King County Accountable Community of Health

Governing Board Meeting Summary

September 18, 2017, 8:30 a.m. – 4:30 p.m.

Alvine Room, King County Elections, 919 SW Grady Way, Renton, WA 98057

Members Present:

Teresita Batayola (International Community Health Services), Elizabeth "Tizzy" Bennett (Seattle Children's Hospital), Roi-Martin Brown (Washington Community Action Network), Molly Carney (Evergreen Treatment Services), Elise Chayet (Harborview Medical Center), Kristin Conn (Kaiser Permanente of Washington), Shelly Cooper-Ashford (Center for MultiCultural Health), Steve Daschle (Southwest Youth and Family Services), Ceil Erickson (Seattle Foundation), Patty Hayes (Public Health – Seattle & King County), Stephen Kutz (Cowlitz Indian Tribe), Maureen Linehan (Seattle Aging and Disability Services), Esther Lucero (Seattle Indian Health Board), Daniel Malone (Downtown Emergency Service Center), Adrienne Quinn (King County Department of Community and Human Services), Jihan Rashid (Somali Health Board), Jeff Sakuma (City of Seattle), Amina Suchoski (United Healthcare), David Johnson (Navos Mental Health Solutions), Erin Sitterley (Sound Cities Association), and Preston Simmons (Providence Health Services of Washington)

Members Not Present:

Betsy Lieberman (Betsy Lieberman Consulting), Marya Gingrey (Regional Equity Network), Sarah Rafton (Washington Chapter – American Academy of Pediatrics)

Staff:

Lee Che Leong, Susan McLaughlin, Gena Morgan (KCACH), Christina Hulet (Hulet Consulting)

Guests:

Diana Bianco (Artemis Consulting), Cathy Homkey and Cathy Kaufmann (HMA), Mike Bonetto (TenFold Health), Tavish Donahue (Mercy Housing NW), Bill Rumpf (Mercy Housing NW), Brad Finegood (King County Department of Community and Human Services), Bill Benham (Evergreen Treatment Services), Sharon Poch (Qualis Health), Laurel Lee (Molina Healthcare), Lois Bernstein (MultiCare Health System), Lauren Thomas (Hopelink), Wei-Lin Huang (Qualis Health), Erin Hafer (Community Health Plan of WA), Allie Franklin (Crisis Clinic), Christine Stalie (WA State Department of Health), Rose Quinbey (Sound Generations), Caitlin Safford (Amerigroup), Ross C. Baker (Virginia Mason), Brook Buettner, Travis Erickson, Ingrid McDonald, Marguerite Ro and Kirsten Wysen (Public Health – Seattle & King County)

Welcome & Introductions

Co-chair Esther Lucero (Seattle Indian Health Board) called the meeting to order. She previewed the meeting objectives which are for the Governing Board to:

- prepare for project portfolio and funds flow decisions in October
- prioritize "leave behinds"

Brief introductions were given by all members and guests.

Esther asked about approving the minutes from the August 30 Governing Board meeting. No changes or suggestions were made. All in favor, none opposed.

Executive Director Susan McLaughlin welcomed attendees and explained that this full day meeting is in preparation for the October 12 Governing Board meeting, where decisions will be made regarding the Medicaid Demonstration project portfolio.

Diana Bianco introduced herself as meeting facilitator and explained the day and the tractor tread ice breaker activity. Governing Board members gathered in a section of the room to do the ice breaker, which included brief discussions of questions like: What are the greatest opportunities for health and well-being in King County? If you had $1 million to give to charity, what would you give it to? What does equity mean to you? What are the top values the King County ACH (KCACH) should adhere to in making decisions?

Context Setting

Susan gave a series of updates to provide context for the day, including:

- the timeline for project plan application completion including a first draft that will be posted for public comment and provided to the Board for input (October 17-24), a next draft that will be provided to the Board for final comments (10/31 – 11/6), and brought before the Board at the November 9 meeting for final approval before the November 16 submission deadline;
- the current work of the Finance Committee to develop recommendations for project incentives funds distribution that will be brought before the Board at the October 12 meeting;
- the work of the Demonstration Project Committee (DPC) to develop recommendations of projects to be included in the KCACH project portfolio, which will also be brought before the Board at the October 12 meeting;
- a reminder of the KCACH's and Healthier Washington's system transformation goals.

The following discussion point was raised:

- We (the KCACH) can't do everything, but we also don't want to do something too tiny. Susan responded that the board would spend time in the afternoon on a "leave behinds" discussion that would help them think through the kinds of system changes they want to see, whether that be in workforce, health IT systems, or sustainability.

Susan requested that as board members listen to the DPC update, they keep in mind what's coming in terms of board decision-making in October.

Demonstration Project Committee (DPC) Presentation

Review Approach and Process for Project Recommendations

Shelley Cooper-Ashford provided an introduction of the role of the DPC (slides 12-15 of the Supplementary Materials packet), describing how the DPC has been meeting weekly for 2 hours, reading and analyzing the draft project plans that the Design Teams have been putting together. She mentioned that the projects will need to produce a return on investment. Some assessment has been made to-date where the DPC is evaluating each project, the target populations, scope, alignment of measures, and infrastructure needs. The DPC will develop a recommended portfolio for the Board's October 12 meeting. DPC members on the audience were asked to stand and were recognized. Shelley also recognized all the work the Design Teams have been doing.

Elise Chayet continued the update (slide 16-17). She discussed how the DPC is considering the following questions: How do the project plans address disparities and equity? What are the ramifications of accepting all the required outcomes? Will the cost of doing the project exceed the incentive funds available? Will the project have a return on investment valued by payors or governments to enable the work to continue after the waiver? How can we maximize the potential for reinvestment, or how will the projects continue to contribute to the ACH vision? The DPC has received good information from HMA and the Design Teams – now they're looking at the overlap of projects, populations, strategies, and potential leave-behinds.

Overview of Potential Projects

Susan provided an overview of the project proposals to-date. Each Design Team has presented to the DPC. Backbone staff leads for each Design Team were asked to stand and were recognized.

Susan reviewed slides 18-36 of the Supplementary Materials packet, starting first with the required project 2A: bi-directional integration of physical and behavioral health and ending with project 3D: chronic disease prevention and control. Discussion and questions for project 2A included the following:

- Which of the two evidence-based best practices have been chosen? The Design Team is not recommending a single best practice since all practices are in different stages. The goal will be to meet practices where they're at. The Bree Collaborative is not as proscribed as the Collaborative Care model. We would write in the project description that we'll want to bring folks up through the continuum. We want to fit what the community is doing. Provider readiness and willingness is key to success.
- How do we make this as seamless as possible for providers? SAMSA: 6-step model – be innovative as well as evidence-based. One Board member wrote an adaptation that included traditional practices, for instance.
- What about populations that are at risk? The elderly and communities of color will be most at risk. The project must be population-based, not just disease-based.
- If we are delivering services in behavioral health and physical health settings, are the "settings" more than just traditional settings? Yes.
- There is no metric for treatment penetration for adults who continue to show up in the ER. Yes, these are state-proscribed metrics. That doesn't mean we can't add these to our projects.

Discussion and questions of project 2B included the following:

- 2B will require quite a bit of Board discussion, a cost analysis and an IT infrastructure to support it.
- What have other ACHs decided on this project? What are other ACHs thoughts about the needs?
- What about missing data? What does that mean? This is data not yet available from the HCA.
- Families feel strongly about young people and mental health. If we aren't paying attention to young people earlier, we will need much more care later.
- You will see some of the same metrics apply across the different projects, including this project.
- What does "indicates Statewide metrics" mean? We are accountable to these metrics. The starred metrics are the State's metrics that they are being held accountable to by CMS. What happens if the State doesn't move the metrics? All ACHs will be impacted.
- What does the "narrow definition of percent homeless" mean?
- If we do 6 projects instead of 8, the up to $191M available to the KCACH rebalances across the 6 projects.

Susan described project 2C: care transitions; 2D: diversion interventions; 3A: opioid use epidemic (which is a required project and has benefitted from the work of a previously existing task force); 3B: reproductive and maternal/child health (which overlaps with work already going on in King County and is scoped towards reproductive health with strong collaboration with ongoing activities in our community); 3C: oral health (which

includes overlaps in behavioral health screening and chronic disease); 3D: chronic disease prevention and control.

Discussion and questions included the following:

- Don't get too focused on individual projects vs. the overall strategy to draw down funding for performance. The Board needs to think about values and mission and doing right by the people we serve.
- For 3C: Oral Health:
    - There are several outlier metrics – metrics not associated with any other projects. We may not have sufficient incentive resources where disparate measures don't hang together cohesively.
    - What about ER visits? How many of them are related to oral health issues? Washington Hospital Association has that data. This information should be in ER utilization data as well.
    - Narrow geographic scope: data is not narrowed down by regions within King County. What is our ability to reach that metric in just south King County? What capacity do we have in our dental providers in south King County – also an important question.
    - Dental should not be isolated. There is a high demand, but also a high no-show rate.
- The Board will need to focus on strategy. If you think of something more you need, let Susan know so that you are ready to decide in October. Vision and values. Detailed feedback and elicit from your areas of expertise, but have full confidence in projects.

Domain 1 Investments Review

Mike Bonetto (TenFold Health) provided an overview on Domain 1. He spoke from supplementary material packet slides 37-38 and encouraged the Board to think about the alignment of the three categories of domain 1: financial sustainability through value-based payment, systems for population health management, and workforce. The State needs to achieve these VBP metrics. Their definition of VBP includes categories 2C through 4B (of HCP-LAN's VBP framework). What resources do ACHs want to apply to help providers achieve VBP? What will be the role of ACHs to advance VBP capabilities among providers?

Regarding the health IT category, Mike noted that King County is in a unique position – very few other ACHs have the data that KCACH has access to. The question now is how can we put it together to see one big picture? What are the strategic investments this group wants to make?

Questions and discussion included the following:

- What percentage of VBP is being done state-wide? What's an example? MCOs – United is approaching 50% of contracts as VBP. 90% will be a heavy lift.
- All Medicaid contracts are managed contracts. A lot of us take fee for service, but some contracts are quality focused. We will need to see all enrollees at least 1x/year. At ICHS, we are in category 3A-3B and are moving towards 3C. Each organization needs to figure out its organizational capability.

Marguerite Ro provided an update on Domain 1 support activities. She requested that providers complete a provider survey that was sent out by the KCACH by September 30.

Public Comment

Esther Lucero reported that there were no sign-ups for public comment, but announced that the Board was still open to comments. No public comments were given.

Susan announced the submission last Friday of King County's mid-adopter letter to the State. This means the region will qualify for a $16.6M contract as we move to the full integration of physical and behavioral health by 2020.

Gena Morgan announced that we had just received notice of passing phase 2 certification with the HCA. This means the KCACH will receive $5 million of design funds.

"Leave Behinds" Discussion

Diana Bianco called attention to the "menu of leave behinds" hand-out (pages 1-2 of the Supplementary Materials. Board members were encouraged to think about the vision of what will be different for people in our community in 5 years. The handout provides an initial list, not exhaustive, and comes from questions posed by Design Teams, the DPC and the Board. We cannot do everything. We will have 4 years and potentially up to $191 million. How do we be strategic and have measurable change that helps us move towards our vision?

Diana facilitated an individual, then a small group exercise of choosing only two "leave behinds." Small groups discussed, then reported back. Below is a summary of the top "leave behinds" from the large group report back:

1. Collaboration between the health care system and social services, evidenced by an inter-connected HIT/HIE system connecting providers from both systems and payment models that incorporate social service providers.
2. Access to person-centered, multi-disciplinary, culturally competent care teams -- inclusive of social services -- in medical/health homes for everyone, regardless of where a person enters the system.
3. An infrastructure that provides an effective mechanism for meaningful community and consumer involvement and voice in the continuous improvement of the delivery system.

Additional Notes from Small Group Discussions:

As we finalize Leave Behinds, we should consider where KCACH has control and what is achievable.

- What didn't get included in the three bullet points above:
    - Biggest challenge is how/whether to integrate workforce, which was mentioned by many folks. The board talked a fair bit about how the ACH's role is different for workforce – a champion/influencer/advocate/convener, etc. – not really an implementer. We could mention "leveraging a strengthened and expanded work force" or say something like "King County is an active partner with the state to strengthen and support an expanded workforce," but that sounds a bit squishy. Workforce could be a fourth Leave Behind if we can sort out what KCACH has control over and what is achievable.
    - Specific inclusion of #4: Data infrastructure that allows for population health management at the system and provider level. *(Leave Behind #1 might get at some this.)*
    - Specific inclusion of #10 (Minimal to no-barrier access to most needed services). (*Note that this is mostly captured in #2 above.)*
    - Long-term social equity fund that supports addressing the social determinants of health.
    - Mentioned at the end…organizational infrastructure that supports smaller non-profits.

Finance Committee Update

Susan introduced co-chairs of the Finance Committee – Patty Hayes and Amina Suchoski. Patty and Amina shared slides 43-45 of the Supplementary Materials packet, which included Finance Committee process and guiding principles. With our new CFO coming onboard, the KCACH will have a cohesive budget to bring back to the Board. How cash comes in affects how the ACH can invest as a start-up.

Questions and discussion included the following:

- The Board will have to submit a plan for the % use of funds across the different frames in its project portfolio. Flexibility will be important. For example, 20% for Domain 1 – may be too high, but we will find out later. We need to submit the paperwork. The work happens, and then we get paid. The Board

will decide how funds will be distributed by "use categories". Some funds will go out to the community and there will be other things we want to do in Domain 1. We could resource them through Domain 1 investments, or if it's not part of the Demonstration, we may want to have a wellness/social equity fund to invest in the community as we see fit.

- System impact will need to be balanced over provider parity – we're asking them to do a lot. There needs to be some recognition of what we're asking providers to offer.

DSRIP Calculator and Funds Flow to ACHs

Susan McLaughlin introduced Cathy Homkey, HMA consultant based in New York, who reviewed her slides from supplemental materials (slides 46-63) on the various funding pools (design pool; project pool; VBP incentive pool; reinvestment pool, etc.). Cathy and others made the following points:

- Can be applied at their discretion, but the ACH will need to have contracts with partnership providers.
- Timing Considerations: speaks to building plane while flying it. Provides perspective for providers – small CBOs at risk; transition from fee-for-service to VBP. DSRIP represents small part of transition from fee-for-service to VBP. It does not cover full cost.
- Regarding pay-for-performance, there is an 18-month delay on data. Year 3 payment doesn't come until Year 5. Year 5 comes in Year 7. Cash flow is going to flow longer. It's going to be less than the total amounts. It will be spread across 7 years, not 5. Need to be conservative re: budgeting and projections.
- Would encourage the Board to form and work with DSRIP workgroups (with providers). Emphasize the need for good communication: what's the ACH vision and what are we trying to accomplish.
- Year 1 project incentives: it's a numbers game and a confidence game.
- Conservative budget modeling perspective: should assume will not hit full 100%. Will lead you to realistic expectations.

Questions and discussion included the following:

- Could the reinvestment pool enable us to pop above $191 million? Let's make sure we understand expectations around how to get the $191 million.
- When you provide mental health services in the way it should be provided, it's more expensive.
- Pay-for-reporting is reporting on projects. We will need to report on everything related to projects. That means there will be projects that are cash-starved. May need to think about start-up costs, and then switch to "wellness fund."
- Not enough money to pay every agency enough to transform. Other agencies need to understand costs of "going down this path." The Finance Committee needs to advise the Board on what's coming, but Board Members will need to help. How do we invest with providers? What investments and roadmaps are needed to get there? This type of planning needs to happen in early 2018.
- We have to plan carefully with providers: "This is what the new world will look like. Here's the path to get there. There will be some (financial) benefit – join us." Messaging and clear expectations are important. Need to make sure folks don't feel "tricked." This will not be full cost reimbursement. It is not a grant program. What's in it for providers to play?
- For mental health in King County, FQHCs, basic funding is shrinking. Difficult time to go live with this.
- A communications and marketing plan will be important. Perhaps a video. We will need to have folks meet with potential providers. A provider engagement committee has formed and is now developing its strategy. The KCACH has posted a position on clinical provider engagement and is looking for a communications firm to help with branding and marketing.
- This will be a very complex process. How do we maximize funds coming in and predict where we're going to have success? What other activities will influence the project outcomes? Figuring out attribution to each project and what that implies, and what happens to the incentive payments as a result will be tricky.

- The DSCRIP calculator is helpful in understanding revenue trade-offs and how much each project will cost.

Public Comment

Esther Lucero reported that there were no sign-ups for public comment, but announced that the Board was still open to comments. No public comments were given.

Summary, Next Steps and Reflections

Board members were asked what they need to know that will help them make a decision at the October 12 meeting.

In general

- Need to understand **overall strategy**
- Need to understand **why DPC chose 6** (eligible for maximum funding), **7 or 8 projects**
- Need to understand **costs of projects**, as far as we know
- Need to understand **which metrics projects will impact and at what scale**.
- Which projects will have the **greatest likelihood of being able to move metrics**?
- What are the **factors that might interfere with the success of a project**?
- Need assurance that DPC considered and existing efforts in project areas to avoid duplication
- Need to understand whether project **capitalizes on, leverages or aligns with other local efforts already underway**
- Need to understand **alignment in the portfolio**
- How does the portfolio address **social determinants of health**?
- What are the **target population(s)** and how was data used to define them?
- Need to understand what, if any, concerns or questions DPC had about overall package or individual projects and how/if concerns were or will be resolved
- Need to understand **what will be different for an individual** as a result of the project (what is the impact on people we are serving?)

Specific questions

- Are there any updated data we should consider?
- Is there anything we can learn from the decisions of other ACHs? Can we coordinate
- with other ACHs?
- What might we get left out of if we elect not to do certain projects that are being
- designed statewide?
- If other ACHs are not doing 3B: Reproductive, Maternal/Child Health, and we choose not to do it, what are the implications?
- What impact will federal decisions have on ACH? (We should know this by Sept 30)

Other

- How to "sell" project portfolio/individual projects to community partners and providers
- Consider how to involve small providers (may not be actionable until 10/12)

Susan McLaughlin and Esther Lucero thanked everyone for attending and closed the meeting.