Greater Columbia Accountable Community of Health

Leadership Council

Thursday, June 16th, 2016
9:00AM-11:30AM Meeting
Greater Columbia Behavioral Health
101 N. Edison Street, Kennewick, WA 99336

Minutes

Participants	In Person: Caitlin Safford, Andrea Tull, Stan Ledington, Jac Davies, Rebecca Sutherland, Larry Jecha, Andy Nyberg, Janis Luvaas, Sue Jetter, Blanche Barajas, Susan Campbell, Leta Travis, Efrain Quiroz, Alex Howard, Eddie Miles, Carmen Bowser, Darin Neven, Martin Valdez, Sandra Aguilar, Liz Whitaker, Melet Whinston, Jorge Rivera, Amy Person, Bertha Lopez, Jim Jackson, John Sinclair Called In: Kat Latet, Shawnie Haas, Karla Greene, Steve Burdick, Kathy O'Meara-Wyman, Erin Hertel, Stein Karspeck, Sandra Aguilar	
Backbone Support	Patrick Jones, Facilitator Carol Moser, Executive Director Aisling Fernandez, Communications Coordinator Julie LaPierre, Technology Support Sue Jetter, HRSA grant writer Deb Gauck, RHIP consultant	
Guests	Lena Nachand, HCA Marc Provence, HCA	
Special Thanks	• Thank you to Greater Columbia Behavioral Health, especially Julie LaPierre, for providing the facility and support that allows us to hold these meetings. • Thank you Patrick Jones for facilitating the meeting. • Thank you to Marc Provence for the presentation.	
TOPIC	NOTES	ACTIONS
Welcome & Introductions	• Patrick led introductions around the room.	•
Action: Approval of Minutes	• May minutes were approved by consensus, accepted as written.	•

Director's Report (Carol Moser, Stan Ledington, Aisling Fernandez)	• The big news is that the HCA has launched the dashboard, which is intended for ACHs. The Board members and members of the Data Committee will access it. You have to download Tableau reader software and then the data is opened through that software. Carol is on the AIM committee which was formed to help shape the way the dashboard is displayed. Got the opportunity to ask cohorts what they want to see next. Carol went through the measures where we're worse than the State- these three measures will be in the next waves:
	  • Well-child visits in the 3rd, 4th, 5th and 6th years of life
	  • Antidepressant medication management (measured at 12 weeks and 6 months)
	  • 30-day all course hospital readmission
	• Data is displayed geographically, by county, by region, by race, ethnicity, etc.
	• Stan and Carol participated in the interview process for the new practice facilitator for the Pediatrics Practice Transformation Initiative. This is a DOH initiative. They have hired Anne Buchan, and hopefully our ACH will work closely with her to help identify pediatric practices who are interested in transformation projects. The aim is to improve health outcomes and reduce costs. Hoping she will be housed in the Benton-Franklin Health District.
	• Stan gave an update on the Plan for Improving Population Health (P4IPH), which spawns from prevention framework. On May 25th he met with the internal advisory group and the external advisory group and heard that that the focus for this has changed from a single, one-time document to a website, which is a living-breathing opportunity to share tools and strategies. On the website there will be links about value-based payments, promoting community-clinical linkages, tools that align with the Prevention Framework, and information about other transformation efforts in the State (including the ACHs). It's a journey. They've become less prescriptive over time. The website will be live on September 30th.
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	• Aisling gave an update on the Communications Plan. Carol & Aisling developed a stakeholder's wheel to depict different levels of engagement. The Communications Committee has been developing activities and appropriate audiences within the Community Engagement Spectrum (the IAP2 Public Participation Spectrum) adopted developed by the International Association for Public Participation. Aisling talked about how community engagement is a key part of the Regional Health Improvement Plan (RHIP) and sustainability.	
Database for Communications (Sue Jetter)	• Sue Jetter has been pulling together the list of agencies from all of the sectors within the GCACH in the process of creating a distribution list which will be used for community engagement (both internal and external communications). • The process includes establishing the distribution list in a format that will be compatible with MailChimp • How do we make choices to effectively reach the appropriate number of people with the right communication activities? • Plans to include physical street addresses for formal mailings. • One part of the data will be Entity Type, for example Catholic Services is faith-based, community-based, and deals with housing (provides many types of services). The distribution list will include information on the type of agency and the services they provide. Will add additional sectors for those organizations that belong in more than one sector category. • There will be drop-down lists so data/categories are entered consistently. • If you know of anyone who wants to work on building databases, let us know. • Sue will be talking to 211. Hopefully we can transfer a lot of their information to the distribution list. • If anyone has contact lists, send them to Aisling or Sue. • If you have capacity for data entry within your agency and you're willing to lend some time, let us know because developing the distribution list will be time-consuming.	•

	• We'll be bringing the list back before we do any distribution in case anyone is missing or changes should be made. • The sectors reflect the sectors of the GCACH Board and beyond. • We'll have to determine some limits and some sections will take longer to populate, for example business. • Patrick: One way to keep things current is through a newsletter. • Will coincide the newsletter with the RHIP when we think the plan is ready to announce and the distribution list is ready.	
Health Care Authority: Medicaid Waiver Updates (Marc Provence)	• Lena introduced Marc Provence, the Medicaid Transformation Director at the HCA. • Marc: Here to focus on development of the project framework. HCA is still in negotiations with CMS around size of budget. We'll see how much room we can negotiate with the Federal government to get resources. The Medicaid Waiver is a tool. It's yet another tool in another tool in our toolbox to transform health in the state of WA. At the 40,000-foot level, there are the 3 initiatives of the waiver. Initiative 1 (ACHs & delivery system reform) is the focus for today. "Each region, through its ACH, will be able to pursue projects that will transform the Medicaid delivery system to serve the whole person and use resources more wisely." Thinking broadly, Domain 1 is about delivery system components that are not traditionally represented. Domain 2: Access to the kinds of resources to help improve health. Domain 3 is about health prevention and promotion- chronic disease prevention/management and maternal/child health. Caution, don't assume because project title doesn't show up doesn't mean it couldn't be funded under the waiver. Domain 1 is about building capacity to achieve the goals in the other two domains. There many need to be some capacity building such as workforce and non-conventional service sites, etc. Capacity building is a means to an end. • Eddie: Domain 2 is where ACHs build up care coordination with care coordinators. In Domain 1 is where an entity needs to build up a workforce of	•

	care coordinators, but they don't have the cash to pay people. Maybe one way to do that is to front load the ability to hire people so they can do that. Is that right? Marc said yes.
	• Marc: The Waiver is designed to award ACHs for the achievement of milestones. It's not a grant. The Federal government doesn't hand us money. ACHs are incentivized along the way. ACHs should develop a project plan with local partners, this is milestone one. There's money for reaching that milestone.
	• Bertha- If we have a plan in place, do we have to cover the cost up front?
	  • Marc- The risk could be the cost of developing initial plan. There could be costs. Milestone 2 is the beginning of staffing of the plan. Set the milestones along an achievable path. Trying to learn as much as we can from other waiver states.
	  • Bertha- Is there room for trying something and making mistakes? Trial and error are parts of success. Will that be taken into account when we're being reimbursed?
	  • Marc- Projects need to be evidence-based or based on promising practices. Likely there are 1000s of great ideas out there some of which just haven't demonstrated their effectiveness. When reviewing project ideas, look critically to see if there is sufficient evidence that this project is likely to succeed. Recently visited with colleagues in NY. It's different because it's very hospital-focused, but methods are similar. Slide 6 shows NY DSRIP funding. The greys sections of the bars are project progress milestones, and it starts out more process-focused. The yellow section of the bars is pay-for-reporting. The blue part of the bars is pay-for-performance. Over the 5 years, it gradually changes from process-oriented measures toward outcome-oriented measures. This gives an example of how that's been implemented in NY. There's a balance between being prescriptive and letting things organically develop in each region. ACHs should have	

	projects in their toolkit which can translate from one region to another. If it's too broad, we may come back and say, "Can we scale that down?" From the perspective of the HCA, ACHs should be paying attention to when doing project identification. If someone is bringing forward a project, ask, "Does it fit with our vision?" "How does it relate to our Regional Needs Assessment?" "What data are available to assist in decision-making?" "Is there something that the project sponsor is bringing forward that helps us know that they have already demonstrated effectiveness?" "Who is going to be the decision-making body?" TPACs could be. Not trying to prescribe a particular structure for an ACH, the HCA leaves that to ACHs to come up with a good structure. How do you assure yourselves that you have people recuse themselves from a project they are connected with? After you've received projects, the HCA reviews projects before CMS reviews it. • Andrea- 2 questions about who decides. 1. Is HCA setting parameters around the Board or LC or steering committee who decides on projects? How open and transparent and public do we need to be? Who can provide input? 2. Regarding projects that can be selected, given that it's Medicaid, what kind of threshold impact is there for the broader community vs. Medicaid lives that it impacts? • Marc- The bias is toward transparency and the bias is toward representation. How those are carried out, the HCA doesn't have specific set of rules. It's a good subject for us to continue working on. • Andrea- Recommended that HCA sets certain guiding principles. • It's a Medicaid transformation waiver with funds from CMS for Medicaid. The less it affects a Medicaid population, the less likely that it will be considered to be a priority. The HCA does hope that it benefits the broader community. There's no threshold test or minimum number of people at	

	this time. It's about the effect on Medicaid beneficiaries and the effect on Medicaid providers in the community. It's about providers who are interacting with and providing assistance to members of the Medicaid community. • Jac- ACHs are required to select a regional project and also select individual projects on the toolkit. Will there be funding for smaller community-based projects as well as a larger, regional SIM project? • Marc- In terms of a collection of smaller projects and the ultimate/final project toolkit, one of the objectives is to keep the number of projects under the umbrella to a reasonable number. Just want the number of projects to be manageable. • Lena- Think about systems changes and how does the new system sustain itself? • Marc- Within one project you could have a number of partners participating. • Eddie- A small project as part of the overall plan may start small and be scalable, right? (Marc said yes.) Eddie: When we were submitting ideas for the toolkit, anyone could submit. Will other non-ACH entities be able to apply for the Medicaid Waiver? ▪ Marc- Someone could be coming from outside of the ACHs, letting HCA know that this set of projects meets the set of criteria. • Deb- Can Lena talk about the relationship between the RHIP and Medicaid waiver? If we're only looking at a small number of projects, shouldn't it be aligned with RHIP? ▪ Lena- Think of the RHIP as the plan/vision for the ACH's vision for a transformed system. The HCA is trying to be reasonable with expectations for SIM (which is a grant). The waiver is not grant. ACHs encompass both, and both are tools to achieve the vision of	

	the ACH. There are different mechanisms. SIM and waiver are two ways of addressing the same priorities. It's not about a definite list, it's about a vision. Lena- RHIP should fit both SIM and Waiver. ▪ Caitlin- SIM could be trying to get people organized around CC and that would be the base to apply for a Waiver project. ▪ Marc- There are number of projects ACHs will have to do under the waiver. There will be at least one project coming forward under each of the 5 categories within the domains. ▪ Can you talk about the relationships between ACHs and provider entities? ▪ Marc- There are links to MCOs and provider systems. There are sets of relationships. With MCOs, it's a contractual relationship with performance incentives to move toward value-based payments. In terms of financial risk, MCOs understand financial risk. Over time, there will be an increasing percentage along value-based payment. ▪ One entity for accounting and handling the finances will be hired by the Health Care Authority. ▪ CMS expects ACHs to move the provider community (broad definition) toward value-based payment. Expects and hopes for close collaborations between ACHs and MCOs. How do we define value? Could spend a lot of time talking about that. There are certain expectations. • Patrick- Where does ACH fit in if we're working in the first, left-hand box? • Marc- Think about care transitions and HCA would encourage GCACH's evaluation of projects to include social determinants of health. Think about providers broadly.	

	• Lena- Initiative 2 and Initiative 3 are new Medicaid services that weren't available before. Initiative 1 is about delivery system transformation service. We need to think about how we're going to connect with these new services. • Bertha- One of the biggest focuses is around addressing equity. There's been no separation or highlighting of this focus, no incentives to look at data by race or ethnicity so we may not be as effective at addressing health disparities or equity. It doesn't seem that way from a metrics approach even though we seem to be tasked with that? • Marc- If you know there is the potential for a project to have a particularly positive effect on equity, then that's good, but how do we measure that? How do we build that out even if we can't achieve the perfect metrics? How can we advance our ability to achieve and measure that?	
Review draft RHIP (Deb)	• Deb led us through the draft of the RHIP. It's a very condensed summary of the process. This is 6-weeks' worth of work by the Strategic Issues Committee (SIC). It's very, very condensed work. • The draft RHIP is a 4-pg document starting on page 15. The red text represents strategies. There are 3 overarching strategies. **Key:** Red text = strategies "Sentences" = Medicaid Transformation Waiver Project Toolkit Blue highlights = measures for which all of the counties in the region had outcomes worse than the state • The RHIP draft/table shows how all strategies cut across all strategic issues, goals and objectives. • The Community engagement strategy is to provide training and assistance to local coalitions and cross-sector groups to implement the RHIP. We have talked about, "What is our capacity?" We're talking about creating a culture of health. Each local community is going to need to tailor the broad strategies based on their	•

	needs, capacity, etc. We're trying to keep the strategies broad enough that communities that implement them will also have ownership. It has been a group decision for Deb to lead us as far as the RHIP Draft & Logic model, but look at the guiding principles on your own.	

Focused Conversations on the RHIP Draft Report	• We didn't have time to break into small groups.
	• Sue led us through a couple of Objective, Reflective, Interpretive, Decisional (ORID) questions as a large group:
	  • After absorbing those numbered strategies in the draft, is there anything that jumped out at you or caught your attention initially? Where there any surprises? Anything you see or didn't see?
	  • Patrick was surprised at item #6, complete streets, which is also a hot issue in Spokane.
	  • Deb clarified that the strategy is "healthy community design" and complete streets is an example of this. We will work with local communities to tailor which approach they take for that strategy.
	  • Liz- Complete streets is a fairly urban approach, but maybe it will take a different approach in rural areas.
	  • Carol- We realize the rural nature of many of the communities in our region. It could be simply providing a sidewalk from a neighborhood to a school. All strategies could be adapted to each community.
	  • Jac- One opportunity would be to have a menu of evidence-based strategies, with options that rural or urban appropriate.
	  • Bertha- Evidence-based practices don't take rural or minority communities into consideration in every case. If we consider safe places, safe parks, these can take these populations into consideration.
	  • Eddie- To add to bertha's comments, in Yakima, there's a project around a multi-sports complex. It's designed to be one of the largest in the nation, and it's about a quarter of the way done. The project has solely relied on
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	the good graces of donors. Yakima has one of the fewest green spaces in in the state. We have to build up opportunities for kids to exercise since there's no green space. We are relying on donors but not on an organized system. • John Sinclair- On the healthy community design, having worked on this in his local community when redoing the ordinances for safe streets and livable communities, this is a community effort. This involves community development. Relates to the built environment. If people don't feel safe to go out, they won't, even to magnet sites or to a lake or a series of parks as long as people don't feel safe. Some of those places are safe depending on the time of day. Something for us to focus on is the diabetes prevention. You read a lot about this in public health literature, that it's a pandemic. It's multi-faceted. A less active generation and it's based in nutrition. There are some things we can do with community to deal with the diabetes issue. • Caitlin- When we're thinking about tailoring to local communities and when we talk about care delivery strategies, I start to get concerned. Referral patterns don't work like that. Making sure there's some consistency will help with systems change. Trying to think about forming a community based approach vs. an individual level approach. A tailored approach may not work for clinical redesign. • Sue: Which strategy would your community be most excited to implement? • Bertha- Want to echo diabetes, especially diabetes prevention. In Yakima County, there have been phenomenal efforts for the last two years around prevention efforts, food insecurity and community re-design. If we look at bending the cost-curve, we really need to focus on the prevention side and addressing the behavioral change early on rather than after developing a disease. There is a management program in Yakima with tons of local	

	data, but also the prevention program with data that shows it's been very effective. Supporting prevention efforts and eliminate health disparities. • Deb- Forgot to mention that the SIC tried to make sure that all guiding principles applied to the strategies. • Liz- Really excited about the trauma-informed approach. Long-term that has a lot of power. • Sue- Any recommendations for the Strategic Issues Committee (SIC)? • John- While we have Marc in the room, it might be interesting to see what his gut check is. What does Marc think of this? • Marc- This is an impressive body of work and impressive attention around the framework. In selecting strategies, it's tempting to select everything but the lessons we can learn will serve us well as we later select other initiatives. This is a learning experience for all of us and we will demonstrate that we can do this to ourselves. • Patrick- In Spokane, we are working on a collective impact initiative called Priority Spokane. At the GCACH, we should be mindful of the timeline to show demonstrable change and not bite off a 20-year effort but something that can move the needle relatively quickly. • Amy- I would argue against that, if you want to do something that's going to have a big change, look at something longer-term. We tick off a lot of boxes, but we don't make a lot of changes. We need to change the process of people who evaluate things. The 5 year goal may not be that diabetes would drop by half in 5 years. The tendency is to go for too many short-term goals. • Liz- We spend so much money on end-of life care. If we're looking at end of life care, that's a place where there could be savings. • Deb- We have 3 different care coordination pieces.	

	• Liz- Need to transform medical thinking. We need doctors and providers in hospitals to think sooner about less expensive care for end of life. • Dr. Jecha- We also need to change patients' perspectives. • Martin- There are some national discussions, such as the article by Atul Gawande in The New Yorker. It's a great story about this topic, basically the overuse of interventions at that age. We need to challenge the medical professionals. • Liz- There is still a divide in the medical community between those who think you should do whatever you can to lengthen life and those who are thinking in terms of quality of life. • Eddie- To address the issue of measurement for long-term and short-term goals. If it's a perceived 20 year return, we could adjust our mindset to ask "what is the measureable goal?" Oral health in children is a 10 year goal. Everyone gets screened within the next few years (a short-term goal) to get us to the long-term goal. • Deb- It's important that the Priority Work Groups feel that that their work is still in this RHIP. • Bertha- Deb has done amazing work and research and has moved us along quickly. I think it reflects diabetes and prevention. • Jorge- Deb's work has been incredible, and we're in a decent spot of agreement so far. Haven't had enough input from CC group to see if it reflects CC work. Need some validation at some point. Hard to represent the group. There is still work to be done to check in with the Priority Work Groups. • Caitlin- for HYEC, we've moved away from high school graduation rates. If the trauma-informed approach is tailored to youth and adolescence, then it can improve HYEC goals. Don't see much of the HYEC work- maybe go back to that group and ask if HYEC sees their work in the RHIP.	

	• Carol- If youth suicide is a concern, then you want to tailor that strategy to be around youth. • Sandra Aguilar- There are hardly any strategies that address getting to increasing high school graduation rates. • Patrick – Here's a process question for us, the timetable goal is to have the RHIP draft complete in a month. We have special dispensation from HCA for another month or two to tweak this more. If we had a little more time, would we want to break out in priority workgroups in July? Do we want to say that the priority workgroups concerns have been voiced today except HYEC & CC? • Andrea- Get nervous with timeline that we need to complete this. We need to do a final check over email between now and the next meeting. • Jorge- Nice idea, but CC is so large and so diverse. Would feel more comfortable meeting in person for 1 hr. The feeling of inclusion is important. Make sure smaller communities feel a connection to this. • Carol- We need to touch base with the priority workgroups via conference calls. • If we meet the last week of July, on July 28th, the workgroups would have time to meet in between. Jorge in favor of that.	
Final Discussion	• Where do we want to be in one, two, and three months? • Sue- I envision a menu for different communities. Maybe not something that we can develop right away, but something we create that over time. • Lena- HCA recognizes that we're going through this process. Sometimes a deadline helps, but we don't want deadline to hinder the process of the group. Lena can be here on the 28th. • Caitlin- We can talk about pre-work at Board level today. • Decision to move the July LC & Board meetings to July 28th.	•

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Adjournment	• The meeting was adjourned around 11:30AM.	•

2016 Meeting Schedule	The GCACH Leadership Council meets the Third Thursday of the month.
	• Location: Greater Columbia Behavioral Health, 101 N Edison St, Kennewick
	• Time: Leadership Council: 9-11:30
	• Dates:
	  ○ Thursday, July 28th, 2016
	  ○ Thursday, August 18th, 2016
	  ○ Thursday, September 15th, 2016
	  ○ Thursday, October 20th, 2016
	  ○ Thursday, November 17th, 2016
	  ○ Thursday, December 15th, 2016
	Thank you for your time and engagement with the Greater Columbia Accountable Community of Health!	