal for this, but it's a really difficult starting point. ▪ As a starting point, all counties for all projects will undermine your ability to hit targets ▪ Equity focus needs to be operationalized ▪ **Dr. Goldberg –** It's been great to see the DSRIP calculator, and understand that a lot of this is going to be based on performance. Although we don't know the baseline for the metrics we need to move, we do know that our performance will be based on how well we move these specified metrics within the Medicaid population. I think our next step is figuring out how we sit down with MCO's and get some baseline data. ▪ One of the first things they'll probably bring up is that there are 10 ACH's asking them for the same thing. This may be a good opportunity for the MCO's and ACH's to go to the state together and ask for some resources to produce some of these data sets. ▪ Understanding where you are, and what the baseline is will be critical in moving these metrics. ▪ **Jac Davies –** Focusing on the common denominators is a very pragmatic approach, but it automatically precludes doing anything in rural communities; and there has to be a balance. ▪ **Cathy K –** This is a great comment. Not only is this a rural community consideration, but also equity. This is where the broader vision of the GCACH really comes into play. The DSRIP calculators are just one tool to help with this process; and we hope that you will leverage other tools as well. Just because we need to pay attention to our metrics and dollars doesn't mean we forget our values and our commitment to the rural areas. ▪ **Dr. Goldberg –** The metrics and the projects help get some resources into your region, which helps you hopefully get some savings that will be sustainable in the future. Those savings would hopefully be invested in those communities. There's a logic and a strategy on how to approach this as a region. ▪ **Cathy K –** This goes back to 'no margin, no mission'. If you make all the investments that are in line with your values in the beginning, where does that leave you in the performance years? The DSRIP tool is not the be-all end-all for the GCACH. It's just one tool. If you draw down the reinvestment dollars effectively, you have an opportunity to make upstream investments, invest in your communities, and do the work that has all brought you here today. o Projects need to be able to move performance metrics ▪ Need for demonstration projects to "study to the test" ▪ This is a concrete step toward regional health system transformation, not just chasing dollars o Need to identify partnering providers and funds flow

	▪ Along with identifying who it is we need to go after to hit these performance targets, the other part of the equation is who are the providers we need to work on these initiatives with. We need the right providers at the table to reach the target populations. ▪ **Cathy H –** This is where you're going to be looking at your big network of providers. This combined with data will inform the budget and funds flow work group. They look at: do the funds get distributed at the provider partner level? Or do they look at distributing funds at a local health improvement coalition (LHIC)? o Domain 1: Workforce, VBP and HIT ▪ We need to start preparing what will go in the project application in November. Investments in Domain 1 should have a lasting impact and support the ability of projects to meet performance metrics. ▪ You're making investments that will outlast the life of the DSRIP demonstration, but they should also be part of your strategy to hit your performance metrics. ▪ Overview of what the 3 domains are: ▪ The projects you all are working on are in Domain 2 & 3 ▪ Domain 1 is considered foundational to all of these projects. It covers workforce, moving to VBP, and HIT/HIE (population health management). o Sustainability Strategy ▪ **Dr. Goldberg –** You're going to earn dollars based on your ability to get the DSRIP dollars; but those go away in 5 years. The work you'll be doing will hopefully do a couple of things: improve the health in your community, but also improve healthcare costs. There will be not only savings of human lives, but also savings in the healthcare system. As you look at putting this together now, look for how those savings accrue. ▪ **Cathy H –** I would also encourage you all to go back to your organizations, because sustainability is a business model that each of you will need to develop. o Importance of Portfolio Alignment: We need to get laser-focused on project metrics and we need to have as much mutually enforcing activities across the projects as possible. o Project Feedback: ▪ 2A: ▪ Strengths: Clear plan to determine gaps and readiness, Addresses regional priority and strong potential for alignment ▪ Areas of improvement: Think about how this project will work in partnership with managed care, and more work to draw straighter lines to the physical health issues in 2A. ▪ 2B:

	▪ Strengths: Strong proposal with focused approach for selecting target population, MCOs are engaged in planning ▪ Areas of improvement: Some metrics very difficult to move (e.g., follow-up after discharge from ED for SUD or MH, % homeless). Will take a strong, focused effort and alignment with transitions projects and diversion projects. ▪ 2C: ▪ Strengths: Strong proposal with clear target population and goals, Project can impact ED utilization and readmission rate ▪ Areas of improvement: Partnering providers: who are they, how will they be targeted, How will partnering providers be given training /tools needed for increased collaboration?, and then linkages with other projects. ▪ 2D: ▪ Strengths: Strong proposal that builds on existing efforts throughout region, Potential for strong alignment with other projects ▪ Areas of improvement: need to clarify potential partners with more specificity, need to clarify workforce needs, and looking at some of those more difficult metrics. ▪ 3A: ▪ Strengths: Addresses key need in region, Identifies key gap in services ▪ Areas of improvement: Need more detail about project interventions and operationalizing them, making sure it meets the requirements of the project toolkit, and Stronger alignment with bi-directional integration, care coordination and diversion ▪ 3B: ▪ Strengths: Builds on successful programs in the region and allows local flexibility, Identifies connections to other projects ▪ Areas of improvement: Metrics include childhood immunization status -- How will this intervention address that?, contraceptive measures can also be challenging ▪ 3C: ▪ Strengths: Strong proposal with innovative idea, Addresses identified regional health priority ▪ Areas of improvement: Consider implementation challenges and how they will be navigated, Consider whether or not scale will be sufficient to impact performance metrics, many outlier metrics ▪ 3D: ▪ Strengths: Reflects primary, secondary and tertiary prevention strategies, Builds on successful programs in the region

	▪ Areas for improvement: Needs a stronger connection to performance metrics and target populations/ sub-regions that will be identified in 2A, Consider re-focusing efforts on chronic disease in office-based setting ○ Strategic Considerations: This is the conversation we intend to have with the board. ▪ 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 "leave-behinds," including Domain 1 investments ▪ What investments will outlast this demonstration? ○ Projects: Workplan & Timeline ▪ 8/18 Communication to Project Teams about board's decision ▪ 8/18-8/30 Finalize LOI/RFQ's, post on 9/1 (LOI's were actually posted on 9/5 to avoid the holiday weekend) ▪ 9/5-9/12 HMA develops initial drafts of projects in project application template to identify remaining gaps ▪ 9/12-10/20 HMA works with project teams and facilitators to address gaps. PAC gathers data and works with project teams to strengthen alignment. ▪ 10/23-11/1 HMA finalizes project application drafts ▪ 11/-11/7 Project Teams/GCACH reviews drafts ▪ 11/7-11/12 HMA works on any further edits ▪ 11/16 Project application template submitted to HCA ▪ January 2018 State makes decisions on ACH demonstration projects and determines funding amounts ▪ GCACH Procurement/contracting phase begins after funds are determined ○ LOI/RFQs ▪ 8/18-8/24 HMA drafts LOI/RFQs ▪ 8/24 PAC reviews draft ▪ 8/25-8/31 PAC reviews draft with project teams ▪ 8/31 PAC brings final LOI/RFQ edits back ▪ 9/1 LOI/RFQ posted (LOI's were actually posted on 9/5 to avoid the holiday weekend) ▪ 10/5 LOI/RFQ due ▪ Assessment of LOI/RFQ to determine if respondent meets minimum qualifications ▪ 10/26 List of identified partnering providers submitted to the Board

Leadership Council Discussion & Vote on Projects to Move Forward to the Board	• **Caitlin –** We've had a lot of questions about our data and what MCO's can provide. Most of our data is claims data, and we have to send that all to the state; so the state has that data. This is why we've gone back and forth with them, as we don't have any additional data to provide.
	  o They way that MCO's work is we don't all have numbers in every single county. There are only a couple plans that cover the entire region; and within those plans the number of users may be fairly small. That's why it's important to get this data from the HCA.
	  o It's also important to note that 'savings' is not the same as 'cost avoided'. This comes into play with VBP and reducing ED visits in hospitals.
	• **Dr. Don Ashley –** When we started this process 8 years ago, MaryAnne Lindeblad said that "We'll be paying for healthcare we want, not what we're used to having". I personally question is it appropriate to abandon those people (that need Maternal Child Health Services) with everything happening in Washington right now.
	• **Michelle Roth –** One thing I want to point out is that we are very focused on community health. It's important to think of organizations that are not health related, and to partner with those groups.
	• **Brian Sandoval -** It seems to me that HMA is saying we need to look at how to move forward to receive the most amount of funding. Let's say we don't go forward with Dental and Maternal health. How can we reinvest in those populations even if we don't move forward with projects?
	  o **Liz Whitaker-** If chosen, the pathways hub project has the potential to include maternal and oral health.
	• **Jac Davies** – I just want to reiterate that if we decide to not do those projects, it doesn't mean we won't be helping those populations. There are ways to weave those populations into the other projects. How do you balance focusing on the denominator and assuring rural populations will be included? There needs to be some assurance that these populations will be woven in and not forgotten.
	• **Ed Thornbrugh** - Part of me wants to say if we're going to fail, fail while daring greatly and choose all eight projects because it's the right thing to do.
	• **Heidi** - Oral health is always left out. This is a perfect example of how it happens. We are healthcare. Periodontal disease effects the heart, and includes higher cancer risks, higher chance of having asthma, and autoimmune conditions. Diabetes exasperates it bidirectionally. If there's one thing I hope you consider, it's to include a dental hygienist in every project. It's in a hygienist's scope of practice to work within hospitals. Preventative health is what we do. It's easy for us to move the metric.
	• **Bertha –** I think part of the reason we are having this dialogue of "6 vs 8 projects", is because we haven't been able to tie all 8 projects together. Virginia Mason Memorial did an ER Hot spotting room project. Dental reasons and maternal and child health services are both big reasons for ER use. Financially that's one lens, how do we get the most amount of money. These are tied together, not separate. You won't see the financial gains if you don't look at the actual programs and reason why people are using the ED. We should not go with 6. We need help in tying projects together from a metrics and data standpoint to help move the projects along. You see the weakness in all of them without the support to tie them together. We don't have the expertise in each group to tie them together.

	• **Kevin Martin -** Do we have the ability to implement those interventions without implementing them in the portfolio (to avoid the metrics)? Is there an opportunity to make unfunded work more sustainable? There are human reasons to keep dental and maternal because they matter. I think what we would want from the Board is an explicit statement about what projects we'll be doing and separating that from the portfolio.
	• **Brian Sandoval –** Is there any way to do all 8 projects, but only submit 6? This would allow us to only be accountable for the 6 projects financially.
	• **Cathy H** – There is an opportunity to use the funding that areas not included in portfolio by building those areas into your remaining projects.
	• **Cathy K –** As long as you are meeting the requirements of the toolkit, there is nothing stopping you from bringing in other components to make it stronger.
	  ○ **Caitlin** – I think in the past, there's been no accountability to ensure that maternal and oral health gets funded.
	  ○ **Cathy K** - I think the discussion right now is specifically regarding the November Application, but that doesn't mean that we can't still move forward with folding those other areas in.
	  ○ **Caitlin** – I agree, I just think that the metrics help provide that accountability.
	• **Mandee Olson** – A lot of the outcomes in other groups will affect the ED Diversion metrics.
	• **John Christenson**- How can we have the 6 projects chosen help the other 2 that are left out? We should ask the Board to address this when they make their decision.
	• **Carol** – I just wanted to say thank you; the passion for all of these areas is clear and evident. We anticipated that this would happen. One of the reasons we asked you to make those connections between the groups was to make this decision easier. Wes and I have come up with template that shows how all 8 projects link together. That means that if we choose to move forward with all 8 projects, we have the potential to link them all together. There are 11 metrics that are outliers if we choose all 8 projects; and that is a heavy lift. Even if we take the top 5% of the 255,000 Medicaid lives, that only equates to $9,200 per person (12,500 people) for 5 years. This is not a lot of money.
	  ○ The challenge ahead of us is to align all of projects together. We know we can do this; it's just that the project plans we put together didn't necessarily reflect this. If you're willing to modify your projects, we have the potential to do it.
	  ○ It will be very hard to move these metrics including the 11 outliers; at the very most, we could get 80% for pay for reporting.
	  ○ We are not leaving anyone behind by any means. We just need to bring the Project Team facilitators together to create that alignment.
	• **William** – There was concern about accountability. We can build that into the funds flow process. These funds can be allocated based on those certain metrics for the areas we don't choose. We can still use those metrics.
	• **John Christenson** - I move that we just do 6 groups; and leave out maternal and oral health with the consideration of folding these areas into the remaining groups.

	○ **Seconded by Dr. Don Ashley** ○ Discussion ▪ If you take on a goal and you reach 79.997% of your goal, you get nothing. I would also think about the reassurances from Carol that the Board will keep these other areas in mind. I think it's wise to avoid those outlier metrics and that 6 is the correct way to go with the reassurance from our board. ▪ **Vote - All in favor - 27** ▪ **Opposed - (including on phone) 27** ○ Comment – There are some organizations here that have more than one representative. Should each organization only get one vote? ○ **Jac Davies** – I think that we just send this to the board and let them know that the Leadership Council is split about half and half.
ADJOURNMENT	
	Meeting was adjourned at 11:47 a.m. Minutes taken by Megan Kummer and Aisling Fernandez
	Thank you for your time and engagement with the Greater Columbia Accountable Community of Health! The regular Leadership Council meetings for 2017 will be from 9-11:30 a.m. on the following dates: • September 21st (Columbia Basin College, Pasco) • October 19th (Columbia Basin College, Pasco) • November 16th (Columbia Basin College, Pasco) • December 21st