Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

Leadership Council
Meeting Minutes

August 16, 2018 | 9:00 a.m. – 11:30 a.m.
Columbia Basin College, L102 | 2600 N 20th Ave, Pasco, WA 99301

ATTENDANCE	
Participants (* called in, † GCACH Board member):	Susan Sisson, Dr. Amy Person, Sean Domagalski, Chas Hornbaker, Kirk Williamson, Nicole Austin, Fenice Fregoso, Shelly Little, Aida Juarez, Lisa Gonzalez, Angelina Thomas, Miguel Mesina, Joe Vela, Bertha Lopez, Tim Anderson, Becky Grohs, Kat Latet, Brisa Guajardo, Bill Dunwoody, Jac Davies, Barbara Mead, Dulcye Field, Hayley Middleton, Samantha Frederick, Dana Quentin, Jorge Rivera, Ronni Batchelor†, Chuck Eaton, Stein Karspeck, Michele Carly, Diane Campos, Jocelyn Pedrosa, Michelle Sullivan, Marcy Durbin, Sandy Quiroga, Lisa Hefner, Rhonda Hauff†, Lindsay Engh, Martin Valadez (former Board President), Jean Murrow, Susan Campbell, Dr. Don Ashley, Sandra Sanchez†, Liz Whitaker*, Dr. Kevin Martin*, Reese*, Corrie Blythe*, Meghan DeBolt†*, Mike Hindmarsh (guest speaker), Mandee Olsen
Staff/Contractors (* called in):	Carol Moser, Wes Luckey, Becky Kolln, Aisling Fernandez, Rubén Peralta, Lauren Johnson, Sam Werdel, Diane Halo, Jenna Shelton, Martin Sánchez, Patrick Jones
THE MEETING	
Welcome & Introductions (Patrick Jones):	• Dr. Patrick Jones facilitated the meeting and asked for self-introductions and a status on the air quality in the participants' home towns. Most agreed that the air quality was unhealthy due to the various fires across the region and surrounding states.
GCACH Report (GCACH Staff):	• Staff gave the GCACH Report: o Greater Columbia announced the 23 organizations that were selected (and approved by the Board in July) for the first cohort of provider partners for practice transformation. The first cohort are the lead actors and there many supporting roles for organizations in practice transformation as well. o Meetings with the Yakama Nation: ▪ Recently, there have been many meetings in Toppenish with the Yakama Nation providing support for collaboration between Astria hospital and the Nations' program areas.

	▪ There is a new Detox Center at Astria hospital with 15 beds. They are working to better address urgent needs and support for support services, like transportation. o Outreach to the behavioral health (BH) agencies: ▪ GCACH staff is traveling constantly to work closely with the BH agencies by aligning goals, and supporting the agencies in completing their deliverables toward integrated managed care (IMC). Schedules are already booked for the remainder of August and September. o Washington Financial Executor (WAFE) Portal Updates: GCACH has been processing payments bi-weekly using the WAFE portal to partnering providers for completing specific tasks. o Integrated Managed Care (IMC) Updates: ▪ GCACH is working with 17 BH Providers (have been to 14 clinics) to complete the Maine Health Access Foundation (MeHAF) and Billing/IT Toolkit Assessments. The Practice Transformation team will meet with the remainder of the BH providers this month. ▪ Once the contracts are signed, the providers will receive funding from IMC dollars. ▪ Three simultaneous workgroups that are working toward IMC: The Provider Readiness Workgroup, The Integrated Managed Care (IMC) Communications Workgroup, and The Early Warning System (EWS) Workgroup ▪ GCACH chose to be a mid-adopter for Behavioral Health Integration, which means there will be funding for the providers to prepare for implementation by January 1st, 2019. ▪ The Health Care Authority (HCA) made a decision that Greater Columbia ACH would have 4 Managed Care Organizations (MCOs) going forward, no longer receiving services from United HealthCare (UHC). o The very first GCACH Car provides cost-effective access to a vehicle for staff members.
Presentation: "2018 Current State Assessment Summary Highlights & Number-Needed to Treat Review" (Wes Luckey)	• Greater Columbia staff completed the first Semi-Annual Report (SAR) in July. The SAR covers ACH activities from January 1, 2018 to June 30, 2018. The primary component of the SAR is the analysis of the ACH's Current State Assessment (CSA). 1. The highlights of the 2018 CSA included: ▪ The CSA was conducted in May of potential partnering provider organizations. ▪ 73% response rate (58 organizations responded) from the 78 organizations that the CSA was sent to (those that previously submitted LOIs) ▪ The main purpose of the CSA is to identify gaps, barriers and assets in existing services. ▪ Four broad conclusions from the Practice Transformation Workgroup that analyzed the CSAs: 1. Need clinical care management to prevent vulnerable patients from falling through the cracks. The high-needs, high-risk population is between 10,000 and 15,000 which fall in the top 5%. These comprise a broad spectrum of demographics, socioeconomic status, and types of needs. May need support from a nurse care manager, a community health worker, maybe mobile services. What are the sustainable models? What are the roles of the MCOs?

2. Need formalized collaborations to support Practice Transformation and the Patient-Centered Medical Home (PCMH). Health IT is essential. For example, Ellensburg has already had success with Digital Health Commons.
3. Need healthcare workforce capabilities that supports PCMH, which includes training for team-based care and workers practicing at the top of their licenses. Create career pathways linked to teaching institutions for long-term solutions. Short-term opportunities include training for opioids and transitional care and the INTERACT and BOOST tools to help with readmissions.
4. PCMH is the right strategy to achieve the triple aim and to be successful under the Transformation Project. GCACH has a lofty goal to achieve successful implementation of PCMH across 95% from partnering provider organizations. A more comprehensive and coordinated approach to change management within the primary care practice is foundational to the success of the Demonstration. PCMH can be linked to enhanced Medicaid reimbursement and is needed for success in the Value Based Purchasing (VBP) marketplace. The NY Demonstration showed that practices with change management were six times more likely to achieve outcome measures! GCACH has received a lot of positive feedback that people are welcoming this model and what we're trying to achieve.

- There was a Q&A about Wes' presentation:
  1. Comment: Many other types of health workers can help with care coordination, not just nurses. Need to help with the social determinants of health.
  2. Have there been any formal assessments of the partners with the PCMH models? There are different views of this model. There are some challenges. Any feedback?
     - GCACH Staff:
       - We have been working with Behavioral Health providers and when we explain what transitional care is, then they're interested. There's a need for more education about this opportunity.
       - This is not a model, GCACH staff is working with each group independently and then developing a plan together with their staff.
       - Part of the work of the staff has been to get together people from YVFWC, CHCW and others who can speak to PCMH. We will have a business model that is proactive and will likely achieve the Triple Aim long after GCACH. GCACH is the only ACH using the PCMH model of care as is foundation for transformation. Other ACHs are using change plans, but we think this is a more strategic and sustainable model.
  3. There is some concern about burnout for providers who are implementing PCMH and these people need support.

Presentation: The Chronic Care Model and the Patient-Centered Medical Home: Complimentary Strategies for Transforming Care (Mike Hindmarsh, Hindsight Healthcare Strategies):	• Mike Hindmarsh, Founder of Hindsight Healthcare Strategies, presented on the Chronic Care Model and the Patient-Centered Medical Home (PCMH) strategies. • Hindsight Healthcare Strategies, based in Toronto, is an established healthcare improvement consulting firm that offers strategic planning, project direction, and technical assistance for implementing chronic disease management programs in primary specialty and ancillary care settings. Mike and colleagues created the Chronic Care Model (CCM), a system redesign strategy to improve the care for chronically ill patients. For the last 25 years, Mike has directed and advised over 200 clinical improvement efforts for implementing the Chronic Care Model and the Patient-Centered Medical Home in the United States, Canada and other countries. • PRESENTATION: 1. Brief History of CCM and its Contributions to PCMH ▪ Patients and families in America are increasingly recognizing the defects in their care for chronic disease. We have to catch up with them and give them the care they expect. ▪ The CCM and the PCMH are complimentary strategies for transforming care. ▪ In the new systems, care is done proactively rather and patients are registered in a medical home. Evidence-based care is used as well as Quality Improvement (QI) and measuring performance over time. You need an interdisciplinary team where everyone is working at the top of their license. ▪ FQHCs and CHCs adopted CCM and developed learning collaboratives. ▪ Plan, Do, Study, Act (PDSA) is the best method to experiment with change on a small scale. ▪ To become proactive, you have to stop being reactive. Visits are planned and prepared for. There is a clear process to help patients self-manage. ▪ What do teams struggle with the most? It's self-management support. In the 90s, they used the 5 A's, which was very theoretical. You need a quicker model. Since then the Brief Action Planning was developed, which can be developed in 2-3 minutes. Not only do you get medical support but you also get behavioral support in a short visit. ▪ Clinical information systems- one of the barriers is people not being payed to do population management to plan care and to know your patient's care (individually and as a group). ▪ One of the biggest changes since CCM and systems change in the 90s is that at that time they thought that *enhanced access* was outside their scope of work, but they realize now that it's not, especially with payment reform. 2. The transformative work entailed in implementing the CCM ▪ Empanelment is one of the major differences between CCM and PCMH. ▪ Use organized, evidence-based care and be prepared. PCMH is about reducing inefficiencies and errors. The LEAN movement was an important addition to reducing duplication or unnecessary work. ▪ Patients that see the same provider and same provider team have better outcomes.

- Distributing tasks across team members is important. When you get people at the top of their licenses, there's more joy in their work. The quadruple aim includes provider satisfaction, which wasn't addressed in the 90s.
- Risk-stratification is an important concept to PCMH.
- The role of leadership is critical. The front-line team has to have time to get together each month to do this work and often they come up with creative solutions that work for them that will be different for teams working in different regions. There will be incredible diversity across and within regions of patients.

3. Resources that can help support PCMH
   - Early evidence for PCMH in AHRQ Report 2012. Teams did well making improvements with specific aspects of PCMH. Very few teams created an actual PCMH that is accredited or beyond, but use those groups as models.
   - Update from NCQA- possibly biased
   - Patient Centered Medical Home Resource Center (pcmh.arhq.gov)
   - Improvingprimarycare.org- has excellent assessments
   - QHmedicalhome.org- one of the higher functioning QI orgs in WA State.

- Q&A Session for Mike's Presentation:
  1. The last three slides (PCMH Resource Center, Improvingprimarycare.org, and QHmedicalhome.org) are the training curriculum for the GCACH practice transformation navigators
  2. Regarding the informed and activated patient's role in meeting improved outcomes, what are the best practices for patient engagement?
     - MIKE: In the 90s, one of the mistakes was just to put patients through goal setting, but the real issue is confidence. Patients with higher levels of confidence had more success. If you help them choose a goal, keep it small and doable. Once they've succeeded with that goal, it will help them build confidence. Some patients will not be willing to do any self-management and will wait until they have something acute until they're ready to act.
  3. Are you aware of any research being done on illness cognition and success in the chronic care model (CCM)?
     - MIKE: I don't know and he's not sure if it relate to CCM.
  4. On the medical home model, there appears to be a catchment group, and the intention is to expand the catchment group. There is no language about how the medical home reconfigures to catch those clients we seem to be missing over and over. How do we bring those people into the medical home?
     - MIKE: One of the most important interventions for the high-utilizers is to follow up with them after a hospitalization, helping them to understand a discharge plan and what needs to be changed. That's where he sees a lot of traction being made.
  5. Do any of the Chronic Care Models look at prevention or population health rather than just treatment?

	▪ MIKE: The Federally Qualified Health Centers (FQHCs) stopped calling it the Chronic Care Model (CCM) because they were doing a lot of preventive care like screenings with the model too. When looking at subpopulations within a panel, the concepts are very applicable. 6. Is there a way to go further? To address the barriers that prevent people from being healthy? ▪ MIKE: We urge the teams to do that kind of work but they don't get paid to do it. 7. Whose responsibility is a patient? The Primary Care Provider (PCP) will say a patient hasn't come in to get established. I hope to see that the clinics think innovatively to get the financial push to do outreach and be responsible for those who are hard to reach but are the top 5-10% heavy utilizers. ▪ MIKE: There was a lot of effort to do outreach, but the mobility of those patients is an issue and the continuity of care is very hard. Financial incentives do make a difference. FQHCs are reimbursed to reach out to those patients and bring them in and sometimes once they bring them in to get primary care, they can keep them there by helping them see the benefits of receiving care.
Presentation: Chronic Disease Prevention and Control: Partnering with Physicians to Improve Population Health (Bertha Lopez)	• Bertha Lopez, Senior Director for Community Health Planning and Development at Virginia Mason Memorial Hospital, has been a long-time dedicated member of the GCACH Leadership Council and a leader for the Chronic Care Priority Workgroup. She is responsible for the leadership and operations of multiple departments, programs and assessments for Virginia Mason including the Community Health Department, Diabetes Education, Pediatric Therapy Services, Maternal Health Services, Environmental Sustainability, Health Equity, Community Benefit and Needs Assessment. She serves on the UW Latino Center for Health Research Board and Healthier Washington's Communities and Equity Accelerator Committee. • PRESENTATION: 1. Project Toolkit Evidence-Based Approach: The project objective is to integrate health system and community approaches to improve chronic disease management and control. 2. The Community Guide is a resource center to help you select evidence-based interventions to improve health and prevent disease. It is a collection of all the evidence-based findings and recommendations of the Community Preventive Services Task Force. 3. Stanford Chronic Disease Self-Management Program (CDSMP): a self-management education workshop for people with a variety of chronic health conditions. The workshops are 2.5 hours per week for 6 weeks and include problem-solving, decision-making, addressing the physical and psychological effects of chronic disease, also education about exercise, nutrition and using medication. There is strong evidence from peer-reviewed publications and program evaluations for health benefits (decreased pain and health distress, increased energy, increased physical activity, decreased depression, increased confidence in managing chronic disease, better communication with physician). Provides social support so people keep coming. 4. National Diabetes Prevention Program (DPP): DPP is an adult intervention program for patients who are at-risk or are pre-diabetic with A1C<=6.5. A 12 month program, taught at clinics and community centers in

	English and in Spanish, baseline data is collected at week 1. 10% of participants have been able to stop taking a medication since taking these classes! Some participants have achieved diabetes remission. Physicians see the value in the program for their patients. 5. The downside of these programs is that we're barely scratching the surface of the barriers. There are a lot of disparities. There should be some energy put into assessing why participants of diverse groups are not participating in these programs. We have not yet addressed the disparity gaps that translate into disparities in health outcomes. • Q&A for Bertha's Presentation: 1. Is the CDSMP program in Spanish? ▪ BERTHA: It was successful in the Hispanic population, however there is a greater drop-out rate with Hispanic groups, perhaps due to social determinants. 2. The barrier might not be the language but the message, perhaps overwhelming people with a scary message. We don't want to scare people into going into the program. ▪ BERTHA: All of the evidence-based programs were designed with the message in mind. The curriculum is very complete in Spanish and something different than the curriculum in English, if anything, more complete. These messages have been vetted with other community groups. You build a relationship with your patients too. 3. One of the things that is really important is community health workers. Patients come from referrals from providers but other patients come from family history. You need a provider champion/ lifestyle coach like the registered dietician at TCCH. TCCH is focusing on Franklin County. The CHWs know the community and maintain trust. Those people who are success stories become advocates, they go out to support others in preventing or delaying the onset of diabetes. The next step is negotiating with insurance companies to offset the costs of these courses- it will be cheaper to provide the courses than to treat diabetes. 4. BERTHA: we want to reach people younger than Medicare age. It would be advantageous to not subsidize this program given that the volumes of Medicaid community members is higher than Medicare Part B clients. We see 500 participants a year but only 50 from Medicaid Part B. 5. How do we get people who have completed a chronic disease self-management class to become a care coordinator? ▪ BERTHA: We hope that the PCMH and Chronic Care strategies can help with this.
ADJOURNMENT	
Adjournment	• Meeting adjourned at 11:33 a.m. • Minutes taken by Aisling G. Fernandez.
Thank you for your time and engagement with the Greater Columbia Accountable Community of Health! Upcoming Leadership Council meetings: • Thursday, September 20, 2018 • Thursday, October 18, 2018	

- Thursday, November 15, 2018
- NO DECEMBER MEETING