Olympic COMMUNITY of HEALTH

# Board of Directors Meeting

July 6, 2016

Clallam • Jefferson • Kitsap

# 2. Consent Agenda

- Attachment 1. Director's Report
  - Pages 2-6
- Attachment 2. Board minutes 6/1/2016
  - Pages 7-12

# 3. Voting on the Executive Committee

- Attachment 3. Bios of nominees
  - Pages 13-16
- Attachment 4. Ballot
  - Handed out in hard copy
  - One vote per sector & one vote per Tribe
  - 22 possible votes total

# 4. Selecting a project

- Attachment 5. Eight Submitted Proposals
  1. Pages 17-19 Ready for Kindergarten
  2. Pages 20-23 Behavioral Health Student Assistance Services
  3. **Pages 24-27 Olympic Peninsula Coordinated Opioid Response *RECOMMENDED 1st***
  4. Pages 28-30 Family Fit Camp
  5. Pages 31-41 Kitsap Aging SAIL Project
  6. Pages 42-45 Improving Health through Connections: Increasing Community Health Worker Capacity
  7. **Pages 46-49 Investing in the Health of Future Generations *RECOMMENDED 2nd***
  8. Pages 50-53 Child Check
- Attachment 6. Regional Health Assessment and Planning (RHAP) Committee Recommendation
  - Pages 55-57

# Project Selection Process

**DEVELOP** 5/16-20
- RHAPC creates project proposal template
- RHAPC establishes project scoring criteria

**REQUEST** 6/1-21
- OCH Board disseminates request for project proposals due 6/21
  - 6/1 post Board meeting by email to OCH Partner list
  - 6/14 in person at OCH Partner meeting

**REVEIW** 6/22-27
- OCH staff compile submitted proposals
- RHAPC members score proposals and make recommendation on 6/27

**VET** 6/28-7/28
- OCH Partners vet RHAPC recommendation (electronic)
- OCH Board reviews recommendation and makes selection on 7/6
- RHAPC assists with final submitted product to the HCA on 7/25

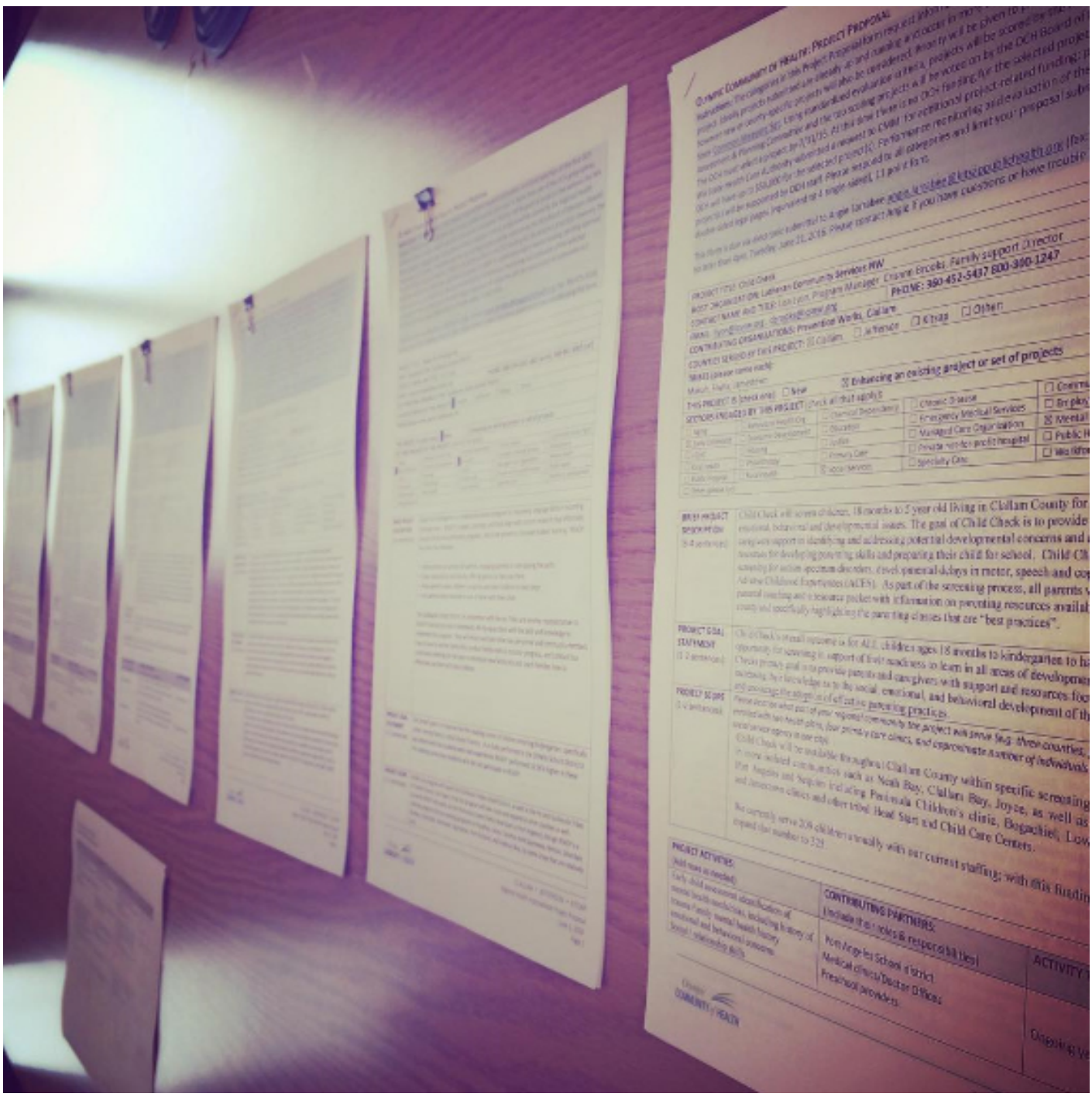
**SUBMIT** 7/29
- OCH staff submits project(s) to HCA on 7/29

**June 27, 2016 RHAPC Review Process:**

1. Review Score Results table
2. Proceed by reviewing TOP 3 (ranked by average score)
   - Any compelling request that we consider any proposals not in the top 3?
3. All: Read Project Description/Goal/Scope
4. Reviewers: Discuss their score if they want
5. All: Discuss proposal
6. All: Final selection made by near consensus

# RHAP Committee Guiding Principles of Project Selection

1. **Honor the applicants**.
2. **Place a high value on the review and scoring tool.**
3. **Conflicts of interest** are around every corner. We will do our best to acknowledge our conflicts in a productive way.
4. **Don’t let perfect be the enemy of good.**
5. **There is an inherent tension** between focusing on projects that have an earlier return on investment versus social determinants that affect health and wellbeing but have a longer return on investment**.** We accept this space.
6. **Enjoy!**



# Ranked Scores

**Ranking of proposal submissions, June 27, 2016**

| # | Proposal Name | Total # Reviewers | Range in Scores | Average Score |
|---|---|---|---|---|
| 1 | Olympic Peninsula Coordinated Opioid Response | 4 | 27-30 | 28.5 |
| 2 | Investing in the Health of Future Generations | 5 | 23-30 | 27.8 |
| 3 | Improving Health Through Connections | 4 | 21-31 | 27.3 |
| 4 | Behavioral Health Student Assistance Services | 5 | 24-28 | 25.8 |
| 5 | Kitsap Agining SAIL | 5 | 22-28 | 24.0 |
| 6 | Child Check | 5 | 18-26 | 22.4 |
| 7 | Family Fit Camp | 6 | 14-24 | 21.3 |
| 8 | Ready for Kindergarten | 5 | 13-23 | 17.2 |

**TOTAL POSSIBLE = 31**

# #1: Olympic Peninsula Coordinated Opioid Response Project

- Packet page 24: Review Project Description, Goal, and Scope
- RHAPC Summary:

| Strengths | Concerns |
|---|---|
| - Strong buy-in: Addresses an immediate health need that is shared by Tribes, multiple sectors, and all three counties.<br>- Will directly impact the Common Measures.<br>- Likely to have measureable impacts on process and outcome measures within a relatively short timeframe.<br>- Aligns the OCH with behavioral health integration and practice transformation, two key components of Healthier Washington.<br>- The OCH has a clear, value-add role. | - Not clear how the funding will be used.<br>- The outcomes may not be realized quickly and may be difficult to measure.<br>- It is important to support and not duplicate work that is already happening in this area. |

# #2: Investing in the Health of Future Generations

- Packet page 46: Review Project Description, Goal, and Scope
- RHAPC Summary:

| Strengths | Concerns |
|---|---|
| - Strong theme of social justice and health equity.<br>- Evidence-based.<br>- Long term investment in improving health that also includes some immediate results.<br>- Will directly impact the Common Measures.<br>- Opportunity to align with the CPAA ACH south of us doing similar work. | - Not clear how the funding will be used.<br>- Data sharing with Tribes may pose barriers.<br>- Majority of benefits will be realized many years down the road.<br>- Likely to see mostly process results in the short term, as opposed to outcomes. |

# Funding Considerations

- Anticipated $50,000 from HCA to support a SIM project(s)
- Potential to re-allocate ~$19,500 from the OCH budget towards SIM project(s)

# Recommendation:

The RHAP Committee was unanimous in the following:

1. The RHAP Committee recommends the Opioid Project and Future Generation Projects as the first regional health improvement projects, also called “early wins”, under the SIM grant.

2. In the event that the Board only selects one project, the RHAP Committee recommends the Opioid Project.

# Call for Decision

1. Presuming we receive $50,000 from HCA to support the SIM project(s), make a decision about re-allocating the remaining ~$19,500 to support the project(s)
2. Select one or both recommended projects to be considered for funding.
3. If we select both projects, identify which project will be submitted to the HCA as the SIM project
4. Recommend funding allocation(s) for the selected project(s)

# 5. Why and how to move the OCH forward

- Attachment 7. Pathway toward incorporation and next phase of governance
  - Pages 58-60  Discussion paper
  - Page 61 Proposed motions

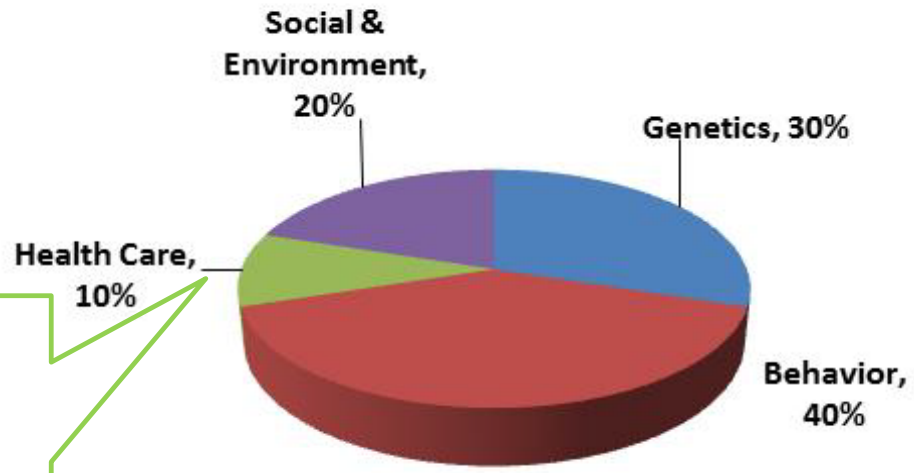
# My greatest hope

**l hope for transformational change through a participatory community process.**

**l believe that the ACH is currently best opportunity for achieving this.**

**l know that I am not alone in this belief.**

# The WHY




What Determines Health?

Source: New England Journal of Medicine: We Can Do Better - Improving the Health of the American People, September, 2007

**We haven't done enough to solve the problem of rising costs because we are so focused on only 10% of the pie**

**Based on US Census population:**
**Olympic Community of Health regional health care spend is**
**$3.39 billion per year**

- **We spend $3.0 trillion per year on health care, $9,523 dollars per person, or 17.5% of our gross GDP**

(NHE Fact Sheet 2014; CMS.gov)

- **30% of spend may be "wasteful" defined as: if eliminated, would not harm consumers or reduce quality.**

(Berwick Health Affairs; 2012)

- **86% of spend is for treatment of people with one or more chronic health conditions**

(CDC 2010; CDC.gov)

- **Population attributable risk percent for Adverse Childhood Events ™ on select health outcomes that plague the US health care system:**
  - 25.5% cardiovascular disease
  - 24.3% cancer
  - 22.2% asthma
  - 34.4% poor mental health
  - 36.7% tobacco use
  - 55.7% anxiety

(Adverse childhood experiences & population health in Washington: the face of a chronic public health disaster. Results from 2009 BRFSS. Washington State Family Policy Council. July 2010.)

# The value statement for the OCH

## Assumptions

- **Health is local** and 90% of it is driven by factors outside of the health care delivery system.
- **Health care is local**. We rely on it. We receive high quality but at a high cost.
- We can **accomplish much more together**, across sector and county lines, together with the Tribal nations, than we can separately.

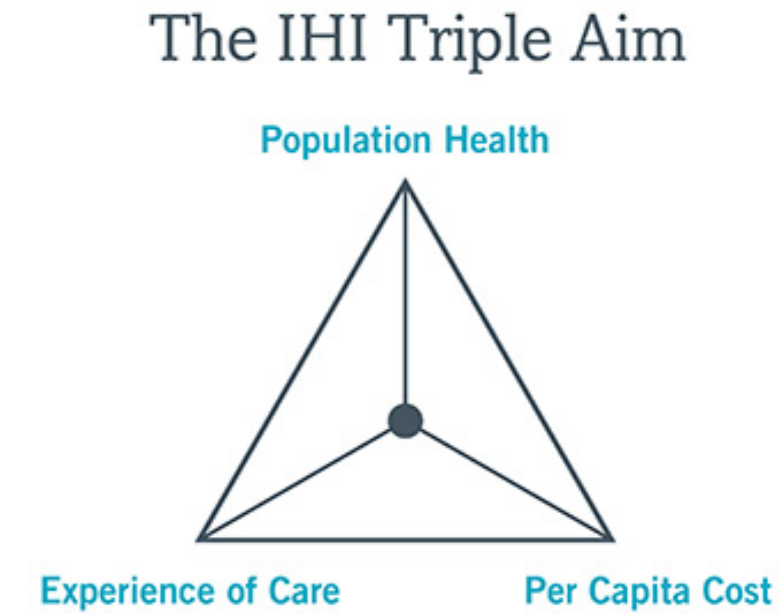
## Why do we need the OCH?

- **Sweeping changes are coming** on both the purchasing and delivery side of care. With great change comes great opportunity.
- It is critical for our communities to both **understand these changes and maximize the opportunities** based on what is important to us.

# What is our GOAL?

To improve the health of our communities in Clallam, Jefferson, and Kitsap Counties through achievement of the Triple Aim:

1. Improving patient care, including quality, access and satisfaction;
2. Reducing the per-capita cost of health care; and
3. Improving the health of the population.

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# Who will help us?

Local **architects and stewards** of a participatory process that can help sustainably align resources and services to achieve the highest attainable level of health and wellbeing for all members of our communities.

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# How will we get there?

- Cultivate diverse, purposeful partnerships
- Identify solutions
- Broaden our definition of health
- Authentically engage our communities in plans for transformation and setting health priorities. Act on our commitments.
- Acknowledge our current health system is exceedingly complex and not sustainable. The reforms needed to address this problem challenge and threaten some.

# No really! How will we *actually* do it?

## Strategy examples

- Prevention and management of chronic disease
- Promotion of healthy, active living
- Linking the health care system with the community
- Integration, improvement, and transformation of care delivery
- Advocacy for health policy

## Tactic examples

- Engage with and listen to community partners
- Identify shared regional health needs
- Advocate to policy makers and state agency leaders using a unified, local voice
- Create the space to build collaborative partnerships across sectors and counties, inclusive of tribal nations
- Implement health improvement projects, both inside and outside the delivery system, that address these shared needs

# Before we start, what is our shared purpose?

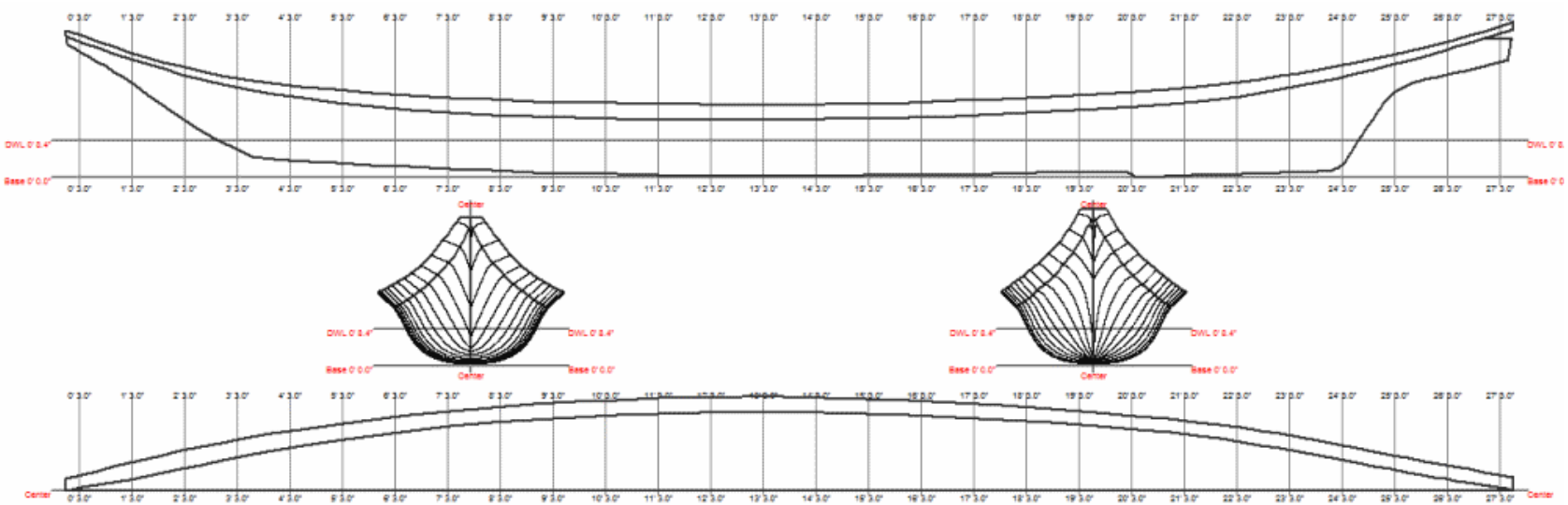
Most important LESSON LEARNED from Bruce Goldberg*, MD, from his presentation at the ACH convening: *Planning for success: Models for community health improvement from around the country and what we can learn from them*

**Have a common vision and purpose for reform, changes, and interventions amongst partners.**

** Senior Fellow at the Center for Health Effectiveness at the Oregon Health and Sciences University; Founding Director of the Oregon Health Care Authority*

# The vessel BEFORE the voyage

We may not have a complete marine chart, but we know we need to build a vessel for the coming voyage.



Coming soon to a theater NEAR YOU:

Adventures of the OCH! An inspirational story of a group of committed individuals who improved the health of their communities through daring to believe in...

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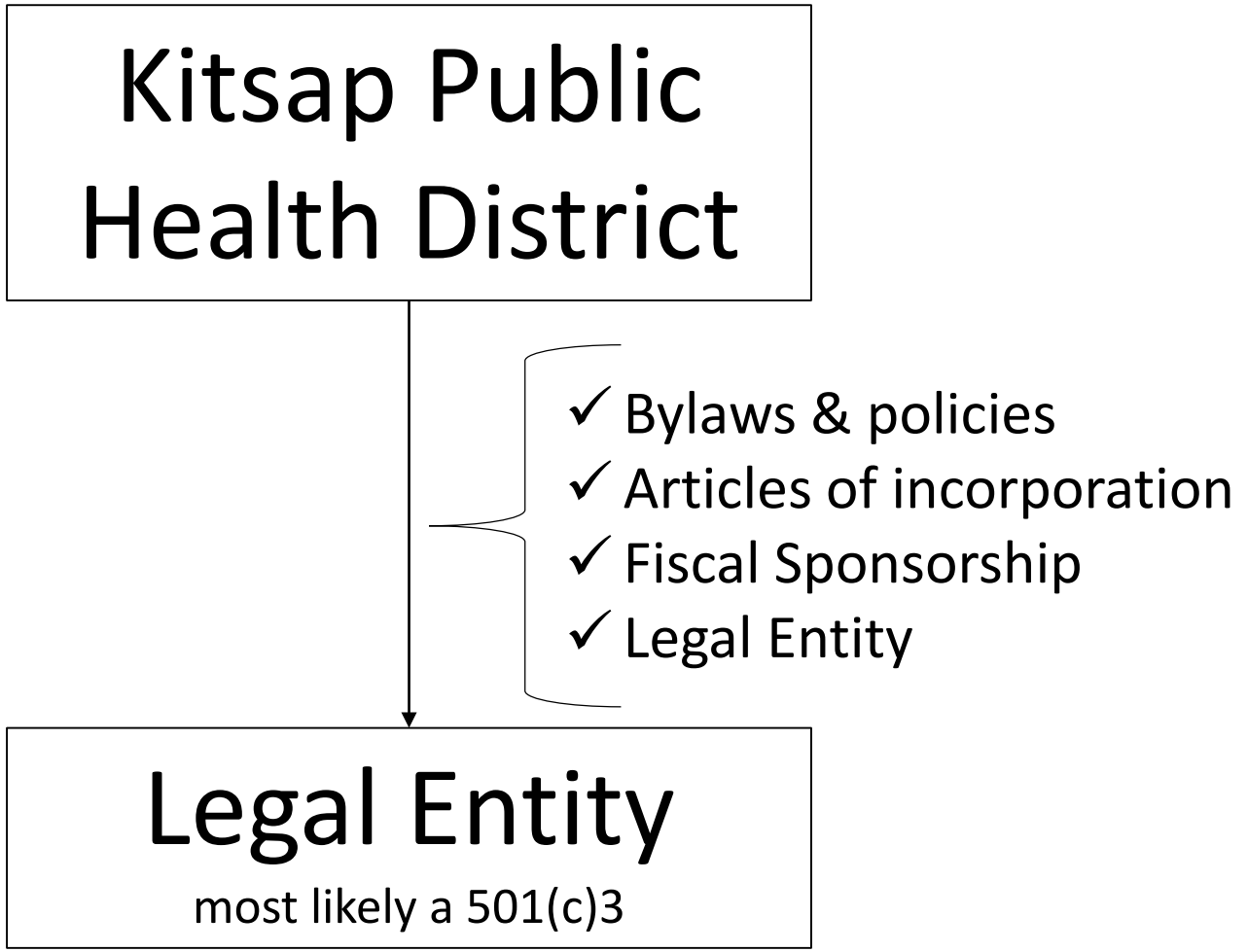
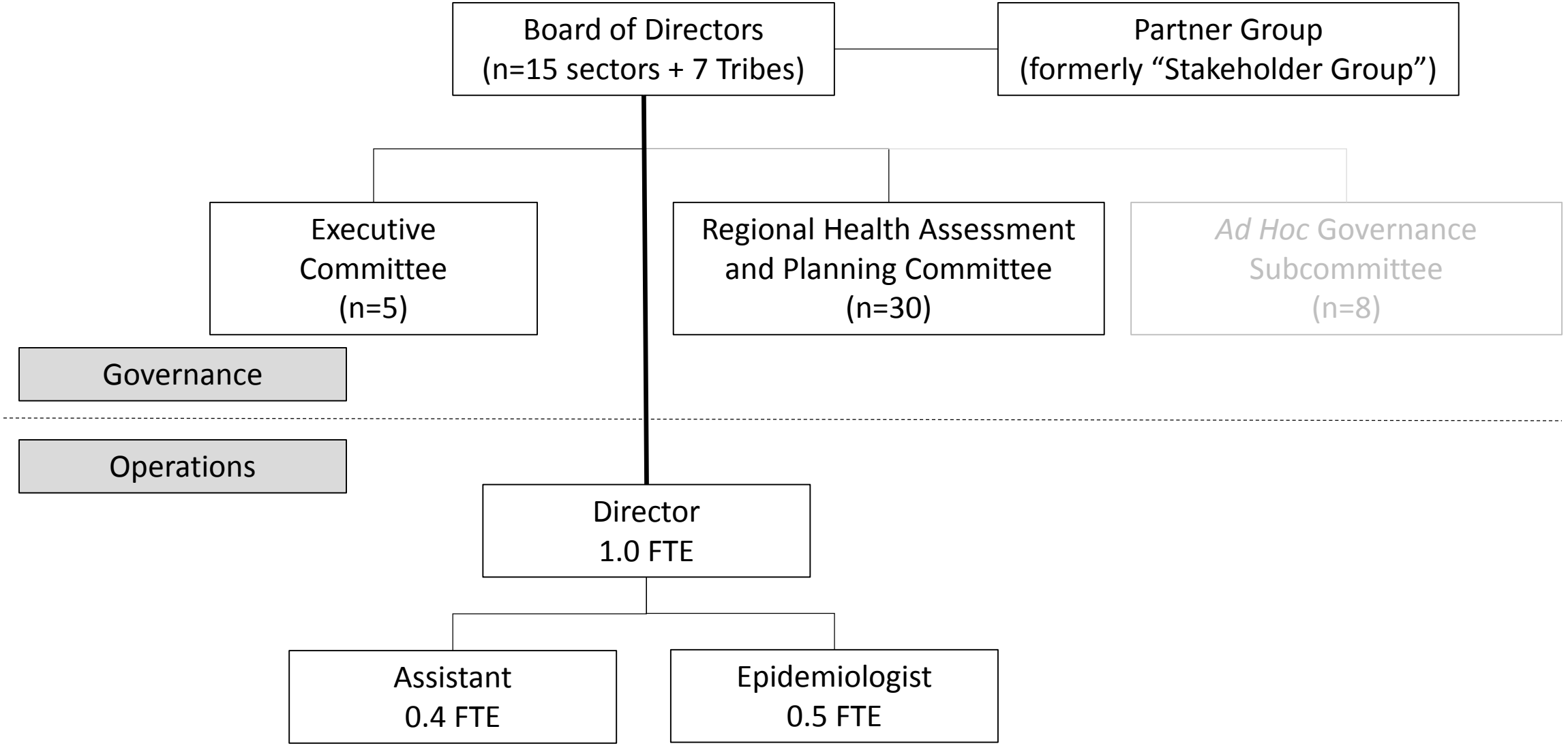
# Olympic Community of Health

Pathway



# Olympic Community of Health

Current governance structure
6/14/2016



## North Sound ACH

- Incorporating new multi-county 501c3
- Interim fiscal sponsorship agreement in place with backbone 501c3

## North Central ACH

- Either converting existing multi-county 501c3 or incorporating new 501c3
- Interim resolution in place with Chelan-Douglas Health District for fiscal management

## Better Health Together

- Existing multi-county 501c3
- Formerly a subsidiary of a philanthropic foundation
- Putting operating agreements in place


## Cascade Pacific Action Alliance

- Existing multi-county 501c3
- In process of forming a new, single member, LLC subsidiary of the 501c3
- Putting operating agreements in place

## Greater Columbia ACH

- Incorporating new multi-county 501c3 ACH
- Interim fiscal sponsorship agreement in place with backbone 501c3

## SW-WA ACH

- Existing multi-county 501c3 nonprofit organization

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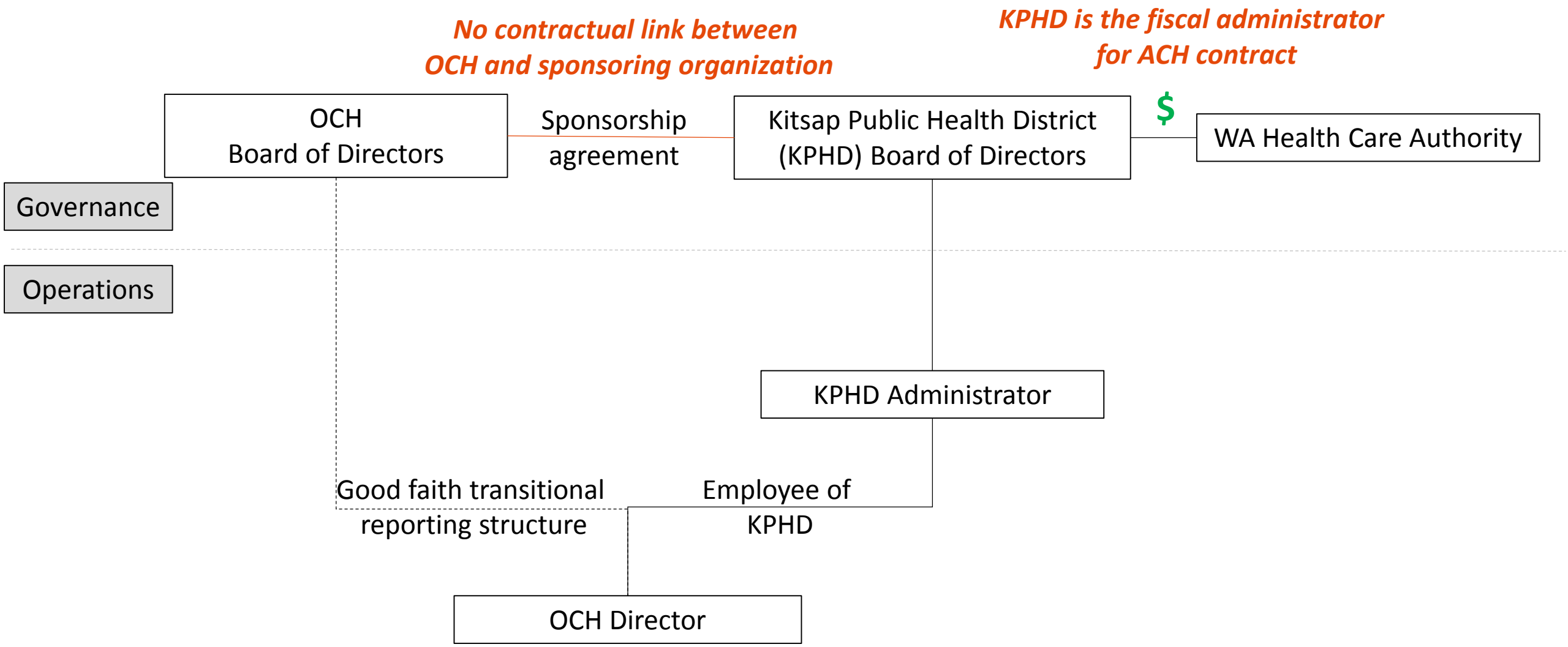
# Olympic Community of Health (OCH)

Current contracting and reporting relationships



# 5. Why and how to move the OCH forward

- Attachment 7. Pathway toward incorporation and next phase of governance
  - Pages 58-60  Discussion paper
  - Page 61 Proposed motions

# 6. Debrief Early Adopter – Fully Integrated Managed Care Panel Presentation

- Attachment 8. Evaluation summary
  - Pages 62-63

# Upcoming Meetings and Events

## OCH upcoming meetings and events

- 8/2/2016, **Board of Directors Meeting**, 8:30 a.m. – 11:00 a.m.
- 9/3/2016, **Board of Directors Meeting**, 8:30 a.m. – 11:00 a.m.
- 7/25/2016, **Regional Health Assessment and Planning Committee**, 2:00 p.m. – 4:00 p.m.
- 9/12/2016, **Regional Health Assessment and Planning Committee**, 1:00 p.m. – 3:00 p.m.
- 9/13/2016, **OCH Partner Convening**, 9:00 a.m. – 12:00 p.m.

## Healthier Washington upcoming meetings and events

- 7/29/2016, **Health Innovation Leadership Network (HILN)**, 9:00 am – 12:00 pm, Cambia Grove, Seattle

# Comments or questions from the public?

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# BREAK

## OCH Staff Contact Details


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http://www.olympiccommunityofhealth.org

# WORK SESSION

## Value-Based Purchasing: Why talk about it?

- Attachment 9. HCA Value-Based Payment Road Map
  - Pages 64-74

Two questions to run on:

1. Why are we talking about value-based payment?
2. What is the role of the OCH, if any, in value-based payment?

# Premise of movement towards value-based payment

Paying for more

towards

Paying for better

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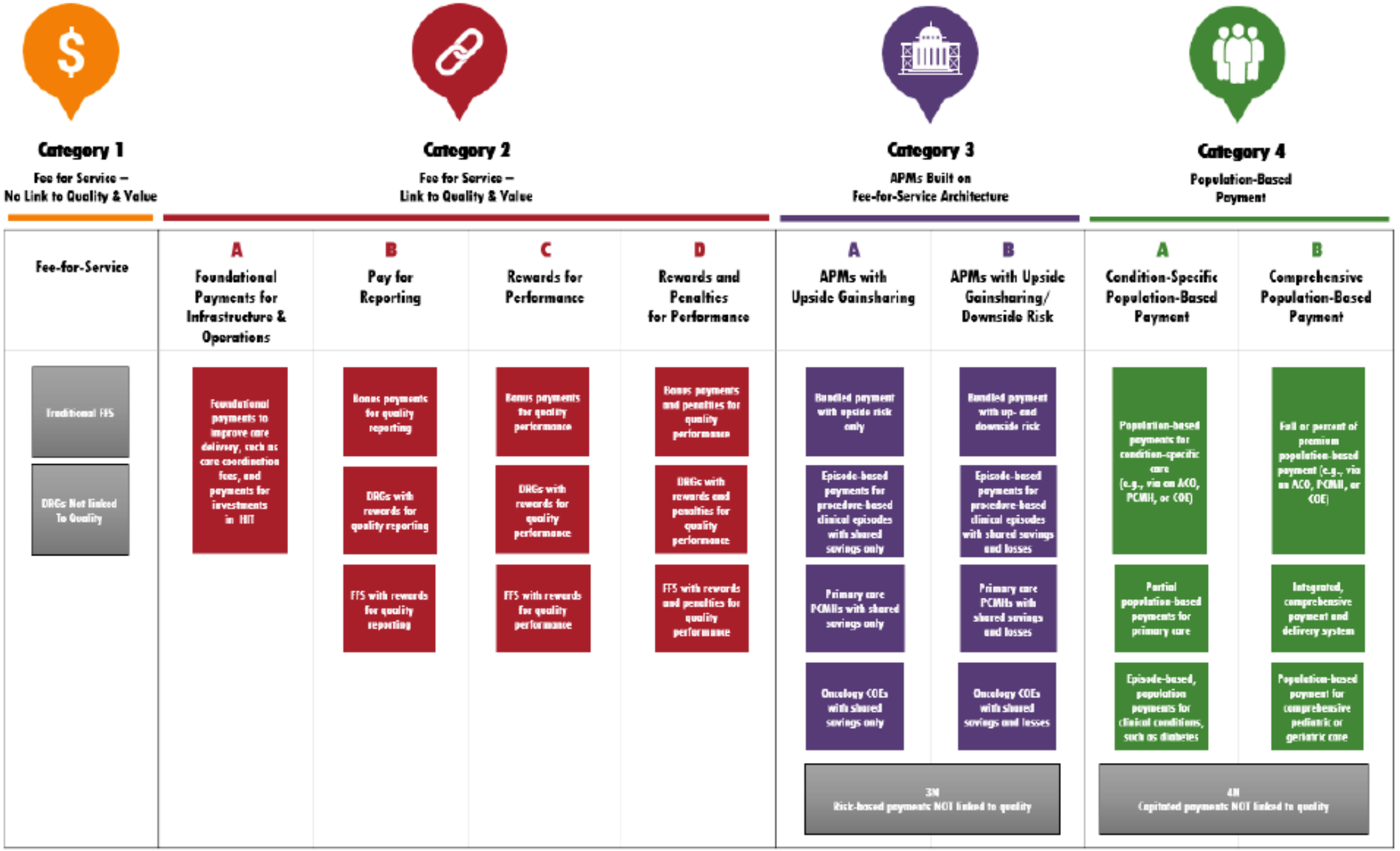
# What is VBP?

A broad set of performance-based payment strategies that **link financial incentives to providers' performance** on a set of defined measures of quality and/or cost or resource use. The goal is to achieve better value by driving improvements in quality and slowing the growth in health care spending by encouraging care delivery patterns that are not only high quality, but also cost-efficient.

Definition derived from (1) the CMS Roadmap for Implementing Value Driven healthcare and (2) comprehensive 2013 research reports developed by the RAND Corporation on behalf of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS) to inform HHS about future policy-making related to VBP.

# Alternative Payment Model Framework

Refer to page 66 of your board packet, or page 13 of the HCP LAN APM Framework for Alternative Payment Model examples.




*HCP LAN Alternative Payment Model Framework Final White Paper, January 2016*

# MACRA

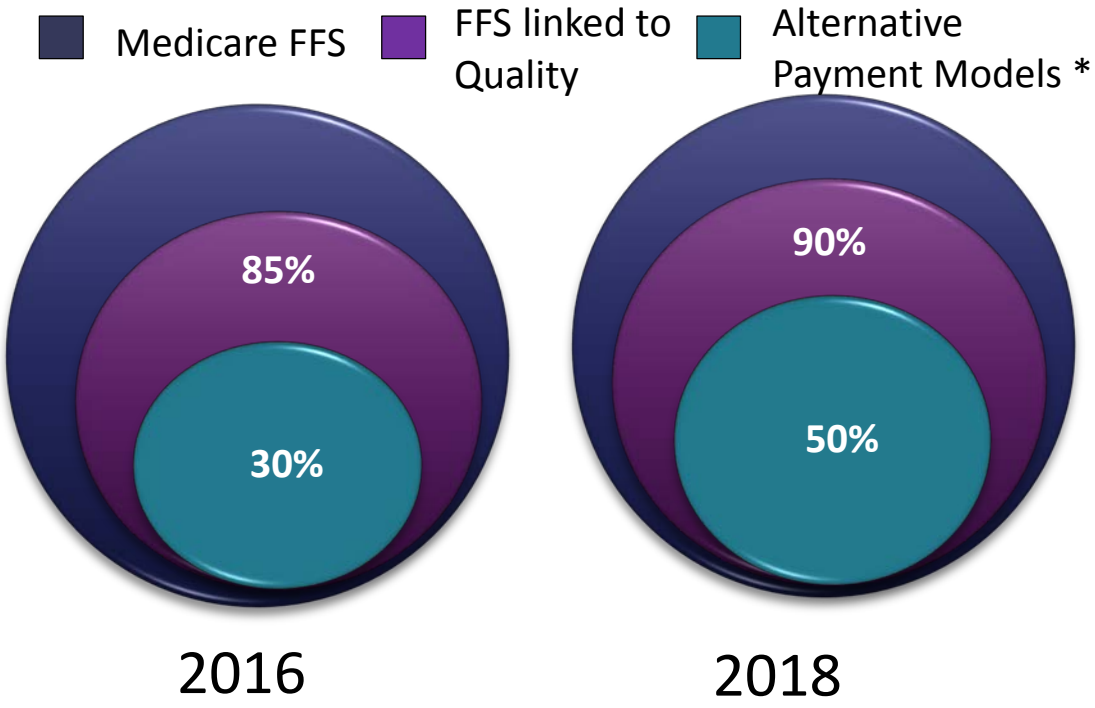
*Medicare Access and CHIP Reauthorization Act of 2015*

# Medicare Moves Aggressively Toward Value-Based Purchasing

**CMS already reported hitting 2016 target, 30%**

**MIPS**

**Target % of Medicare FFS payments linked to quality and alternative payment models in 2016**




*Slide adapted from Tracey Moorhead, President and CEO, Visiting Nurse Association of America*

# Federal and Washington State Purchasing for Value Goals

**Medicare**

30%

In 2016 at least 30% of **Medicare** payments are linked to quality and value in Alternative Payment Models (APMs) or VBP arrangements.

50%

In 2018 at least 50% of **Medicare** payments are so linked.

**Healthier WA**

50%

In 2019 at least 50% of **commercial** health care payments are linked to quality and value in Alternative Payment Models (APMs) or VBP arrangements.

80%

In 2019 at least 80% of **state-financed** health care payments are so linked.

These payment reforms are expected to demonstrate **better outcomes** and **lower costs** for patients.

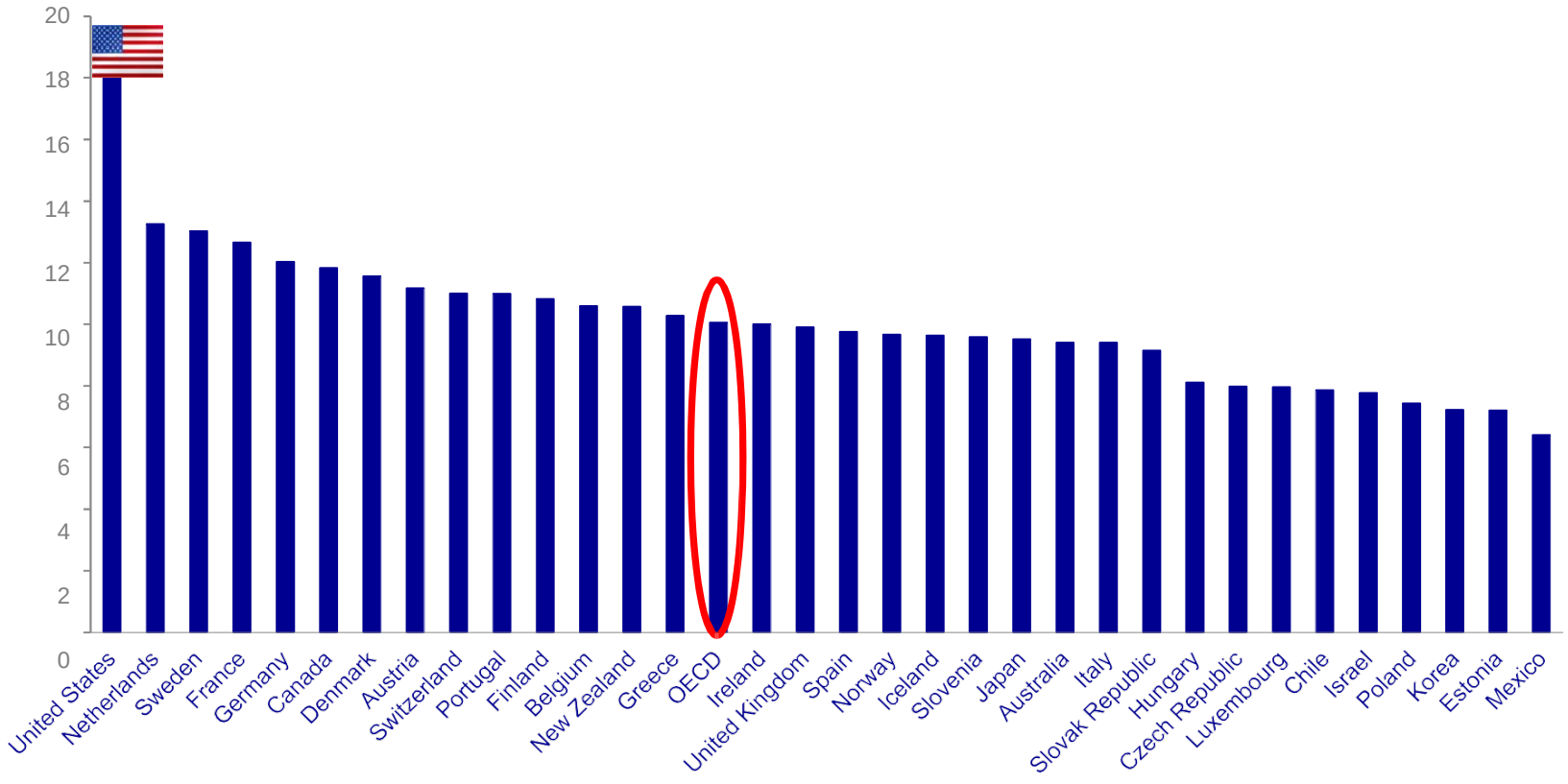
Healthier WASHINGTON

# WHY Value-Based Payment?

Next six slides presented by Bruce Goldberg, MD, Senior Fellow at the Center for Health Effectiveness, OHSU at ACH Convening in Chelan last week

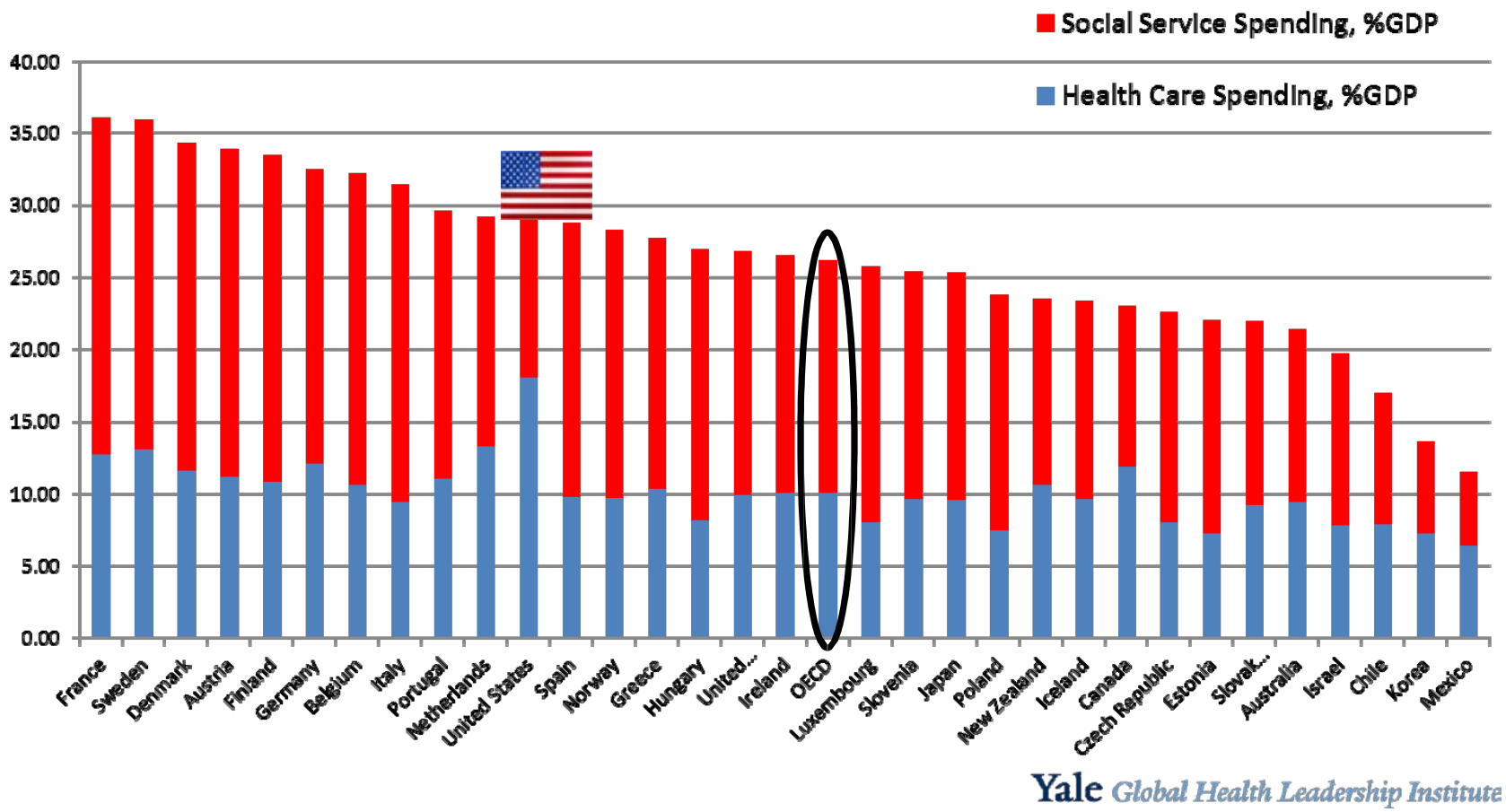
Adapted from Liz Bradley, PhD, Yale Global Health Leadership Institute

# Health Expenditures as % of GDP, 2009



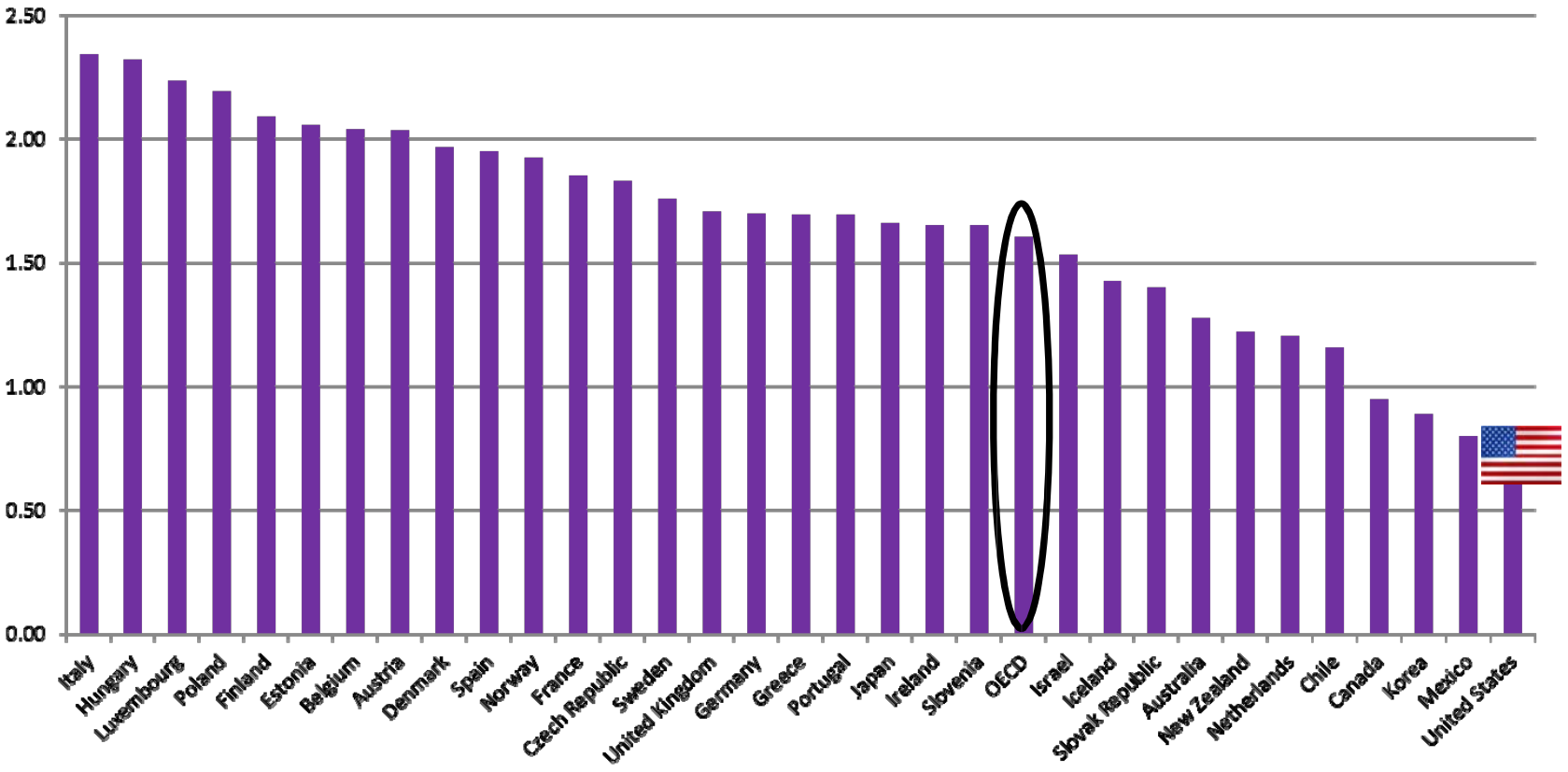

Yale Global Health Leadership Institute

# Total Investment in Health as % of GDP




Yale *Global Health Leadership Institute*

# Ratio of Social Service to Health Care Spending




*Switzerland and Turkey are missing data for 2009

Yale *Global Health Leadership Institute*

# Opportunity Costs!

- 1 ED Visit = 1 month's rent
- 2 hospitalizations = 1 year of child care
- 20 MRIs = 1 social worker per year
- 60 echocardiograms = 1 public school teacher per year

Society General Internal Medicine
Presidential Speech
Dr. William Moran, April 2015

# STATE EFFORTS TO IMPROVE HEALTH
# &
# INCREASE INVESTMENTS IN SOCIAL SPENDING

- Foster better value and efficiency in health delivery systems through payment reforms, value based purchasing and delivery system changes
- Invest some of those savings into social enterprises that improve health
- Increased partnerships across health and social service endeavors
- Creating coordinating/integrating organizations

# Value-based payment

- Efforts to deliver “person-centered care”* have been stymied by a payment system that rewards volume
- Reconfigure payments to:
  1. Incentivize value (cost effectiveness) INCLUDING quality (patient outcomes and patient satisfaction)
  2. Compensate appropriately (certain types of services are systematically undervalued or simply not paid for at all)

** Person-centered care: high quality care that is both evidence-based and delivered in an efficient manner, and where patients’ and caregivers’ individual preferences, needs, and values are paramount.*

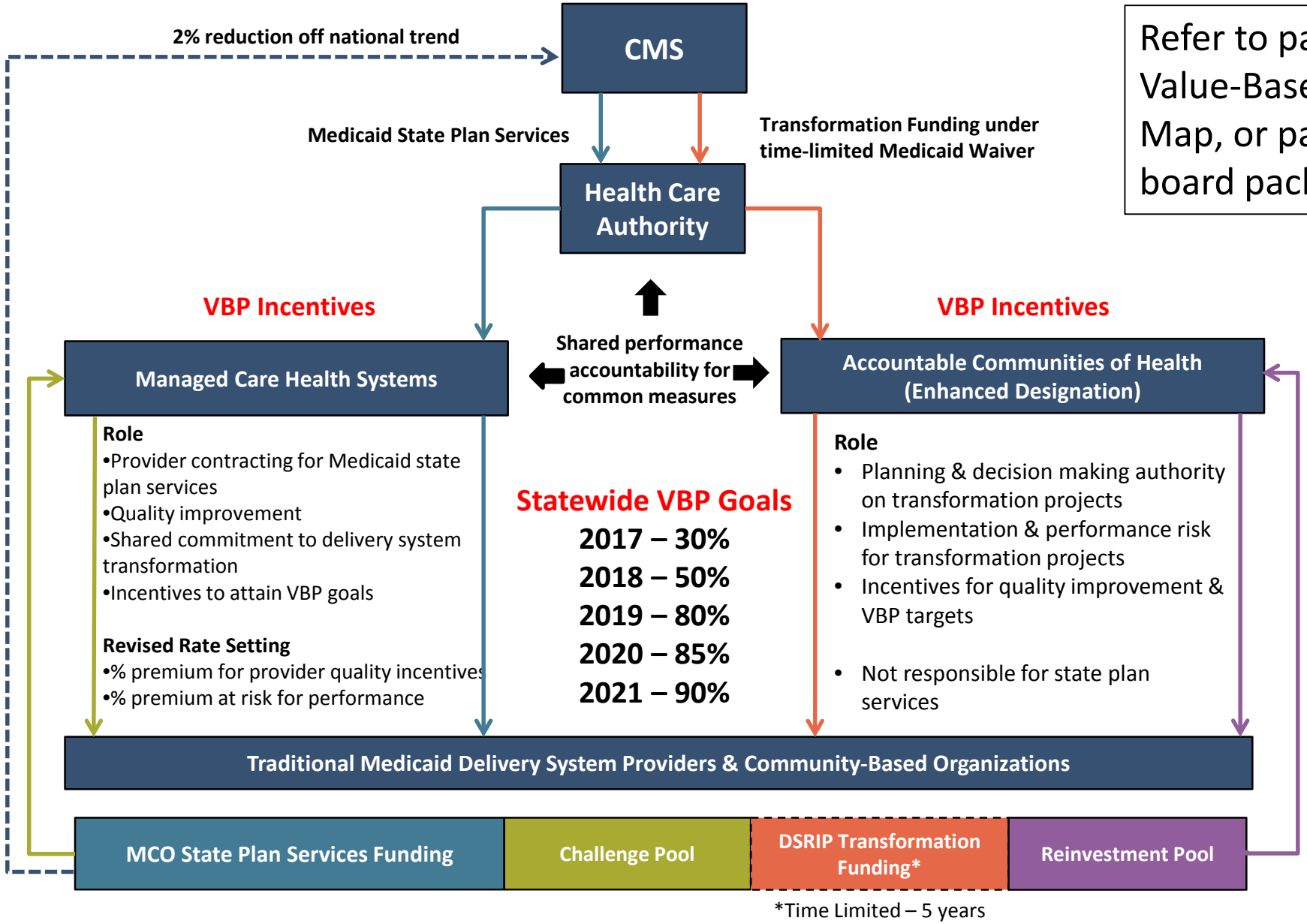
# Value-based payment logic model

# Why does this matter to the OCH?

- Incentivizes the delivery system to keep people out of the hospital and the emergency room through
  - Prevention
  - Healthy, active living
  - Chronic disease case management
  - Social services and supports
  - Community paramedicine

# Value-based payment - necessary but not sufficient

# Washington State Value-Based Purchasing Framework




Refer to page 8 of the HCA Value-Based Payment Road Map, or page 71 of your board packet

# Role of the OCH in Value-Based Purchasing

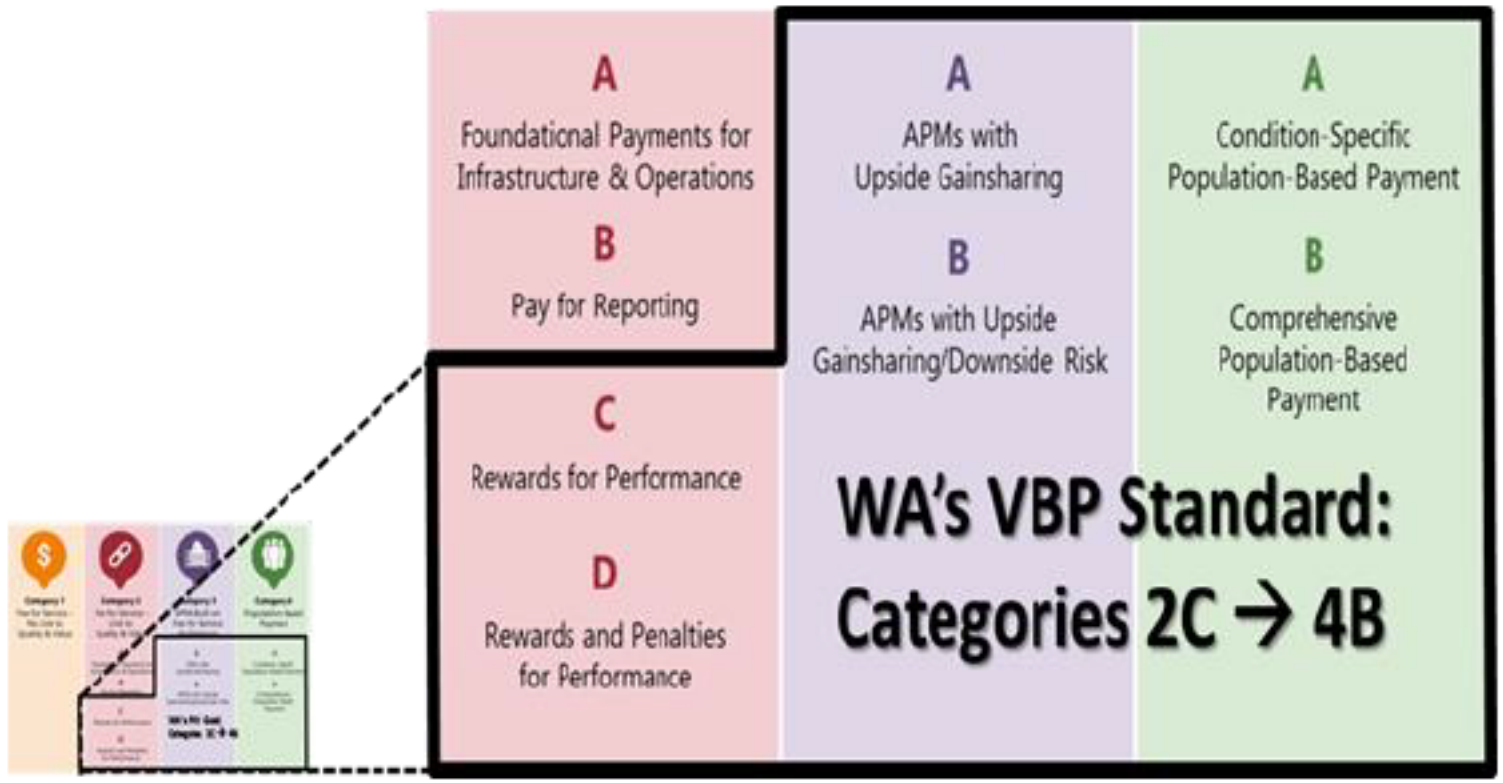
- Planning and decision-making authority on Medicaid Transformation projects
- Implementation and performance risk for transformation projects
- Rewarding providers for taking on VBP contracts
- Incentives for quality improvement based on availability of funds through the reinvestment pool

# Value-based payment resources

- **Health Care Payment and Learning Action Network (HCP-LAN)** https://hcp-lan.org/ published the Alternative Payment Model (APM) Framework (January 2016) which explains the foundational components of the HCA's VBP Road Map.
- **National Association of Medicaid Directors** http://www.medicaiddirectors.org published the Role of State Medicaid Programs in Improving the Value of the Health Care System (March 2016).
- **Health Care Transformation Task Force** http://www.hcttf.org/ offers an easy-to-follow overview of the different types of VBP financial arrangements.
- **Medical Group Management Association** (MGMA) www.mgma.com offers the provider group perspective with details of contracting and benchmarking.

# Extra slides

# Transition to Value-Based Payment




HCA's interim purchasing goals and key VBP milestones along the path to 90 percent in 2021

| | |
|---|---|
| 2016: 20% | 2019: 80% |
| 2017: 30% | 2020: 85% |
| 2018: 50% | 2021: 90% |

| CALENDAR YEAR | VBP INCENTIVES | | | MANAGED CARE ORGANIZATION (MCO) INCENTIVES | | CHALLENGE POOL | REINVESTMENT POOL |
|---|---|---|---|---|---|---|---|
| | Managed Care Organization (MCO specific) | Accountable Communities of Health (ACH Specific) | | Managed Care Organization (MCO specific) | Managed Care Organization (MCO specific) | Managed Care Organization (MCO specific) | Accountable Communities of Health (ACH Specific) |
| | VBP Target Incentive[1] % of each incremental % point of premium over/under VBP target[2] | Region Specific VBP Target Incentive[1] $ tied to each 1% over State VBP Target[3] | STATE VBP Target | Provider Incentives % premium for provider quality incentives | Quality Withhold % premium at Risk for performance[4] | Unearned VBP Incentives[5,6] % of unearned MCO Incentives and withhold | Unearned ACH VBP Incentives[5,6] % of unearned ACH VBP and a share of unearned MCO incentives |
| *Pre* | - | - | 20% | - | - | - | - |
| 2017 | (+/-) 2% | $200k for each 1% | 30% | 0.75% | 1.0% | (up to) 1% | |
| 2018 | (+/-) 1.5% | $300k for each 1% | 50% | 1.0% | 1.5% | (up to) 1% | |
| 2019 | (+/-) 1% | $666k for each 1% | 75% | 1.5% | 2.0% | (up to) 1% | |
| 2020 | (+/-) 0.75% | $1m for each 1% | 85% | 2.0% | 2.5% | (up to) 1% | |
| 2021 | (+/-) 0.5% | $1.2m for each 1% | 90% | 2.5% | 3.0% | (up to) 1% | |
| *Post* | Not extended beyond the five year waiver period | | 90%+ | 3.0% | 2.5% | 0.25% + 25% of remaining withhold[7] | 0.25% + 75% of remaining withhold[7] |

# Sample Scenario

| CALENDAR YEAR | VBP INCENTIVES | | |
|---|---|---|---|
| | Managed Care Organization (MCO specific) | Accountable Communities of Health (ACH Specific) | |
| | VBP Target Incentive[1]<br><br>% of each incremental % point of premium over/under VBP target[2] | Region Specific VBP Target Incentive[1]<br><br>$ tied to each 1% over State VBP Target[3] | STATE VBP Target |
| *Pre* | - | - | 20% |
| 2017 | (+/-) 2% | $200k for each 1% | 30% |
| 2018 | (+/-) 1.5% | $300k for each 1% | 50% |
| 2019 | (+/-) 1% | $666k for each 1% | 75% |
| 2020 | (+/-) 0.75% | $1m for each 1% | 85% |
| 2021 | (+/-) 0.5% | $1.2m for each 1% | 90% |
| *Post* | Not extended beyond the five year waiver period | | 90%+ |

- ACH "A" exceeds VBP regional target by 10% in year 1 and earns $2M of DSRIP incentive.
  - It is expected, as part of project design, that earned VBP incentives will be paid to providers
- ACH "B" is short in meeting the VBP regional target in year 1 and does not earn a DSRIP incentive.
- Unearned incentive dollars are sent to the Reinvestment Pool.

# Sample Scenario

| CHALLENGE POOL | REINVESTMENT POOL |
|---|---|
| Managed Care Organization<br><br>(MCO specific) | Accountable Communities of Health<br><br>(ACH Specific) |
| Unearned VBP Incentives[5,6]<br><br>% of unearned MCO Incentives and withhold | Unearned ACH VBP Incentives[5,6]<br><br>% of unearned ACH VBP and a share of unearned MCO incentives |
| - | - |
| (up to) 1% | |
| (up to) 1% | |
| (up to) 1% | |
| (up to) 1% | |

- The **challenge pool** is funded with a portion of unearned VBP incentives (red columns) and uncollected withhold payments from managed care premiums (blue columns).
- The **reinvestment pool** is funded with a portion of unearned VBP incentives (red columns). If all incentives are earned, there will not be any funds available in the reinvestment pool.
- Total combined value of challenge and reinvestment pools will not exceed $25M on an annualized basis.

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