GREATER COLUMBIA ACCOUNTABLE COMMUNITY OF HEALTH

Practice Transformation Workgroup Meeting Minutes

Thursday, August 27, 2020 | 10:00 AM to 12:00 PM

Teleconference ONLY

Board Member: *Name*
Absent: Name

ATTENDANCE			
Workgroup Members	Angela Gonzalez	Deb Watson	Mark Wakai (Chair)
	Barbara Mead	Everett Maroon	Phillip Hawley
	Becky Grohs	Jorge Arturo Rivera	*Rhonda Hauff*
	Bill Dunwoody	*Kat Latet*	Rick George
	Brian Gibbons	Kevin Martin	Ryan Lantz
	Dan Ferguson	Liz Rice	
GCACH Staff	Becky Kolln	Diane Halo	Ruben Peralta
	Brittany FoxStading	Laurel Avila	Sam Werdel
	Carol Moser	Lauren Noble	Sulamita Savchuk
	Chelsea Chapman	Martin Sanchez	Wes Luckey
Guests	Mandee Olsen (for Kevin Martin)		

WELCOME & INTRODUCTIONS	
Welcome & Introductions Mark Wakai/Carol Moser	Mark Wakai and Sam Werdel facilitated the meeting. Brittany and Laurel introduced themselves as the new Navigators with GCACH. Brittany came from Lourdes and was in the PT efforts prior. She has over 15 years of healthcare experience and worked in pharmacy, hospital, clinic, and long-term care. Laurel has experience hospital leadership, nursing, quality improvement, and direct patient care as an RN. She was a part of Lourdes as Director of Primary Care Clinics and worked in the PT program as well. They are both delighted to be a part of the team. There was a total of 8 voting members present (or calling in) to the convening. Meeting items included: 1. 2020-08-27 PTW Meeting Agenda 2. 2020-06-04 PTW Meeting Minutes

Thank you for your engagement with GCACH!

	3. Aug 2020 PTW Meeting Presentation 4. 2020-08-27 PTW CSI Reporting Results 5. 2020-08-27 PTW – WHA Results
MEETING MINUTES	
Meeting Minutes Carol Moser	Carol reviewed the minutes from the 02-06-2020 workgroup meeting. No comments or revisions were recommended. ✓ **Motion by Everett Maroon to accept the 06-04-2020 Practice Transformation Workgroup meeting minutes. Seconded by Dan Ferguson. Motion passed with no additional discussion.**
DISCUSSION ITEMS	
CSI Reporting Portal and Dashboard Wes Luckey/Sam Werdel	Wes reviewed the CSI reporting portal results. This is from information loaded by providers as well as the data that came out of the dashboard. He highlighted the different reporting periods for the cohorts.

	2019												2020												
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	# Sites
Cohort 1	P1-Q1			P1-Q2			P1-Q3			P1-Q4			P2-Q1			P2-Q2			P2-Q3			P2-Q4			45
Cohort 2							P1-Q1			P1-Q2			P1-Q3			P1-Q4			P2-Q1			P2-Q2			17
Cohort 3													P1-Q1			P1-Q2			P1-Q3			P1-Q4			9

Clarification around the number of sites for each cohort and that not all sites have reported for some milestones.

He reviewed the following:

- Empanelment rate
- Care management of high-risk individuals
- Follow-up: ED Discharge – increasing
- By provider type: Hospitals are increasing
- Follow-up: Inpatient Discharge within 72 hours (by cohort type and provider type)
- Providers, consistent progress as grow through process. Note about not pulling in substance use disorder data.
- Top risk 5 stratification methods: cohorts

Thank you for your engagement with GCACH!

	Cohort 1 (45)	Cohort 2 (17)
1	Social Determinants of Health	Depression Diagnosis
2	Diabetes Diagnosis	Other
3	Depression Diagnosis	SUD Diagnosis
4	Other	Other Psychosocial / Behavioral Risk Factors
5	# Hopitalizations	Clinician Judgement of Risk

Cohort 3 not reporting data

- Sam noted that its exciting to see that providers are taking SDOH seriously and implementing systems to using this information.
- Carol asked the MCOs when they see risk stratification coming out of cohorts knowing that they also employ CHWs and care coordinators, is there a particular follow-up they would implement with SDOH? Is this info helpful?
    - Jorge said it was very useful. It is important to do a crosswalk of the way we are doing certification methods because many of the members would be the same. He spoke to maximizing resources and services to members. What he sees is similar to health services team. SDoH screening, how do we make that consistent with screening with nurses and care coordinators do. To make sure that the numbers add up and are prioritized in a similar way. Should create a group of HC experts to work on this together.
    - Rhonda- this is true for most Community Health Centers, they have care coordinators and CHWs that are dealing with SDOH, and over the years it is in one of the challenges with MCOs— find selves tripping over each other. Part of that conversation is to make sure strong connection with providers and MCOs that have CHWs working on that. Have been times, one is going in front door and one going in back door because of community health centers. This is a challenge to remember. Jorge agrees. Wes stated community health centers report to HRSA, part of reporting is required that they indicate different levels of data (which include SDoH).
    - Dan asks, how do we pay for workforce that is doing the work and can we measure the impact on focusing on SDoH, who is doing that work? Are we able to actually quantify the impact of that specific work? It sounds like this group is going to get to that point.

Thank you for your engagement with GCACH!

	○ Rhonda shared how they are able to provide that data. The work that prepared group, there is a lot of literature on cost savings. Study RWJ funded in King County- took analysis on Medicaid data from several different data bases and compared level of support and cost basis. Rhonda to find report and send it out. • Behavioral health integration models: all provider types. Question around challenges with integration or lack of resources to provide the level of integration itself? Martin shared a mix both. There is a shortage of BH in our area- big barrier. What our sites have been doing is – we've given them flexibility as they achieve this integration. Challenges around integration and the lack of primary care willingness to take BH patients, or how much is it related to access to BH workforce, vs. primary care professionals being trained and being more mid-level BH work. A lot of patients having challenge to PCP are chronically mentally ill. Half of all PCP visits are for depression whether they know it or not. There a lot of patients who don't seek care at the PCP. They seek care through mental health therapist. That is why GCACH has tried to be flexible in BH model. A lot of people would prefer to go to mental health provider and receive primary care there. Barb has been an example of those collaborative visits. Discussion around patients and their mental illnesses and decisions around receiving care. No one size fits all and appreciation at process coming from different angles.
Q2 Successes/ Barriers Martin Sanchez/Brittany FoxStading/Laurel Avila	Brittany and Martin shared information and key takeaways from the quarter 2 of the practice transformation program. This included: • COVID-19 successes and barriers (including equipment/technology and broadband access). With respect to Yakima Valley trying to improve broadband access, if you go to connectourvalley.org. They are trying to work with congress for a one click needs assessment. They need 99,000 by early September. Click early and click often. To test internet speed. GPS mark your location. DOC and FCC to work with internet providers to improve pockets that are slow or have no speed at all. **Lauren to add to website and CSI dashboard.** • Regular successes and barriers ○ Joel asked for the reason for turnover as they are seeing burnout and was wondering if it was the same. Martin said it was a lot—COVID due to personal reasons, also rotating between orgs. Division of Sites between Martin, Brittany, and Laurel. Carol pointed out the capabilities of our navigators via bringing medical expertise to the table.

Thank you for your engagement with GCACH!

ACH Rankings – WHA
Wes Luckey/Mark Pregler

Wes introduced Mark Pregler and Theresa Tamura from WHA. He reviewed their 2019 Quality scored for the ACHs.

These metrics represent Medicaid beneficiaries and 2019 claims data experience. He reviewed the list of the measures used for the quality composite score: prevention and screening, chronic disease care, coordinated cost-effective care, appropriate cost-effective care, and appropriate cost-effective care.

ACH Rankings

- A positive score indicates better performance than the state average with a negative score indicating performance below the state average. The higher the score is (positive or negative), indicates the degree to which the entity's performance is better or worse than the state average.

Place or organization	Composite Percentile	Composite Score	Prevention and Screening	Chronic Disease Care	Coordinated, Cost-Effective Care	Appropriate, Cost-Effective Care
Greater Columbia ACH	69.9%	0.520	0.700	0.100	1.060	0.290
Olympic Community of Health	55.2%	0.130	-0.390	0.380	0.470	0.390
North Sound ACH	53.5%	0.090	-0.420	0.430	0.130	0.610
Better Health Together	52.7%	0.070	0.020	0.140	0.110	-0.090
HealthierHere	49.8%	-0.010	0.050	0.060	0.080	-0.580
Cascade Pacific Action Alliance	44.0%	-0.150	-0.160	-0.140	-0.140	-0.210
Pierce County ACH	43.9%	-0.150	0.020	-0.460	0.030	-0.030
North Central ACH	43.1%	-0.170	0.460	-0.690	-0.490	0.040
SW WA Regional Health Alliance	21.8%	-0.780	-0.920	-0.460	-1.440	-0.070

The GCACH's Composite Score performed on top of all nine WA Accountable Communities of Health for state Medicaid clients. In particular, the GCACH scored highest on Prevention and Screening and on Coordinated, Cost-Effective Care.

Rhonda requested a key with respect to the scores. Mark explained how the scores are calculated via standard deviations and weighted averages. He will provide more information if needed.

Mark shared that when they looked at the composite methodology, it was built to score medical groups and clinics, but because of COVID they wanted to introduce it by taking it to a geographic group. They weren't seeing anything in the composite, it was trying to tailor to the needs of frequent needs of purchasers- having quality information but how to assess how well a region or medical group is performing. Launched the methodology to create composite. They are still working on the methodology, discussion on cost.

Knowing this, how would GCACH could be leveraging this information with our MCOs to say look, we are providing great level of care in our region, our Medicaid providers are doing well across these domains, potential for VBP and looking to leverage info to get into more VBP contracting. Knowing contractors are pretty small, how would you advise us to use this information while talking to MCO friends?

Thank you for your engagement with GCACH!

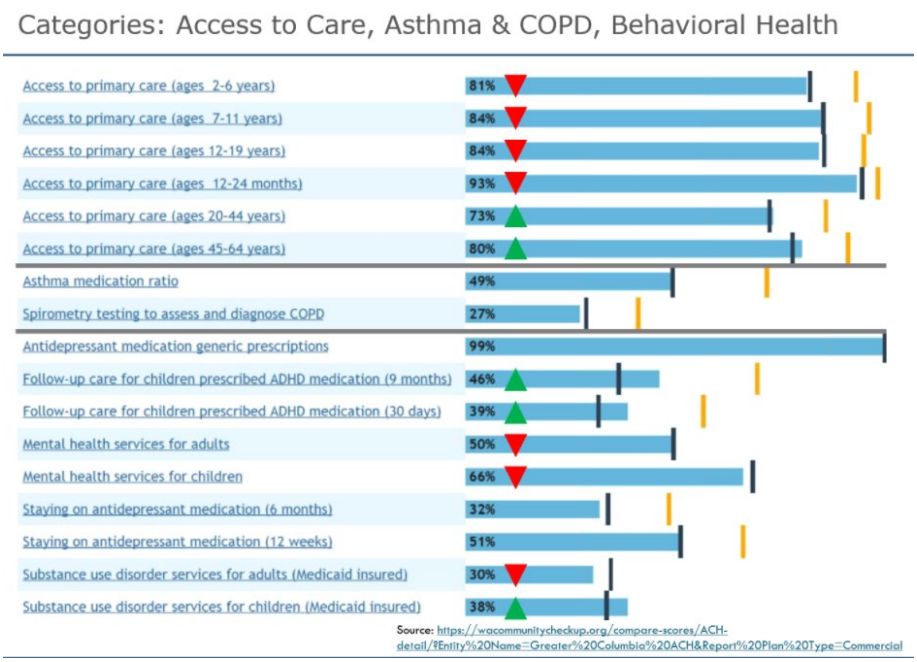
Mark stated it can be quite complex because it is new. Figure how best to utilize it. The fair answer is to get back to you on that.

Theresa, have other ACH's and other groups asked how did this happen? They don't have the year to year comparison that they did have before. It will happen eventually. Still new. May get called out a little more with other reports coming out in the next month.

Will this be at the state of reform conference? One of sept- no. talking about how to highlight work and what it means to state at the one in January.

Rhonda—are the measures shown reflecting current health status or is it showing improvements since ACH started measuring. Confirmation that it is current status.

Wes continued to review the scores.

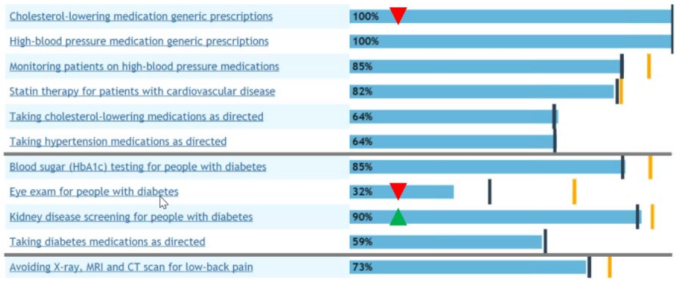


He highlighted the access to primary care of youth and adolescent are below the state average, and mental health services for adults and children, and substance use disorder for adults. Eye exams, and cholesterol-lowering medication generic prescriptions.

Discussion around retiring measures that are reaching the state average.

Thank you for your engagement with GCACH!

Categories: Cardiovascular Disease, Diabetes, Low-back Pain



GCACH Opportunities for Improvement

- The GCACH earned worse than average scores for the following measures:
  - Access to primary care (ages 2-6 years, 7-11 years, 12-19 years)
  - Adolescent well-care visits
  - Avoiding antibiotics for adults with acute bronchitis
  - Avoiding antibiotics for children with upper respiratory infections
  - Eye exams for people with diabetes
  - Mental health services for adults and for children
  - Potentially avoidable ER visits
  - Substance Use Disorder Services for Adults
  - Well-child visits (ages 3-6 years)

Wes reviewed the WHA website with resources to compare scores and information grouped by different categories. He walked through how to see the measures by category in our region.

Sam asked the MCOs for their insight re: working with the state and other ACH.

Jorge is the first time he sees this and it always helps organize in contacts. The key question is – if we compared this by providers that are already evaluated by them, who is driving this information. He does believe there is an opportunity to contract with smaller providers. It is very encouraging and they need to understand the drivers of those metrics (if providers, which providers?) up to MCO to understand the contracting situation. A lot to say about what is driving metrics, what we will have to do is work with QI to work with WHA to understand the driver. For Molina, do more VBP with key community health providers. Situation will be different for each MCO depending on the contract and depending on which providers are driving this metrics. His assumption is that the drivers are the medium to large providers—hospitals and high specialty care systems.

Thank you for your engagement with GCACH!

CSI Finance Portal Update Becky Kolln	We have been working with CSI to create a finance section in the portal. It will give power to login and see payments and what payments are for. This will give the opportunity to have information readily available for providers. This will also be sending auto emails versus her team. Hopefully going live in the next week.
ADJOURNMENT	
Adjournment	Meeting adjourned at 12:01 PM. Minutes taken by Chelsea Chapman. Recap of motions and GCACH next steps: ✓ APPROVED: June 2020 meeting minutes

Thank you for your engagement with GCACH!