Greater Columbia Accountable Community of Health

Leadership Council

Thursday, May 18th, 2017
9 a.m. to 11:30 a.m.
Regular meeting
Benton Franklin Community Action Committee
710 W Court Street, Pasco, WA 99301

Minutes

ATTENDANCE	
Participants:	In Person: Kathy Story, Sarah Dorn, Robert Martin, Susan Campbell, Carla Prock, Kevin Martin, Dan Ferguson, Rick Helms, Dell Anderson, Virginia Janin, Amy Person, Lauren Schoenwald, Debbie Dumont, Jessalyn Waring, Jodi Ferguson, Amanda Hinrichs, Susann Bassham, Michele Roth, Chuck Eaton, Stein Karspeck, Jorge Rivera, Karla Greene, Sierra Knutson, Mandy McCollum, Matt Davy, Kayla Down, Caitlin Safford, Sue Jetter, Kim Keltch, Meghan DeBolt, Angelina Thomas, Mandee Olsen, Diana Vinh, Sharon Eloranta, Kat Latet, Brisa Guajardo, Andy Nyberg, LoAnn Ayers, Kirk Williamson, Rhonda Hauff, Stan Ledington, Sandy Quiroga, Lara Sim, Paul Dillon, Fenice Fregoso, Ben Shearer, Grant Baynes, Les Stahlnecker, Bertha Lopez, Sandra Aguilar, Marcy Durbin, Everett Maroon, Anna Marie Dufault, Ben Miksch, Erin Tomlinson, Lupe Mares, Martha Lanman, Elissa Southward, Joyce Newsom, Corrie Blythe, Barbara Mead, Isabel Jones, Erin Hertel, Mark Koday, Ed Thornbrugh, Eddie Miles, Shawnie Haas, Becky Grohs, Brian Sandoval, Nichole Smith, Sam Werdel (There were 71 participants in person, not including backbone) One the Phone: Jim Jackson, Liz Whitaker, Mike Maples, Bethany Osgood, Scott Adams, Shane McGuire, Deb Gauck (There were 7 participants on the phone)
Backbone:	Carol Moser, Aisling Fernandez, Wes Luckey, Patrick Jones
Special Thanks:	Thank you to Community Action Committee (CAC) for providing the facility and support that made it possible for us to hold these meetings.
MINUTES and REPORTS	
Welcome & Introductions:	Patrick facilitated the meeting & welcomed everyone to the meeting. There were self-introductions around the room and on the phone.
Minutes (Action):	Approval of April 20th, 2017 minutes with no corrections.
Director's Report:	• Carol presented her Director's Report. • Certification Phase I:

	○ She began by talking about the GCACH biggest recent achievement, which was submitting the certification phase I document to the Health Care Authority! She thanked the Project Team facilitators. The certification process ensures that each ACH is capable of serving as the regional lead entity and single point of performance accountability to the state for transformation projects under the Medicaid Transformation Project Demonstration. ○ Certification Phase I Updates since May 18th: ▪ On Friday, May 26th, we heard from Chase Napier, Community Transformation Manager at the Health Care Authority (HCA), that we passed Phase 1 Certification and we heard that we had a strong application. We have some areas to work on, but we're very pleased with our overall scores: THEORY OF ACTION & ALIGNMENT STRATEGY = 5/5 GOVERNANCE & ORGANIZATIONAL STRUCTURE = 5/5 TRIBAL ENGAGEMENT & COLLABORATION = 4.3/5 COMMUNITY & STAKEHOLDER ENGAGEMENT = 4.3/5 BUDGET & FUNDS FLOW = 5/5 CLINICAL CAPACITY & ENGAGEMENT = 4/5 GCACH staff poured many hours into this certification application. Thank you all for helping us get through phase 1! On to Phase 2, which is due August 14! As of May 31st, it was announced that all nine Accountable Communities of Health (ACH) have achieved a critical milestone in the Medicaid Transformation Project Demonstration – Phase 1 Certification. Click here to read the announcement. • Carol thanked everyone for coming to the Leadership Council meeting. She said that we have the subject matter experts in the room to plan how to use the Demonstration money wisely.
Regional Survey Results (Patrick):	• Patrick Jones presented the Regional Survey Results: • He presented results by county & by sector (the top sectors of the organizations that responded were 1. Healthcare, 2. Social Services and Supports, and 3. Education). • The Medicaid Demonstration has two required project areas (1. Bi-Directional Integration of Care and 2. Addressing the Opioid Public Health Crisis). The Regional Survey asked responding organizations to rank the importance of the 6 optional projects, and the top 3 ranking optional projects were: 1. Oral Health, 2. Chronic Disease Prevention & Control, 3. Transitional Care. • Organizations were largely submitting their programs through the Regional Survey.

	• The Regional Survey included questions about Behavioral Health Integration. Most of the respondents said that their organizations are either executing or planning integration. There were multiple questions asked of those organizations that say they are executing integration. Among them, 10 of the 12 organizations said they "systematically collect data on all patients identified to receive integrated care services." In contrast, only 3 have Mental Health Counselors and only 2 have Community Health Workers (CHWs). Patrick said that Eastern WA university has the largest social worker program in the state, but there are still social workers looking for work. • In the section about workforce, respondents said the that greatest needs for our region are: 1. Mental Health Counselors, 2. Other behavioral health workers (e.g. chemical dependency, substance use, etc.), and 3. Psychiatrists and Psychologists. • There were open-ended questions at the end of the survey, but there weren't that many comments. Some expressed concern about the relevance of the Medicaid Demonstration to non-clinical service providers. • Patrick said that only a minority of the organizations identified themselves and this was not required.
Project Team Discussion (Wes):	• Wes reviewed the timeline and the questions for the Project Teams that they were to work through during the Project Team breakouts.
Project Team Breakouts:	• The 8 Project Teams broke out into small groups in different locations around the CAC building.
Project Team Report Outs:	• Project Team Facilitators reported out on their teams' meetings: o Project Team 2A for Bi-Directional Integration of Care & Primary Care Transformation: ▪ Participants: Amy Person (BFHD), Angelina Thomas and Brian Sandoval (YVFWC), Dell Anderson (TCCH), Barbara Mead (Lourdes) Sue Jetter (PMH), Nichole Smith (Molina), Ed Thornbrugh (Comprehensive) Rick Helms and Sam Werdel (Qualis), Debbie Dumont, (Walla Walla County) Ben Miksch (United Health Care), Kat Latet (CHPW), Eddie Miles (Virginia Mason Memorial), Rhonda Hauff (YNHS). ▪ The group discussed: • The projects in the toolkit • Outcomes in the Common Measures • improve mental health penetration • depression screening and follow-up

	• follow-up after hospitalization (7 days) • ED metrics • Co-Occurring Disorders: 1. may be more than just CD & MH 2. may be Physical health & BH • For those projects in place, and those wanting to develop, what additional services and supports need to be added to improve the outcomes? • Interoperability: 1. Phase 1 – can we utilize the planning dollars of the infrastructure to help improve efficiencies / build technology to improve the interoperability? 2. How do we collect the data? 3. Whose responsibility is it? 4. What registry will we use and how do we avoid duplication of data entry? 5. Can EDIE be more efficient? • Project approaches: 1. What do we have potential to show impact in 2-3 years, maybe not for the chronic populations? 2. We need to work collaboratively with Chronic Disease, Care Coordination, Maternal Child Health, Opioid, & Oral Health Project Teams. 3. We will also need to work closely with Initiative 3 – Foundational Community Supports (supportive housing and employment) 4. Consider health risk scoring of CDPS or CDEMS risk scoring, including use of the Z codes to collect Social Determinants. • Next Steps: 1. Agree on desired/ intended outcomes. Projects will need to shoot toward those outcomes. 2. Decide on continuum of prevention vs treatment approaches. 3. Identify areas of penetration where new efforts are needed (once outcomes are identified) 4. Will they receive grants or be paid on incentives for meeting those outcomes? o Project Team 2B for Community-Based Care Coordination:

	▪ Participants: Jorge Rivera, Bill Hinkle, Brisa Guajardo, Corrie Blythe, Deb Gauck, Kayla Down, Kirk Williamson, Sandra Aguilar, Sarah Bollig Dorn, Shawnie Haas, Susan Campbell, Susann Basham ▪ Comments/Questions At-Large: How adaptable is the platform used for the Pathways model? Which of the Pathways models are applicable across all nine counties? If you do Pathways, do you have to use the platform? ▪ Q1 (what are current issues/gaps/upstream issues, how do approaches address root causes): evidence-based; helps address social determinant issues in theory; build up on the personal relationships that exist in the community. ▪ Q2 (high risk Medicaid clients that would be served by this approach): top 5% of the Medicaid population who are equated with the highest spend; those eligible for Health Home; groups that have already been identified (high ED utilization, Medicaid); total cost of care inclusive of poly-pharmacy, in-patient psychiatry, etc. across the entire spend versus activity; Medicaid members of PRISM score 1, 1.5, etc.; suggestion to not set the number in stone and have a larger net for who to capture since it's not an absolute for who is the 'highest need'; ensure there is still an upstream approach when deciding on a population given critical social determinant needs. ▪ Q3 (Toolkit outcome metrics and health system costs affected in 2-3 years): Successful implementation would potentially affect all the metrics listed in the Toolkit and then some. ▪ Q4 (collaboration with other Toolkit areas, which ones): Opioid utilization; child and maternal health; behavioral health/mental health treatment; discussion around how the bi-directional project would be difficult to filter through the Pathways model, but connects with capacity. ▪ Q5 (access to care and clinical-community linkages): potential risk of compounding the access to care through integrated settings by stressing the physical/behavioral health providers; frequency of service utilization needs to be a discussion when selecting target population. ▪ Q6 (what programs as missing needed given the spreadsheet and survey results): need to clarify the roles of this workgroup and adding to the inventory, i.e., current initiatives that could be/should be connected to the Demonstration and care coordination work; add FQHCs, Health Home, entities that currently do care coordination in the community to avoid duplication and align resources. o Project Team 2C for Transitional Care: ▪ Participants: Virginia Janin, Kevin Martin, Mandee Olsen, Kim Keltch, Sierra Knutson

- Welcome and Introductions – Mandee Olsen
- Goal: To identify evidenced based diversion strategies to divert high use individuals from ED to PCP and urgent care facilities.
- Review of Minutes –None
- Group discussion on roles and responsibilities of each member and the cross walks between everyone and their roles in the community. Identified gaps are police, EMS, and insurance company staff member.
- Will need to have tools identified that will assist in identifying high ED users. Examples presented were Jail stat sheets, EMS run reports, 30-day re-admission stats, police contact sheets, I-leads, EDDY, interlocal agreements.
- Pathways Identified for models that can be expanded to other counties include; Medical Home, Housing, Behavioral Health, etc.
- Will need to focus on models that best serve complex and diverse counties, not just one.
- Focusing on Model not ownership.
- Next Steps:
  - Identify team member for police, EMS, insurance staff member
  - Identify concrete pathways for recommendations
  - Review tool kit for next meeting
- Next meeting: TBD

- Project Team 2D for Diversion Interventions:
  - Participants: Stein Karspeck, Karla, Greene, Matt Davy, Ben Shearer, Grant Baynes, Elissa Southward.
  - Lots of discussion on why people are in the ED so often
    - Convenience
    - Culture
    - Unable to get in to PCP in timely manner
    - Health literacy
  - Gaps
    - How do referrals get f/u on? If patient referred for community services, how long is the wait to get actual services in home?
    - Need coordinator of all resources available

	• Get in the home- essential component to understanding root cause for that specific person. ▪ We discussed requiring a small copay, for example $10 for visiting the ED. This has much support in literature/research as being a useful deterrent. Just as long as we can waive it in certain cases. Also mention that the in-home care coordination/education is highly successful with reducing ED visits and is considered a successful practice. ▪ Concerns discussed about how to coordinate use of paramedics in Yakima since there has been little interest from the area in expanding their role in the community, and there is not representation in the ACH from the FD or EMS agencies. Concerns expressed by FD rep from Pasco about their medics lacking information about patients they may f /u on in their community. Would like to have another agency coordinate visits and compile information. Consistent Care program has good working relationships with FD and EMS in both Tri Cities and Yakima. Could add facet to existing program where EMS agencies would be another tool in the tool kit to coordinate care for high risk patients. Maybe include use of Hot Spotter data as well. ▪ Working Idea: Consistent Care Program helps coordinate use of local Community Paramedics to do home visits on high risk patients for ED use and Readmissions. o Project Team 3A for Addressing the Opioid Use Public Health Crisis: ▪ Participants: Becky Grohs (Facilitator), Everett Maroon, Robert Martin, Mike Norton, Chuck Eaton, Liz Whitaker ▪ Discussion: • The group decided that we didn't want to get too stuck on the data and felt that moving ahead with identifying a project would be best so we discussed an idea that Everett Maroon brought to the table called "Opioid Crisis Response Collaborative (OCRC)". • This collaborative would serve as a type of hub model where the hub is essentially the organization that provides the necessary ongoing Case Management for patients that enter the program through many ways such as: • Emergency Department, Law Enforcement, jail, Educational System/schools, Syringe Exchange, PCP offices, BHS (Substance Abuse treatment providers and Mental Health providers), and others. • We discussed that this program should be highlighted as a Harm Reduction strategy. We may face some political opposition with this but evidence shows this to be most effective in saving lives.

	• Each of the components below can be provided by the entities within each community that are already providing these services (spokes) through an RFP process. Each of the below components need to have clear expectations and a communication feedback loop that reports back to the hub (Case Management). Components of the OCRC will be: • Coordinating access to MAT, including early initiation in the ED and building the network to facilitate access to MAT in areas that there is poor access • Addressing social determinants that reduce success in addressing opioid misuse- transportation, housing, food security, access to healthcare • Need Exchange availability- including funding for a co-located nurse/ARNP available to address IVDA related medical issues • CHW outreach into communities • Availability of CDP's or partners that can provide this service (contracted with BHO). • Access to Naloxone for OD prevention • Integration with the medical care team- communication with PCP, care guidelines in the ED • Address policy gaps regarding funding for ongoing sustainability • Use of individualized service plan and goals for each patient. • We discussed needing to identify metrics to measure success of our program. • We discussed needing to make sure we address the complicating issues around co-morbid pain and addiction and the co-use of other substances when receiving MAT. More research is needed in this area. • We concluded that we will pull together the next meeting time via doodle poll. ○ Project Team 3B Maternal & Child Health: ▪ Participants: ▪ Discussion: • For those of you who are new to the group –we have chosen to focus our proposal on a combined project that includes LARC emphasis/education and an Evidence Based Home Visiting proposal to support NFP and PAT programs expansion and implementation. • Please see project 3B (page 45) https://www.hca.wa.gov/assets/program/project-toolkit-draft.pdf

	• We need to be sure that our proposal clearly illustrates how we feel this program can integrate and support other project areas: 1. Bi-directional Behavioral Health 2. Care Coordination 3. Opioid Crisis 4. Oral Health 5. Diversion Alternatives 6. Chronic Disease Management 7. Transitional Care ▪ We also need to define which system wide and project level metrics will be addressed by our plan (above link page 45). ▪ It will also help if we can address the Common Measure Sets that will be addressed - https://www.hca.wa.gov/sites/default/files/measures_list.pdf o Project Team 3C Access to Oral Health Services: ▪ Participants: Mark Koday, Wes Luckey, Aisling Fernandez ▪ Compressed time table for submitting projects for approval ▪ Need to be sure that both oral health system wide and project metrics found in the tool kit are addressed for a successful project application. As a result, it was recommended that we submit a project that has multiple elements covering all, or the majority of, the metrics ▪ We can submit one plan in which multiple organization can apply for funding ▪ Each application could apply for pieces of the project ▪ The project needs to be evidence based ▪ If funded, organizations could apply for startup funding for year one. After that funding will betide to successful metric outcomes and milestones ▪ Project elements can include current successful programs that need to be scaled up or innovation in care that are evidenced based. ▪ Elements of the project Plan were discussed an approved: ▪ Decreasing children's caries rates: ▪ Expand Mobile sealant programs ▪ Embed hygienists in primary care medical teams ▪ Increase access for adult care:

	▪ Expand dental hygienists working in community settings such as medical offices, nursing homes and community programs ▪ Establishing tele-dentistry: Expanding the ability to provide other dental services including radiographs and exams and connecting patients to dental offices. ▪ Establish a community based oral health case management program ▪ The next committee call is scheduled for May 24th at 5:30 o Project Team 3D Chronic Disease Prevention and Control: ▪ Participants: Bertha Lopez, Rebecca Sutherland, Martha Lanman, Fenice Fregoso, Michelle Roth, Joyce Newsom ▪ 5210 – Rebecca and Martha can do some research ▪ DPP, CDSMP both reduce Utilization/cost, 5210 we are not sure (more research is needed) ▪ Yes, transportation, mobile food banks, dental/BP screenings and at different times throughout the day. Care Coordination. Cross pollinate screenings and services – Health Fairs. If the community members need food, they come for that and may not know they have pre-diabetes and then they get checked and we refer them to the program. Go to the community – Housing sites. ▪ Yes, ED diversion, medication management, Comprehensive Diabetes, obesity, BMI all except child immunization. ▪ Yes, social determinants of health ▪ Yes, upstream health ▪ Food insecurity, dental, vision, health screening, housing, transportation, public spaces to do exercises, safety. ▪ Weaknesses – Yakima issues seasonal workers, disparities in health. strength outcomes, we go to the community where they live ▪ Care Coordination – hub and community based, Utilization, Mental Health, Dental – housing, food, transportation, employment ▪ Once the project is identified – who bids? How does it roll out to different counties? What is the Contractor role? Do we decide that? Who does the Marketing? When we submit the project ideas can the board not approve the project? ▪ Michelle will arrange a place in Prosser for the meeting – doodle poll 2 meeting, 2 hours each Michelle ▪ Fenice will get a WebEx and co-facilitator–

	▪ To do: send meeting notes from other meeting, send Michelle list of members for doodle pool. Send the members everyone's contact info.
Adjournment:	Patrick thanked everyone. Meeting was adjourned at 11:30 a.m. Minutes taken by Aisling.
ANNOUNCEMENTS	
Future 2017 Meetings:	**Thank you for your time and engagement with the Greater Columbia Accountable Community of Health!** The regular Leadership Council meetings for 2017 will be from 9-11:30 a.m. on the following dates: June 22nd July 20th August 17th September 21st October 19th November 16th December 21st