North Sound Accountable Community of Health

Governing Body Meeting

June 12, 2015: 10am – 1pm

Skagit Station Meeting Room

MINUTES

Present	Present	Apologies
Gary Goldbaum, Vice Chair	Dan Murphy	Joe Valentine
Robin Fenn	Chris Phillips	Debra Lancaster
Tim Key	Bob Burden	Stephen Gockley
Erin Hafer	Marilyn Scott	Scott Forslund
Don Wick	Jason Smith	Justin Iwasaki
Linda Gipson		David Kincheloe
Linda McCarthy	**Staff**	John Stephens
Kim Williams	Elya Moore	Carl Bruner
Federico Cruz-Uribe	Lee Che Leong	Keith Higman
Greg Winter	Veronica Smith	
Glenn Puckett	**Guests**	
Barbara LaBrash	Lorali Gray, Ed. Dist. 189	
Suzanne Pak	Laurel Lee, Molina	
Regina Delahunt	Alan Fisher, UHC	
Connie Davis	Caitlin Safford, Coordinated Care	
Jennifer Johnson	Vanessa Mousavizadeh, CHPW	
Larry Thompson	David Jefferson, Skagit County	

Topic	Action
1. Welcome and review • Approve agenda • Review minutes • 2nd bullet, early adopter contract not RFP • consent agenda approved	Approved agenda, consent agenda and minutes with change to the left
2. What is the focus of the North Sound ACH? • HCA sees ACH as centerpiece health system transformation • Want to make sure services are available to most vulnerable members: MH – assuring access • Bring usual suspects from silos together to make decisions at the local level • Access to LEP immigrants, staff that speak those languages • 1) getting all the sectors together into one room, 2) set tangible and measurable goals,3) planning process to move toward those goals, 4) foster actual projects on the ground. Expect more agreement on what than how. • Agree that we need shared vision, shared goals and driving in the same direction but as we look at more folks being insured. Most of us don't make money on Medicaid. We shouldn't lobby each other about how money should be spent or creating regulatory redundancies • As things shift we could actually end up decreasing access • WA is beating national trends and will continue – we expect resources • Many of us lack the infrastructure to share data • Communicate back to the communities we're a part of, *clarify how we're accountable to them* • Ambitious goals will help us figure out our role and we need to be advocates • The state seems to have additional aspirations for ACHs • Need moral courage to eradicate things that don't work (48 other states don't have county designated MH professionals)	***Summary:*** Key themes surrounding ACH Role include: Convener to ID common good, safe space to agree tough issues and ID strategies to move us forward as a community. Facilitate, collaborate, motivate, advocate *Access, cross-sectional convening, attaining tangible, measurable goals, potential regional project management*

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• Don't have exclusive control so need to be focused on what our objectives are, obligation to weigh difficult questions: we're going to need major changes and we need to call that out • Critical to look at how much more money we spend than other societies but need to be mindful that other societies invest money in other services • We are starting w/ Medicaid but setting precedent to be adopted elsewhere. • Don't close the door on anything; funding not figured out yet • Also work in partnership w/ HCA as pilot and weigh in on MH provided in Criminal Justice • The ACH is also not interested in hosting a fight over $. • ACH relationship to our communities enables us to facilitate broad communication, be accountable, align assessments and find commonalities in the work already being done	*services and advocacy.*
3. Global 1115 Waiver Overview • Sign up for webinar on June 15th; please cc staff w/ concerns • Dan Murphy presented the State's idea: bending cost curve, feds intrigued by clinical/community linkages. Strategies are where state wants to go: BH integration w/ physical health, community based service, long term supports • 1115 waiver allows HHS to take state proposals to bend the rules. • Potential for upfront funding if bending cost curve from *US* trend; WA already doing better • LTC has saved $5.8 b in 8 years; negotiating for a chunk for a 5 year period • DSRIP is performance based program, live in 7 states • Must be budget neutral, 5 year demonstration (policy piece can be reviewed, money piece cannot), rigorous evaluation, public notice & tribal consultation. • State has nailed most current RHNI priorities • Must be evidence based • Using existing state funds to match and want ACHs to convene, evaluate, report • Feds require regional entity to coordinate • Want to cut this deal before Obama leaves office; 2 year negotiations • Opportunity to create 5 year investment pool for cross sector wins, to get Medicaid match for not traditionally paid services like housing, to invest in population health • This is an opportunity but raises administrative complexity significantly • Timeline: application in august for public comment, apply in September, start in April 2016 • There has been a tribal white paper on waiver. After the concept paper was released, April 17 consultation re ACHs. Tribes in WA are getting funding from state to determine if there will be a state wide ACH for tribes or involved regionally. Tribes need to be at local ACH table to ID services for general population and tribal communities. Yesterday met w/ HCA… Previously had joined the state to apply for uncompensated care waiver that was not budget neutral. We were told to look at OR's waiver to determine how to reapply. Two tribes impacted by early adopter: Cowlitz and Yakima. Asked if the North Sound could be a model region for the tribes as the 8 here have collaborated in the past as a test for how to form. • Would like staff presentation on 7 states	**Action** Request for staff to provide information to ACH members on how the waiver has been used in other states ACH needs to play a pioneering function the waiver development.
4. Sustainability • Larry Thompson presented the Sustainability Work group's recommendations, as currently drafted. Caveat: conceptualized prior to the release of the Waiver concept paper, the recent release of information related to the 1115 Waiver has major implications • Conversation focused on the North Sound focusing on the "real work" and not becoming pulled into the work of the State. • Key to the North Sound value proposition is that is it facilitating a "safe place" for disparate, often conflicting groups to come together. • Motion was made by Larry Thompson, seconded by Kim Williams, and all approved the Sustainability Recommendations as presented; with the understanding that sustainability considerations will change in light of the 1115 Waiver.	**Action:** Sustainability plan was approved with caveat. Even with the waiver, agreement that State infrastructure funding is necessary for ongoing investment in ACHs.
5. Break	

6. Regional Health Needs Inventory and Plan • Linda McCarthy presented a summary: still in first steps of Regional Health Needs process • Behavioral Health and care coordination from Organizing Committee interviews • Behavioral Health from CHA and CHNAs • Substance Abuse from qualitative interviews • Survey *results* not included in RHNI report; summary of design will be • Will continue to collaborate with Local Health Jurisdiction CHA alignment	
7. CASE: pilot initiative • Robin Fenn presented the work (to date) of the CASE Initiative and reviewed the accelerated time line, the revised scope, and the key points of the final deliverable. • The key learning from this work group is that collaboration occurs at the speed of trust: Taking the time to build trust essential • Governing Body discussed the future of the CASE Work group and its role in the ACH. They agreed that retaining CASE as a support for continuing care coordination activities and as an ACH advisory group for issues related to care coordination were valued functions. CASE to inform the GB of issues related to data sharing and barriers therein, when appropriate. • The need to identify duplicative work in care coordination and improving models of care coordination between primary care providers and state Medicaid resources also discussed. • CASE was to prove that we can work together • Group wants to be supportive of ACH; also want to identify challenges to the state • To be clear, continue with care coordination • Everyone believes they should manage the patient but we need to support the patient • The CASE group should also ID challenges • Ask CASE to propose more options for how to continue	**Decision:** work group to continue
8. Steering Committee Selection • Kim Williams presented the work group's recommendation • Steven Gockley, Greg Winter, Glenn Puckett and Laurel Lee served • Three categories of sectors with sectors primary and counties secondary • Two phase process: first select treasurer and secretary • Continuity: chair and vice chair; additionally, 4 current members willing to continue • Have 3 medical and 3 non-traditional medical with current ISC • Chris willing to be secretary, Dan willing to be treasurer • Staff will email to ask for nominations – non-medical members especially	**Actions:** Approve recommendation Approve Dan as Treasurer and Chris as Secretary Staff will call for nominations via email
9. What to expect over the next six months • A motion was made, seconded and the CASE Future Collaborations document was approved as submitted, for inclusion in the Readiness Proposal due to the HCA on June 15, 2015. • Continue bi-monthly GB meetings and rely on work groups and subcommittees • ACH Designation Timeline: submitting Monday • Changes to Steering Committee and Governing Body members will be discussed • Stronger focus on communications and community engagement • Amend bylaws • More activity with coming Healthier Washington initiatives: Hub, AIM, health care purchasing	**Action:** Approved CASE future collaborations to add to lesson learned deliverable
8. Public Comment Period	
9. Next Steps **Mark calendars for next meetings** o Governing Body: July 15 from 11 to 1 o Please give us feedback!	
10. Adjourn	