Greater Columbia Community of Health
Governing Board Minutes
June 18, 2015

Governing Board Members Present:	Leslie Stahlnecker, ESD 123; Gail Fast, ESD 105; Darlene Darnell, CFCS (Catholic Charities); Rhonda Hauff, YNHS (Yakima Neighborhood Health Services); Commissioner Kevin Bouchey, Yakima County; Martha Lanman, Columbia County Public Health; Martín Valadez, TCCH; Ed Thornbrugh, CWCMH; Lori Brown, SEWA ALTC; Renee Biles, People For People
Call in:	Jorge Rivera, Molina Healthcare; John Sinclair, Kittitas EMS; Alan Fisher, Associate Director, Vendor Management, United Healthcare; Steve Burdick, Providence, CEO; Carrie Green, Three Rivers Community Foundation; Brian Gibbons, CEO, Sunnyside Community Hospital
Backbone Support:	Dr. Patrick Jones, Eastern WA State University, Facilitator; Blake Rose, PMH; Carol Moser, BFCHA; Aisling Fernandez, BFCHA
Guests:	Vickie Ybarra, YV Community Foundation; Amy Norton, RN, YSD/ESD 105

Topic	Findings and Discussion	Concerns, Conclusions, Recommendations, Actions, And/or Motions	Follow-up
Introductions	Meeting began at 9am. Facilitator Patrick Jones thanked the Board members for attending this GB meeting and asked each member to introduce themselves. He gave overviews of the content of the meeting (Intent to talk about governance, consider subcommittees, and the GB retreat), of the environment we're working in (including the ACA and state), and emphasized that we must succeed in getting the full designation of ACH. Our ACH covers a large area geographically and we make take more time than other groups.		
Approval of May 21, 2015 Governing Board Minutes		Motion to approve the May 21st minutes; Ed Thornbrugh, Second, Rhonda Hauff, Motion approved.	
Discussion of Concept Paper- Global Medicaid Transformation Waiver	Patrick suggested we go through the Waiver Proposal being submitted to CMS in person to have a discussion. Blake led the GB through the paper with intermittent discussion: **Global Medicaid Waiver**: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:	**Ed & Lori** had cautionary tales and **historical perspectives** for the group. **Ed** said that 10 years ago this waiver was killed for behavioral health. How do we safeguard against using federal money to save federal money? **Lori** said that the system has been under transformation for more than 20 years. In 1995 ALTC relocated people into homes from skilled nursing	☐ Blake will send out the pdf for the WA State Common Measure Set ☐ Carol & Aisling will create a draft white paper for September GB

	- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible - Providing services not typically covered by Medicaid - Using innovative service delivery systems that improve care, increase efficiency, and reduce costs. In general, section 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years. Demonstrations must be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver. Recommends looking at Delivery System Reform Incentive Payment (**DSRIP**) programs in **NY** and TX. NY is a successful program, TX has not been as successful. DSRIP is funded by these federal savings reinvested to transform Medicaid. Not a grant, 5 yr. testing period, we must show that our work at the regional level is effective. We must compile information on activities we know are generating savings. Concept paper states that managed care and LTSS interventions have saved the fed gov approx. $5.8 billion (Jan 2003- Dec 2015), but has had little opportunity to reinvest the federal savings. WA seeking a fractional reinvestment of these federal savings into the future of their program. **Coordination**: "ACHs will serve as the coordinating entities to develop applications for DSRIP financing within rheir region that align with the key waiver investment areas, satisfy State expectations and Medicaid transformation priorities, and also address regional capacity for providers to participate in transformation. ACH members will be responsible for supporting each other to assure achievement of regional milestones and metrics." (pg 10) ACH's will play a big role: will have the authority to administer and coordinate investments and transformational activities. **Baselines:** (Blake) Shared savings. The Centers for Medicare and Medicaid Services (CMS) will split the savings 50/50. Baselines will establish current spending. State put together a panel (the Performance Measures Coordinating Committee) in 2014 and created The Washington State Common Measure Set for Health Care Cost and Quality Report. (Patrick) This established 52 metrics which are evidence-based and available at a frequent basis at the county level. **Consequences**: (Blake) There is no payback or clawback if this	facilities. This system needs more investment like in unpaid family care givers – people have to impoverish themselves to get into this program. Health homes and care coordination was the first roll-out for the duel eligible program. There has been a 5% reduction of Medicare with HH initiative. We need to be careful not to destroy a **system that works**. We already have one of the best systems in the country. **Health Homes** have been successful but they are only funded through the end of the year and won't be funded again. HH's turned the cost curve according to a recent UW study. **Kevin** asked what **baselines** are being set and by whom? Are baselines across disciplines? **Blake** explained that there is a set of 52 measures, (Washington State Common Measure Set for Health Care Quality and Cost) that will enable a common way of tracking health and health care performance as well as inform public and private health care purchasers. **Ed** said it's not appropriate to call all reduced spending **"savings"** considering the Medicaid expansion and crippled economy in WA in recent years. Does this reprioritize our need to become a legal entity? He advised to use an abundance of caution and ask a lot of questions. **Martha** asked about **consequences** for not meeting the goals for savings. Who's on the hook to pay back this money? **Rhonda** commented that the Medicaid population looks very different now; sicker, more chronically ill. The mix of client base is 50/50; 50% adults and	meeting. Public comment period sometime in late summer, so may need to accelerate our schedule.

	demonstration period is not successful in meeting savings goals because it is a waiver not a grant. **Medicaid Population:** (Blake) Now there are 50/50 adults and kids, 50% increase. **Interventions**: (Carol) We can point to many successful interventions within our own communities, programs that are saving MCOs money. For example, the Consistent Care program reduces "frequent flyers'" emergency room use. How do we scale up successful programs to broader regions? In terms of Mental Health, we don't have enough capacity in our community. How do we increase capacity? Through telemedicine or working with our universities? (Blake, Patrick) Discussion of regional vs. county approach. NY used public hospitals rather than ACH. Oregon has CCOs.	50% children, many more low-income working adults, an overall sicker working population. 50% increase (almost all adults) added to Medicaid. **Lori:** Working adults are not the sicker population; the greatest costs come from the aging population. **Les** brought up that five years is a short time frame for lasting change. Some systems cannot be changed (or demonstrate change) within five years, but we may miss an opportunity to make social changes and to understand why we're an unhealthy population if we only focus on what we can change in five years. It's really more of a 20-year investment, and there may be things we need to do for the betterment of population health even if we won't see returns in five years. **Darlene** asked if the ACH will be working county by county and which counties will these be delivered to? **Lori** said that the HCA is looking at transportation and access. Mentioned that 80% of health happens outside the medical system. Seems like a disconnect for NY to use hospitals as backbone organizations when the ACH goals is to reinvest in non-traditional resources.	
ACH Timeline/Backbone Organizational Responsibilities	GB reviewed Crosswalk document containing the timeline. Carol led the discussion on the dates and emphasized that we need to move forward with the ACH designation by the end of the year. The Regional Health Improvement Plan (RHIP) needs to be in draft form by 1/31/16 which means we need to accomplish the Needs Inventory, especially on our priority areas in short order. By establishing ACH status, we will become a purchasing and contracting agency. Blake said that it's really helpful if you have data and metrics to share. Blake stated that there are funds to hire a full-time or part-time	**Gail** asked about the request for information for programs- are they program specific or grant specific? **Les** pointed out that school and community data do not cross. Patrick **said that you should submit what you do track.** **Lori** asked about using evidence-based vs. promising practices.	In 2015, we need to establish By-Laws and Apply for ACH status. Information for programs (already being implemented in our 9-county region) will be collected this year by Aisling Fernandez.

	communications person. This person will reach out to FQHCs, help convene, help with communications, strategies, newsletters, minutes, provide info to steering committees, share information as it becomes available to Blake and Carol, create a website, internal communication and some external facings, engagement with organizations not yet at the table (figure out who's missing from each sector?). We still need business and consumer groups.		If the GB has someone in mind and/or space for a communications person, let Blake know.
Representation of MCOs on GB	MCOs have struggled to find one representative for their sector. The proposal on the table is to rotate the representative between their five organizations by serving one quarter each beginning with July 1- Sept 30, 2015 as quarter 3. The rotation would be: Molina Q3, United Healthcare Q4, Amerigroup Q1, Coordinated Care Q2 and CHPW Q3. Darlene suggested added a public comment time. Rhonda supported consistent rep idea for MCOs and a chance for public comment. John also spoke to the need for public comment, especially on items of great import. Openness and inclusion is vitally important. Jorge asked for the GB's help and to rotate representatives because of the many differences between MCOs. He believes that the proposal works well, and is consistent with some of the other ACH governing boards. Ed pointed out that the Leadership Council also provides an opportunity for all MCOs to collaborate and share ideas. Jorge said the sticking point is how to choose the GB rep, and asked the GB board to select a process for them to use.	Les and others concerned about continuity and commitment and that during the first year there is a heavy focus on making sure the GB can handle issues. Kevin shares the concerns although he believes they should be able to represent their own group however they choose. Lori, Martin, Steve, Carrie, Darlene, Brian and John support one MCO sector representative as a sign of commitment to the COH and its formative process. Will establish a public comment agenda item during the meeting where MCOs and public can participate in the process. Ed believes we should pursue a 501 c 3 org. The GB declined to advise the MCOs on how to select their representative.	GB Motion: Rhonda moved that MCOs will have one sector representative who will serve for one year. Each GB member affirmed the motion. The MCOs are encouraged to own their process for GB rep. The GB meetings will include a public comment agenda item where any member of the public, including MCO reps present at GB meetings, will be able to make comment. **Rhonda, Ed, Les, Blake, Patrick, Carol and Martin** will help with by-laws: a new By-Laws Committee. The By-Laws Committee is asked to have a

			draft set by September GB meeting. □ Carol to send out DRAFT Bylaws as written by RSN to GB members.
Election of Officers	Rather than having a vote for officers at this meeting, it was changed to a discussion due to the fact that there are no Bylaws to give guidance on how to select the officers, terms of office, etc.	Rhonda, Les, Carrie and Brian all submitted that the GB wait until the Bylaws are written to hold an Election of Officers.	□ By-laws will determine *how* to vote.
Sub-committees	The GB decided not to have sub-committees for communications, members or assessment. Rhonda believes that the medical private sector piece is missing, and this is the revolutionary piece. Blake said that Brian was added to the GB to represent the physician community. Carol said we need direction from the GB for the agricultural private sector. The LC suggested someone from the Broetje Orchards. Discussion to include Broetje Orchards or another large business with an interest in health. Darlene said that Broetje has agricultural ties throughout the entire region. They are a grower that has integrated social services, education, housing and a small medical clinic. Darlene also thinks that this will provide opportunities for businesses to intersect with each other and invest. Martin believes Broetje does a lot of great work, but they are the outlier. Les contributed that much of the work and discussion will come up from the Leadership Council to the Governing Board. The GB members need to have a broader view of the region. Also the GB current representation may only exist for a year with the purpose to establish the organization and set up the operational infrastructure. Darlene liked the idea of asking someone from the agricultural sector to be the Business Rep. Renee suggested the GB connect with Mike Gempler from the WA Growers League as they represent a broader view of the agricultural Sector. Martin suggested that Broetje represented a less typical agri-business and that it might be more strategic to convince the more typical business to join the Board.	There will be the following new committees under the Governing Board: By-Laws Committee, Finance Committee, and Communications Under the Leadership Council subcommittee will be: Membership, Assessment & Planning	□ Carol to work with Renee & Kevin to reach out to Mike

			Gempler from the Growers League.
Next Steps: **Planning August 20th Retreat**	The leadership council needs to meet again. Goals for the August 20th Retreat: To make progress on the Regional Health Improvement Plan that will be part of the submission in November. August 20th was picked earlier in the year. Discussion of different timelines for GB & LC meetings. Brian urged for monthly meetings because of the reinvestments and other work to do. Carol urges GB to look at the Crosswalk document to understand the differences between the LC and the GB. The August meeting is for RHIP. RSN space needs to be set aside.	There will need to be an agreement between the LC and GB on the structure of the document to submit in November. Members agreed to meet for a GB Retreat on August 20th at the Walter Clore Wine Center (will need to be reserved) from 9-11:30am. Governing Board Meeting Dates: August 20th (Retreat) Sept 24th Oct 22nd Nov 19th December 15th	□ Aisling & Carol will put together the information set for the retreat. □ BFCHA needs to resend the schedule. □ There will be monthly GB meetings through the end of the year, and then the GB will re-evaluate. □ LC & GB meetings will meet back-to-back on the same day (in that order with lunch in between). □ GB members agreed to be consistent by having meetings in the Tri-Cities until the end of the year.
Adjournment	The meeting was adjourned at 11:22am.	The meeting was held in Yakima this time to be considerate of the folks there.	