Date	February 14, 2018	**Time**	11:00 to 1:00
Facilitator	Jac Davies	**Next Meeting**	March 14, 11:00 to 1:00
Location	Garfield County Christian Youth Center, Pomeroy, WA		
Attendees	1. Sherry Greenup, ALTC-Clarkston 2. Mary Cleveland, SE ALTC-Columbia 3. Leta Travis, Garfield Co Health District 4. Cindy Wolf, Garfield County Hospital District Board 5. Brady Woodbury, Asotin Co Health District 6. Shannon Jones, Asotin Co Health District 7. David Jones, Tri-State Memorial Hospital 8. Shane McGuire, Columbia County Health System 9. Larry Jecha, Columbia County Public Health District 10. Cicily Zornes, Quality Behavioral Health 11. Danika Gwinn, Quality Behavioral Health 12. Jac Davies, Northwest Rural Health Network		

Key Points Discussed	
Topic	**Highlights**
Potential transformation projects: Bi-directional integrated care	Jac Davies led a discussion of potential Medicaid transformation projects that each of the three county collaboratives are considering (detailed information from Asotin and Garfield Counties attached to these notes). She asked the group to think about what population would be served, how potential projects fit into the GCACH project framework, whether the organizations involved in the project or the populations to be served cross county boundaries, whether there would be operational efficiencies from a multi-county effort, and how the potential project ranks among community priorities. *Project 1: Bi-Directional Integration of Care and Primary Care Transformation* Both Garfield and Asotin Counties are considering telehealth-based psychiatric services. Garfield would focus on Medicaid clients in general and also jail inmates. Asotin would look at alternative delivery sites for telehealth-based services including schools and senior living centers. Participants from Garfield county noted that residents can't get behavioral health services in Pomeroy and so are traveling to Clarkston for care. Tri-State Hospital in Clarkston has just started using a tele-psychiatry service and is learning from that process. Garfield is also interested in having psychiatric care providers come to Pomeroy and provide services in the hospital or clinic, as some patients respond best to in-person care. Columbia County Hospital in Dayton has an in-house psychiatrist who is seeing a large number of patients from both Columbia and Walla Walla Counties. They have had success by partnering a social worker with the primary care team to identify patients who need referral for behavioral health services.

	The social worker and psychiatrist also work together to ensure patients are getting the level of care necessary. The social worker/psychiatrist model could be expanded to other clinics and other settings. Asotin County is also considering projects that would utilize Community Health Workers (CHW), including an integrated CHW to work with clients across multiple agencies for coordination of services and appointments and CHWs to support "Stabilized Care" that focuses on improving access to services. Asotin is also considering approaches that would help strengthen families and create Assertive Community Treatment teams to provide wrap-around services for adults. Several members of the group noted that information sharing between organizations and informed consent by patients will be critical for the success of any projects. There will also be a need for interagency agreements and strong collaboration with local behavioral health organizations. They also recognized that care coordination is a common theme across projects, with integrated, bi-directional communication. Care coordination could be done by CHWs in each county who utilize the Pathways Hub platform, although it will be important to be very clear on what is being coordinated. Another common theme across projects and counties is the need for transportation services. This is primarily a need in Asotin and Garfield, although Columbia has some challenges helping patients get home after hours.
Potential transformation projects: Transitional Care	*Project 2: Transitional Care* Garfield County proposes focusing on transportation support as part of their plan for improving transitional care. This would help ensure patients are able to receive important follow-up appointments after discharge from a hospital or other facility. Asotin sees some of the same solutions proposed for bi-directional integrated care as being applicable to transitional care, including the use of telehealth services for follow-up appointments, CHWs and Assertive Community Treatment Teams. Asotin also sees the need for secure crisis beds, which could be based in local hospitals and be organized and supported by multiple agencies across multiple counties. There is a need for beds in all counties that would support 72 hr holds and detox. Whitman County could be part of this planning process. Asotin is also considering permanent supportive housing that includes on-site CHWs and a separate cell in jails for juvenile offenders who would receive extra CHW support.
Potential transformation projects: Reducing Opioid Use	*Project 2: Reducing Opioid Use* Several members of the group commented that a lot of work on opioid reduction is being done at the state level, which makes it hard to plan. The state's EDHI (Emergency Department Health Information) system can help providers identify drug-seeking behavior before prescribing. This system should include Oregon and Idaho hospitals as well to help providers in border communities.

	Dayton Hospital representatives noted that they are focusing some of their work on reducing the supply of opioids in the community through programs that require pain contracts along with suboxone treatments. To be effective, pain contracts need to be widely used and supported in the community along with local programs for drug testing. Both Garfield and Asotin are considering projects focused on public education, to help increase knowledge about what to do in the event of an overdose and about local services to help individuals and families dealing with opioid addiction. There is also a need for more education for providers on opioid issues and prescription monitoring and more detox resources in local communities.
Potential transformation projects: Chronic Disease	*Project 4: Chronic Disease* Care coordination and telehealth are both being considered by Asotin and Garfield counties as part of their approach for addressing chronic disease prevention and control. Both also mention strategies for increasing access to dental services and providing oral health education. Asotin also recognizes that providing housing for the homeless can help those indivdiuals better manage their chronic conditions. Garfield emphasized community classes around chronic conditions including Alzheimer's, diabetes and hypertension. These classes include support and education for caregivers as well as individuals with these conditions. Classes could also provide an opportunity to bring in health professionals such as podiatrists and pharmacists to provide services or counseling. Representatives from Columbia County noted opportunities for collaboration with Garfield in this area, as there are already Alzheimer's education programs happening in Dayton.
Potential transformation projects: Next steps	Jac asked the three county groups to continue their work on developing project ideas for Medicaid transformation. She emphasized clearly defining potential projects and also the population that would be affected (e.g. children, older adults, homeless, etc), and trying to estimate the number of people that would be affected. The county groups should also prioritize their project list and consider which might be best suited for ACH funding or might be eligible for other fund sources. As part of the prioritization process, they should consider how well any proposed projects will likely support the key measures GCACH will be tracking. Jac will send out the key measure list. Jac noted that the GCACH is modifying their approach to soliciting project proposals from the counties and also their timeline. She will check with GCACH and send out updated information.
Consumer Councils	The group briefly discussed the need for consumer councils, one of the requirements for funding of the Local Health Improvement Network. They all agreed that holding meetings with Medicaid recipients is very difficult and it is rare that any actually come to meetings.

	As an alternative, they suggested taking advantage of situations where they are already interacting with Medicaid recipients, such as WIC appointments. The SE WA Health Partnership could develop a standard list of questions to ask Medicaid recipients across all three counties as an alternative strategy for gathering input on transformation efforts. Jac agreed to discuss this strategy with GCACH to see if it would work.
SE WA Health Partnership Charter	Jac noted that she and Martha Lanman have revised the new SE WA Health Partnership Charter to include a signature section. She will send it out to Partnership members for review and signature.
Actions and responsibilities	*Action*: Continue working on developing and prioritizing project ideas *Responsible:* Leads for each county partnership *Action:* Clarify the next steps and timeline for project selection with GCACH *Responsible:* Jac Davies *Action:* Discuss with GCACH options for obtaining input on transformation efforts from Medicaid recipients. *Responsible:* Jac Davies
Next meeting	The next meeting is March 14, 2018 from 11 to 1.

Garfield County ACH Project Plan
Draft #2
1/3/2018

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. Dr. Rooney spoke about this topic with the medical providers. They want more information, and would like to have a say in how it is accomplished.

Update: this will be considered as a side project down the road.

Project Option 2- Telehealth psychiatric services for clients and inmates in the jail

Both QBH and the Pomeroy Hospital have telehealth capabilities. This could take place in Pomeroy, at QBH, or both for Medicaid clients.

Provide 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 or emergency services. Would Medicaid fund this project?

Update: We could possibly contract with Locum Tenens, as service that provides telehealth providers. Katie at QBH checked into codes and locations for telehealth for the team. See below:

Exclusion in the SERI is an Intake or Assessment to determine Access to Care so that would not be covered by the BHO. (Medical codes are also allowed just didn't include them since we are looking at behavioral services only right now.)

It also looks like BHO, Medicare, and other private insurances just want us to add a GT modifier to the service code and use place of service 02 (Telehealth)

We would be considered the Distant Site and the Originating Site is where the client is physically at. If the originating site is set up for telehealth then they have their own billable code so it wouldn't have to be approved by the insurance for us the bill our service.

This is what I have found to be billable codes with the GT modifier and I have reached out to a few reps at different places (Molina, Amerigroup, Premera and Regence) to verify rates and/or allowable codes. I'll keep you posted.

BHO Billable Codes (Current SERI)
T1016 – Case Management
H2015 – MH Case Management
H0023 – Behavioral Health outreach
H0046 – MH NOS
H0047 – SUD NOS
H0004 – Individual
96153 – SUD Group
96154 – SUD Individual w/ family
H2011 – Crisis Intervention
90846 – Family Psychotherapy w/o patient present
90847 – Family Psychotherapy w/ patient present
90832 – MH Individual 30 min
90834 – MH Individual 45 min
90837 – MH Individual 60 min

Private Insurance Billable Codes (might be more, checking with Premera and Regence)
90832 – MH Individual 30 min
90834 – MH Individual 45 min
90837 – MH Individual 60 min
90846 – Family Psych w/o patient present
90847 – Family Psych w/ patient present

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- 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. If a hub is not financially feasible, then employ Community Health Workers to act in place of the Hub and coordinate treatment for clients.

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 paid for by SMS, causing more barriers. Pomeroy is currently using a donation-based transportation system. Rather than working with SMS, the team would

like to use project funding to increase transportation from Pomeroy to Lewiston/Clarkston by one day per week.

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- 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 attendance issues

Update: this will be considered as a side project down the road.

Project Option 2- Adopt state standards at the Pomeroy medical clinic. Educate medical providers on opioid issues and prescription monitoring. A written policy on pain medication management has been approved for use in the hospital. Get providers in the Pomeroy hospital and clinic certified for Suboxone treatment. Dr. Rooney to research what the certification entails. Use project funds to pick up expenses for provider certification. Dr. Parker and Dr. Talbot are already working on their certification

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.

Update: Dr. Rooney will get in touch with Shane from Dayton for more information on getting a hub set up.

Challenges- Cost and implementation support

Project Option 2- Public Health Department and Aging and Long Term Care (ALTC) collaborate to provide community classes for the following chronic diseases: Alzheimer's, diabetes, and hypertension. Provide 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. ALTC would like to start a class for diabetes prevention and aging self-management. Additional thought to bring providers and specialists along to classes to give expert advice and information. Possible professionals to bring- foot care, eye doctors, massage, and pharmacists. Bring a different specialty to each class to keep people interested and involved.

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 issues with low attendance.

Update: this will be considered as a side project down the road.

Project Option 4- Dental. Currently elderly people do not have dental coverage, but there are two dentists in Pomeroy that accept Medicaid. Susie will get in touch with them to see if they would like to get involved in a project to provide dental care to the elderly. Per Martha, Chas has mentioned being willing to bring a chair into the hospital quarterly to provide care.

Asotin County ACH Project Plan
Draft #2
2/8/2018

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- Telehealth- Coordinate medical and psych telehealth services for children, adults, and seniors. Split care between different places: one day a week in the school, one day a week at Tri-State Hospital, one day a week at QBH, one day a week at senior living homes, one day a week in the schools, etc. Tri-State Hospital will provide support, as needed. Challenges: cost and physician recruitment.

Project Option 2- A new integrated Community Health Worker to work with clients directly to assess their unmet needs and get them set up with services. Work with the different medical, dental, and behavioral health agencies to get appointments for the client, and then make sure that they get to their appointments. Possible use of the Pathways system in place of Community Health Workers. Challenge: high cost.

Project Option 3- "Stabilized Care" with Community Health Workers- child, adult, seniors. Medicaid clients are not getting the medical, dental, and behavioral health care that they need due to many barriers. Some barriers include: Medicaid not being accepted by a provider, client doesn't have a car, client doesn't have gas for their car, or the client is referred to specialists that takes months to get into. Many Medicaid clients are utilizing the emergency room or express care for issues that can be addressed with a primary provider.

Create a place for a point-of-service provider in the schools for urgent cases, including dental. Also create a referral system that allows nurses to set up medical or dental appointments for students. Include transportation of children to and from appointments during school hours. Challenges there include getting parent or guardian permission for treatment. Possibly implement a blanket consent form for services that goes with all registration paperwork at the beginning of each school year.

Family strengthening services- couples counseling, budgeting help, legal services, classes about what healthy relationships look like, help with court cases and filing court documents, classes for single parents or blended families. Referrals to Head Start, WIC, PCP, etc. Preventative approach. Collective community response to teach children skills that they are not learning at home or in school, such as: conflict resolution, acceptable behaviors, coping skills, how to access medical or other care.

Project Option 4- Transportation Expansion- Many Medicaid clients name transportation as a major barrier for them to access medical, dental, and behavioral health services. Issues- the bus stops are too far apart, and they can't easily walk to one. They cannot afford the cost to ride the bus both ways, although minimal. Possibly create a bus card for low income clients that will allow them to ride for free. Funding for Interlink, more routes, Community Health Worker bus, Family bus

Project Option 5-Secure crisis bed with Community Health Worker coverage 24-hours per day.

Project Option 6- Assertive Community Treatment (ACT) Team for adults- Wrap-around services completed by therapists and community health workers. Referrals to long term care facilities upon hospital discharge. This is for the chronically mental ill client. ACT Team staff works with the clients in their homes, dispenses medication, helps shop for groceries, and help with laundry. Also work with clients that are released from the jail to get them stabilized.

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- Telehealth- Coordinate medical and psych telehealth services for children, adults, and seniors. Split care between different places: one day a week in the school, one day a week at the hospital, one day a week at QBH, one day a week at senior living homes, etc. Tri-State Hospital will provide support, as needed. Challenges: cost and physician recruitment.

Project Option 2- Community Health Worker or MH/SUD therapist in the jail, and at Tri-State Hospital

Project Option 3- A secure Crisis bed at Tri-State Hospital. This station would be manned by a Community Health worker who would have access to MH and SUD Therapists as needed. This will get clients out of the ER and off of the street when they are in crisis mode.

Project Option 4- Permanent Supportive Housing with a Community Health Worker on site.

Project Option 5- A cell in the jail specifically for juvenile offenders with Community Health Worker support.

Project Option 6- Assertive Community Treatment (ACT) Team for adults- Wrap-around services completed by therapists and community health workers. Referrals to long term care facilities upon hospital discharge. This is for the chronically mental ill client. ACT Team staff works with the clients in their homes, dispenses medication, helps shop for groceries, and help with laundry. Also work with clients that are released from the jail to get them stabilized.

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Project Option 1- Telehealth- Coordinate medical and psych telehealth services for children, adults, and seniors. Split care between different places: one day a week in the school, one day a

week at the hospital, one day a week at QBH, one day a week at senior living homes, etc. Tri-State Hospital will provide support, as needed. Challenges: cost and physician recruitment.

Project Option 2- Detox Resources

Project Option 3- Information on opioid epidemic- where people are going to get opioids, which providers are prescribing them. Create a list of providers that are doing medication-assisted treatment such as Suboxone. Resources for people who want to get off of opioids. Provide education to providers at Tri-State Hospital during the monthly provider meeting.

Project Option 4- Opioid prevention events (EPIC). Preventative culture campaign that can be tied to Project One's Stabilized Care. Contact: Christy Sharp, and Everett from Heart to Heart in Walla Walla.

Project 4- Chronic Disease Prevention and Control-

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

Project Option 1- Telehealth- Coordinate medical and psych telehealth services for children, adults, and seniors. Split care between different places: one day a week in the school, one day a week at the hospital, one day a week at QBH, one day a week at senior living homes, etc. Tri-State Hospital will provide support, as needed. Challenges: cost and physician recruitment.

Project Option 2- Homeless shelter. Lindsey will reach out to Catholic charities that help with homelessness in other parts of the state. Low income housing.

Project Option 3- Oral health education and screenings provided by CHAS in the schools and senior centers. If consents are obtained for students, dental services can be brought into the schools.

Other long-term projects-

Project Option 1- Teen Center