King County Accountable Community of Health

Interim Leadership Council Meeting Summary
January 23, 2017, 1:00pm
American Red Cross, 1900 25th Ave S, Seattle, WA 98144

Members Present:
Teresita Batayola (International Community Health Services), Betty Bekemeier (Northwest Center for Public Health Practice), Elizabeth “Tizzy” Bennett (Seattle Children’s Hospital), Molly Carney (Evergreen Treatment Services), Elise Chayet (Harborview), Shelley Cooper-Ashford (Center for Multicultural Health), Steve Daschle (Southwest Youth and Family Services), Kayla Down (Coordinated Care), Erin Hafer (Community Health Plan of Washington), Patty Hayes (Public Health – Seattle & King County), David Johnson (NAVOS Mental Health Solutions), Betsy Jones (King County Executive's Office), Laurel Lee (Molina Healthcare of Washington), Gordon McHenry, Jr. (Solid Ground), Adrienne Quinn (King County Department of Community and Human Services), Bill Rumpf for Betsy Lieberman (Betsy Lieberman Consulting), Caitlin Safford (Amerigroup), Jeff Sakuma (City of Seattle), Erin Sitterley (Sound Cities Association), and Melet Whinston for Amina Suchoski (United Healthcare).

Staff:
Candace Jackson, Ingrid McDonald, Gena Morgan, and Marguerite Ro (Public Health – Seattle & King County)

Guests:
Liz Arjun (King County Department of Community and Human Services), Sharon Bogan (Public Health - Seattle & King County), Kipepeo Brown (Overlake Medical Center), Roi-Martin Brown (WACAN), Tavish Donahue (Mercy Housing Northwest), Travis Erickson (Public Health - Seattle & King County), Anne Farrell-Sheffer (YWCA), Maureen Finneren (Washington Dental Service Foundation), Carrie Glover (Hopelink), Katherine Gudel, Steve Gustaveson (King County Department of Community and Human Services), Truong Hoang (Washington State Department of Social and Human Services), Sybill Hyppolite (SEIU 1199 NW), Sarah Jackson (Health Connections), Elaine Kitamura (American Heart Association), Kay Knox (Within Reach), Brad Kramer (Public Health - Seattle & King County), Maureen Linehan (Aging and Disability Services), Jennifer Louch (Public Health - Seattle & King County), Tricia Madde (Harborview Medical Center), Daniel Malone (Downtown Emergency Service Center), Susan McLaughlin (King County Department of Community and Human Services), Hani Mohamed (Community Health Plan of Washington), Lena Nachand (Washington State Health Care Authority), Glenn Puckett (Washington Dental Service Foundation), Leah Rosengaus (COPE Health Solutions), Mia Shim (Virginia Mason), Lauren Thomas (Hopelink), Trisha West (Evergreen Health), Ellie Wilson Jones (Sound Cities Association), Lee Wong (Pioneer), Kirsten Wysen (Public Health - Seattle & King County), Kelly Youngberg (CHI Franciscan Health)

Welcome, Meeting Goals & Agenda Review

Gena Morgan (Public Health – Seattle & King County) welcomed leadership council members and guests and reviewed the agenda and the following meeting goals:

1. Learn about recent developments of the Medicaid Transformation Project (MTP) demonstration and King County Accountable Community of Health (ACH) governance.
2. Broaden ACH understanding of two Medicaid Transformation Project areas on opiate addiction and care coordination.
3. Discuss recommendations of the Physical-Behavioral Health Integration Design Committee (IDC).

Medicaid Transformation Project (MTP) Update

Ingrid McDonald (Public Health – Seattle & King County) presented an update on the Medicaid Transformation Project.

Updated Project Toolkit

The waiver was signed January 9, days after a draft version of the Medicaid Transformation Project toolkit was released. Public comments on the toolkit are due by February 2, 2017 to the Health Care Authority (HCA). Last week, King County ACH backbone staff hosted an information sharing meeting to understand what other sectors will be submitting. King County government will compile internal comments and email them out to the ILC, to which other sectors can reply-all with their own comments, some of which include:

- Request for more detail regarding data requirements and data analysis capacity and a recommendation for a statewide taskforce on data.
- Clarification regarding the role of the ACHs in accelerating Value Based Purchasing (VBP) and recommendation of a state-wide VBP task force rather than provide technical assistance to providers and lead in monitoring regional progress towards VBP targets.
- Concern that the project descriptions are overly prescriptive, recommendation that ACHs have the option of proposing alternative evidence based approaches to meet the project goals and objectives.

Medicaid Transformation Project Demonstration Timeline

A timeline of the ACH certification and application process can be found on page 8 of the agenda packet. ACHs will be receiving information from the Health Care Authority soon regarding accreditation requirements necessary to receive capacity funding, with a Phase 1 Application due in March and a Phase 2 Application due in July. These applications will trigger funding to hire ACH staff, retain consultants and undergo project planning. In September 2017, the ACH will submit a portfolio of its project plans. The Health Care Authority will approve project plans by the end of the year, with project implementation beginning in 2018.

Early Project Planning

Backbone staff proposed an interim structure to support early project planning. This structure is intended to support and connect interested parties in information sharing and idea exchange until such time that further funding is available for more robust project development. The interim approach will focus first on the required projects: Project 2A) Bi-directional Integration of Care and Primary Care Transformation and Project; and 3A) Addressing Opioid Use as a Public Health Crisis.

Existing coalitions working on both issues have agreed to host open meetings in February to share information about the project opportunities and discuss how current efforts underway in King County can be leveraged and accelerated through the transformation project opportunity. These coalitions include:

- The Physical and Behavioral Health Design Committee
- The Heroin and Opiate Addiction Task Force

The ACH will notify the ILC and broader community regarding the upcoming meetings to discuss these two projects. ILC members were also invited to indicate there interest in the other optional projects outlined in the Toolkit. Glenn Puckett from the Washington Dental Service Foundation expressed his organization’s interest in hosting an information sharing session/information meeting on project 3C) Access to Oral Health Services, and

Maureen Linehan, Director of Aging and Disability Services, expressed their interest in doing the same for Project 2C) Transitional Care. The new ACH Governing Board will develop prioritization for these projects and offer direction going forward.

MTP Planning: Opioid Briefing

Molly Carney (Evergreen Treatment Services) introduced Dr. Jeff Duchin (Public Health – Seattle & King County) and Brad Finegood (King County Department of Community and Human Services), co-chairs of the Heroin and Opiate Addiction Task Force. In King County, there are over 20,000 injecting drug users and someone dies every 1.5 days. To respond to this problem, a taskforce was developed with a broad range of sector partners representing legal, fire, police, public health, emergency medical services, clients, mental and behavioral health, schools, housing, and hospitals. The taskforce had three focus areas:

1. Primary prevention (screening, education, and judicious prescribing)
2. Treatment expansion (providing more treatment and removing barriers to treatment)
3. User health services and overdose prevention (Naloxone kit distribution and safe use sites that offer non-stigmatizing compassionate services to meet holistic needs)

The waiver creates a more robust opportunity to move forward in these three areas.

Brad Finegood described the problem and the work in more depth while addressing the statics shown in his presentation (viewable in the agenda packet). For example, last year was the first time heroin and opiates became the most used drug seen by health professionals and are the leading cause of injury-related death for 20-65 year olds nationwide. He also made note of the inequitable impact of the "War on Drugs" on people of color. There is recognition that the opioid problem is primarily affecting a white, middle class demographic. Measures to address the problem will need to be intentionally planned to ensure that they serve marginalized communities and that racial disparities are not exacerbated. A comprehensive report can be found online.

The following questions and comments were discussed:

- What would you recommend to the ACH as a waiver project to move this work forward? The ACH is well positioned to focus on treatment expansion, which includes addressing the lack of buprenorphine prescribers. Doctors must have a specific waiver to prescribe this medication, and there are many prescribers who do not want to prescribe the drug. Those that do would prescribe more if they had additional support. Another potential focus is the promotion of good prescribing practices in the community using the data from the Prescription Monitoring Program. Legislation now allows healthcare systems access to the aggregated data.
- Would the Affordable Care Act (ACA) repeal affect this? Yes. Prior to the ACA there was only about a 35 percent engagement penetration. Post ACA it is now about 85 percent. Prior to ACA, this was not a qualifying disorder for Medicaid.
- What is the gap in the demand for long-term recovery services versus the need? Long-term residential treatment is not a gap, but front-end services have huge gaps. For example, adequate access to detox services is a gap. Another element to consider is whether people who need certain services know to access them. This underscores the importance of educating people on their choices and shows why co-locating services with safe use is valuable.

- The taskforce will be hosting a meeting in February for a broader audience that may want to intersect with this work. A specific date will be out next week.

King County ACH Governance Update

Christina Hulet (Hulet Consulting) gave an update on the ACH Governing Board process and timeline, referencing documents on page 20 of the agenda packet. Applications for the King County ACH Governing Board are due February 10 and everyone was encouraged to solicit nominations. Once applications are received, the Steering Committee will review them and recommend a set of names to the ILC who will vote on a slate of candidates. In addition to helping to solicit nominations, current ILC members are encouraged to apply. Christina Hulet is available to present to groups who want to know more about the ACH and the opportunity that exists as a Governing Board member.

The following question was raised:

- If the ACH Governing Board is not seated by April, what are the implications? There may be a requirement from the Washington State Health Care Authority (HCA) to have a seated board, but the specific implications are still unknown.

MTP Planning: Care Coordination Briefing

Gena Morgan introduced Dr. Sarah Redding (Pathways Community HUB Institute) to present the Pathways HUB model, which is a recommended model for Project 2B) Community-Based Care Coordination of the MTP. The model seeks to find the right at-risk people and completely assess their risks and protective factors, track all identified risks with Pathways, and measure the results. Measurement is central to the model and important to showing results. Using an example, Dr. Redding discussed the risk factors involved in a typical family at risk. When the broader community system gets involved, the family has a broader base of support, but a coordinator from each system will overburden the family. An at-risk family might have two, five, or more care coordinators. In contrast, community care coordination becomes homebased, not healthcare based, and confirms the connection to both health and social services.

In this model, there are 20 standard pathways which are translations of risk. These are tracked by a central community HUB in order to eliminate duplication, streamline referrals, and “braid” funding to address specific needs. The care coordinator is held accountable to achieve outcomes and is paid for pathway completion. Those coordinating care in high-risk areas are paid more because their work is more complex, which incentivizes the work according to the greatest needs. The HUB also tracks “finished incomplete” pathways to understand what is not working in the community. The HUB helps streamline care coordinators, and leverages their skills to get to resource specific needs.

The following questions and points of discussion were raised:

Community Context

- What is the level of engagement from providers and the community? This is not something you can force on a community of people and providers -- they must be willing. Start with a specific population and an issue that is already being worked on with this population, which will help to determine where to start. Do not try to do everything at once.

- How has this model worked in a community where there are already ongoing care coordination efforts? The model is meant to overlay with existing efforts. There has to be buy-in, and the community has to agree to work centrally under the model. An entity may choose to be connected to the HUB but not use Pathways.
- What is the biggest population size the model has been applied to and can this ACH connect with them to develop a learning cohort? Columbus, Ohio is likely the largest and yes, connections can be provided.
- How does the care coordinator interface with the medication management team (as an example)? The care coordinator is responsible to collect information and connect back to providers. Data and technology were developed to assist with the communication across providers. This includes a standard dashboard that can be transferred through the system.
- What are the early signs that the model is right for the community? Consider whether providers are up for it and funders are ready. Identify a population you want to start with and bring people together. A pathways "champion" helps to make the model successful.

Structure and Implementation

- What is the largest HUB size? Eight staff, but most HUBs have 3-4 members. King County may need to have a larger HUB, given its size.
- Have the pathways changed much over the years? No, they have remained consistent. This is the first year that an update is being considered.
- Who gets certified, the providers or the HUB? The HUB gets certified and is responsible to ensure it has capacity for all 20 pathways.
- How do you determine who will be eligible to provide services? The HUB should take everyone who wants to be a part of the HUB.
- Who is responsible for the quality of community care coordination training? The HUB is responsible.
- Managed care organizations (MCOs) have been having conversations with the technology platform and they are trying to connect emergency department information exchange (EDIE). Better Health Together (Spokane area Accountable Community of Health) has moved forward with a software solution (CCS). Implementing different software solutions statewide would be problematic from the MCO perspective, who also work statewide.

Financial

- What is the dollar amount of one pathway? It depends on who you're contracting with and where, but approximately $175-$200.
- How do you pay for another layer of care coordination and what percent does Medicaid make? HUBs take only a small percentage to sustain themselves. HUBs can take some off the top or take the savings and reinvest it. Medicaid makes up 75 percent and that includes up to 17 pathways through one of the MCOs.
- King County is a large county with neighboring counties to the north and the south. Does it matter where clients live versus work? Is the state planning to assign Medicaid lives to ACHs? In the state's funding formula a life will be attributed to the county of the home address, not the work address.

Model Application and Outcomes

- Is there any strengths-based prioritization of the pathways? The client's needs and wants are factored in and this model can overlay any program or service, which can certainly be strengths-based. The workforce can be trained to bring out a strengths-based approach.
- If a client has multiple complex needs and multiple systems involved, how do you know who to assign? The model is client directed. The client has to be comfortable with whomever they chose as their coordinator and who is on their care team.
- There is a huge connection between public policy and some of these pathways. Are there some pathways that remain persistently problematic to resolve? Yes – housing, for example.

Physical-Behavioral Health Integration (PBHI) Briefing

Liz Arjun (King County Department of Community and Human Services) gave a history of the PHBI work and briefed the ILC on current state. The work of the Integration Design Committee (IDC) happened in three phases. They established a common vision and principles, learned together, and then designed together. They started with changes that needed to take place at the clinical level as opposed to focusing on the financing first. The work of the IDC has now sunset and during their time together, they developed the following recommendations:

1. Implement core components of a clinically integrated system of care that addresses whole-person needs (core system categories and components are detailed on page 53 of the agenda packet).
2. Establish a local shared governance structure that aligns and leverages the array of financing and policy levers, including Medicaid, King County resources and other resources necessary to support a clinically integrated system of care (agenda packet page 55).

The second recommendation of shared governance is important for many reasons. Even with the integration of Medicaid dollars, funding will fall short of what is proposed and a collectively agreed upon approach is necessary. Shared governance will promote shared outcomes with aligned financing and policy and creates a space for greater funding alignment beyond Medicaid.

These recommendations received strong support from state and county leadership. This work is a strong foundation for the physical and behavioral health Medicaid waiver project. A meeting of stakeholders and interested parties sponsored by the IDC has been scheduled for February 21, 2 – 4 pm

The following questions and points of discussion were raised:

- What is the relationship between the PBHI work and the Medicaid waiver projects, and what is the relationship between the suggested governance of the PBHI work and that of the ACH going forward? Governance needs to be carefully considered in the context of roles and responsibilities. This is one of many types of integration that may need to happen. If this work proceeds without the ACH, it will be disconnected and siloed. Once the governing body of the ACH is in place, a conversation about collective governance will take place.
- Financial and clinical alignment are both issues to address.

ACH Developments

Around the State

Better Health Together is already implementing the Pathways model. The North Central ACH is also really interested in this model. It may be helpful to understand what they are doing around IT specifically. Additionally, the Performance Measurement Workgroup will do a site visit at the Data Across Sectors for Health meeting. They are also beginning to think about how the next phase of the workgroup should look. The needs around data and the data committee work will also be revisited.

Housing and Health Partnership

The ACH State Innovation Model funding for the housing and health project is ending in January, but the project is just getting started. The project is a collaboration between NeighborCare, Global2Local, and Mercy Housing with the support of Public Health – Seattle & King County and the Seattle and King County housing authorities. Currently, they are working on a common metric and evaluation plan, which combines public housing data with Medicaid data. They will be working to test the model over a 24-month period. The project group meets monthly and those who are interested can contact Bill Rumpf (Mercy Housing Northwest).

Staff Report

Gena Morgan made note of the following items in the staff report:

- The HCA is doing a listening tour and will be in Seattle on Wednesday, February 22, 2017 to talk about the Medicaid Transformation Project. Help colleagues and stakeholders learn more about the MTP by helping to spread the word. Staff will share information about the meeting when the location is finalized.
- The King County ACH is on a fast track to become a legal entity and is now focused on completing an operating agreement with The Seattle Foundation as fiscal sponsor.

Close and Next Steps

Gena closed the meeting by sharing that the next ILC meeting is scheduled for Tuesday, March 7 at the King County Elections building in Renton with networking and refreshments to start at 12:30pm.