North Sound Accountable Community of Health

Governing Body Retreat

February 13, 2015: 10:30am – 3:30pm

Skagit Casino's Summit Ridge Room
Approved April 10, 2015

Minutes

Present	Present	Apologies
Tim Key	Larry Thompson	Ken Stark
Robin Fenn	David Jefferson	Debra Lancaster
John Stephens	Erin Hafer	Don Wick
Suzanne Pak	Chris Phillips	Scott Forslund
Jason Smith	Glenn Puckett	J. Scott Hale
Justin Iwasaki	Linda McCarthy	David Kincheloe
Gary Goldbaum	Greg Winter	Keith Higman
Joe Valentine	Regina Delahunt	Connie Davis
Federico Cruz-Uribe	Dan Murphy	**Guests**
Linda Gipson	Carl Bruner	Craig Nolte, Federal Reserve
Marilyn Scott		Rena Riley, Molina
Bob Burden	**Staff**	Teresa Litton, WA Health Alliance
Kim Williams	Jim Reid	Sara Needleman-Carlton, Coor. Care
Barbara LaBrash	Elya Moore	Kathy Burgoyne, Healthy Generations
Stephen Gockley	Lee Che Leong	Amina Suchoski, UHC

Topic	Action
1. Welcome and Review Meeting Agenda • Review binders • Review Common Agenda	**Information**
2. "Why are you here?" ***Introductions*** ➢ In 30 seconds: Why are you here? What brings you to this table? What energizes you about this process?	**Goal:** Get to know each other better
3. What is the promise of ACHs? • The State's perspective & the North Sound ACH perspective • The North Sound ACH Common Agenda ○ The state has some ideas, some less clear but we all come to the table with goals ○ As 1 of 2 pilots: start up initiative & as a learning community, we get to make mistakes and the state will learn ○ Triple aim plus access – our goal is to improve health, the state's focus is lowering cost ○ We need to accomplish a short term initiative as well as investing in the long term	**Information:** Get to know the big picture
4. What are we going to do together these next 5 months? • What are the State's expectations? • What can be achieved through care coordination? • CASE Initiative description • Questions we need to resolve for the North Sound ACH (basis of lunch discussions) ○ Would we still do this if we didn't get funded? **Yes.**	**Action:** Agreement on what we need to accomplish.

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○ There will be a phase in a process for design communities ○ 5 deliverables: governance, backbone, RHNI, sustainability, CASE ○ RHNI needs to reach beyond usual suspects ○ How will the tribes and their separate structures interface w/ the ACH and the RHNI? ○ The NW Tribal Health Board may be an appropriate forum, at least for the 5 tribes. Tribes can't speak for other Tribes ○ WA state commission on API affairs looking into disaggregating data, a recommendation from this groups would be helpful ○ Major disparities in utilization & cost ○ Inventory almost 1 year old: a lot of care coordination ○ Target populations intentional: high utilizers of Emergency Department, EMS & criminal justice ○ Leverage investments already being made to standardize ○ 5 questions for lunch	
5. Pick up your lunch and go to the group of your choice (see below)	
6. How are we going to accomplish all of this? *Smaller Group Discussions to refine strategic direction over lunch* • Pick a topic for break-out discussion: 1. What are accountable communities of health? What and how should we be communicating with the people who live in our communities? 2. How should we build a Regional Health Needs Inventory and link this with a Regional Health Improvement Plan? 3. How will our governance model be accountable to the community? Where are the gaps in our governance model? 4. To be a high-functioning ACH, what are our essential functions? How do we build capacity for these functions? 5. How should we build a solid sustainability plan going forward?	**Action:** Draw from expertise in the room to shape responses to key questions
7. What have we learned? Report out of small group discussions 1a: We have no authority or money but should be voice of community. If we don't communicate w/ the community, we're useless. 1b. Must communicate to formal groups: 5 standard slides to update. Each have professional network 1c. We must amplify the voice of those who experienced health disparities. There is also the new donut hole – high deductible, not access care. Potential of key informant interviews w/ CASE clients People like reshaping triple aim – grad rates as imp as immunization rates 2a. we have CHNA from public health (population based) and hospitals (specific patient pops) 2b. we must reach out beyond usual suspects 2c. we have to know what questions we want to ask 2d. anticipate 2 step process – need to plan for our plan and also ID how we want to move forward for regional plan. Could frame as "this may be more important for one county but there may be different issues raised and we need to support each other" 2e. we must push back on the state – this will not get done in 5 months. 3a. must be 2 way dialogue w/ all the different groups 3b. may need to create new structures 3c. must return to constituents and CAA, consumer boards, parents 3d. recognize not all planning models in alignment (Tribes & military) 3e. King county created community engagement board. 2 from that sit on ACH. 3f. didn't create sustainable community engagement forums. 4a. we need data sharing agreements – but for what? Need the ability to gather and sort through data. We have data but we need understanding. We have claims data and clinical data	**Action:** Consensus on direction of each discussion

We can measure ER but what is the social thing in each person's life leading to this? Here's how you define this type of housing risk…build bridge w/ individual care coordination. 5a. We have lots of funding in the region 5b. need to focus on measures on ACES and long term impacts. 5c. Need to think outside of the box – housing. 5d. There's a lot of fear and entrenched interests but if community is bought in and involved, it can endure. Need to look for opportunities to engage. need to take informed risks. 5e. the current incentives punish the wrong behaviors – how do we get from here to there? 5f. must get all health plans together to discuss ○ Community will bring pressure to do the right thing ○ We need all players at the table – not just plans – because their investments are key. The shared savings can't just be among us – can't just be providers. ○ In Snohomish we're including the criminal justice system, considering more about the individual and what the root cause of their use is ○ Wrap around services using criminal justice as incentives ○ 85% of our interests are in common	
8. Break	
9. Your first action as the Governing Body • Approve Bylaws ○ NOTE: We are not a legal entity • Sign and return Governing Body Agreement and Conflict of Interest forms	**Action:** Approve bylaws: Joe moves, Gary seconds, approved with 2 abstentions (David Jefferson and Marilyn Scott). 0 nays. **Return signed:** Governing Body Agreement and Conflict of Interest forms
10. How should we meaningfully engage communities? • Which communities are missing from the conversation? How do we include them? • How do we engage communities that experience the largest health disparities? ○ Would like to see more employers ○ Law enforcement and justice (tribal & MH courts) ○ Populations that experience barriers: homeless, MH, limited English proficiency ○ How do we engage the media? Do edit board letter ○ Health equity advisory committee ○ Local elected officials ○ 4 year school? UW Bothell/WWU/NWIC ○ Latino community/minority and immigrant communities ○ Private ambulance ○ We want to engage general consumers ○ Connect with the people who are failed by the health system ○ People enrolled in QHP ○ Community Coalitions ○ Food banks/WIC	**Action:** Charge SC to prioritize meaningfully engage with employers, Law enforcement and populations that experience disparities.

○ Civic organizations: rotary ○ Family resource centers/CD/Work source ○ (inter)Faith community ○ Military & VA, spouses ○ DV service providers ○ Rural populations ○ Make sure we incorporate outreach to these communities w/ understanding that they may not be on the Governing Body ○ Pomegranate foundation: affinity groups are the same view (prof. associations) whereas community (commitment to a sense of place that requires sorting through the differences) ○ Community engagement board for the future? Substantially larger group that meets periodically?	
11. Delegation of duties to subcommittees • Present draft charters for ➢ (Interim) Steering Committee, ➢ Communications Committee, ➢ Regional Health Needs Inventory Work Group, ➢ CASE Work Group • Plan to formalize Steering Committee • Populating committees **RHNI:** Linda, Regina will delegate Steve Hortegas (Molina health homes) Kim will delegate hospital Carrie McLachlan from Snohomish health district John Miller from Upper Skagit Tribal Health Administrator Checking: Bob Hicks doing data for Skagit *Require hospital engagement* **Communications:** Scott Forslund Chris Phillips Suzanne Pak David Kincheloe *Teresa Litton nominated and declined* *Add crisp PPT and succinct message to deliverables* *Draw on expertise as appropriate* **CASE work group** Robin Fenn Qualis health Kim will bring ER case manager Dan will bring names: health home people for MCOs **ISC** Governing Body makes decisions but Steering Committee is a resource for staff Who's missing? Consumers, Education Clarify process and membership for recommendation for June 12th	**Action:** Charters will be modified by committees and workgroups Identified committees and a plan to populate committees
12. Health Plan Representation • Should we add all 5 Medicaid Plans as non-voting members?	**Action:** Vote to amend

• How do we want to engage with commercial plans? • How to address the implications for medical sector dominance? ○ Need all health plans engaged ○ Governance follows function ○ If they contribute $, they should vote ○ If they're at the table, they all should vote ○ Could we ask that them to pick one? ○ I want to speak against the motion as WAHA; there's a difference between involvement and governance. It's a mistake to think about just Medicaid health plans – have to look as a whole. This should be something other than the usual suspects. ○ They should either all vote or none vote. ○ Shouldn't just be 5 Medicaid plans – dozens to hundreds of plans. 256 plans for federal employees – this is a short term issue. There will have to be some universal solution. ○ Appropriate to have sector representation, we can't speak for everyone in sector but we can commit to representing more than our employer. ○ Propose 2 voting members for Governing Body, one MCO and one Commercial, but agree that critical issue is plan involvement. ○ They should sit together so they can decide how to vote. ○ State doesn't know how to solve this but will have to standardize. ○ State as 1st mover: don't win until you get private sector involved but start with chunk ○ 8 Tribes but 3 votes. We can't represent each other. We have the right to be on governing board. ○ We don't have the authority to say only 3 votes.	bylaws: strike "no more than 3 may vote" for Tribes in bylaws. Invite formal liaisons for the health plans. All health plans invited to participate on committees. Caucus on 2/ votes. Will revisit in 6 months.
13. How did today go? • Feedback and reflection from Governing Body • What worked? What didn't?	Agree to answer survey rather than discuss
14. Public Comment Period	
15. Next Steps: Mark calendars for next meetings ○ Governing Body: April 10 from 10 to noon ○ Governing Body: June 12 from 10 to noon ○ Other committee/work group meetings TBD ○ Please respond to feedback survey next week	Agree to hold dates
15. Adjourn	