Date	January 10, 2018	**Time**	11:00 to 1:00
Facilitator	Jac Davies	**Next Meeting**	February 14, 11:00 to 1:00
Location	Garfield County Christian Youth Center, Pomeroy, WA		
Attendees	1. Michael Rooney, Garfield County Hospital District 2. Julie Leonard, Garfield County Hospital District 3. Bob Johnson, Garfield County 4. Sherry Greenup, ALTC-Clarkston 5. Rachel Anderson, ADRC-Pomeroy, GCTA 6. Mary Cleveland, SE ALTC-Columbia 7. Don Wee, Tri-State Memorial Hospital 8. Lindsey Ruivivor, CHAS Health 9. Leta Travis, Garfield Co Health District 10. Cindy Wolf, GCHD Board 11. April Manyon, Garfield County Fire District 12. Brady Woodbury, Asotin Co Health District 13. Shannon Jones, Asotin Co Health District 14. Martha Lanman, Columbia County Public Health District 15. Cicily Zornes, Quality Behavioral Health 16. Danika Gwinn, Quality Behavioral Health 17. Sarah Bollig Dorn, United Healthcare 18. Jac Davies, Northwest Rural Health Network		

Key Points Discussed	
Topic	**Highlights**
Organizing the SE WA Health Partnership – organizational structure and responsibilities	Jac Davies reviewed two diagrams to help clarify the organizational structure for the SE Washington Health Partnership and the relationship of the work of the partnership with work that will be done at the county level and by individual organizations on GCACH funded projects. The multi-county SE WA Health Partnership is intended to promote coordination and alignment of work within the individual counties and across the three county region. Each county has established its own partnership to focus on county level planning and coordination. Specific projects funded by GCACH will be implemented by individual organizations within a county with support from community partners, and will be planned and coordinated within the framework of each county partnership to ensure larger community needs are met. Jac noted that GCACH will be providing some funding to support the SE WA Partnership, which will serve as the Local Health Improvement Network (LHIN) for the region. To help facilitate the process, the Columbia County Health Department has offered to serve as the fiscal agent for the multi-county partnership in the first year, recognizing that the partnership members may elect to change this arrangement in the future. The Asotin, Garfield and Columbia County Health Departments have all offered to serve as sponsors for the LHIN, helping to coordinate meetings and other group activities. During the review of the overall LHIN framework, several questions were asked that need to be answered with input from GCACH: • Can project funds be used to help administer the projects in a community, including supporting some of the planning and coordination activities by county-level partnerships?

	• Are the GCACH funded projects supposed to last for one year or three years? • Who will be the official representative from the SW WA Health Partnership to GCACH? How will that individual be selected and how will communication between the different groups occur? Jac agreed to follow up with GCACH to seek the answer to these questions for further discussion at the next meeting. Jac then reviewed the responsibilities and deliverables that GCACH has outlined for each LHIN. A major expectation for the LHINs is the development of consumer councils to provide a mechanism for getting input and feedback from Medicaid recipients. At least 75% of the members of each council have to be actual Medicaid recipients. The group discussed the best way to develop such councils and agreed that it should be done at the individual county level.
Organizing the SE WA Health Partnership – Charter, Sponsorship and Fiscal Agent	Martha Lanman described the development of a draft charter for the SE WA Health Partnership. Jac noted that the draft is intended to provide a framework for the multi-county activities of the partnership and to meet requirements of GCACH for LHIN governance. Members of the group felt that the draft charter is sufficient for the multi-county partnership but that documents with a more formal structure and framework might be better for the individual county level partnerships which might be more involved in funded projects. The group also agreed that having signatures of all organizations committed to participating in the SE WA Health Partnership will help formalize the partnership as LHIN for GCACH. Several members of the group asked that the adoption of the charter be formalized by a vote. *Motion by Leta Travis to adopt the draft charter with the addition of a signature section for use by the SE WA Health Partnership. Seconded by Rachel Anderson. Approved by all meeting participants with no dissent.* Jac asked the group if they had any concerns about the three county health departments serving as sponsors of the SE WA Health Partnership or Columbia County Health Department serving as the fiscal agent. Martha emphasized that the CCHD is willing to do this to help get the LHIN started and would be happy to turn to role over to another organization should the group decide on a change in the future. *Motion by Michael Rooney to recognize the Columbia County Health Department as the fiscal agent for the SE WA Health Partnership and the Asotin, Garfield and Columbia County Health Departments as sponsors. Seconded by Don Wee. Approved by all meeting participants with no dissent.*
Multi-county community health needs assessment	Martha described work that the CCHD has been doing with the Walla Walla County Health Department to develop and implement a joint Community Health Needs Assessment (CHNA). Walla Walla has identified an individual with extensive experience who is taking the lead on the CHNA development. Martha asked if Garfield and Asotin counties are interested in participating and willing to help cover the cost of the CHNA. She estimated that cost to be about $3,000 per county in addition to the use of some of the funds that GCACH will be providing to each LHIN. Martha emphasized that while the money would need to be paid up front, the CHNA would include an initial report and updates in years 2 and 3.

	The group identified possible sources for data that could be used in a multi-county CHNA, including the United Way and various state agencies. Asotin County also has a lot of community specific data. There was also discussion of which indicators would be used in the CHNA. Martha noted that Walla Walla has a starting list that could be adapted to meet local community needs. Members of the group expressed interest in the idea of a multi-county CHNA but asked for more information on the cost and the indicators. Martha agreed to send those out.
Reports from counties	Representatives from each of the three counties reported on meetings and discussions they have had since the last SE WA Health Partnership meeting. Garfield and Columbia have begun to identify potential projects and provided a summary of their discussions (attached to these notes). Asotin is just beginning the project discussion process. The group agreed that at the February meeting they would share potential projects and identify common priorities where projects could serve multiple counties. Possibilities already identified include transportation, housing, and care coordination. Several asked for more information on the Pathways framework for care coordination. Jac will bring that to the February meeting.
Actions and responsibilities	*Action*: Identify potential candidates for each county-level consumer council *Responsible:* Leads for each county partnership *Action:* Add signature blocks to the SE WA Health Partnership Charter and send to participating organizations for signatures *Responsible:* Jac Davies and Martha Lanman *Action:* Send out estimated costs of a multi-county Community Health Needs Assessment and the draft list of indicators from Walla Walla *Responsible:* Martha Lanman
Next meeting	The next meeting is February 14, 2018 from 11 to 1.

Garfield County ACM Project
Plan Draft #1
12/15/2017

Project 1- Bi-Directional Integration of Care and Primary Care Transformation

Focus: Address physical and behavioral health needs through an integrated network, better coordination, and seamless access.

Project Option 1- Putting psychiatric providers in the Pomeroy Hospital and/or medical clinic in order to give clients greater access to medication management

Challenges- Making sure that the community is aware of the presence of the provider, and utilizes the services. Shortage of available providers.

Action steps- Dr. Rooney will talk to the providers during the provider meeting to try and get buy-in

Project Option 2- Telehealth psychiatric services for clients ,

Both QBH and the Pomeroy Hospital have telehealth capabilities. There is a provider in Dayton that can possibly be used for this. This could take place in Pomeroy, at QBH, or both.

Challenges- Cost is high. It is about $250-$300 per hour for telehealth provider time. Will Medicaid cover this service? The provider would have to learn the billing codes to ensure payment.

Project Option 3- Telehealth psychiatric services within the jail for inmates. This would bring cost savings because inmates would no longer have to be transported to the hospital.

Challenges- Medicaid coverage is supposed to cease for incarcerated persons. Inmates are only to receive crisis emergency services. Would Medicaid fund this project?

Project Option 4- Create a HUB that everyone communicates through in order to ensure seamless access to services by clients. This could be in the form of an EHR computer system (Pathways), or a person in the role of coordinator. The EHR system would be more ideal.

Challenges- Making sure that a system or position is sustainable if funding is cut. If providers pooled resources, would we be able to sustain better over the long run?

Project 2- Transitional Care

Focus: Eliminate avoidable admissions and readmissions to intensive care settings such as hospitals, skilled nursing facilities, prison or jail.

Project Option 1- Transportation support to get clients from home to their appointments, then back to their front door. Currently the SMS program is not being utilized because it is too difficult to get through via phone to get transportation scheduled. Finger prints and background checks required by SMS are not covered by SMS, causing more barriers. Pomeroy is currently using a donation-based transportation system. Is it possible to fund a person to do the SMS billing?

Project 3- Addressing the Opioid Use Public Health Crisis-

Focus: Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.

Project Option 1- Adopt state standards at the Pomeroy medical clinic. Educate medical providers on opioid issues and prescription monitoring. There is not a current written policy on pain medication management in the hospital or clinic. Dr. Rooney will talk to medical providers about getting one in place.

Project Option 2- Begin educational classes or hold community events for education of the general population on opioid issues. A possible class would be training for the general population on the steps to take when they witness an opioid overdose.

Challenges- notifying the public of the events and keeping the public interested in attending, low population issues

Project Option 3- Get providers in the Pomeroy hospital and clinic certified for Suboxone treatment. Dr. Rooney to research what the certification entails.

Challenges- We will need to determine a way to work with MH and SUD providers to work with Medical providers as long as the client is following through with services. Also, we will have to find out how billing works.

Project 4- Chronic Disease Prevention and Control

Focus: Integrate health systems and community approaches to improve chronic disease management and control.

Project Option 1- Integration of the Pathways system to ensure that information is seamlessly shared between Medical, Mental Health, and SUD providers. Danika will research the cost to purchase and implement the system, as well as methods for training among the different providers.

Challenges- Cost and implementation support

Project Option 2- Public Health Department and Aging and Long Term Care (ALTO) collaborate to provide community classes for the following chronic diseases: Alzheimer's, diabetes, and hypertension.

Challenges- Implementing recruitment for providers to teach the classes, and referrals for people to attend. Do we get referrals from the medical clinic providers? Possible low population issues.

Project Option 3- Caregiver training for chronic diseases. Ongoing care, warning signs, disease-specific chronic care plans. Include family caregivers in these classes. Can measure by taking a snapshot of hospital and clinic visit counts, and then do another snapshot after the project has been in effect for a number of months.

Challenges- Finding providers to teach the classes. Possibly incorporate telehealth for teaching? This will bring increased cost.

Columbia County projects overview
01/03/2018

Bi-Directional Care and Primary care transformation

- Depression screening at clinic and emergency room
- Media/brochures specific to local resources
- Extended clinic hours
- Emergency Room Followup
    - Within 24 hours
    - Fund additional care coordinators

Transitional Care

- Chronic disease followup
    - In home, within 24 hours by Care Coordinator
    - Senior/chronic disease homes -check housing suitability-Falling/Stairs
- Adult Friendly homes
    - Permission from client to visit home for analysis
- Train Fire/EMS for home fall prevention/ Community health worker?
- Chronic Case management by Community Health Workers
- Transportation
    - Access to needed health care in Spokane/Tri-Cities
        - Requirements for gas cards
        - Cost analysis on using vans
            - Alternate methods
    - Transportation to local appointments (media campaign)
    - Transportation from Emergency Room in off hours.
        - Funding for set rate on transport to home
    - Transport needed outside normal hours
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Opioid

- Media/Prevention resources
- Youth-School assembly
- Behavioral Health and Clinic share roster to emergency room admits with behavioral health needs.

Chronic Disease

- CDSM training/Classes
    - Incentives with classes
        - Podiatrist
        - Pharmacist
- Diabetes Prevention Program
    - Columbia and Garfield Counties

    - Are they available in Asotin County
- Education in school
    - Healthy Activities
    - Assembly 5,2,1,0 media campaign
    - Incentives for 5,2,1,0 activities
- Annual wellness visits funded
        - Information /media campaign
        - Incentive for this to be done

Dental Access

- School education
- Fluoride varnishes in schools (include starbuck)
- Low income dental evaluations ie nursing home/senior center
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Maternal child Health

- Obesity in ECAAP program
- Help with activities
- Activities to track at home
- Parent education
- Well child visits
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