Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

Leadership Council & Practice Transformation Learning Collaborative

Minutes

April 18, 2019 | 9:00 a.m. – 11:30 a.m.

ATTENDANCE	
Participants (*: called in, †: GCACH Board Member)	Hayley Middleton, Sierra Foster, Jenny Krueger, Susan Campbell, Donna Albaitero, Joel Chavez, Kendra Palomarez, Dr. Antonio Gonzalez, Barbara Mead, Dana Oatis†, Kevin Taylor, Jocelyn Pedrosa, Michelle Sullivan, Lisa Hefner, Diane Campos, John Christianson, Christina Rodriguez, Cheri Snowhite, Eric Nilson† (Guest Speaker), Stein Karspeck, Ben Shearer, Becky Grohs, Sandra Suarez†, Morgan Linder, Tracy Ribbing, Cameryn Flynn (Guest Speaker), Tyler Platt (Guest Speaker), Karla Greene (Guest Speaker), Michele Crowley, Bill Whealan (Guest Speaker), Paul Carlyle (Guest Speaker), Mandee Olsen, Bertha Lopez, Ronni Batchelor†, Sara Clark, Penny Bell, Jane Simpson, Bill Dunwoody, Raquel Moore, Kristi Thien, Ed Dunker, James Hempsted, Angie Pitman*, Judy Miller*, Danny Smith*, Joyce Newsom*, Everett Maroon*, Chris DeVilleneuve*, Adam Davis* (Guest Speaker), Devon Brown*, Marissa Ingalls*, Marcia Baden*, Ally _____*, Kelly Sanders*, Theresa Kwate, T. Jay Osborne*, Kim Nygreen*, Keith Monosky*, Siobhan Brown*, Meghan DeBolt*, Ryan Lantz*, Katie Zoerb*, Dr. Kevin Martin*, Carrie Barr, Deborah Watson, Minnie Smith, Jean Murrow
Staff (*: called in)	Carol Moser, Wes Luckey, Becky Kolln, Sam Werdel, Rubén Peralta, Rachael Guess, Diane Halo, Martin Sanchez, Lauren Johnson, Aisling Fernandez
MEETING PRESENTATIONS & REPORTS	
Welcome & Introductions (Sam Werdel, GCACH)	• GCACH Executive Director Carol Moser welcomed everyone. She gave a big thank you to Gesa Credit Union for the food and refreshments for the meeting/learning collaborative. ○ This Learning Collaborative focused on EMS (Emergency Medical Services) which are really critical to filling in gaps in medical care. GCACH received letters of interest from 11 EMS agencies. Thank you Stein Karspeck for your efforts. Not sure if legislation is being funded around this. EMS as a first responder visits patients sometimes many times before. Might be getting calls from different fire districts. Trying to accommodate

	that. GCACH is working to find ways so EMS groups can communicate together and explore technology. It's a costly endeavor to respond multiple times to a patient. • Sam Werdel shared a history of the Fire-Based EMS system, which started with the Federal EMS Act of 1973 for the delivery of health care. It became a principle duty of the fire department. Today, the community-based fire station, with its ready availability of personnel 24 hours a day, coupled with the unique nature of medicine outside of the hospital, creates a symbiotic blend of the traditional public concepts and duties of the fire service with the potential for the most rapid delivery of advanced prehospital 9-1-1 emergency response and care. EMTs learn the essential skills. EMTs learn the essential skills to help in life-threatening situations and their education is the foundation for all other levels of provider. As one EMS instructor recently put it, "You can't learn and be good at advanced skills without having a solid foundation of basic skills." Many paramedics, doctors, nurses, and firefighters have used their EMT education and work experience as a stepping stone to their new career. • Both EMTs and paramedics have the knowledge and skills to transport patients and provide them with emergency care. The biggest difference between them is the amount of education they receive and what they are allowed to do for patients (scope of practice). • Community Paramedicine (also called Mobile Integrated Healthcare) is taking EMS by storm. The concept of community paramedicine, also called mobile integrated healthcare, is taking EMS by storm. Numerous articles have been published and considerable discussion has occurred regarding community paramedicine at many EMS conferences. But what is it and why is it occurring? o Some thought it was a strategy to **decrease EMS utilization by targeting frequent users**. o Other programs worked with local hospitals in an effort to **decrease readmission of high-risk patients** such as those with congestive heart failure, chronic obstructive pulmonary disease and similar maladies. o There have been other iterations of community paramedicine that have **included primary care, home healthcare and other nontraditional EMS roles.** o Despite this, the **definition of community paramedicine remains nebulous**. The concept of using paramedics in a nontraditional primary care role is not new. • Please review the April GCACH Report on your own! • There were introductions around the room and on the phone.
GCACH Emergency Department Utilization (Wes Luckey, GCACH)	• Wes Luckey gave a presentation titled, "GCACH Emergency Department Utilization Review." o The data for the presentation was sourced from the Washington DSHS Services and Enterprise Support Administration's Research and Data Analysis (RDA) Division and the Washington Health Care Authority's Analytics, Research, and Measurement (ARM) Division. o "All Cause Emergency Department Visits per 1000 Member Months"
Today's Challenge in an Ever-Challenging EMS Environment-	• Sam Werdel introduced Eric Nilson. • Eric Nilson is the EMS Officer for the Kennewick Fire Department, where he has served the community since January 1995, starting as a firefighter and progressing through the ranks to fire captain; to his current position overseeing the

Funding (Eric Nilson, Kennewick Fire Department)	all EMS operations. Eric is also a member of the GCACH Board, serving as the representative for the Public Safety sector.
	• Eric's Presentation was titled, "Today's Challenge in an Ever-Changing EMS Environment… Funding."
	  ○ Eric appreciated Sam's introduction and history about EMS, especially the history from the 60s and 70s. When the highways where built across the country, the birth of EMS was related to all of the highway auto collisions. At that time, hospitals paid, but also the funeral homes! In the 70s, the funding for EMS began at the federal level, and over time, the funding went down and down, becoming more and more local.
	  ○ The Fire Service is there to pick up where the rest of the services leave off, and they are happy to serve the community however they can.
	  ○ Right now, they feel like an island of services. It would be much better to have an island that is connected to other islands and the mainland! This is the vision, to have a network that is integrated, especially around information.
	  ○ He quoted Robert T. Kiyoski, "Doing more with less is a crucial principle to learn; especially if you're going to be in a business in this rapidly changing world."
	  ▪ What about the over-utilization of EMS? Even if it just the costs of diesel and manpower it costs money.
	  ▪ Eric provided a quick global view of how EMS is funding, which is not the entire fire department budget. The 2-year budget is $26.6 million (so $13.3 million for 1 year).
	  ▪ The Cost of Service studies show that in Kennewick, just one ambulance ride costs $2,083, including all immediate and long-term costs for the operation.
	  ▪ Medicaid:
	  • Max reimbursement to EMS from Medicaid is $115 plus $5.08/mile.
	  • Between 30% and 40% of the patients are Medicaid in a month.
	  • In other words, Medicare and Medicaid do not cover the costs of the EMS services.
	  • Medicare can cover some non-transport services.
	  • Some of the most expensive calls are Medicare and Medicaid.
	  ▪ GEMT reimbursement was approximately $1,160/transport in 2018.
	  ▪ Current funding systems incentivizes transport to the ED. EMS agencies cannot charge for non-transport services and cannot itemize billing like EDs and physicians can. EMSs agencies receive a flat rate based on the primary diagnosis code. If you have a cardiac arrest event and you don't have a heartbeat, you don't transport that person. That means there's no reimbursement (in most cases) even if they put a lot of resources into that patient. This is not a complaint; this is the state of today's Healthcare industry.
	  ▪ Some relief is in sight:

	• Ground Emergency Medical Transport (known as GEMT) is helping a lot, which is new to EMS, but has been around in Healthcare for 25 years. GEMT provides some relief for up to 50% of the cost of services. Provides some funding for the traditional 911 services. • The Treat-and-Refer idea. There is legislation that has been passed. EMS goes out, treats a person appropriately, is able to bill them, and then refer them to a less expensive option or place like primary care or urgent care. • Thinking about the psyche of a paramedic or EMT: if they don't transport a person to the ED, using their best judgement, and that person dies, it will change how paramedic or EMT thinks and will want to transport people in the future, even if it costs money that can't be covered. It is hard if they were the last person who was called for help. ▪ Funding Healthcare Services. • Eric said THANK YOU to GCACH for seeing early on that EMS was an important part of this conversation. • The three legs of the stool to fund healthcare services: 1. Traditional funding mechanisms (GEMT is helping here). 2. Financial partnerships with stakeholders (this will help everyone by being able to share information across organization). Alliance Consistent Care is a good example. 3. Reducing costs by reducing inefficiencies: there are many initiatives going on like mobile community health (community paramedicine).
Introducing FDCARES and the Health Commons Project (Adam Davis, Puget Sound Fire)	• Sam introduced Adam Davis, a doctor ally-prepared Family and Psychiatric Nurse Practitioner. He leads a Community Paramedicine program at Puget Sound Fire, called the Fire Department Community Assistance Referral Education Services (FDCARES), and is the Community Health Advisor for the Health Commons Project. • Adam's presentation was titled, "Introducing FDCARES and the Health Commons Project," and he gave the presentation remotely via phone. • Adam said that was a privilege to speak to this group and he was excited to hear the quality of the conversation. He said he wanted to amplify what Eric Nilson just presented on. Community Paramedicine and the community health transformation is the ultimate team sport. It's about breaking down silos and building partnerships. Can't succeed at taking care of people with complex needs alone and to move the needle. • The focus of the presentation was on care in South King County through 2 innovations. 1. FDCARES and 2 The Health Commons Project (a non-profit organization to do whole-person care). These two innovations are related. • There are many types of community paramedicine. Similar to the transformation when they went from fire to EMS 40 years ago. Fire departments recognize there's a new need in the community. 1. FDCARES: • Here is the definition of FDCARES from the Puget Sound Fire website: "The Fire Department Community Assistance, Referrals and Education Services program (referred to as FD CARES), is

a fire agency-based community injury and illness prevention program. FD CARES has been developed so that fire departments may assist community members with issues before an issue becomes an emergency. The program works to improve the quality of health throughout our community and provide for a longer healthier independent lifestyle."

- FDCARES is one flavor of community medicine and they are working out how to meet this community need. It is designed to connect community members to whole person care with mobile care units.
    - We operate mobile care teams that:
        - Respond to low-acuity 911 callers and connects them to right care services
        - Identify / outreach / engage individuals with complex needs, make whole-person assessments, connect / coordinate whole-person care services
- Adam gave an example of a woman named Betsy Jones. Puget Sound Fire personnel found a woman who could not take care of herself in her home. They connected her to the right care in the community and then to access "death with dignity" 3 months after contact with her.
- Believe that community paramedicine is an essential service. The funding source is tied to the community for the fire department. They don't operate in the fee for service system so have the time and space for whole person assessment work, they are mobile, out in the homes of individuals, and they have a diff lens than those who are in the clinical setting. They can be the eyes and ears of those in clinical providers.
- We have a growing problem. 5% of the community members are consuming 50% of the healthcare resources.
- How does FDCARES work?
    - North Star vision for how 911 medical services should be organized in the community. Primary mobile response teams operate a truck (a Chevy Silverado rather than a big fire truck) and respond to 911 calls. Can be deployed through other response teams. When a care unit gets dispatched (when they arrive on scene) they do an initial assessment and make sure they have low-acuity needs. CARE71 and CARE72 teams.
    - Then there's a group of social workers. Care71 and care72 teams will hand care off to social workers who can get more to the root causes. We employ one social worker and partner with the REACH to subcontract to have two other social workers on our tea. The REACH focuses on homeless or those who are unstably housed. Get people into supported care.
    - The north star for FDCARES is step 30 and we're on step 5 or 6. Asking the care team to be provider heroes and the amount of care coordination they need to do.

2. The Health Commons Project (HCP) is a collaboration between communities, health and social services orgs, and technology. Dr. Martin is one of the leads to get this going. Those over in Olympic

	Community of Health and providers in South King County. The Health Commons Project is to set up deliver and sustain personalized, whole person care services. Create a kind of community health system with the right digital tools and right processes to work together. The need for the Health Commons Project came from need for people with complex needs, caregiver and provider heroes, and community leaders who want help for delivering whole-person care.
	• 80% of the work is helping to align people, processes, incentives, etc. How do you integrate this into primary care?
	• 20% is identifying, installing, managing. Not creating new tools, but identifying needs, shopping for best in class tools.
	• How do communities benefit from HCP? What are the goals?
	  ○ One goal is to identify the people who are using the most expensive services in the community. The cost of 3 days in the hospital = 3 months in the jail = 1 year of affordable housing!
	• Why join the Health Commons Project? One of the benefits has been the shared learning and shared IT costs.
	• The Health Commons Project is well aligned with what's going on at the national level. There's ET3 grant. Recently North Carolina got a grant to pilot this; they are actually paying to excavate a home full of mold for people with asthma, for example.
	• There are a lot of insights to be gained from the home environment and also to connect with a person's family and see what level of social support this individual has. They have seen how they take medications, is there food, are there unkept conditions? There's a layer of understanding that comes from the home assessment that relates to social determinants and behavioral health.
	• Wes said that there's a new Health Commons Project in Kittitas. We hope to have a health commons network.
	• Dr. Taylor asked: Are there any comments about the financial sustainability of this long-term of community paramedicine?
	  ○ Adam replied: This is set up for sustainability because the fire service knows this is the next core service they want to provide. There are two ways of delivering value from the fire service to community: 1. Providing a better-quality service to high needs people that would ultimately be using more expensive care services. Anecdotal data that 911 call volume didn't increase the last few months and can't yet confirm that's because of the FDCARES program. 2. Looking for sustainable revenues outside fire service. Talked about the ET3 innovation. Also, the treat and refer, treat and release payments.

Fire Department Community	• SAM introduced Chief Bill Whealan and Captain Paul Carlyle.

Assistance Referral and Education Services (FDCARES) Bill Whealan & Paul Carlyle, Benton County Fire District)	• Chief Whealan was born and raised in Las Vegas, Nevada. He joined Las Vegas Fire & Rescue in 1982 as a young twenty-year-old Firefighter, and proudly promoted his way up the ranks to Paramedic, Engineer, Captain, and Battalion Chief. He retired from the Las Vegas Fire Department in 2010 to accept the position of Deputy Fire Chief in Hemet, California. While in Hemet, he also filled the position of Interim Fire Chief. Bill and his family relocated to West Richland in 2011 to accept the position of Fire Chief for Benton County Fire Protection District #4 (BCFD4). Chief Whealan is enjoying his seven plus years in the Tri-Cities area of Washington State. He is committed to serving the residents and visitors of the community and is passionate about being the Fire Chief and the challenges that the position brings. He appreciates the support of his Commissioners and residents and is excited about the potential growth and development of the fire district and community. Chief Whealan is honored to have dedicated 37 years thus far to the fire service field and is enthusiastically embracing the ever-changing needs of his chosen career path, the fire department. • Captain Carlyle was born in Tacoma and moved to the Tri-Cities as a child. Captain Carlyle started as a volunteer firefighter and progressively moved up to become a Volunteer Lieutenant. In 2006, Captain Carlyle was offered a full-time career position with BCFD4. In 2007, Captain Carlyle became a Lieutenant with the Department. In 2013, Captain Carlyle was promoted to a Captain. He is also the BCFD4 EMS Officer. His passion for Emergency Services has brought BCFD4 tremendous knowledge. In his off time, he enjoys boating, motorcycling and spending time with family and friends. • Chief Whealan and Captain Carlyle co-presented, “Presentation Title: “Fire Department Community Assistance Referral and Education Services (FDCARES)” o Chief Bill Whealan: Riding the coattails of Adam Davis and the work at Puget Sound, they gave us the idea to implement this in Benton County District 4. Chief Whealan said he remembers his first year where he responded to the same person 4 times in ONE day! There’s a saying, “You call, we haul, that’s all.” Now we’ll take him to an alcohol rehab center. He felt early on like “we’ve got to do something differently.” There’s a saying about fire departments, “200 years of tradition, unimpeded by change.” He started researching different models and found FDCARES and felt this had the best opportunity for success in this community. He’s really proud to be a part of this. He recently learned recently about the Health Commons and he believes that’s the next evolution what we’re doing. We can make a difference working together. We have volunteers that help rescue the cost for our organization and they can do a lot with a small organization. He respects Eric Nilson very much. Captain Carlyle really makes the magic happen. o First Define the Problems: ▪ “Every sector of the HC industry is remaking itself in response to healthcare reform and to economic and market forces that are demanding better value.” Fawn Lopez. ▪ When Chief Whealan left Vegas in 2010, most of the calls were EMS but they didn’t do community paramedicine. ▪ There has been a 17% increase in call volumes recently! They hope to offset this a bit. Captain Carlyle does the magic and talks with the public.

	▪ They have an obligation to respond if it's a 911 call. ▪ They go do the detective work and reach out to people here; work on building contacts here. ○ How do we transform our services? ▪ Need to stop you call, we haul, that's all. Nurses keep saying why are you bringing people here? ▪ On May 15, 2013, the governor signed FD CARES legislation (RCW 35.21.930) to partner with other organizations so they can do this legally. ▪ We can save the hospitals money. We have the highest emergency room visits and work together and not stay in silos. ○ Community Paramedicine Set Up Process • Assess the scope of the problem in your community with the FD CARES Database. • Benton County has the database part of the FD CARES program. Trying to get better and bigger at this. • Co-design the service model with fire department partners and community partners. • People will call the EMS not 911. • Benton County launched a community paramedicine service • Install IT tools, reporting metrics, and continuously improve the service to meet the needs of the community • Health Commons will take it to the next level where there won't be 5-6 databases to look at ○ Captain Carlyle presented next: • The Fire department is good at collecting data but not that great at looking at the info they have. • Benton County Fire relaunched the records management system. • Phase 1: FDCARES Databases- clean data, finds mistakes, put it all in one space and fix it up. • Categories 1-9 (1 is low hanging fruit where you can make a quick impact) • How many repeat patients do we think we have? They thought about 6. Later identified that there were 25 from the data! Quickly realized they had a bigger issue than what they realized. Different work shifts play a role in this. • We've had some big successes with this. One patient was on track to activate 911 about 100 times, and they lowered that a little bit. They did an at-home visit, found the root causes and got them help-finding the right people who can build a wheelchair ramp and fix a medication issue (there were conflicting prescriptions from two different providers.) Had volunteer nurses and a PA, called them up to review the case, worked with the two doctors. ○ Question and Answer with the audience: • Q: What happens when you get a call from 911? • Captain Carlyle: Right now, it's more retroactive. They either refer the patient to EMS or after so many activations. There are 3 diff shifts and a whole diff crew set, so sometimes they don't

	ID them (the frequent users) until after so many activations for a person. Not as advanced as Puget Sound, but crews are doing a great job. Gotten really good in the last year. • Chief Whealan: Puget Sound is a lot like this region, it's the same size. We need to work together to see the same success ratios as they do, where they reduced this lady from 100 to 75 visits. Partner with EMS; we'll go with you on some of those calls. • Q: What about the utilization of health care workers and mental health peer counselors. Could that be the invention of a new direction? • Chief Whealer: We want to get there but haven't made it yet. • Captain Carlyle: We would really like to refer the home visits to community and social organizations. We're a huge referral source and the individual doesn't know about the resources and care they need. • Q: What about community block grants and partnerships? • Chief Whealer: They're a stand-alone entity so they can't do a lot of the grants- they're not eligible. • Q: What about doing partnerships with orgs that are eligible? • Chief Whealan: They're doing something and in a different way for their community.
Prosser Community Paramedicine Program (Tyler Platt & Karla Greene, Prosser Memorial Health (PMH))	• Sam Werdel introduced Carla Greene and Tyler Platt from Prosser Memorial Health (PMH) • Karla Greene's nursing career spans over 20 years since graduating from Washington State University (WSU). Karla has spent the majority of her career in the emergency department where she is double board certified in emergency nursing and pediatric emergency nursing. Her current role at Prosser Memorial Health (PMH) is diverse and for the last 5 years has included beside nursing as well as the opportunity to work as their community paramedic program coordinator. During her time at PMH, Karla has enjoyed watching their paramedics grow into their roles and take ownership of the program. She also enjoys watching community paramedicine take hold in health care and the benefits of these programs be recognized. Throughout Karla's career, she has also had the pleasure of teaching first year nursing students at Heritage University. • Tyler Platt has been working in the Fire and EMS industry for 11 years. Currently, Tyler is the Director of EMS for Prosser Memorial Health (PMH), of which provides 9-1-1 response and community paramedicine to western Benton County and parts of the lower Yakima Valley. Tyler is a paramedic by trade, although he also volunteers as a firefighter at Benton County Fire Protection District 2. Tyler attributes his fascination of medicine to his continuous drive in the industry and is eager to continue working towards his master's degree as a Physician Assistant. Tyler gathers the majority of his experience from various fire departments in Western Washington. Tyler moved to Benton City four years ago, although he feels as if he's home. He enjoys meeting new people and treating patients. • They co-presented, "Prosser Community Paramedicine Program" • Tyler Platt: He's fairly new to PMH and has been in Prosser for 3.5 years. They have a pretty huge area to cover. He introduced Karla Greene: She is the expert in the community paramedicine area.

	• Karla: We are not a fire department, we're part of a hospital. It started with a CMMS grant which was tax based. We work from Sunnyside to Benton City to Patterson- have a lot of clinics and the hospital. PMH began the Community Paramedicine program in 2012.
	  ○ She's an ER nurse- working with this program. Paramedics are uniquely qualified- paramedics should get paid more. Prosser has paramedics, they're available, they have their own transportation. Are we going to miss something if we send a nurse? The paramedics, they don't mis the urgent stuff, this is their specialty. Paramedics can get patients to talk with them in a way – to many people paramedics feel more like a regular guy than a doctor. Everyone loves a paramedic.
	• They've been off grant about 3 years. The hospital board decided to pay for the budget. It costs money- the only excess cost- she's a 0.1 FTE because the paramedics are so good. Also, EPIC makes her life easy. Their costs are running the rig. We're not that big- no more than 3 community paramedic visits per day. As far as the GCACH, we're representing the little guy. So excited about what we can do in the Tri-Cities. When you're talking about a town of 5,000 people. Not horribly expensive, we have excess capacity, not running 100 calls a day. This makes the PMH CEO very happy. The main thing that makes us different is that we're little and owned by a hospital and this changes the kind of patients we see. We see a lot referred from OB dept, from the clinics, etc. not just 911 users. We have the information- we have EPIC and we are a satellite of Kadlec. We've been doing this for almost 7 years and have developed a pretty extensive training program. PMH continues this work and we're not getting paid for it. The CEO at the time was Julie Peterson, and it was the best community relations investment ever.
	• Community Paramedicine program design:
	  ○ They receive referrals from Epic.
	  ○ Review it and make sure it's an appropriate person to see. Schedule that patient- look at their chart notes, discharge instructions- go to their home- most home visits involve teaching on medicine, scan the environment.
	  ○ People put together the letter summarizing their visit.
	• What we learned:
	  ○ Super users are hard to work with – we did not have a lot of success with them- you can ID a problem that's a fairly easy solution. Some of them have complex issues or they'll do what they want.
	  ○ The PMH CP program has had the most success with patients with diagnoses of heart failure, pneumonia, COPD, diabetes and chest pain.
	  ○ Really helped the age group 50-75 the most.
	  ○ Surgery patients are open to visits and surgeons love the program.
	  ○ The older group is they kept dying on us. Last 6 months of life is very expensive.

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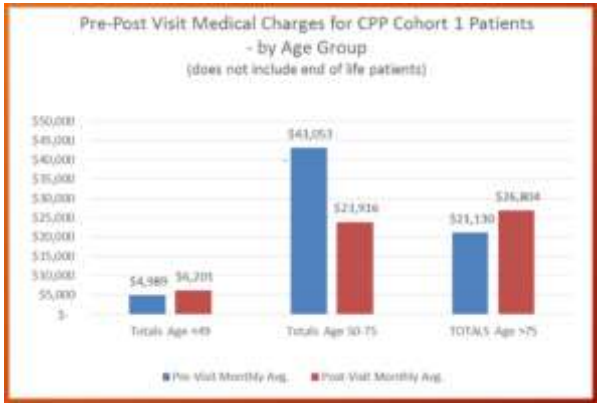

We would go see a patient, the medic would call their doctor and prevent an ER visit. By accident, they starting tracking what the paramedics were doing when they called for help (setting up an appointment within 24 hours, a medication correction, doing a provider contact, etc.).
Avoided a lot of money being spent. The estimated health care savings in 2018 was $617,617.44.
$1,300 dollars are NOT being spent for every time the paramedics go out. 30-day readmission rates of only 2%!!! So proud of them. Have consistently run 2.5 to 3.5%. pretty excited about these numbers.
55% reduction of ED visits and hospital admissions 6 months after Community Paramedic visits versus 6 months prior to visits.
One patient- Michael was difficult and not a nice guy- didn’t like doctors and nurses- he was incredibly sick and had terminal cancer. They worked hard with Michael. He really liked the paramedics- they would pop by and check in on him- saw him 9 times in 2018- had 4 ems transports 6 months prior to spending time with him. Reduced his expenses by $67,000! He died in October and they reduced the costs by 63% in the last 6 months of life (typically a very expensive time of life).
When someone doesn’t need transport to the hospital- stabilize this person at home. Refer this person to the community paramedic program- now the State will pay for this no-transport. There’s a little bit of money coming in through CMS. These are things to help with sustainability- it’s coming slowly.

Tyler Platt talked about the ET3 program- go out to treat patient. Will only be awarding this to 40 provider (hospital based) and supplier (fire department based) agencies.
Eric Nilson: Current WA State law is that they can only transport to WA State E.Ds.
Tyler Platt: This new legislation – giving them the options- this is very important go to this clinic or this clinic.

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<td>Spokane Ride-to-Care (Cameryn Flynn, Spokane Ride to Care)</td>
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Sam introduced Cameryn Flynn from Spokane Ride to Care.
Cameryn Flynn, serves as SNAP’s Supervisor for several Social Determinants of Health initiatives and the unique Emergency Diversion Program - Spokane Ride to Care. She has an extensive experience in Hospital Administration, Healthcare Transportation (including Ambulance services), and Program Development in Health and Wellness industries and Social Service Agencies. She began her career as a Care Coordinator at a small rural hospital in the

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Appalachian mountain region providing case management/care coordination for clients. She went on to work as a Consultant and Life Coach in a variety of areas throughout the United States, Ireland, and Africa. She obtained her Bachelor of Arts in Business Administration from Gonzaga University and her Master of Arts in Psychology from Antioch University – Seattle Campus.

- Cameryn's presentation was titled, "Spokane Ride-to-Care"
    - She represents a community action partner program and agency in Spokane- it's called SNAP over 30 programs in the region in Spokane and eastern WA. Asked by the mayor of the city to enter into a program to reduce ED visits especially with low-acuity folks.
    - We use this at the Better Health Together ACH. In Reno there is a large program. It started with the city of Spokane and have moved to the county and launching into fire districts that are rural similar to dynamics here.
    - Spokane Ride to Care:
        - Engaged 20 members of community to create a consortium. Launched in 2017 and have operated since. Had a pilot and then a third-party evaluator. Although having the evaluator upped the costs for the first year, it was very valuable for the knowledge they gained.
        - Cameryn showed a video that explains Spokane Ride to Care.
            - In 2016, the old-school way of dealing with medical calls was 10,000 rides to the ER. Doctors later determined that a lot of them weren't really necessary.
        - At no cost, transportation is provided to urgent care. Patients are taken to urgent care symptoms if there's no major problem. Also takes patients form urgent care to participating pharmacies. Not denying care, but trying to get them the right care.
        - To make sure that ride to care is meeting standards having the health district independently asses the program.
        - There's a third-party vendor- there are about 10 vans in Spokane area to operate the program.
        - Operates from 8am to 8pm – these are the hours of the urgent care clinics.
        - There were 10,000 calls that were EMS medical. Of that, during the operation hours, it went down to about 7500 calls.
        - We have a lot of challenges in the referral process of this program. It's 911 activated we are still dispatching the fire engines, ambulances, and the determination of ride to care is not done until they get to the scene. Want to get to do a different approach like doing nurse referrals to save more money.
        - Later they go review each of the cases clinically to make sure they've gone to the right place. They sometimes find out that it wasn't the right referral then go back to the paramedics. The first year, probably 100 calls that weren't appropriately routed and not it's down to 3%.
        - We have a 400-page protocol the paramedics have to remember. Many different processes.

	• When we formed our coalition received money from MCOs, private foundations, municipalities, Department of Commerce, WA Department of Transportation, 5310 funds from local transit, HCA (worked with them to work with MedStar vendor and others to determine that each ride would be a fee they would pay and then get reimbursed for them). • The clientele/target population- 75% of these people are Medicaid so 75% of the costs have been reimbursed. • There are some streamline processes they could do to make it more and more efficient. Made a determination that transportation was a huge gap in the community. Work with partner orgs and ACH (BHT). ○ Cameryn manages 6 initiatives where they send community health workers into homes. Work with CHAZ. • Q&A with Audience: ○ Q: Do you think in a smaller rural environment this arrangement could work? • Cameryn: Depends on how close the alternative destinations are and the other thing is the volume. You'll need some operational pieces. They are still averaging 1.5 calls per day (some days they have 10 and some days they have none). The society/the population believe culturally that they receive care through E.Ds. Working with MCOs to do education with the population. Educate about the benefits of urgent care vs. emergency care. ○ Q: Do you have CHWs? Are they paid? How is that funded? • Cameryn: CHAZ is a contracted service. The CHWs are paid and paid in 15-minute increments. CHAZ was spending a lot of money on transportation so took the money from that pot and moved it over to them getting transportation and support.
Facilitated Discussion (Audience, Presenters and GCACH Staff)	• There was no facilitated discussion at the meeting.
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)