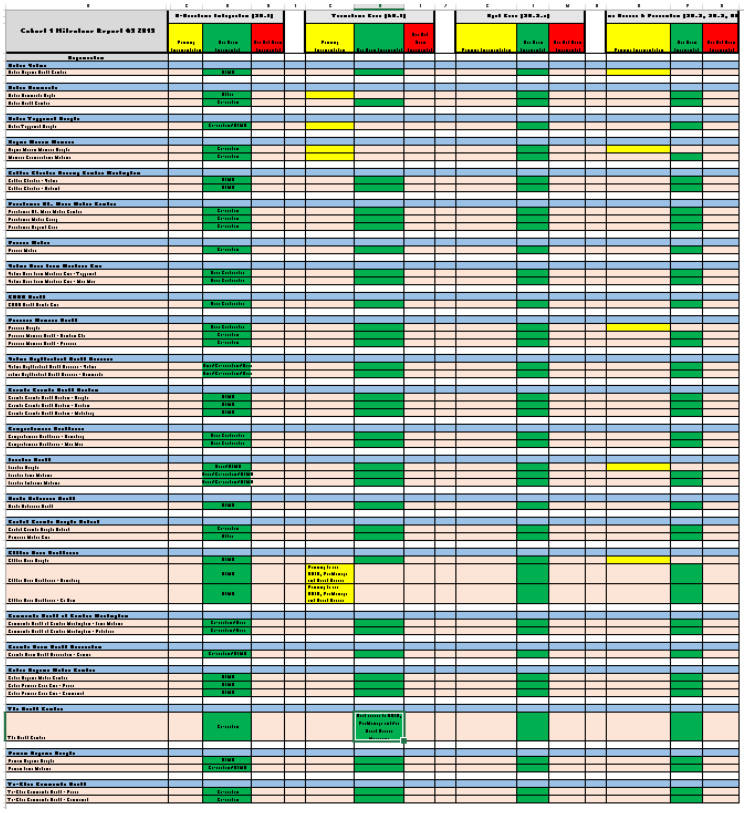
GCACH Practice Transformation Workgroup Meeting Minutes

November 03, 2019 | 10:00 AM – 12:00 PM | United Way of Benton & Franklin Counties

Participants (* denotes they called in)	Amelia Davis (Coordinated Care)*, Paul Kaschmitter (Community Health of Central Washington)*, Rick George*, Sam Werdel, Sierra Foster, Liz Rice, Jenna Shelton, Carol Moser, Martin Sanchez, Wes Luckey, Becky Kolln, Lauren Noble, Becky Grohs, Chelsea Chapman, Marissa Engolls*
PTW Member Participants (* denotes they called in)	Everett Maroon, Ed Thornbrugh (Comprehensive Healthcare)*, Bill Dunwoody, Becky Grohs, Dan Ferguson (Allied Health Center of Excellence)*, Kat Latet (Community Health Plan of Washington)*, Brian Sandoval (Yakima Valley Farm Workers Clinic)*, Barbara Mead
Welcome & Introductions	Carol welcomed the group and stated the purpose of reviewing the agenda items and providing feedback accordingly. Motion by Barbara Mead to approve the July minutes as presented. Seconded by Bill Dunwoody. Motion passed.
Q3 Report for Cohort 1	Martin walked the group through the Practice Transformation Dashboard, which demonstrates the progress for each site. Green means that Practice Transformation has been implemented in that milestone for the respective organization. Yellow means that it is in progress. Red means it has not been implemented.



All sites have implemented milestones to some capacity (i.e., no sites have red).

Organizations have accomplished a lot in the first 3 quarters. Some barriers have included:

- EHR transitions
- Staff turnover including leadership
- 42 CFR compliance
- Billing workflows
- Hiring new staff
- Rural sites

Questions and comments included:

- Clarification that although the yellow is only on hospitals, it could simply be from a tracking perspective (i.e. numbers were not provided, yes or no question). In other words, there is no correlation.

Q1 Report for Cohort 2

Martin walked through the dashboard for Cohort 2. Cohort 2 is made of Behavioral Health and Substance Use Disorder (SUD) organizations. (Image below).

Transitional Care has a lot of yellow because MCO's are just now getting this cohort connected with Collective Medical. There are a lot of organizations already doing it, but that is because they are a part of a FQHC, or because an MCO was quick to get them access to this service.

For Opioid Crisis, a pharmacist is not possible due to the fact they are smaller organizations. However, they are doing some form of medication management by either having a provider on site or with staff performing those activities.

For Chronic Disease, this includes providing self-management on a specific condition (diabetes, depression, anxiety), and is tracked via clinical quality metrics.

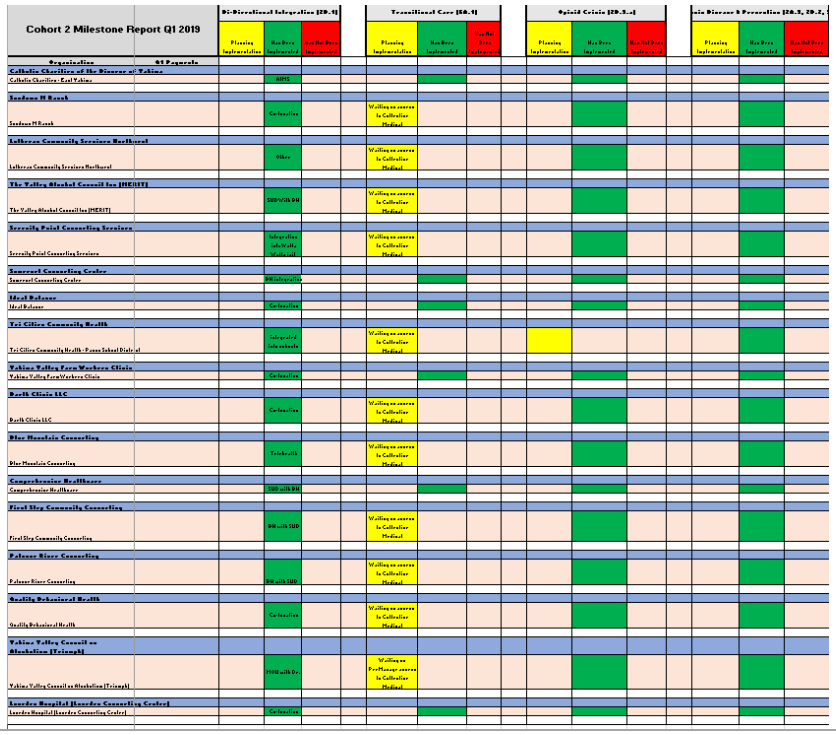
Martin reminded the group that this is quarter one, so there aren't any numbers or data. It's just measured on an election basis. A lot will be green, but we will likely see some changes in quarter two.

Barriers include:

- Staff turnover
- Technology implementation planned for later in the year that will allow for risk stratification, patient rostering, population health management
- EMR transitions
- 42 CFR
- Billing workflows

Questions and Comments;

- Have you seen any organizations that are doing peer-to-peer telehealth? (e.g. family practice to BH to consult with each other). Martin provided a use case of Blue Mountain Counseling going for that model, where the provider will be in the room with the patient. Some have it where it's just virtual.



Cohort 2 Milestone Report Q1 2019	Bi-Directional Integration [ED-1]			Transitional Care [ED-1]			Opioid Crisis [ED-2,...]			Acute Disease & Prevention [ED-2, ED-2,]		
Organization – 61 Payerals	Planning Implementation	Has Been Implemented	Has Not Been Implemented	Planning Implementation	Has Been Implemented	Has Not Been Implemented	Planning Implementation	Has Been Implemented	Has Not Been Implemented	Planning Implementation	Has Been Implemented	Has Not Been Implemented
Catholic Charities of the Diocese of Yakima												
Cathedia Charities - East Yakima		BHMS										
Sundown M Ranch												
		Co-location			Willing en caurse to Cultivation Medical							
Lutheran Community Services Northwest												
		Other			Willing en caurse to Cultivation Medical							
The Valley Alcohol Council Inc [MERIT]												
		SUD-With BH			Willing en caurse to Cultivation Medical							
Serenity Point Counseling Services												
Serenity Point Counseling Services		Integration into Walk-in Medical			Willing en caurse to Cultivation Medical							
Somerset Counseling Center												
Somerset Counseling Center		BH Integrated										
Ideal Balance												
Ideal Balance		Co-location										
Tri Cities Community Health												
Tri Cities Community Health - Pasco School District		Integrated into schools			Willing en caurse to Cultivation Medical							
Yakima Valley Farm Workers Clinic												
Yakima Valley Farm Workers Clinic		Co-location										
Rosh Clinic LLC												
Rosh Clinic LLC		Co-location			Willing en caurse to Cultivation Medical							
Blue Mountain Counseling												
Blue Mountain Counseling		Telehealth			Willing en caurse to Cultivation Medical							
Comprehensive Healthcare												
Comprehensive Healthcare		SUD with BH										
First Step Community Counseling												
First Step Community Counseling		BH with SUD			Willing en caurse to Cultivation Medical							
Palouse River Counseling												
Palouse River Counseling		BH with SUD			Willing en caurse to Cultivation Medical							
Quality Behavioral Health												
Quality Behavioral Health		Co-location			Willing en caurse to Cultivation Medical							
Yakima Valley Council on Alcoholism [Triumph]												
Yakima Valley Council on Alcoholism [Triumph]		MHD with Co...			Willing en PreManage caurse to Cultivation Medical							
Lourdes Hospital [Lourdes Counseling Center]												
Lourdes Hospital [Lourdes Counseling Center]		Co-location										

Update on CSI Reporting Portal for Year Two

Jenna provided an overview to the prospective changes to the PT toolkit for 2020. These changes included:

- Empanelment Status is mandatory. Comments included:
  - Clarification around "active" patients
  - Discussion around reviewing rosters and accountability (primary care providers and behavioral health agencies). Kat confirmed that individuals are not assigned to BH agencies. It is requirement from HCA to have a PCP assignment. Moving into this space with an integrated approach is still being explored.
- Risk stratification increase
  - Comment that patients are not considered high risk and do not need additional care management.
  - Concern around consistency across organizations on risk stratification.
- Social Determinants of Health (SDOH) screening will be mandatory
  - Used for all patients? Applying it like the PHQ9. Providence has already implemented it. Tool used for all patients empaneled or within a certain group? All individuals.
  - Request for Jenna to send Providence tool to group.
- Giving narratives around risk stratification is required
- Risk stratification reporting is mandatory
- Conducting a team-based huddle is mandatory re: Opportunities for those at Highest Risk
  - Clarification around huddle frequency and definition
  - Inquiry around output and intended purpose of the huddle
- Patient follow-up tracking
  - Clarification on number of attempts
- Mandatory (Medicated Assisted Treatment) MAT referral source as well as Opioid Resource Network
- Minimum of 10% to receive self-management support
- Patient Activation Measure will be mandatory if organization is interested in becoming a Health Home
  - Clarification if its agency wide or specific to that element

    - Comment that PAM is not the only self-management tool to achieve this outcome
    - Reminder that origin is to assist organizations into becoming a Health Home, and this would complement that
    - Discussion around if this is necessary given the current contractual arrangements with Health Homes. Suggestion to talk with Health Home workers to see if this is a good plan for the region (i.e. adding more Health Home workers)
- Self-management outcomes reporting
- Medication reconciliation will be mandatory
    - Comment around requirements for execution (e.g. can an MA conduct med rec? The answer is yes).
- Engaging pharmacists will be mandatory
- Contracted or staffed pharmacists will be mandatory
- Minimal of 25% patients seen in the quarter will receive surveys
    - Return rate vs. offering rate
    - Statistical equivalent of 30 is too many
- Minimum of 25% of patients with the selected conditions that were seen in the quarter receive shared decision aids.
- Minimum internal monthly QI team meetings are mandatory
- Weekly or monthly review is mandatory
- CQM report examples are mandatory
- Minimal monthly meetings with Practice Transformation Navigator is mandatory
- Use of Collective Medical will be mandatory
- Attest OneHealthPort is being used. Mandatory by Quarter 2.
- All options are required for reporting regarding care coordination options (track ED visits, contact at least 75% of patients who were hospitalized in target hospitals within 72 hours, enact care compacts/ collaborative agreements with at least two groups of high-volume specialists)
    - Clarification around report – census without names. Why? So we can see trends for our region e.g. how many patients are coming, see at the provider level issues at a lower level
    - From hospital perspective, the first option, are we talking about contacting what percentage of patients? Are we only talking about the clinic? The thought was the hospital with their collaboration agreement, would work with each other to ensure who is following up with those patients.
    - Hospitals are required to follow up with the patients that aren't going to their clinics? No, the hospitals would not know that those patients are not going their clinic? The PCP would be more associated, it would just make sure they are having a collaborative agreement with their hospital, the hospital would need to work with the clinic to provide share that data in a collaborative effort to make sure that within their healthcare system that they are followed up on. On PCP side they are making sure they are following up on all patients regardless if they are in their internal health care system.
    - Comment around workbook and target hospitals.
    - Comment around patients that go to the emergency room who are not assigned a PCP. Those are the folks who need the follow-up the most. Jenna suggested modifying an option around a percentage of those without a PCP for hospitals, and leaving ED follow-up for providers.
    - Comment around capacity issues that makes it a challenge to ensure individuals are getting the care that they need. MCO commented that patient compliance isn't always easy.

	• Mandatory Learning Collaboratives on: Billing training, Shared Care Plans, Shared Decision-Making aids, and Self-Management Tools
CSI Dashboard Reporting Measures	Wes provided a brief overview of the provider facing report. Wes asked the group to review the measures and provide any comments. If any metrics are missing please bring those forward at the next meeting. Becky notified the group that the cohort 1 will receive an updated contract soon.
Adjournment	Carol concluded the meeting by thanking all for attending. Meeting was adjourned at 11:58 am.