North Sound Accountable Community of Health

Organizing Committee Meeting

October 3, 2014
10:00am-4:00pm
La Conner, WA

Attendance

Present	Present	Apologies
David Kincheloe	Gary Goldbaum	Don Wick
Joe Valentine	Keith Higman	Debra Lancaster
Larry Thompson	Linda McCarthy	
Barbara LaBrash	David Jefferson	**Guests**
Linda Gipson	Scott Forslund	John Stephens, Swinomish Tribe
Bob Burden	Kim Williams	Marilyn Scott, Upper Skagit Tribe
J. Scott Hale	Carl Bruner	Kate Paris, United Health Care
Glenn Puckett	Dan Murphy	
Greg Winter	Regina Delahunt	**Staff**
Ken Stark	Chris Phillips	Jim Reid
Stephen Gockley	Erin Hafer	Elya Moore
Federico Cruz-Uribe	Connie Davis	Lee Che Leong

Executive summary

1. The Organizing Committee reiterated its agreement from the Inaugural Meeting that the plan submitted to the State must include **short-term** initiatives that can make significant progress in the first six months and demonstrate **cost savings**. They also agreed that work should begin on **longer term strategies**.

2. Additionally, whether or not NSACH is chosen as a pilot project or design community, **we are committed to building stronger relationships in the five-county area** and will pursue initiatives that have both short- and long-term benefits for the North Sound.

3. Two initiatives with the potential to begin in January 2015 were chosen by consensus of the Organizing Committee for further investigation, definition, and consideration:
   1) Intensive Case Management for high frequency Emergency Room utilizers
   2) Support for the Opportunity Council's Healthy Homes Initiative

4. The Organizing Committee supports the criteria adopted at the Inaugural Meeting, but added these considerations: 1) potential to build trust among NSACH member organizations; 2) improving work across existing systems, not creating new ones; and 3) potential to generate savings that could be reinvested into health transformation.

5. Community forum lead organizations will decide on most appropriate format for their county: building on existing momentum vs. getting people in the room who aren't coming to the conversation.

Agenda Topic & Discussion	Decisions & Agreements
1. Welcome! • Review Sept. 30th meeting summary ○ Emphasize consensus statement beyond the third sentence of the executive summary ○ Request to add concern to do no harm to small underfunded systems • Review today's agenda & the process for selecting initiatives	Emphasize consensus statement: **Meet the state's request for short term results AND will also look at long term transformation.**

2a. Framing the Discussion: Behavioral Health Integration (10:26 am) • Last session bill passed to integrate mental health and physical health • Handout circulated to illustrate integration initial technical and fiscal process • Counties have been invited to send representatives. • Our goal is to better serve populations neglected by current mainline services ○ Snohomish agreed to move forward if state adequately funds behavioral Health ○ Differences between RSN & newly legislated BHO: Chemical Dependency (CD) will now be part of capitated services. Currently CD outpatients are contracted between counties and providers but pays directly for in-patient. BHO will have to pay for in-patient now. ○ Someone has to operate the crisis services, largely a state funded system so state is thinking about hybrid model. ○ All 5 counties have to agree for BHO to apply, otherwise an request for proposal (RFP) goes out.	*NSACH has a role to support this process and amplify the community voice as the process moves forward;* **WAHA Staff Action:** Email slides for all presentations in PDF to Organizing Committee Members
2b. Framing the Discussion: Department of Social and Health Services advice on Selecting Targets (10:45) • <u>Pick measures and targets we can agree on</u> • Last year DSHS convened work groups to pore through data to identify how to measure progress and for whom	*As we evaluate initiatives, the Organizing Committee should **use these measures to gauge potential success**. If the State wants results in 6 months, they would probably prefer them in this format.*
3a. Potential Long-term Initiative: Prevention (10:58 am) • Cannot rely solely on medical system changes to reduce cost. • Health spending disproportionate but costs will continue to rise as we need to deal w/ upstream drivers of health as a community. • Public health is cost effective, especially environmental public health, such as... The Triple Aim should include social and environmental determinants of health. • In choosing things the state is trying to do, the Prevention Framework has 4 objectives, 3 of which are public health. • 98% spent on medical care, 2% on prevention: shift the distribution of funds for reinvestment	*To be truly transformative and have long lasting effects on population health improvement, **the NSACH must focus energies on prevention.***
3b. Potential Long-term Initiative: Health Homes (11:12 am) • Federally Qualified Community health centers (FQHCs) receive capitated payment which allows them to provide comprehensive health services for their patients. • This payment model allows FQHCs to provide patient-centered services that are typically not reimbursed by health plans, such as care management • There is a scale issue as well – not all FQHCs are as big as Sea Mar, and have the critical mass to be able to provide these services • SeaMar has as many behavioral health providers as medical providers.	*The FQHCs benefit from a payment model that allows for innovation in how health services are packaged and delivered.*
4a. Potential Initiative: Collaborative Care Management (11:28) • High Utilizers are where the opportunities for the largest costs savings are • We need to figure out how to bring the key systems (e.g., area agencies on aging, regional support networks, FQHCs, health plans, etc…) together to identify these folks and work together to decide who should do care coordination. ○ Housing has to be at the table. With adequate housing, intensive case management can pull back as patients stabilize. ○ We need all 5 counties involved: patients will visit emergency rooms in different counties ○ Is there a way to make this both community-based and self-sustaining? ○ When Snohomish tried to share information, risk management was substantial obstacle ○ Each health plan will also need to fit in, ideally into a common system across the region ○ While we agree that focusing on this population will yield immediate, marked results,	*The Organizing Committee has agreed that some form of collaborative, **intensive care management is a likely candidate for an early stage, short term initiative for the NSACH.*** ***WAHA Staff Action:** Research existing areas of innovation around this item in the North Sound and provide the OC with relevant information.*

the broader population can also benefit from case management at some level. For example, if we can move the average blood pressure of an entire population down just slightly, we will see large scale benefits in terms of cost and health outcomes on a population scale. o Not talking about collaboration for all patients, just high frequency utilizers o Community health centers could be grown as their funding mechanism allow for ICM	
4b. Potential Initiative: Adult Dental Care (11:46 am) • Oral health is a key component of overall health. • There is a major issue region wide to connect adults with dental needs to dental services, particularly for the adult Medicaid population • Addressing oral health needs for a subset of the population with other co-morbidities has been shown to yield thousands in cost savings • Referral system in Spokane directly from the emergency department for people with dental emergencies. Called Dental Emergencies Need Treatment (DENT): Goal is a 50% reduction in ER utilization o Bill to integrate mid-levels into oral health delivery system: o Building of the trust key from the Tribal perspective: we provide health care access for our members, other natives, non-natives w/ connection to our community.	*Dental access is a universal issue in the North Sound region. All agreed that that **increasing dental access points should be considered as a focus for the NSACH for a long term strategy.** This includes further investigation of the DENT model.*
4c. Potential Initiative: Care Transitions from Hospital (12:05 pm) • Refer to September issue of Health Affairs article about care transitions • WAHA has contract with CMS to provide care transitions to Medicare fee-for-service beneficiaries o Regional Support Network is also funding care transitions from inpatient psychiatric unit o Providence partners w/ Everett Clinic and hospital group, though don't do home visit. o Health plans have multiple care transition mandates. Need a single one and could engage o Opportunity for the Organizing Committee to go to the state and present a regional care transitions plan. Health Care Authority has the ability collaborate	*The Organizing Committee agreed that **Care Transitions has the potential to be a focus for the NSACH**. The planning and negotiations make this an unlikely candidate in the short term. However, there was consensus to Investigate the potential for this to be incorporated into intensive care management for the high utilizers in the short term.*
Lunch (12:20) Homeless is Bellingham video series played	
5. Criteria Overview (1:00) In addition to approved criteria from September 30, Organizing Committee emphasized these considerations for potential NSACH initiatives: 1. Potential to lead to long term, transformative health improvement 2. Potential to build trust among NSACH member organizations; 3. Potential to work across existing systems, not create new ones; and 4. Potential to generate savings that could be reinvested into other, longer term, community health initiatives.	*The Organizing Committee agrees that the plan the NSACH submits to the State must include **short-term** initiatives that can make significant progress in the first six months and demonstrate **cost savings**. They also agreed that work should begin on **longer term strategies.*** *Additionally, whether or not NSACH is chosen as a pilot project or design community, **we are committed to building stronger relationships in the five-county area** and will pursue initiatives that have both short- and long-term benefits for the North Sound.*

6. Additional Initiatives to Consider (1:22) ○ **Healthy Homes Program**: All Community Action Agencies are trained in this program. The goal is to reduce respiratory problems related to childhood asthma by going into homes and reducing asthma triggers such as mold. Operates in 3 counties (Island, Whatcom & San Juan) and is currently under review by a private firm to measure health outcomes and cost savings. Draft report expected in December. Funded by philanthropy. ○ **Health Education:** educate low income parents about appropriate use of the ER and primary care. Decrease 9-1-1 calls and improve health outcomes for children. ○ Programs to **reduce unintended pregnancy** ○ **Fall prevention** ○ **Building out the FQHC model** presented earlier **Growing more midlevel dental providers** ○ *Longer term:* **Integrating oral health into primary care** ○ Screening Brief Intervention Referral to Treatment **(SBIRT)** Use of SBIRT in multiple clinical and non-clinical settings; requires training ○ **Community-based end of life planning**/advanced directives; includes long term care setting as well	Agreement to **share data** to identify best practices by program or model **Consensus that activities that improve behavioral health access and enhance integration with primary care are needed**. This is something we should support, as a long term goal. **Consensus** that, eventually we need to focus on strategies that will **improve the lives of children**
7. Deeper Discussion of Initiatives • Considerations: ○ Ready to launch? ○ Measureable? ○ State is primarily interested in Medicaid, not Medicare ○ Need money for infrastructure? ○ Can we take it to scale? ○ Existing momentum? The following initiatives were identified as longer term priorities for the NSACH and will be researched as time allows: ➢ Emergency Department referral to Dentists (challenge: need willing dentists) ➢ End of life initiatives ➢ Care transitions *(*State primarily interested in Medicaid, not Medicare. Medicare transitions is quicker because of fewer actors*)* ➢ Health education & literacy (longer term: parent education, fall avoidance, sexual health education etc.) ➢ Use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) (longer term: need places to refer to, operational difficulties of primary care integration)	Staff will research the 2 initiatives identified as most likely for January 2015 regional collaboration: 1. Case management of high utilizers 2. Healthy Homes for low income families *Staff may also research other initiatives as time allows.* ⬅ Additional initiatives identified will be considered by NSACH governance body as time allows/in the future – post January 2015.
Break (2:53)	
8. Community Engagement (3:00 pm)[i] Geof Morgan & Kathy Adams: • Introduce NSACH, what are the health outcomes that are important to the community, how does the community want to engage w/ NSACH? • Not looking for representative voice, but to get people in the room who aren't coming to the conversation. • What is the question in your community that will bring people to the table? • Vision is not "what's wrong?" but to building thinking about future ○ Don't over promise or over commit. ○ in 2 weeks can't get adequate stakeholder representation - go to existing community group and they can host a meeting ○ Need to keep this very simple: You have 5 counties and 8 tribes. Robust community engagement in ACH structure. ○ Do not duplicate what is going on but ask those doing this work and start to integrate. ○ central question: what is the mechanism going forward to stay in touch w/ communities ○ Tribal nations have a number of different forums who would need to participate to have more robust tribal participation. We were not at the table when this proposal was	**Consensus that each county lead will decide on most appropriate format**: building on existing momentum vs. getting people in the room who aren't coming to the conversation. **Action:** **Skagit:** David Jefferson will co-host **Island:** Keith Higman suggested a targeted invitation for Island and will connect with Kathy & Geof. **Snohomish**: CHA process underway and lots of

developed. Tribes across the state are looking at whether we should form our own in addition to participating in regional ACHs. As an elected leader, tribal members rely on tribal government to set up and provide services. Access to health care is a treaty rights. I don't know where we fit ○ There's something to be said about being in the room with your peers, rather than pulling together people who have gathered before. ○ Doing this the same way in every county is better for consistency. The currently process isn't necessarily the process for the future. ○ Supplement this with online survey? ○ Integrate Community Health Assessment processes ○ Make clear the approach to community engagement in the fall of 2014 under the Organizing Committee is not necessarily the approach that NSACH will eventually take once formally established. ○ In the report to the State in December, lay out the philosophy and approach that will be taken in the future.	ongoing efforts; Scott Forslund will connect with Kathy & Geof. **San Juan:** Barbara LaBrash will connect with Kathy & Geof next week. **Whatcom:** WAHA staff can take the lead. Opportunity Council can invite for San Juan, Whatcom & Island, Mount Baker Planned Parenthood for Whatcom, Skagit, and San Juan
9. Field/Sector Engagement (online) expectation calibration	Tabled to online conversation
10. Task Force Identification and Assignment (3:20 pm) ○ Marilyn invited to participate in Structure Task Force: Tribes may designate a staff person, perhaps Barbara Juarez of the North West Indian Health Board? ○ **Data Task Force:** tabled until October 31 meeting	**Communications Task Force:** Connie Davis David Kincheloe Scott Hale Keith Higman Carl Bruner **Structure Task Force:** Joe Valentine Larry Thomson Greg Winter Ken Stark Stephen Gockley Regina Delahunt David Jefferson Scott Forslund Chris Philips
11. Public Comment Period (3:50 pm)	No comments from the public.
12. Adjourn (4:00 pm)	

[i] *Community Engagement language from the Pre-planning grant (p 12, emphasis added):*
Consistent with HB 2572, we will "Base decisions on public input and an active collaboration among key community partners, which can include, but are not limited to, local governments, housing providers, school districts, early learning regional coalitions, large and small businesses, labor organizations, health and human service organizations, tribal governments, health carriers, providers, hospitals, public health agencies, and consumers."

Additionally, the state considers the strengths of the ACH to include:

- *Knowledge and understanding of local people, circumstances, programs, interests and culture*
- *Engagement of many, often with significant experience and expertise, who will not engage directly with the state*
- *Proximity to the actual service delivery and to those being served*
- *Connection and commitment to their community as their home*