GREATER COLUMBIA ACCOUNTABLE COMMUNITY OF HEALTH

Practice Transformation Workgroup (PTW) Meeting

Thursday, February 6, 2020 | 10:30 AM to 12:00 PM

GCACH Office -OR- Call-in Option

ATTENDANCE			
PTW Members Quorum: N/A Italicized: Board Member Name*: Called-in	Angela Gonzalez (CHCW)*	Barbara Mead (Lourdes)	Becky Grohs (Consistent Care)*
	Bill Dunwoody (Kadlec)	*Brian Gibbons (Astria)*	*Dan Ferguson (YVCC)*
	Deb Watson (Pullman Regional)*	Everett Maroon (BMH2H)*	Jorge Rivera (Molina)*
	Kat Latet (CHPW)	Kevin Martin (KVH)	Liz Rice (TCCH)*
	Mark Wakai (Providence HC)	Phillip Hawley (YVFWC)*	*Rhonda Hauff (YNHS)*
	Rick George (Comp HC)*	Ryan Lantz (SignalHealth)	None (YVMH)
GCACH Staff	Becky Kolln	Carol Moser	Chelsea Chapman
	Diane Halo	Jenna Shelton	Lauren Noble*
	Martin Sanchez	Rachael Guess	Ruben Peralta
	Sam Werdel*	Wes Luckey*	
Guests	Greg Wolverton (CSI)*	Jeff Wasserman (CSI)*	Joe Ketterer (Astria)*
	Joleen Carper (Tri-State)*	Michelle Sullivan (YNHS)*	Myrna Ridenour (Lourdes)*
	Penny Bell (Ideal Balance)*		

WELCOME AND INTRODUCTIONS	
Welcome & Introductions (Carol Moser)	Carol opened the meeting and facilitated introductions.

ACTION ITEMS	
CSI Dashboard Review (Jeff Wasserman/ Greg Wolverton)	This first look at the dashboard. Jeff Wasserman of CSI walked through the new online dashboard. The benefit of this dashboard is real-time feedback on performance in Practice Transformation. This includes viewing other sites performance with restrictions

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Questions and comments:

- Number at top represent providers or patients? Top ten, it is a roll up of all the sites, so it is the most common across all the ten sties from Cohort 1 and Cohort 2.
- Over 800,00 patients, likely empaneled in other provider clinics. Not actual.
- Unique patients? No, it could be duplicate. If somebody goes to Lourdes for PCP but Somerset for counseling it would be counted twice.
- How often the data is updated? Quarterly.
- How do I, or other members of Lourdes access to this dashboard? Someone has administrative access- Dana, Shawna, Myrna, and Laurel. Access is here, but it hasn't been officially rolled out
- So, they're input somewhere by the providers and then uploaded as a group quarterly? Cohorts enter quarterly, CSI automatically pulls into this dashboard.
- 12 measures:
    - Care management for high-risk patients
    - Empanelment rate
    - Top 5 risk stratification methods: Out of all sites, this is the top 5. Some sites are ADD, ADHD, IV users, pregnant pos-partum women,
    - Importance of separating cohorts and association to quarters. The numbers are varied greatly between cohorts, the number of patients can be far less with one cohort. If we just filter down to Cohort 2, you'll see the numbers change just representing that cohort for the number of quarters they have completed. Cohort 1 has had four quarters, Cohort 2 has only completed 2. Each cohort has started at different times.

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	○ Care coordination: Collaboration agreements with other organizations. Breaks down quarter by quarter what percentage of organizations are tracking ED follow-up and inpatient follow up and having collaborative agreements with other organizations. ○ BH integration model: reflects what model people chose. Aims, Bree, Co-location, or other. Other would include SUD with mental health, integration into schools, jails, etc. Anything that is not traditional BH integration. That option was geared more toward Cohort 2 since having co-location might be difficult as smaller organizations. We created that flexibility to be creative so that they can integrate into the system of care. ▪ Jorge: When you look at the changes from quarter to quarter, is this because you're counting different organizations or because the same organization is choosing different models? Are same providers changing models or counting new providers? Counting new providers, when most sites pick a model, they stay with it for the year. As new organizations are added, that is why it would change quarter to quarter. Carol: Since the emphasis is really bi-directional and mental health, are we going to try to encourage primary care into behavioral Health? ▪ Answer: Yes, it's just figuring out who will work operationally (staff, schedules, billing). ○ Medication Management Services: This question asks what are the prescribing guidelines? E.g. opiates. Bree, CDC, AMDG, other are the options. This question has a lot of different options within the workbook with how sites are doing their medication management for their population. ○ Follow-up within 1 week of ED discharge: this just tracks the percentage of follow-up within 1 week of ED discharge with all sites. There is a very big jump between quarters. It varies because sites might have added staff to do the follow-up. This was not required in quarter one, so quarter two we started to get more data. Quarter 3 is when cohort 2 was added so it added some flux there. ○ Follow-up within 72 hours of discharge: Very similar to previous. We expect once everyone is on collective medical, they will have access to this information. We are working with hospitals that are not providing that info to collective medical as a means to embed that consistency and transparency with care being provided. Still some things to work out so that this can be a smoother process. ○ Higher referral community partners: Who do you refer to the most? This gives us an idea of top one: other (food bank, community partner, CAC). Behavioral health, Cardiology, SUD Providers, and gynecology. ○ Identify patients needing integrated care: In the workbook this question is specifically asked. Categories include positive screen, the presence of diagnosis, etc. Inability to reach goals in management of chronic conditions.

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	▪ Bill: Concerned with "Other" being a very large number in chart. Is that SDOH types of referrals, could it be classified in some fashion so we know what it is? ▪ Jenna- there is other comment option with a narrative. Jenna can review and provide high level themes. Doesn't provide with accurate full level information. Is there another category that could be collected and be called SDOH, common nutrition, housing, etc. ○ Behavioral health integration assessment tools: How people are assessed- MeHAF, PCMH-A, AIMS, Other, Integration Academy. General observations in response to first look at new dashboard: • It's great. Fairly sophisticated with dashboards compared to those worked with historically. It has a lot of a great features. It will provide meaningful info as we move forward. Carol asked how the group sees themselves using the dashboard: • Barb: It is a tool we can share with administration and with PT teams at each site to say "this is how we compare to others, this is what we're doing for the whole ACH." It's important and easy to forget that when you're on a small team that you're a part of the entire ACH. Likes this option and good tool to share with people. • Bill: Physicians introducing this information to physicians will help with buy-in. Barriers with getting physicians to participate. • Diane: Good storyboard to roll it out to inform providers that this is what we're working on. This is why we're requiring you to do this much work. Good viewpoint of what PT is really doing. • Provides a tool to see how the work we are implementing is improving the outcomes as well • How do you see it working? Jenna- good reminder for what they are doing. Meeting monthly, need encouragement to know that you are doing well. • Bill: Look at an entire cohort, we have a problem but everyone else is having the same problem. Identify those organizations that are the exemplars and learn from them. Connect with navigator, I don't need to know who, but how do we do with what they're doing. • Lauren: use this to market to other prospective potential partners. As well as legislature. • Barb: When we split up different cohorts, cohort 1 has most experience. Milestones for cohort 2 aren't exactly the same but similar. If cohort 2 is struggling, look back at cohort 1 and use their learnings as motivation. • It tells a story for our region and provides value for the MCOs. How does it impact your work? Joel: Getting used to this still, can be beneficial as looking at bi-directional care and seeing where the providers are and make connections with those not in contact with. Opportunity to participants for cohort 1 to mentor participants in cohort 3 on what they did to increase their numbers or service to provide better care. Do you see taking this to providers and demonstrating to providers? GCACH to provide a list of providers to Joel.

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	• Jorge: Looking at it today, it looks really robust and provides valuable information. This is enormous progress and very important for community and state to use this information. Most of these metrics come from the contracted providers of yours. It would be interesting to see how numbers measure up from the state when they start coming out. How this stacks up against reporting from the state. Identify providers in work vs. providers not in this work. Question- How do you measure the actual engagement of the organization? Some are really into this. How do you measure degree in engagement of providers? Very interested to see BH specific numbers, believe approach GCACH took with exclusively BH cohort is unique. Everyone in state should be looking at this dashboard as a part of the integration work. • Jenna: We are actively engaged with PT navigation. Sites are seen at least once a month. No sites are less engaged. Every site sees the value of the work and has identified internal champions to push this work forward. It's been really cool to see people be engaged. If they are not engaged they don't get paid. • Barb: Sustainability for services provided to patients. One of the challenges is around financial sustainability with BH primary care integration. It is an expensive service to provide and the reimbursement for non-FQHC for primary care is very challenging and very limited. There has been a tremendous amount of literature written about how it improves care. The Medicaid population is reimbursed minimal at best. Medicare, is very difficult. Be aware of and bring up to legislators. MCO response: Corner of the conversation. Numbers are coming out. During the message in central Washington, improvement is penetration of BH services. NW central is receiving lowest reimbursement for BH health services. Now that we are increasing 15 points, those numbers are now released. Is the state going to increase reimbursement? Not part of conversation controlled by MCO, rates are controlled by HCA. As we start to see benefits improving, state is supposed to review based on this. The goal, next step is that will be VBP agreements with PCP providers. Set measured outcomes. The state is starting to feel the pressure. We don't control conversation, but we're with you. Goal is to get into VBP contracting and show results. Wes spoke to providers vs. quarters. We eliminated Q1 because it has such a dramatic change. It adversely impacted the data. There was an uptick in the registered nurse. This is exciting to us because we know care management, when you can use an RN case manager, it is a billable service. It's an indicator that people are practicing to the top of their license. There was an uptick in physician and medical assistant. We are excited that MA's are being used for more care management activities. Encourage to reflect on what this data would mean to you. Bill: Interesting that the BH specialist is less than the RN. I think that reflects the variability in reimbursement for that particular position depending on whether it is a licensed independent social worker or a bachelors level community health worker. Or even a master's level social worker

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	that isn't' licensed. Ideally, for the AIMS model, we'd like to see an increase in those people. They are lacking, they aren't around. People are using the staff on hand as much as possible. We are not doing the warm hand of integration that we should be doing, as much as would be beneficial to the system. Barbara: Speaking to my point that I made earlier. Wes: This information is important for a few different things. First of all, earlier on in the PT project, carol and I realized that costs were focused on a small population. Being able to focus on the high cost high needs patients that have reoccurring disorders and often have social service needs (important part of population health management). We're being effective of that, this shows. Another perspective, what we focus on team based are is that those folks' practice at the top of the licensure. PT has for the most part been effective in making that change happen. Jenna: Spoke to seeing outcomes related to transitional care and chronic disease management. Seeing an uptick of peer support counselors and reducing provider burnout. Something we hoped to see reflected in that graph. Martin: This builds the case that these positions are beneficial to the PT organizations who are moving forward with VBP. Michelle: We utilize a team-based approach to care management with all members of the team carrying a portion of the load. Our numbers reflect that distribution of the load among the team.
Minutes	The 2019-12-12 Meeting Minutes were reviewed and accepted by the committee with one correction regarding empaneled patients being applied to all patients (not just high-risk patients). Bill Dunwoody motioned to approve the 2019-12-12 PTW Meeting minutes with the correction as stated. Seconded by Barbara Mead. Motion passed.
Cohort barriers	Jenna and Martin spoke to the predicted barriers for each cohort in their presentation. Cohort 1 • Pulling Data • Learning New Population Health Management Tools post EHR transition • Recruitment of medical staff • Establishing new workflows • Leadership Engagement • Contracting with Collective Medical • Impact of non-traditional care team members Cohort 2 barriers:

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	• Implementation of Collective Medical • EHR Transitions • Workforce shortages • NATIVE Data • Billing Cohort 3 Update: • Tri-state memorial hospital • Walla Walla clinic • Prestige Post-Acute rehab- Ellensburg • Yakima Neighborhood Health Services—spoke with Michelle, Rhonda is working on budget, reviewing the assessments • Astria- Kick off meetings have been made. Clinic in Grandview and union gap. • Yakima Valley Farm Workers clinic – picking a site and move forward with next steps. • Ideal option- kick off, assessments, • Trios—hospital and two clinks. Assessments and kick off complete. Reviewing PTIW in next week or so • Richland rehab – same • Kadlec- selected site • Lourdes- second IM site in cohort 3 • CHCW- waiting on site identification but working with QI team • Chaplaincy- doing palliative care and behavioral health. BH department doesn't have EHR, so that will be an obstacle. • Garden Village—Last week had a meeting to start assessments. Tom Adams did an activity prior with clinicians to determine the value of those functions. It's good for reporting, easy for you guys to use, able to create patient registries, risk stratification (important things of any HER). Getting input of his staff. Informed they are looking into implementing Care logic. Excited to do QI just don't have resources there. WRHC: Partnership with WRHC. Something new for us, we got the opportunity to bid being able to participate with WRHC. We were selected over some big names (Bree collaborative and Comagine). We'll be taking on 11 additional sites. Much more scaled down PT effort. They have a clinical focus on diabetes care, blood pressure, and depression screening. Additional focus on traditional care management, chronic care management, and annual wellness visits. The sites are scattered statewide, so more travel will be required. Barb: Why did we bid? Carol: We were requested. Work with Elya Prystowsky when Olympic Community of Health. Knew what we were doing in PT and reached out. It'll be good to see how organizations react to not being paid but are still pursuing PT. First partnership of its kind across the ACH's. Really excited about it. Questions?

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	May 7th next meeting? Because number of practice sites, hard to get accurate reporting. Might push out so that we have more quarterly data available. Probably have lag in reporting out previous quarters data. Still working through that, but will let you know. When will dashboard go live? Coming soon to a screen near you.
ADJOURNMENT	
Adjournment	Meeting adjourned at 12:00PM. Minutes taken by Chelsea Chapman.

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