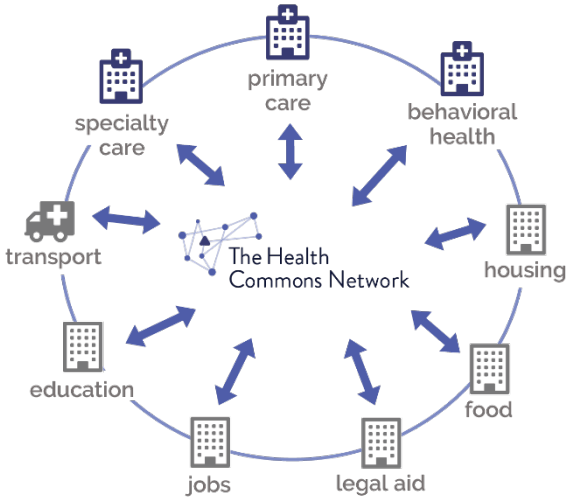
Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

Leadership Council Meeting Minutes
September 20, 2018 | 9:00 am – 11:30 am
Columbia Basin College (CBC), Library 102 (L102), 2600 N 20th Ave, Pasco, WA 99301

ATTENDANCE	
Participants (* denotes they called in, † denotes a Board member):	Rhonda Hauff, Jac Davies, Ronni Batchelor, Michelle Crowley, Dr. Kevin Martin, Miguel Messina, Dan Ferguson, Ben Shearer, Caitlin Safford, Julie Grove, Hailey Middleton, Corrie Blythe, Nicole Austin, Susan Campbell, Jean Murrow, David Paulson, Dave Wilson, Michele Crowley, Carlie Prock, Larry Jecha, Kay Olson, Chuck Eaton, Diane Campos, Lisa Heffner, Loanne Ayers, Cheri Snowwhite, Lara Simon, Rob Arnold, Adam Davis, Kat Latet, Sandra Suarez, Sandy Quiroga, Angelina Thomas, Dr. Amy Persons, Elya Prystowsky*, Kirk Williamson*, Jorge Arturo Rivera*, Alia Brosowski*
Staff/Contractors:	Carol Moser, Wes Luckey, Becky Kolln, Diane Halo, Jenna Shelton, Martin Sanchez, Rubén Peralta, Lauren Johnson, Patrick Jones, Sam Werdel*
Special Thanks:	Thank you, Columbia Basin College, for use of the facility. Thank you, CG Public House & Catering, for catering.
MINUTES & REPORTS	

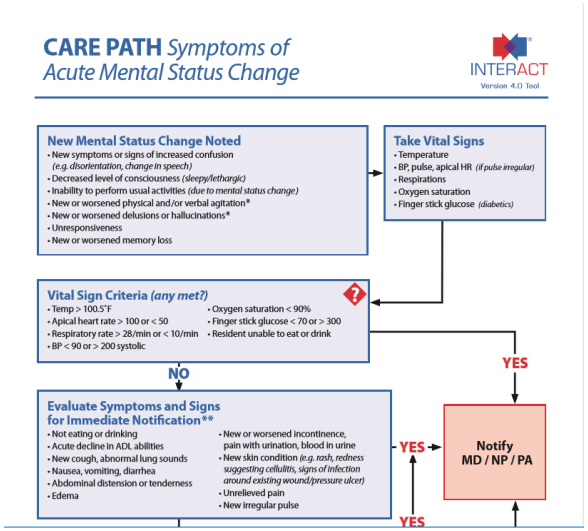
Welcome & Introductions	• Welcome & Introductions: Patrick Jones, Ph.D. Executive Director of the Institute for Public Policy & Economic Analysis at Eastern Washington University, facilitated the meeting. He welcomed participants to the meeting. Participants around the room introduced themselves by name and organization.
	• GCACH Staff reviewed the GCACH Report:
	  ○ GCACH's Practice Transformation Navigators (PTNs) gave the group an update on the month of August. The PTNs have been traveling all over the Greater Columbia region to conduct Kick-Off meetings, complete MeHAF and Billing/IT Toolkit Self Assessments, follow up meetings and more.
	  ○ Becky gave an update on the WAFE Portal to the group. To date, GCACH has released a total of $335,000 in payments through the portal.

	○ Rubén gave an update on the Wes and Rubén Road Show. Both Rubén and Wes have been traveling to all the Local Health Improvement Networks (LHINs) to present the conclusions of the Current State Assessment (CSA) and reasons why PCMH is the right change management tool. ○ Diane gave an update on the Behavioral Health IMC Update. To date, we have met with 15 of the 17 Behavioral Health Providers. ○ Carol gave an update on workforce and Patient Centered Medical Homes (PCMHs). Carol's article discusses how the PCMH model is the perfect fit for our four project areas, target population, strategic issues, and provides a good foundation for providers to be successful in a value-based payment (VBP) system. • Click here for the September 2018 Director's Report
Introduction to HealthCommonsProject.org	• Rob Arnold is the CEO of Quad Aim Partners and founding member of HealthCommonsProject.org. Rob is also a Digital Transformation Advisor at UW, OHSU and Fred Hutch. • Elya Prystowsky is the Executive Director at Olympic Community of Health (OCH). OCH is currently focusing on access, aging, Behavioral Health, Chronic Disease and early childhood. • Dr. Kevin Martin, MD, Kittitas Valley Healthcare (KVH), has been involved in medical directorship, leadership, and a wide range of quality improvement initiatives starting with the first Washington State Diabetes Breakthrough Collaborative in 1999. • Adam Davis is a Doctorally-prepared Family and Psychiatric Nurse Practitioner. He leads a Mobile Integrated Health program at Puget Sound Fire, called FDCARES, and is a member of HealthCommonsProject.org. • Rob Arnold, Elya Prystowsky, Kevin Martin and Adam Davis' Presentation was titled "Introduction to HealthCommonsProejct.org." • The Health Commons Network (Commons) is a digital communication system that connects health and social service agencies in a community. Where agencies in a Natural Community of Care are connected to the commons: ○ Providers can share the information needed to coordinate and track care as an integrated team ○ Organizations can disseminate strategies, workflows, and best practices that can improve health and well-being. 

	• It is difficult to learn about who individuals are when you only have a short amount of time. With the Health Commons Network, information is available on patients to properly diagnose.
	• With the Health Commons Network, patients can be tracked. For example, did the patient make an appointment? Did the patient go to their appointment? Did the patient show up to their counseling appointment?
	• The Commons operates like a public utility. Partnering organizations in a Natural Community of Care develop a financial model to sustain the Commons. Each organization that connects to the Commons uses their voice to drive the system improvements.
	  ○ When you join the Health Commons Project, you are assigned a Commons Project Team. The team works with your organization at the "grassroots" level to create and sustain a Natural Community of Care.
	• Dr. Kevin Martin discussed Kittitas' need for flow of information. Through the beginning stages of the Health Commons Project, Kittitas found that there were people that the police and fire department were interacting with, that the hospitals were not seeing. Through the project, Kittitas has had a chance to learn more about patients and find specialized ways to help them, avoiding emergency services such as the fire department and police departments.
	• Rob and Adam discussed the need for organization in the flow of information. HealthCommonsProject.org is a technological platform that connects health and social service providers together to improve patient/client care transitions into one e-referral network.
	• Elya shared her organization's work (OCH) with the Health Commons Project. OCH began working with Rob to allow information to flow from primary care providers to a substance use provider. They began a pilot project in Clallum County and has worked on creating forms and communications that benefit both the SUD and Primary Care Provider.
	• Adam shared his organization's work with the Health Commons Project over the past 5 years. His program is called FDCARES, and focuses on high risk, high utilizing populations. Through his work, Adam and his team learned that there are many community members working to provide care for individuals, but they are not communicating. They are working on building relationships between hospice, housing, behavioral health providers, fire departments and police.
	  ○ Dr. Kevin Martin asked, "You have three hospitals over in your region, a couple of different fire agencies, and layers of social service agencies, how many of those people aren't at the table yet and how are you going to get them there?
	  ○ Adam's answer "We have built the system over time to address the individuals in need, what they haven't done is considered how to build a sustainable and connected system. This is the challenge. King County ACH has the challenge of getting everyone together. What they've done is look at the

	community and the people in process who they can work with. They are working on bringing others to the table." ○ Jenna Shelton asked, "How do you picture the digital aspect of the Health Commons Project incorporating into this for community paramedicine? ○ Adam's answer "It is not enough to just deliver the service, we need a technology service. The project provides an opportunity for coordinated care with potential for reimbursement." ○ Wes stated that the Pathways Hub model is a very robust model, it is evidence-based, offers formalized trainings, comprehensive, yet expensive. Research found the model to be inflexible. Through the Health Commons Project, organizations will bring stakeholders together to do a gap analysis, understand where patients are falling through the cracks, then create workflows to improve those areas. • Click here for Introduction to HealthCommonsProject.org Presentation.
Transitional Care Project Update and Discussion	• Dr. Kevin Martin presented "Transitional Care Project Update and Discussion." • The presentation included a review of the Transitional Care Project on the GCACH level. The needs that the community identified are the needs that we are trying to address in this project area, which includes food insecurity, mental health for the Medicaid population and the insured young. Dr. Martin stated, "mental health issues don't go away as you get older, so there's a tremendous unmet need." • The problem: modern health care is siloed, and safe transitions require that information move from an active care delivery team to a prepared receptive team. • Project 2C Description: This project will improve support for at-risk enrollees at care transitions by strengthening and broadening existing person/family-centered interdisciplinary/interagency (ID/IA) collaborative initiatives across the region and implementing proven tools to support management of acute changes in condition without transport to hospital. These include person/family-centered assessment and service (e.g. ConsistentCare), collaborative community paramedicine efforts, and the INTERACT tool sets.

- Evidence-based interventions called out by HCA: INTERACT, Transitional Care Model (TCM), Critical Time Intervention Model (CTI), CTIMH.
- Evidence-based interventions not called out by HCA for care transitions: Hospice referral/Honoring Choices, RAP, Community-based paramedicine, local network hybrids.
- The INTERACT tool was implemented in 19 Pierce County skilled nursing facilities (SNFs) using a collaborative learning model in 2011, resulting in reduction of 30-day readmission rate from 16% to 11%.
    - The INTERACT tool empowers staff to assess the change in the patient and intervene early.
    - Tool types: quality improvement, communication, decision support tools (guiding history, guiding assessment), and advance care planning tools (patient education tools, CPR training, feeding tube training).



- Transitional Care Model (TCM) emphasizes on nursing-led teams, with care coordinated and delivered by a master's level advanced practice RN.
    - Components include: fostering collaboration, screening, staffing, maintaining relationships, engaging patients and caregivers, assessing/managing risks and symptoms, educating/promoting self-management, collaborating and promoting continuity.
    - Training is seminar and consultant-based.
- Click here for the Transitional Care Project Update and Discussion Presentation.

ADJOURNMENT

Meeting was adjourned at 11:30 a.m. Minutes taken by Lauren Johnson.

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

- Thursday, October 18, 2018
- Thursday, November 15, 2018
- NO DECEMBER MEETING