CPAA Council Meeting Summary: November 8, 2017

I. Welcome and Introductions

The November 9, 2017 Council meeting of the Cascade Pacific Action Alliance was held at the Chehalis Tribe Community Center with more than 40 people in attendance. Executive Director Winfried Danke invited the Council and guests to introduce themselves, and then provided an overview of the desired meeting outcomes: review CPAA Board meeting outcomes from the October meetings, discuss the MDT Project Plan, discuss next steps after PP submittal, discuss financial news, learn about workgroup and committee activities, review and test a health equity decision aid, and learn about Tribal health priorities.

II. Announcements

We have three vacancies on the CPAA Board: Health system representative, Wahkiakum County representative, and a Tribal Gov't Services representative.

CPAA Board Report: Approved Budget, approved 6 recommended project areas to include in the Project Plan, accepted fund allocation principles by use category and org type with one addition, and agreed to approach the HCA with the Olympic ACH to request access to mid-adopter incentive funds. (see slide for language)

III. Project Plan Development Update

There are two main sections: Section One, which summarizes work to date (engagement with partners, etc), and a portfolio of specific projects that are tied to the approved six project areas. This second section consists of a narrative and an implementation plan/timeline for each project area.

Now staff need to know where the gaps are. First staff would like to ask the Council about certain concerns/questions they have. Then we will ask the Council for their input after reading through the documents.

Christina Mitchell, Clinical Director at CHOICE, outlined some concerns from staff:
Chronic Disease area – focusing on asthma diabetes and cardiac disease populations. Question – are you aware of specific strategies in your area that address these?
(See flip chart)

1. Nurse Case Management in certain high needs school districts.
2. Elma – WSU has an extension office for diabetes education and management
3. Ocean Beach Hospital has a diabetic support group
4. Cardiologist goes once a month to Sea mar in Thurston and grays harbor to hold a clinic with cardiac patients. Intersects with SA and BH issues.
5. WHH has diabetic education to community and cooking classes each month and support groups at hospital
6. Mason General – diabetic educators, community classes, work with Qualis for healthy heart measures

7. Morton General Hospital – same as above, plus health coaching for chronic disease at no cost in mult. Locations
8. Thurston – home visiting/healthy homes program to address home environmental hazards that contribute to asthma and other conditions
9. PeaceHealth Longview– Diabetes education – support groups and one on one support, also for high risk CV diseases
10. Providence – same thing

Christina – we will take these strategies into account when developing implementation plans.

Winfried then asked the Council for any concerns they may have about the PP application:
Mike – limitations based on special terms and conditions given by the HCA.

Staff will post entire document on Monday in close to final form. We will continue to work on formatting and attachments, but content will be final unless otherwise noted. Winfried asked the Council to continue to provide feedback, since this is a living document and an ongoing process.

Next steps – once we have submitted, will move into implementation planning. (see slide –What's Next: Planning Phase and Early Imp. In 2018)

- Independent Assessor will review and provide feedback in Jan-Feb
- Implementation Planning phase takes place Jan-June
- Implementation begins July 2018.

IV. Monitoring Project Implementation and Partnering Provider Performance

Jennifer Brackeen, Program Director at CHOICE, introduced this topic. In the project plan, staff outlined a process to monitor the implementation of projects and provider performance, and would like to ensure that the Council This is a process staff has outlined in the Project Plan, and would like to make sure the Council is in agreement with this monitoring process.
(See Flow Chart Slides)

- Implementation and Performance Monitoring (3 steps)
- If progress becomes questionable or is delayed (5 levels of escalation)
- Addressing Ineffective Strategies

Feedback:

- we need a precursor, which would be to provide capacity building and supports to partnering providers. (First bullet)
- we have more than just clinical projects, so we should escalate to non-clinical reps as well, such as social service providers (second bullet)
- we shouldn't wait to escalate to the CPAC, should bring issue to them earlier than indicated in the escalation model (second bullet)
- we should also bring to Support Team for early ID and warning (second bullet)
- can we add an appreciative inquiry (we already will have periodic peer learning collaboratives to serve this function)

With these changes, the CPAA Council agreed to recommend this process to the Board for approval.

V. Medicaid Transformation Finances

Winfried Danke led this section.

Original funding and project scoring framework:
see slides showing what the original funding potentials were.

Recently learning that there were insufficient state matching funds, so we have a cut of 27% of design funds for the first year. (Up to 36%, and potentially in further Demonstration years)

ACH Project Funds adjusted based on performance – decreasing payment hitting milestones, and increasing by hitting metrics over time.

Preliminary project plan scoring framework slide – how the HCA originally indicated ACHs would be scored.

What has changed? See document – Adjustments to MDT PP Scoring Methodology
Three things that are important in this doc:

1. ACHs that choose 4 projects can earn up to 100%
2. HCA agreed to match performance with earning percentages
3. HCA is maintaining idea of a project boost for those that select more than 4 projects

Back page of document – what happens if an ACH chooses more than four, and they need to drop a project later on? HCA does not pull back money, but money does not necessarily get rebalanced over the remaining projects.

Implications for CPAA project portfolio?
Dan Vizzini, of OHSU, used random allocations of project scores, (1000 random scores) and looked at how things landed.
Winfried shared the results:

- 6 to 4 project scenario – we would likely lose 3.01 million dollars (total worst case scenario. Average loss is 1.7 million. Loss due to bonus pool
- P4P – if we focused on a smaller portfolio, could we become more successful in performance?

Combined potential loss of poor p4r and p4p: -10.92 million dollars (total worst case scenario)

Project Portfolio Selection: (slide)

- What does our community need and value?
- What are our providers able to achieve?
- How many projects can we manage realistically?
- How confident are we that we will reach the outcome metrics?

How much money can we actually earn? (with a 6 project portfolio) (see slide for scoring assumptions and revenue projections)

Overall – there is not as much money as we originally thought.
Total estimated performance adjusted project incentives: 47.31 million

What about 4 project portfolio? Same assumptions, now we are down to 46.40 million.

What does this mean? (See corresponding slide)

- Max 5 year earning potential: 47.31M, not 85M (with achievement assumptions)
- Sliding scale scoring increased DY1 earned funds
- 1-3M swing between 4 and 6 projects
- 6 projects provide (four bullets on slide)

But what if we have to drop a project? It depends on when we will drop the project. Most likely this would happen in Year 4 or 5, so financial impact would not be that significant.

Conclusions and Recommendation (see slide)

- Lots of unknowns
- Still a lot of money but not as much
- Perhaps less p4p money potential
- Think integrated project initiatives
- Leverage existing blah blah
- It's not all about money – be guided by community need and provider capacity

Recommendation: Wait and See about final project selection. Don't have the information to make a final decision today, wait until we receive feedback.

Any money that is not earned goes into a pool accessible to other ACHs who are high performing (under current system) All the money will eventually get allocated.

VI. FIMC Funds

OCH and CPAA sent a joint letter to the HCA requesting access to FIMC funding. The HCA declined the request, but offered technical assistance resources.

Letter from HCA about number of MCOs – discussion and clarification

VII. Workgroup Activities

Jennifer Brackeen updated the Council on recent workgroup activities. Slight change for November – will be separating Domain 2 workgroups in person in November, and then may be moving to webinar.
Next meetings – will look at section 2 since we need to start developing an implementation plan.
Identifying assets and challenges in our region. Next few months will need to figure out how to move forward with formal provider contracts, develop implementation plan.

VIII. Consumer Advisory Committee and Clinical Provider Advisory Committee

Justin Wagaman – 1st held on Oct 24th with 10 participants. Approved charter, discussed health barriers, Next meeting in December – will be open to public. Info posted on our website.

Christina Mitchell – 1st CPAC mtg on 10/17 with 10 clinicians and 3 CHOICE staff. Members accepted charter, reviewed 6 projects and agreed on them, but had concerns with available resources to support projects. Also with capacity to support additional referrals if access to care is already strained. Members discussed concerns with metrics, data that is lagging. Missing – dental, BHOs, OBGYNs. Dr Gushee will chair committee. Co-chair is open. Next meeting is January. Will begin discussing implementation plans.

IX. Health Equity

Michael O'Neill of CHOICE provided a presentation to the Council about how to build Health Equity into the CPAA work flow.

He listed three assumptions that we will work from based on prior feedback from Council members:

1. Improve authentic community engagement
2. We need tools that lead to equity driven habits of thought
3. We need to consider equity at multiple points along the way, not just at the end

First draft of the first tool for the Council:
Adopted based on two similar tools from Multnomah county and King County. It was created as a resource for CPAA Board decisions.
It may require pre-work from staff before bringing to Board. It may be too late in the process for major concerns to be addressed.

Three main sections:
Decision/purpose, people/places, and process/power.

Comments: may need list of disparities added to health equity tool

Council was asked to apply the questions on the equity lens to a handout for a test run of the tool. The Council then broke into small groups to decide on Equity lens scoring as a group, discuss possible improvements to the public engagement process, and discuss the experience using the equity lens.

Feedback: (See Flipchart notes for more)

Substitute 'process' for 'decision' in this case. Tough to reach people who really need our help, and help them understand how this process works.

It's good but how to we get it to people in the community? Public engagement work is missing 'communicators' or 'connectors' to translate this to people who are not embedded in this work/familiar with language.

Add: how this is meeting people where they are, since that is not very clear. May be excluding certain populations.

Need to articulate how this will impact people's lives

The engagement process is a top down approach of equity/how to achieve it, rather than asking the people who are marginalized. Missing CHW feedback, etc.

Appreciative that CPAA is asking these questions. But this tool could just represent a token effort of people in power to address this issue, without making reach change for marginalized groups. Need to engage marginalized groups and make decisions from a sensitive and informed perspective.

Are we overreaching with our power dynamics? Power and Privilege questions should apply to all steps of decision making.

Next Steps:
Will check in with Support Team and work on improving draft.
Map CPAA workflow to add places to incorporate equity, and develop additional tools as needed.

X. Tribal Health Priorities

Justin Wagaman introduced this topic. He showed a regional map of the Federally recognized tribes in the CPAA region. He introduced Denise Walker, Clinic Manager of the Chehalis Tribal Wellness Center, who provided an overview of some Tribal health priorities of the Confederated Tribes of the Chehalis Reservation.
Quarterly health board meetings with WA, OR and Idaho tribes. Supposed to indicate if ACHs are engaging with the Tribes. What does this mean? HCA requires that ACHs work with tribes, but what does this mean specifically? Does just going to meetings together count? Have a high Medicaid population, and basically serve as MCOs for the Tribal population. If they are sent outside of clinic, they pay for services, so try to keep as much here as possible. At this clinic, have physician, nurses, pharmacist, ph. Assistants. Do not have narcotics due to crisis. Offer alternative treatments if recommended. Have a full service lab. Not open to public, just Tribe members here. Each Tribe can do that differently. Usually depends on resources available – urban or rural, etc. Also have a diabetic program and nurse. Have had Diabetes grants. Have an RD on staff as well. Unfortunately that funding went away, but it was very successful. Hold monthly Diabetic Clinics – podiatrists, MH providers, eye doctors, mammography, CD, MH providers/services. etc. are there as well. Lots of healthy eating info and literature. Given a passport to get all things done with incentives. This method is much more effective that sending patients to multiple locations at different times. Also use home visiting models.

How do we engage if doors are closed to non-Tribal members? What is the benefit? If we can figure that out, maybe Tribes would be engaged, but Tribes already go to so many meetings. Is there a project that Tribes could help out the CPAA with?

Top 5 diagnoses: HPT/CV, Diabetes, Respiratory infection, low back pain, hyperlipidemia.
Opioid use disorder may be on the list as well, but harder to measure.

Structure/nature of the Tribe as a collection of families, enterprises, cultural customs, etc., allows for a more well-rounded, multi-directional approach to health care than outside of the Tribe.

What can the CPAA do to more effectively engage with/support Tribes?

1. Be respectful of cultural differences
2. Utilize Justin as a liaison to help make connections and facilitate communication between Tribes and CPAA

3. Coordinate through American Indian health Coalition

XI. Next Steps:

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- ❑ Next Council Meeting:
  - o Date: Thursday, December 14, 2017, 12:00 pm- 3:00 pm
  - o Location: Summit Pacific Medical Center, Elma, WA

PHONE PEOPLE:
Alisha cys
Lis cattin peacehealth
Julie baxter
Chris – Wahkiakum
Dian cooper
Thurston AAA ?
Kim – shoalwater bay tribe