Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

Leadership Council & Practice Transformation Learning Collaborative

Minutes

March 21, 2019 | 9:00 a.m. – 11:30 a.m.

ATTENDANCE	
Participants (*: called in, †: GCACH Board Member)	Jenny Krueger, Diane Campos, Jocelyn Pedrosa, Michelle Sullivan, Lisa Hefner, Les Stahlnecker†, Dan Ferguson†, Rhonda Hauff†, Jorge Rivera†, Brian Sandoval, Rick George, Sierra Foster, Tom Adams, Donna Albaitero, Ronni Batchelor†, Laurel Avila, Barbara Mead, Dana Oatis†, Shauna Banner, Joel Chavez, Dr. Larry Jecha, Troy Stratford, Chris DeVilleneuve, Marissa Ingalls, Sierra Foster, Kendra Palomarez, Dr. Amy Person, Tom Adams, Sandra Suarez†, Pasha Pacherou, Matt Davy, Sandy Quiroga, Caitlin Safford, Hayley Middleton, John Christenson, Whitney Garcia, Dan Ferguson†, Gary Castillo, Rick Ballard, Jac Davies, Martha Lanman†, Ashley Walker, Bill Dunwoody, Richard Leigh, Dr. Antonio Gonzalez, Kat Latet, Bertha Lopez, Brenda Swenson, Shauna Banner, Theresa Kwate*, Tjay Osborne*, Kim Nygreen*, Ed Thornbrugh*, Ryan Lantz*, Katie Hammeke*, Kelly Sanders*, Dr. Kevin Martin*, Minnie Smith*, Marcia Baden*, Lindsay Engh*, Mandee Olsen*, Carlos Correa*, Deb Watson*, Joyce Newsom*, Cheri Snowhite*, Carrie Barr*, Tracy Ribbing*, Carla Prock*, Rick Meadows*, Mark Wakai*, Molly Schutt*, Meghan DeBolt*, Kirk Williamson*, Elizabeth Hillman*, Dave Wilson*, Randall Hartman*, Chuck Eaton*, Sean Domagalski*, Randall Hartman*
Staff (*: called in)	Carol Moser, Wes Luckey, Becky Kolln, Sam Werdel, Rubén Peralta, Rachael Guess, Diane Halo, Jenna Shelton, Martin Sanchez, Lauren Johnson, Aisling Fernandez, Patrick Jones
MEETING PRESENTATIONS & REPORTS	

Welcome & Introductions (Dr. Patrick Jones/Sam Werdel)	• Dr. Patrick Jones facilitated the meeting. He welcomed everyone and asked for introductions around the room. • Wed Luckey presented the 2019 GCACH timeline. Correction to the timeline: Quarter One reporting for practice transformation organizations is due April 15th, not the end of March. • Please review the March GCACH Report on your own!
Community Trends (Patrick Jones)	• Dr. Patrick Jones, gave a presentation on Eastern Washington University's Community Indicators Projects at http://bentonfranklintrends.org/loc_map.cfm, with a focus on HOUSING in the Greater Columbia region. ○ The conventional public policy indicator of housing affordability in the United States is the percent of income spent on housing. Housing expenditures that exceed 30 percent of household income have historically been viewed as an indicator of a housing affordability problem. ("Housing Affordability: Myth or Reality? " Wharton Real Estate Center Working Paper, Wharton Real Estate Center, University of Pennsylvania, 1992) ○ Today we are focusing on severely rent-burdened households. Approximately 20% of households in Yakima County spend greater than 50% of income on housing, and find it difficult to meet other obligations. The State of WA has slightly higher rates. The US has a slightly higher rate of total and share of renting households, approximately 21% paying 50% or more of household income for shelter costs. In Benton and Franklin counties, the rate is 20%, pretty close to state of WA and slightly lower than US. We all are confronted with affordable housing challenges in our communities and so is everyone else around the county. This is an endemic issue in our society. For Walla Walla and Columbia counties combined in 2017, the share of renters paying 30% or more of household income is 50.8%, worse than the US and WA State.
Bi-Directional Integration (Brian Sandoval, Yakima Valley Farm Workers Clinic)	• Sam Werdel introduced the first speaker, Brian Sandoval. Brian Sandoval, PsyD is the Clinical Director for Primary Care Behavioral Health with Yakima Valley Farm Workers Clinic. He has been very engaged with GCACH over the last several years. • Brian's presentation was titled, "Bi-Directional Integration." ○ Brian said, I don't like the term Bi-Directional Integration. I don't like this term because it's more of a system integration issue. We need to find ways to integrate models of care. Many of you are familiar with Collaborative Care and the Bree Collaboration. Behavioral Health Homes are important for those with more significant MH health issues. Offsite Collaboration is another model. These all should come together. Multi-Directional Integration is a better way to describe this work."

KEY FEATURES		
PCBH	Collab Care	BH Homes
TYPE		
Horizontal Integration	Vertical Integration	Horizontal Integration
FUNCTION		
Access/⬇ Barriers (lg pop)	Care Mgmt. via Registry	⬇ Barriers/Case Mgmt
METHOD		
Brief visits/Consults PCP	Psychiatry Consult/PST	PCP co-located at MH
DURATION		
Constantly "Enrolled"/Accessible	Enrolled for 6 months	PCP Constantly Accessible
GOAL		
Enhance PC/PCMH	Improve Mgmt. of target condition (e.g. depression)	Improve physical comorbities w/ mental health

- Brian presented simple versions of the Key Features and Evidence Base for three integration models: Primary Care Behavioral Health, Collaborative Care and BH Homes.
    - <u>The Primary Care Behavioral Health (PCBH) model</u>
        - horizontal integration (trying to reach a large subset of the population; horizontal going outward)
        - features warm-hand offs
        - is a consultation model
        - there is someone you can see right now when you need care
        - brief visits and consults
        - The GOAL of PCBH is to increase access and to increase/enhance the patient-centered medical home through the EFFICIENCY AND EFFECTIVENESS of care.
    - <u>The Collaborative Care Model</u>
        - vertical integration
        - working through an identified disease state.
        - seeing a lot of great things come together with MAT, a great way for this to go. Identify populations and measure success over time
        - the GOAL of Collaborative Care is to IMPROVE OUTCOMES, and to increase access for target populations.
    - <u>The Behavioral Health Homes model</u>
        - horizontal integration (integrating primary care into specialty BH settings). Here you are trying to expand primary care.
        - Remove barriers to getting to medical care in a BH setting.

- Can be paired with effective case management strategies.
- The GOAL of BH Homes is to ENHANCE CARE around physical co-morbidities (there are a lot of issues with co-morbid conditions and deaths), and to increase access for medical care.

- Q&A with the Leadership Council:
  - Question: What about consults with the Primary Care Providers?
    - Brian Sandoval: The BH consultant does the visit then consults with the PCP right then and there. It is coordinated at the point of care and the patient leaves with a coordinated care plan. If they're not responding well to a medication or they need a medication, there is coordination and consultation with PCP.
    - Brian Sandoval: Regarding qualifications of BH providers- LMHCs- which can comprise of licensed social workers, licensed family and marriage therapists. There are also integrated masters level folks.
  - Question: What about care managers?
    - Brian Sandoval: Care managers are an integral part of the collaborative care model. Could be through medical assistant or through nursing team. Do coordinate with existing registries. Not a separate registry. Collab care is a separate registry. Primary care is about helping the medical home.
  - Question: So, do they spend most of their time on registry contact?
    - Brian Sandoval: Care managers can do both care coordination and they will often see patients and do both roles within collaborative care. Some collaborative care models have two different people for each of the type of work.

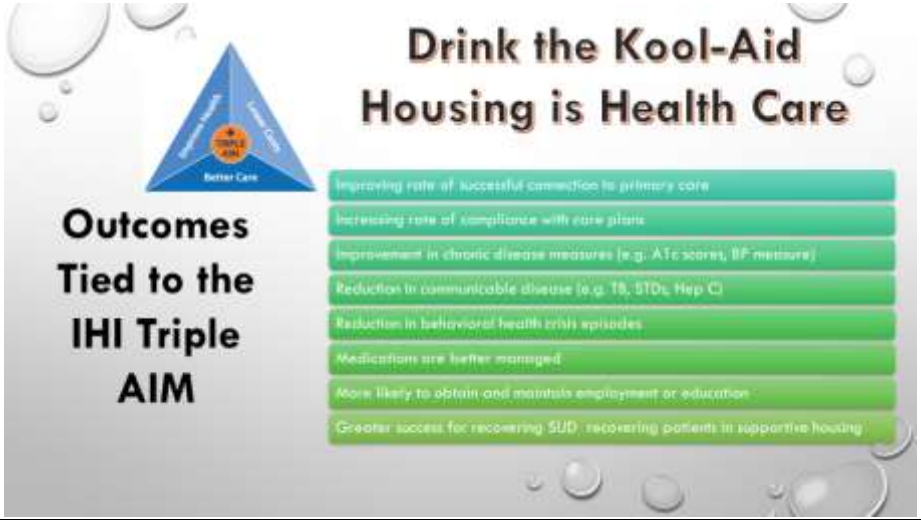
EVIDENCE BASE		
 PCBH	 Collab Care	 BH Homes
ACCESS		
Strong for BH	Somewhat	Strong for PCP
OUTCOMES		
Broad, PCMH efficiency	Targeted/Disease Specific	Physical Health/Mortality
COST SAVINGS		
Indirect/Direct	Direct	Direct/Indirect
PATIENT SATISFACTION		
YES	YES	YES
PROVIDER SATISFACTION		
YES	YES	YES

- Brian made a simple slide (took out the references for ease of use) to show the evidence base for the three models for Access, Outcomes, Cost Savings, Patient Satisfaction and Provider Satisfaction.
    - Access:
        - PCBH: There is a lot of evidence that PCBH will provide better access- they get access right away!
        - Collaborative Care increases access for the target population but not for everyone. For those who fall outside target pop it doesn't help.
        - BH homes provide better access for medical care for those with mental health issues.
    - Outcomes:
        - PCMH can help depression, reduce anxiety, decrease ED utilization. The big thing we're starting to see now is studies that show how PCBH can increase the efficiency of patient-centered medical homes. They can stay on time and see more patients.
- Question for Brian from the Consumer Representative of the GCACH Board: How are you getting the most vulnerable patients to come in?
    - Brian Sandoval: We have outreach people; these are lay folks who go out into the communities. Depends on the clinic and the area. They are working with people who have benefits but who are not engaged. It's a really needed exercise- there are other strategies- community awareness around BH concerns- lots of programs around MH first aid- increase general awareness- how to recognize and engage. We work on the general side and we've done MH first aid side, work on destigmatizing.
- Question: What has your success been?
    - Brian Sandoval: I don't have any data on this. Will be interesting to see what happens at the ACH level.
- Outcomes for Collaborative Care Model: It works really well for some specific diseases. Substance use disorders is a vulnerable population that really needs more wrap-around care.
- Question: Is it true that primary care does more mild-to-moderate patients?
    - Brian Sandoval: That's a misnomer because patients decide where they will get care. Patients we see in primary care should often need more specialized care. So, what do we do about that? We see them every time they come in or see them in between PCP visits. We need to respect that patients will engage where they're more comfortable. Also, E-consultation has been really, really helpful. Sometimes we have patients who speak another language. Let's work with e-consultation. Keep your relationship you have with your PCP. Think about using tech more and delivering care in a patient-centered way. Culturally and relationally for a good fit. Get creative where the patient feels the most comfortable.
- What integration works best?? Depends on what problem you're trying to solve!! Getting to the finish line here is about the problem. For them, the problem was access so they went to PCBH. Lots of folks are without access. How do you get access when there are only 1-2 providers? Answer, you have them serve multiple clinics simultaneously by using tele into another clinic. You can provide on-the-spot-care in 4-5 places.

	• What about combining integration models? This is ok if you're doing it in a way that makes sense. • Quick failure story: we tried to have a Collaborative Care Model for depression and PCBH too. Depression wasn't what we needed to get patients seen for. The model and patients' need wasn't aligned with the collaborative care model we had. Then there are diverse issues but you have a disease-specific model. The way we coordinated that approach didn't work out. Think about how you coordinate the models of care. The approach is more important than the model! • Funding and Sustainability: Right now, we do Fee for service. IMC (integrated managed care) is coming and we're trying to figure out how we're going to integrate this funding. The challenge we're going to have here is the method in which it's paid. Fee for service does not reward good quality clinical care.
Integration of Wraparound Services: Housing (Rhonda Hauff, Yakima Neighborhood Health Services (YNHS))	• Sam Werdel introduced presenter Rhonda Hauff, COO and Deputy CEO of Yakima Neighborhood Health Services. She is Chair of the Respite Care Provider Network for the National Health Care for the Homeless Council. Rhonda is also the GCACH Board President. • Rhonda's presentation was titled, "Yakima Neighborhood Health Services." The YNHS mission is "to provide accessible, affordable, quality health care, provide learning opportunities for students of health professions, end homelessness and improve quality of life in our communities." • We will bring housing to BH primary care. This is really creative. Actually, doing boots on the ground work. We are trying to get to the homeless people by bringing out water, teaching them to cook, etc. • YNHS has 9 sites. In 2018, YNHS as an organization saw about 24,000 primary care patients. We talk about homeless services and homeless patients. The homeless population makes up about 14% of YNHS clients but feels like it's 90% of the organization's time. YNHS provides recuperative care for those not sick enough to be in the hospital. • There are two definitions of *homeless*: 1. HUD does the homeless count annually. They say probably 3 additional homeless persons for everyone you count. 2. The other definition is a year-long count of unduplicated homeless persons. This is between 3,000 and 3,500 according to HHS. Those are people who came into our system last year. • In 2004, when we started the HC for the homeless, we focused on outreach and began by identifying the needs of homeless. They first applied for homeless funding and thought the homeless people would come them for care but they were wrong. Also, they weren't a free clinic. The homeless people went to the ER instead. YNHS developed a team to go to the river and the alleys (and wherever these folks were) and they were successful in bringing folks to care. You need to help these people find a place to live. • In 2006, the Continuum of Care was restructured. (A Continuum of Care (CoC) is a regional or local planning body that coordinates housing and services funding for homeless families and individuals.) 1. One of the shelter and housing organizations dissolved.

2. Another provider no longer wanted to provide housing because it's a money-loser.
3. A need for more medical respite care emerged.

- YNHS has a board member that goes out and asks what they need and "What should we do more of?" Found they need a place to go when they're sick, for people with medically-fragile needs. That got them into housing.
- These are the trending of the point-in-time count. The housed population: these numbers are going DOWN. We've been losing supportive housing options. The number of people in the UNSHELTERED POPULATION is going UP- every county in the state has recording fees, and in the last few years, almost all of dollars have been going towards emergency care. It's the perfect storm.
- There is less capacity for permanent supportive housing.
- In 2007, The Homeless Network developed models for shared standards and named YNHS a promising practice. We master lease housing units from the Yakima Housing Authority. Affordable housing is very hard to access. We rent from the private landlords and we sublease to homeless participants. Do shared learnings around trauma informed care. Try to create a community standard. Do inter-care conferencing for clients and have another group do case management.
- First and foremost, we are a community health center. We do everything with the aim of trying to improve the health of participants. We have a robust street outreach team with a Human Recall System to go find this patient. HEN is for Housing and Essential Needs. YNHS is also a health home provider and provides supportive housing and supportive employment.



	• YNHS' niche is serving the chronically homeless. The HUD definition of someone who is "chronically homeless": someone who has lived on the streets for a year or several times over the last 3 years adding up to a year, and has a disability. • Under Medical Recuperative Respite Care, these folks are in a situation where if they had a home they would recuperate there, but they don't. They have an acute condition that can be improved or stabilized. Patients need to be able to administer their own medications. • 72 Patients stayed 1,418 days last year (an average of 19.7 days per patient). YNHS is very cognizant about taking people in and out of the respite program in a way that doesn't make them ineligible for other help. We've had patients stay from 3-90 days last year. The majority of the people came in from primary care providers and many of them avoided going to the hospital or being readmitted to the hospital. 1. 73% left for permanent housing 2. 6% died 3. 20% returned to homelessness • Takes a lot to get kicked out of the YNHS program. • Our respite program is located a block away from clinic and the two locations work closely together. • It's common to receive support for the idea of building permanent supportive housing until people hear it's going to be built close to them. • There is a need for a permanent year-round shelter. They looked at 3 locations and looked for existing buildings that could be cost-effectively rehabbed. The logical location was a former IGA superstore, Roy's market. Nearby within walking distance you'll find food, health, hygiene and legal services, and right across from the bus line. Began this back in 2013, had many neighborhood hearings. Just last week in March they opened the center! It provides 22 units for 37 individuals, 6 of which are for families and 3 are dedicated for Veterans, a true community project. YNHS was originally in a supportive role but later took on an organizational role. There are 4-5 "pods" which have living unit, shared kitchenettes, shared restroom and shower. Minimum of 2 case managers. Residents managers are there 24/7. Partner organizations can come in. Visitors and service providers can come in and meet with clients. • Overlap between housing and data: 1. Universal Data System- UDS 2. ICD-10 3. HMIS- put the client number into the EMS system to compare to general population. • Increasing access to care in 2018. PSH means permanent supportive housing. PSH is all about case management. Get them in to care when needed and wherever they need to be for a year or year and a half. 1. Need to provide care that meet the person where they are! 2. Rhonda reiterated what Brian Sandoval said about doing what feels comfortable for the person. YHNS uses ALL of the models that Brian described and uses the one that fits the patient the best.

	• In 2018, they saw improvement to primary care medical visits per user. They saw improvement in chronic disease measures for controlled diabetes and hypertension. High rates of administration of the flu vaccine, especially among those in respite care. Saw a reduction in Behavioral Health crises especially among the homeless because of interdisciplinary teams serving high needs families and individuals. • Respite care can save lives and a lot of money, but there are only 6 beds in Yakima. • Story about Million Dollar Murray in 2006: It was costing far more money to provide reactive care than to do case management & provide permanent support housing! • Conclusions: 1. Participants may say *no* today and *yes* tomorrow to receiving care. 2. Trauma informed care and harm reduction works but takes more time! 3. Work vs. disability - sometimes work wins. Some people have been appealing disability for years. Some folks won but said, "No thanks, I like my job I'll keep working." 4. Recovering clients are less likely to relapse when housed 5. Families reunify successfully when housing improves. • Most of the YNHS programs are "housing first" programs.
Pharmacy Integration into PCMH (Veronica Gutierrez and Richard Leigh, Tri-Cities Community Health)	• Richard Leigh and Whitney Garcia from Tri-Cities Community Health (TCCH) gave a presentation called, "Fully Implement and Utilize PCMH." • Defining a primary care practice is as practicing a medical home. There are 6 elements: ○ How do we extend beyond PCP with the team? ○ For disease registration, how do we manage them as a whole? ○ Comprehensive care delivery with necessary preventive care- try to get them well before they get sick. Having extended hours. You also need chronic disease management. As we train and do a practice transformation. Everyone has to understand the point behind it! ○ Everyone wants to feel like they're the center of their provider's world. You need active patient engagement. ○ You need improved patient access. ○ You need cross-continuum care coordination (internal and external). How do we do work flows? It's not just about money but it still earns money. • The Vision statement "TCCH is the clinic of choice for our patients and staff to serve our community." The hope is to get them in. We are there because that's where we want to be- it's patient-centered. • Identification of referrals- try to get patients to come to clinic. • Protocol we use. Refill by the pharmacists in the endocrinology group which takes burden off providers. Keeps prescriptions up to date, make more money, keeps patients compliant.

	• One of the things we've changed is now BH is included in care. It's interesting when someone comes to the pharmacy for diabetes and they've just been diagnosed. This is where BH can be helpful. Depression is a problem and these people don't take meds. When people go from oral to injectable meds, there's a lot of needle fear. Work with them on that. • Under the prenatal care CDTA, if a patient comes who is pregnant, we can provide prenatal vitamins and folic acid with a confirmed positive pregnancy test.

PCMH Certification (Chris DeVillenueve, Catholic Charities)	• Sam Werdel introduced Chris DeVillenueve. GCACH has a toolkit and for partnering providers they are going through milestone toolkit.
	• Chris DeVillenueve, Catholic Charities, gave a presentation, "PCMH Certification through Bi-Directional Integration."
	  o Catholic Charities is doing physical remodeling to change the space for more intentional integration. Everyone comes in through the same point of access, not sent to a different area. Everyone processes through the same way. Intentional to reduce stigma. Actual renovations to the space!
	  o What is PCMH and how is it integrated?
	  ▪ Comprehensive Care:
	  ▪ Patient-Centered:
	  ▪ Coordinated Care:
	  ▪ Accessible Services:
	  ▪ Quality and Safety:
	• At the North Central ACH, we primarily provided crisis services, and as we started to look at this process, we started to look at how we could improve access for patients?
	  o Schizophrenia affects 30% of the CC active patient population. Tells you about the target population for PSA.
	  o Created a patient registry system, maintained in a spreadsheet and with an electronic health record.
	  o Now there's an integrated lab service they brought in.
	• GCACH has been a great partner.
	  o For almost 12 months they worked out a contract for integration services.
	  o Built the clinic. Provided a great way to work together.
	  o Increase the amount of time the providers work together; they increased the lease payment over time proportionately.
	  o Created access to both EHRS, our staff have trained in their system. We do all the scheduling. It's been very helpful. Such a different population with GCACH, including more specialized BH.
	  o Went Mid-Adopter in January 2018 to have time to plan and implement.
	  o Partnered with University of Washington. Patient activation- purchased PAM. Used coaching for activation. It's been very helpful to ID patients.

	• Interesting thing they came across when risk-stratifying and looking at patients with high needs- case managers, primary care, MAs. • One of the biggest challenges was identifying partners with the same VALUES, partners who are not only about generating widgets. The population we're working with is chronically mentally ill, and we're trying to increase the quality of their lives. Strategically looking at hiring to move forward. Went out and looked for staff who are early adopters and hired strategically to meet future goals. • Utilize PDSA cycle to track change and measure progress. How do we improve intake progress? • When we talk about the impact this has on patients, one example is a person who had been in and out of law enforcement contact 14-20 times, but after PCMH services were provided for this person, they were not in contact with law enforcement anymore! • Know your data but also share data that talks about the value of what you're doing! • One takeaway- this is a journey.
Discussion Wrap-Up (Patrick Jones, Sam Werdel)	• Sam Werdel shared that her biggest takeaway from these presentations was about access to care and this work is about boots on the ground. • There was a Q&A with the audience: o Q: For folks who presented, what have been the opportunities that ACH has presented in supporting those who are exemplars? If you're out in front, how are you leveraging ACH to move forward? ▪ Response (from an audience member): Strategic goals are already set, you create systems for appointments, these are all things to expand access. The ACH provided that external structure and you report out when that's done and what progress you're making. ▪ Rhonda Hauff (Board President, Guest Speaker): The timing has been really helpful for YHNS. Looking at 2017 standard, they've had some robust conversations on what to work on next. The topic of empanelment stirs the most robust discussion- we're about access and continuity. What's the biggest priority? The timing that the ACH has brought to us has been very helpful to us. ▪ Comment: The journey at Lourdes has been a little different. The focus has been on bi-directional integration. We've been really grateful to GCACH because of Rhonda and the staff. They've been wonderful and we've had many visits and calls not just about bi-directional integration, but also about integrating primary care- meeting the patient where they're most comfortable. The primary care clinic at Comprehensive. It is easy to read and get the concepts. How do you really do warm handoffs? Kudos to YNHS. ▪ Sandra Suarez (Board Member): Where the GCACH comes in to play is having the right people on board and having fewer misses on the registry we are working on. GCACH helps to shore up the

	quality strategic plan. This will tie into all the things we want to do, which is better quality care at the heart of it. ▪ Carol Moser (Executive Director): GCACH tries to be flexible with the funding; if you have the population health management tools you need, then your organization can the funding for something else. ▪ Comment: That story is very important and it's great that the cross-collaboration is happening. We can share it more broadly. ○ Comment: Earlier when Brian was talking about bi-directional integration, Wes asked a question about mild-to-moderately ill patients in primary care. One of the things they've found at Lourdes is that by far the majority they're seeing are moderate BH conditions but there are some people who are quite severely ill. One guy who was very delusional in particular, wouldn't typically fit into the model. The doctor saw him for 5-6 visits just to engage him. They could have continued to see him in the primary care setting. I want to break the myth that the only people you're seeing is people who aren't that sick. ○ Comment: Patient motivation and engagement trumps everything. ○ Ronni Batchelor (Board Member): At her new position with Lourdes it takes her back out on the street or to peoples' homes. Most of the people she sees are the extreme ones who won't trust anyone, who won't see the doctors, she has to gain their trust and covet this position to see the vulnerable at their most vulnerable. Yesterday she was with a woman who has been extremely delusional and thinks people live in her attic. Ronni tries to see her as her. Ronni has been working with this woman to get her to primary care and it took almost a month to get to keep the appointment and try to get her in there, finally did that yesterday. Next step is to see a psychiatrist that she hasn't seen for a year. Biggest thing is trust! We won't take away what they have as theirs. See who they need to see at the right time and support them through it. Appreciate GCACH for pulling all of us together to help with those processes. • Wes Luckey: For next month, we'll have another Learning Collaborative with a focus on EMS and their role in community paramedicine. We believe this is an important part of the community of care.
ADJOURNMENT & MEETING SCHEDULE	
Adjournment	• Minutes taken by Aisling G. Fernandez

Thank you for your time and engagement with Greater Columbia Accountable Community of Health!

Next Leadership Council Meeting/Practice Transformation Learning Collaborative:
Thursday, April 18th
9:00 to 11:00 a.m.
United Way of Benton & Franklin Counties
401 N Young St, Kennewick, WA 99336

The following 2019 Leadership Council Meetings will be held from 9 a.m. to 11:30 a.m.
at Columbia Basin College, Classroom L102 (2600 N 20th Ave, Pasco, WA 99301) on the following dates:

(PLEASE SEE DETAILS FOR APRIL ABOVE) Thursday, May 16th

(NO JUNE LEADERSHIP COUNCIL MEETING) Thursday, July 18th

Thursday, August 15th Thursday, September 19th Thursday, October 17th

Thursday, November 21st (NO DECEMBER LEADERSHIP COUNCIL MEETING)