Leadership Council

Thursday, June 22nd, 2017
9 a.m. to 11:50 a.m.
Regular meeting
Columbia Basin College (CBC)
2600 N 20th Ave., Pasco, WA 99301
Classroom L102

Minutes

ATTENDANCE	
Participants:	In Person: Karen Richardson, Karen Jones, Gwen Cop, Doug Logan, Joyce Newsom, Ed Thornbrugh, Lindsay Boswell, Sandra Aguilar, Lana Stuart Eskeli, Heidi Desmarais, Cathy Homkey, Nicola Pinson, Madelyn Carlson, Don Ashley, Michele Roth, Lara Sim, Shane McGuire, Darin Neven, Everett Maroon, Jocelyn Pedrosa, Chuck Eaton, Michelle Gardner, Cindy Carrol, Kevin Martin, Barbara Mead, Kim Keltch, Brady Woodbury, Larry Jecha, Grant Baynes, Debbie Dumont, Cendra Clarke, Amanda Hinrichs, Lauren Spilles, Bob Howard, Jennifer Domagaski, John Raymond, John Christenson, Sarah Bollig Dorn, Shelly Ray, Larry Thompson, Britt Redick, Kathy Story, Siobhan Brown, Paul Dillon, Stan Ledington, Susan Bassham, Mandee Olsen, Carmen Boswell, Tim Anderson, Lisa Campbell John, Amy Taylor, Sandra Suarez, Meghan Debolt, Bill Dunwoody, Mandy McCollum, Karla Greene, Michelle Sullivan, Lisa Hefner, Jim Jackson, Rick Helms, Shannon Jones, Jac Davies, Dana Harris, Andy Nyberg, Andrea Tull Davis, Caitlin Safford, Les Stahlnecker, Elissa Southward, Miguel Messina, Martha Lanman, Merle Jackson, Tracie Hoppis, Susan Campbell, Jodi Ferguson, Bertha Lopez, Carla Prock, Dan Ferguson, Lilian Bran, Liz Whitaker, Kirk Williamson (99 people counted in attendance) On the Phone: Approximately 20 callers
Backbone:	Carol Moser, Aisling Fernandez, Wes Luckey, William Van Noy
Special Thanks:	Thank you, Columbia Basin College (CBC), for today's facility and outstanding Information Services support. Thank you, UnitedHealthcare, for sponsoring the refreshments. Thank you, CG Catering, for providing the refreshments. Thank you, Jac Davies, for facilitating today's Leadership Council meeting. Thank you, Susan Campbell and Kirk Williamson, for volunteering during the setup of the meeting.
MINUTES & REPORTS	

Greater Columbia Accountable Community of Health

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Welcome & Introductions:	Carol welcomed everyone and thanked everyone for attending. There were no self-introductions because we had a record number of people in attendance!
Program Manager's Presentation:	PLEASE CLICK HERE TO DOWNLOAD WES' PRESENTATION • Wes Luckey, the GCACH Program Manager, gave a PowerPoint presentation called "Project Team Repots Introduction". o Wes talked about the Collective Impact Model and about some of GCACH's biggest milestones (e.g. becoming a certified 501(c)(3), developing the Regional Health Improvement Plan (RHIP), becoming a certified Accountable Community of Health (ACH), and the completion of Readmission Avoidance Pilot project.) The RHIP is still in draft form. o Wes talked about the five primary objectives of the Medicaid Transformation Project Toolkit: ▪ To improve population health ▪ To reduce avoidable use of intensive services and settings ▪ To accelerate the transition to Value-Based Payment (VBP) ▪ To ensure that the Medicaid cost growth is 2% below national trends ▪ To provide flexibility to fund traditional and non-traditional services for targeted populations o From August 2015 to April 2017, we had 5 Priority Work Groups that guided the work of the organization and the development of the Regional Health Plan. The RHIP Committee (or "SIC" Committee), comprised in part of members from the five Priority Work Groups, guided the development of the RHIP. Starting at the Leadership Council Meeting in April 2017, those workgroups transformed into 8 Project Teams that are based on the 8 project categories of the WA State Medicaid Demonstration. ▪ Wes walked through the roles of the Project Teams and named the Project Facilitators who have been very dedicated and hard-working contributors to GCACH. ▪ Wes reviewed the Project Selection Process that all 8 Project Teams will go through until there is a focused and comprehensive Demonstration Workplan for GCACH that will be submitted to the Health Care Authority (HCA). The three main steps are 1. Review community needs 2. Review list of potential projects and 3. Narrow list against principles o *Working together, we are greater than the sum of our individual parts*. o Wes reviewed the timeline for developing the Demonstration Workplan between June and November 2017.

	○ The next steps for Project Teams: ▪ Project Team facilitators to meet with HMA consultants ▪ Refine the decision-making process to select Project Approaches and Project Partners ▪ GCACH outreach campaign
Jac:	• Jac introduced herself, each speaker will talk for 10 minutes, 3-minute opportunity for questions. Jac asked that the questions are clarifying questions and will do more discussion after all the presentations. Write down thoughts as they strike you. Everything in writing will go into the process.
PT Presentations (Facilitators):	CLICK HERE TO DOWNLOAD THE PRESENTATIONS FOR ALL PROJECT TEAMS **2A: Bi-Directional Integration of Care & Primary Care Transformation** **Presenter: Brian Sandoval** • SLIDE 3-5: ○ Overarching goals: increase access to BH services, improve coordination and community resources. ○ Must build clinical care infrastructure and establish robust reporting structure before we can actually pay for performance. Need to understand gaps, infrastructure & reporting first. Perform gap analysis, integrate, use consultants, work toward milestones. All counties and Medicaid individuals. ○ The WHY: from a health equity standpoint, they have disproportionate amount of MH SUD and Socioeconomic status, many individuals who fall within this category. ▪ 1. Increase access. ▪ 2. Increase coordination. ▪ 3. Building infrastructure- most important 3 things. ○ SPMI diagnoses will come out. a lot more at stake for those with MH and SUD. ○ Build out infrastructure. How do we do this? Bi-directional integration is a huge piece to bite off, the largest portion of funding. When we think about doing this, there needs to be engagement. Think about this from a holistic view. Work with Qualis to get feedback- MeHAF- ties into Bree Collaborative. From access to reporting. PCMHA focused on larger aspects of HC delivery. ○ Phase 2 which is a qualitative data gathering process. Then focus on having discussions around where the gaps are. In order to build synergy, we need to understand what the left and right hand are doing (what all the systems are doing). How do we get everyone around the table? How do we work together

toward common goals at the county and regional level? (Some of the more rural communities may be combined in the process—not sure yet). Then establish a road map. Coordinated rollout of milestones. Important- measure progress while we're doing this. BUILD/MEASURE/LEARN-

- Eric Ries- LEAN startup. The *Build-Measure-Learn* philosophy is important and emphasizes measuring as you go. From implementation and reporting standpoint. As we go, engaging Qualis to help with needs around workforce development, and some clinics who may be helping too. Really important to look at how we're going to aggregate the data. How we adapt to that. Meet the coaching needs and workforce development needs as they arise. Inform the process.
- Ed- comment: only thing considering is review of lessons learned of integration of SUD and MH recently which can help us in the future.
- Heidi- try to limit area-specific acronyms.
  - SUD= substance use disorder.
- Rhonda- only thing she'd add. An evaluation of social determinants of health.

- Find out what is already being collected and from there what is useful for our communities.
- quantitative, qualitative, gaps, road map, workforce development needs according to roadmap.

2B: Community-Based Care Coordination
Presenter: Jorge

- SLIDE 7-9:
  - Recognized Susan Campbell, Shawnie Haas, Corrie Blythe, Carmen Bowser – from the very beginning. A little bit unique- initially was mandated and then went back to being optional. Only one model as an option. We are going to be implementing the prescribed pathways HUB. It's a combination of pathways to healthcare & ___. Members will be assessed. These members will be connected through a centralized HUB. Incent members through standardized pathways. Clinical services and connect through support of CHWs. Standard tools for assessment and pathways are standard. One central HUB. Idea is to glue everything together. The scope is to gradually implement this across all the communities. This will be a gradual implementation. Will target many at-risk population- question about which populations will depend on risk of populations, idea to help as many populations as possible. Probably start with one or two.
  - Examples: high utilizers of ED. Utilizers with more moderate risk. High risk with BH and CD. Maternal & Child population with specific risks. A lot of need for looking at pediatric populations.

Populations impacted by chronic disease. Big decision- same population across the whole region or focus on different populations in different parts of the region.

- Workforce: will rely on CHWs – will provide culturally competent services.
- For implementation- follow HCA recommendation to plan, implement, scale and sustain. Need to determine who the HUB entity will be, need to determine payment model, both clinical and social services, initial priority pops, connect with other Project Teams. There are 8 Project Teams, most of those teams and most of them will utilize a level of CC, then develop a project plan. SCALE & SUSTAIN- how to provide long-term funding. Need to determine long-term funding for social services. Need to discuss interoperability for clinical providers who will be concerned about another layer of work.
- Dr. Ashley- wondering about use of PRISM. Works will population about 4,000. Many of these children already have services. Those with low PRISM score- had Medicaid, one of the better Medicaid plans, but not utilizing it. Many already served somewhere else and many of them with better plans not using them. Concern about PRISM score as the only proxy.
- Ed- clarification- PRISM was primarily for high-needs patients for ED use but not the standard way to assess needs.
- Audience Question: what are the plans for creating integrated systems?
  - Jorge-Very complicated. Systems must have a certain amount of automation. Could be buried by amount of manual work.
- Jorge- just developing this technology. Don't want to fix the system by creating more work for small organizations.
- Jac- already seeing commonalities. IT and data sharing will be common pain points.

2C: Transitional Care (IDIALST)
Presenter: Dr. Kevin Martin

- SLIDE 11-13:
  - Call out Mandy McCollum for her work, pushed the group through many conference calls per week. High risk events because they get siloed. Everything must be interdisciplinary. IOM called out ___. Readmission usually starts in the ER. Transitions to different settings. People come back because they don't get the right services when they go to where they were going and were discharged too early. SNIF numbers typically nationally you see 30% readmission to skilled nursing facility. Reduced number to

10%, big change. How will it address health equity? Those with greatest need will have SDs needs. The metrics we'll focus on are 30-day all cause readmission and _____. Diff workforce needs. We'll need more nurses, more paramedics, more CHWs to augment what we already have. There are some resources we can draw on, Yakima, WSU nursing, etc. but we still need more. Consistent care has laid a foundation. Implement INTERACT toolset across the region.

- PAIN POINTS: need to acknowledge
  - Different attitudes between those who live in a populous setting vs those who choose to live miles from neighbors. Perception that they don't want a solution from the outside. Those tightknit communities have partnerships which is great. Health Homes touch 3500 lives. Community paramedicine has helped 50 lives. If it's perceived that this is a program, could lose funding. Because funding linked to HCA may be perceived as a negative. There's a learning curve. Looking at broadening use of Health Homes. BOOST tool may be a better tool. Will need to address that.
- Audience Question: point of clarification about barriers and about developing a program vs. providing service?
  - Dr. martin- to what extent do people perceive this as being community-based. From the community vs from GCACH and we just drove from Pasco and we're here to help. It's going to be difficult to maintain a community feel with such a large area!
- Caitlin- 3500 lives.
  - Dr. Martin- that's engaged not enrolled.
- Joyce- can he explain PRISM score?
  - How much Medicaid resources. It's cost-based, historical and reactive.
- Shawnie- can you summarize RAP project.

2D: Diversion Interventions
Presenter: Stein Karspeck

- SLIDE 15-17:
  - Three different initiatives to share today. The biggest gap they saw in the system was that referrals weren't happening. Involved with super-users- the hard cases. Expand the scope of that into different populations and create a safety net for much larger group of people in need.

- 2nd initiative- education and public service announcements for TV- PSA "ER is for emergencies." Low-acuity transports kept going up- not sustainable. Not a good use with a mobile ICU. Two –year planning process worked with fire depts., hospitals, etc. could offer that they'll go in a cab to urgent care. Patient can be transported to urgent care, take them to pharmacy, take them back home, saves a lot of money. Three groups by need. They will be managed by consistent care, also build up agency and staffing. Put into long-term/short-term management program depending on needs of patient and actively manage them. Health equity- outreach by CHWs. Workforce- need more RN case manager and CHWs. Using community paramedicine and integrate telemedicine with that. Also need more workforce and infrastructure to build up Ride to Care across GCACH. Differences in resources across GCACH- how do we make this work across different parts of GCACH? Requires active participation of hospitals to keep patients out of their facility who don't need to be there. Consistent care has a footprint in 5 counties. Build community paramedicine across whole GCACH- don't currently have capacity.
  - Dr. martin- Prosser and Ellensburg also have paramedicine programs
  - Les- works well in urban areas.
  - Karla Greene- excited to work in rural areas. If there are EMTs, you can scale them up. She would like to see- maybe you can staff a paramedic now because you have some money. Les- there are other locations such as schools outside medical system. Stein- big opportunity to grow staff.
- Clarify what hot spotter program- based on people with a large interaction with ER, justice system and with jails. Monthly meeting with them – work with courts, jail, police- more criminally and legally involved. Try to get therapeutic sentencing. That's how they define hot spotters.

3A: Addressing the Opioid Use Public Health Crisis
Presenter: Becky Grohs

- SLIDE 19-21:
  - Shout out to Everett, Mike Norton, Chuck Eaton, Liz Whitaker. Culmination of everyone's work. Project area that is mandatory. Every day work with folks and providers who are in the middle of this opioid misuse. Really quick to jump to idea of hub. Really felt that everyone was trying to address this through silos. Folks with opioid misuse to be helped in a centralized way. OCRC- title of project- OPIOID CRISIS RESPONSE COLLABORATIVE. Might be politically opposed but best way to save lives.

- MAT providers- those are physicians (and soon mid-levels) who can provide substantive therapy- not ready for treatment. Harm reduction is the goal- to save lives. It's a bridge to recovery. In some regions, we are more prepared for that. Distribute naloxone of those who continue to use. Referrals to hub through ER, through Primary care providers, pain management specialists, law enforcement, EMS, any concerned citizen. Try to get patients moving toward recovery and remove barriers such as getting people to naloxone apt. going out and doing outreach. Bring them into protective recovery. Go toward saving lives not necessarily push toward recovery. For those who have OD'd, when people get to ED, work with people at the time of the ED. Right now, will focus on adults. Most of the patients will likely be Medicaid but won't exclude anybody. Already working on roles, scopes and responsibilities for the HUB. Need consistent expectations across region. Planning on identifying interest by partner agency. May not just have one hub, may have several hubs, but way for everyone to communicate. Outreach by CHWs will address health inequities, workforce will utilize staff that's already out working with these populations. Case management hub, may have to do a rotating, traveling hub for more rural areas. HIPAA will be a challenge working with these populations. How to sustain this long-term, a common challenge. Lots of motivational interviewing, recovery coaches. Just the distance will be a challenge across the larger area. Do this in staged phases.
  - Caitlin- hub and spoke model. Did anyone apply from east side. No one eastern Washington. Everett- was hard to reach n of 200 qualifying patients for eastern Washington.
  - Dan Ferguson- hearing a lot of reliance on CHWs across all project teams. Will you take CHWs and train them to your specific projects. Becky said she finds the right person and then put them through CHW training. Becky said- would love to do a mass training of CHWs for all Project Teams.
  - Bertha- didn't hear much about prevention? Becky- this is about individuals. There are many other programs that are focusing on upstream around the state.
- Jac- CHWs is another common theme between Project Teams.

3B: Reproductive and Maternal/Child Health
Presenter: Stan Ledington

- SLIDE 23-25:
  - MCH- this group conceived a few weeks ago. Goal is to improve pregnancy and birth outcomes and improve health of children and their development. Access to resources for families and be stronger

advocates for their children's health. Two home visiting programs- NFP & PAT. NFP is a nurse-run program gets involved with moms up to age 2. Other program is PAT model which uses associate-trained (or higher) folks who go out to visit families from pregnancy to age 5. The target pop is mothers and children through the age of 3. The at-risk pop is where parents are referred… poverty, history of birth challenges, living with some SDs, or traumatic situations. Both programs focus around disparities around culture and language. This can serve the GCACH region. Already active in 3 places in our region… NFP in Yakima and in BF. PAT active in Yakima and Walla Walla. Health equity- serves low-income- potentially available for urban and rural. Ethnic minorities. Teenage moms and moms at risk for poor health outcomes. Workforce- NFP needs RNs. PAT has an extensive training program to bring people on board. Haven't worked through details of scaling up, but it can be scaled up. Areas can choose which of the models will be most effective. Difficulty recruiting culturally-competent and huge area… reaching those areas. One piece that hasn't been incorporated yet, but will be – LARC- reduce teenage and high-risk pregnancies.
    - Les- focused on programs with a HC bend to them. There are other programs with early learning that interact with high- risk pops and have home visits. Models are fantastic but also look at other systems to coordinate with them and not duplicate.
- Jac- we're doing great on time.

3C: Access to Oral Health Services
Presenter: Mark Koday

- SLIDE 27-29:
    - To best understand oral health project, give a primer. Right now, it's dentist-driven, regulated within walls of dental clinic, isolated from other medicine, uses a surgical model. Have firmly believed if you improve access you improve outcomes. We've improved children's Medicaid access to 68% which is the highest in state and one of the highest in the country. Costs a lot of money just for under 5 population, this is unsustainable. Helped a lot of kids. But when you look at caries experience rates, it's increased last 15-20 years. When you look at pop, it's a failed system. Hygienists in the community and medical clinics- also doing case management must be explored to turn the current situation around. Dental disease is the only type of chronic disease that doesn't have case management. CHWs are well connected with medical offices- train existing CHWs to work with hygienist. Hygienists will do the main case management and will connect with CHWs to better connect with medical and other services.

Reduce caries rates for low-income children and across GCACH increase access for adults which is abysmal (the number of adults getting in for care). biggest needs for kids and adults is in SE WA. Look at Yakima county. 32% are not getting in and likely those are the high-risk kids. Look at transportation as a huge barrier. Language and cultural barriers. Make access easier by integrating care. kids are coming into medical. Get the care to where the people are. Workforce- won't be easy- need expand hygienists in the community. Not just train CHWs, but also train physicians, everybody in oral health, then the whole process lifts up. Will take time to build workforce. Other big part is we want to PROVE this is a good idea- develop a sophisticated data system, then spread across state and maybe across country. Changing the dental paradigm is very hard. Low reimbursement rates for adult dental. Developing a data collection process. Lack of medical-dental integration.

- Wes- have you explored the idea of expanding the scope of practice of hygienists- state law. Dr. Koday said that we need data to prove that. In Oregon, hygienists can place temporary fillings and place silver diamine fluoride (SDF) that arrests decay. In WA, hygienists can just place SDF.
- Michelle Roth- is it part of the plan where very few dental take Medicaid. Is there a way to increase the dentist is accepting Medicaid? Dr. Koday said that this is a financial problem.
- Dr. Koday said- we're changing the paradigm- there's a move to better connect to medical offices. Hygienists can't do any more under this model than they are currently doing without a change in the state law. What this program does is encourage expansion of what they are doing, coordinate what they are doing, connect more with medical and place them in areas where they are not currently at.

3D: Chronic Disease Prevention & Control
Presenter: Bertha Lopez

- SLIDE 31-33:
  - Start by thanking wonderful team. Approach is regional chronic disease prevention project. Really focuses on multi-collaboration and partnership. If we target diabetes, we'll also affect other chronic diseases. Three-pronged approach: 5210 Campaign, diabetes prevention program, and chronic disease self-management program. One primary, one secondary and one tertiary prevention program. Diabetes prevention program was developed by the CDC, for those with pre-diabetes or those with a history of diabetes are eligible. Chronic disease self- management program- manage their disease through exercise and nutrition. Want to reach every county. Focus on Medicaid children and adult population. These programs are effective in rural communities. The one in Yakima has been active for over 10 years.

	Reaches low-income families, works in urban areas, helps Native American families. All programs available in Spanish and English, focus on disparities. There have been disparities with reaching male population. How do we embed within medical practice to reach males? Haven't assessed ripple effect of having women in the class and how that effects their families. Take programs to communities. We're at community centers, at churches, offering programs where people live and already go. Workforce: need a lead program/project manager to navigate through 9 counties, and other titles. Most of these programs are standardized and require collection of data- need a data specialist. Needs CHWs and marking/media specialists. One of the hardest parts will be scaling some of the counties that don't have the infrastructure yet to reach out and get lay leaders and trainers for some of these programs. 5210 has not been implemented in our region, but has been implemented in other WA counties and we'll take some of those learnings, echoing that in the classes. Depending on each part of the region, tailor each intervention. Rural communities with Spanish speaking populations. Some of our rural areas have small populations and EBPs recommend that the number of people attend each class, if there are smaller counties, maybe provide remote learning. The outreach/intervention piece of health screenings and doing diff areas around SDs- food insecurity- very important. Pain points- shortage of CHWs, need to train the trainers, how do we deploy education? It is important to build trust and relationships within each county. Partnerships are important! How do we build trust within communities with historical trauma? Embed EBPs into primary care. electronic medical records. Pretty intensive and need support to collect pre- and post- intervention data to report outcomes. ○ Carla- is there room for DSMP and Manejo? Bertha said they talk about both. Carla recommends the data point we need to keep in mind.	
Break:	• 5-minute break	
Adjournment:	Meeting was adjourned at 11:50 a.m. Minutes taken by Aisling.	
	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: • July 20th • August 17th • September 21st	

	• October 19th • November 16th • December 21st	