Greater Columbia Accountable Community of Health

Leadership Council

Thursday, December 15th, 2016
9:00AM-11:30AM Meeting
Greater Columbia Behavioral Health
101 N. Edison Street, Kennewick, WA 99336

Minutes

Participants	In Person: Amy Person, Rebecca Sutherland, Susan Campbell, Becky Grohs, Mandy McCollum, Virginia Janin, Cynthia Flynn, Sue Jetter, Lena Nachand, LoAnn Ayers, Martin Valadez, Julie LaPierre, Stan Ledington, Andrea Tull, Bill Hinkle, Dr. Donald Ashley, Jorge Rivera, Juan Sandoval, Dan Ferguson, Heidi Desmarais On the Phone: Melet Whinston, Shawnie Haas, Deb Gauck, Bethany Osgood, Kat Latet, Joyce Newsom, Matt Davy, Andy Nyberg, Janis Luvaas, Susan Martin, Corrie Blythe, Eddie Miles, Alex Howard, Fenice Fregoso, Gina Ord, Bertha Lopez, Meghan Debolt, Caitlin Safford, Lana Stuart-Escali, Tim Cooper, Delphine Bailey, Sandra Aguilar, Kathy O'Meara-Wyman, Martha Lanman, Brenda Parnell, Wes Luckey
Backbone	Carol Moser, Executive Director, GCACH Aisling Fernandez, Communications Coordinator, GCACH
Special Thanks	• Thank you to Greater Columbia Behavioral Health for providing the facility that allows us to hold these meetings.
TOPIC	NOTES
Welcome & Introductions	• Carol Moser welcomed everyone and there were self-introductions around the room. Carol said that she really that GCBH is open for business and provides the capabilities that we can hold this meeting. We really appreciated everyone who made the effort to attend the meeting despite the snowy weather.
Action: Approval of Minutes	• December 15th minutes were approved by consensus with corrections.
	• The two leads on the SIM Project (Becky Grohs & Mandy McCollum), which is titled Readmissions Avoidance Pilot (RAP) gave a report on the project to the Leadership Council: • Becky Grohs, an RN and clinical director for Alliance Consistent Care shared updates: • They have been working on the SIM project since August. Both Benton and Franklin counties were the worst in terms of readmission rates. They are enrolling patients from Trios and Kadlec. They brought in Qualis Health, CCHE and a WSU researcher to help develop ideas and methodology. The RAP Team chose to have a control group to improve the strength of the study results. There is an identification tool (the BOOST Tool) to screen patient and identify them at threshold for risk for readmission. There are three tiers for low-, moderate- or high-risk for readmission. Other partnerships are with Aging & Long Term Care (ALTC) & Columbia Basin College (CBC). We are working with 2 Washington State University (WSU) students (RN to BSN students), each of whom has a project. One student is

	pulling together materials (brochure for patient's bedside) and another student has developed pathways for COPD, diabetes, stroke, and other diagnoses.
	• Mandy McCollum, RAP Project Lead shared more updates:
	  • Mandy has been going to homes and coordinating referrals from hospitals. They started November 7th and are approximately at week 7. They have referrals from Kadlec and Trios. They want to have 24 referrals by end of week 7. Currently they have 13 referrals.
	  • Challenges along the way have included referrals from Kadlec, which is the bigger hospital and facility and they have more case managers. Kadlec uses the GPS system which ranks patients based on risk. She has been seeing 6 people in the intervention group by herself and will have help when students return from break. Other challenges have included ironing out the system, for example, full communication so GPS system can continue to do its work for those not accepted into RAP program. Mandy is educating case managers which is helpful because they work with the patients. There have been a few issues with release of information, for example, doctor's offices not wanting to talk with Mandy to coordinate care. Sometimes patients consent to be enrolled in RAP in the hospital, but getting into their home for a home visit later can be challenging. Now, RAP is getting positive feedback from doctors and doctors can refer patients to this system.
	  • There have been some successes! RAP had its first graduate yesterday who successfully completed 30 days outside without readmitting; it required coordinating in-home antibiotics, wound care and some companionship. There are two others who will complete 30 days next week. RAP is connecting patients with resources. The RAP Team is taking care of things that are being missed in discharge and finishing coordination of care. Another success was with the EDIE system, which alerts Mandy when patients enrolled in the RAP service have gone into the ER for some reason. Two nights ago, one of the RAP patients was in the ER and Mandy was able to talk to physicians and nurses and let them know what's being done outside the hospital so this person was not readmitted! Mandy went to this person's house yesterday to follow-up and made sure her services were set up.
	• There was a group discussion around the program:
	  • Susan Campbell asked what Mandy does when she find holes in the discharge papers or system? Mandy said that she's providing that information back to the hospital case managers. Is there a risk of changing the systems during the course of the study – that this would impact the quality of the study (a contamination factor)? This doesn't seem to be a risk because changes in the behavior of the hospital case managers would affect patients in both the intervention and control groups equally.

	• Susan asked if the RAP Team needs more assistance. Mandy said yes. They need 80 patients by the end of February. Ed Thornbrugh commented that he appreciates the work of the RAP Team and of their startup challenges. He said that there is a lot of value in documenting and reporting these challenges even if they don't meet their targets. • Carol said that in terms of the Medicaid Waiver, this is a great learning project! The Waiver is about changing provider behavior. Providers are trying to adapt to a new system. When it gets to staff level, that's different. Channels of communication are sensitive. We will need to bring providers to table, especially those who are doing the work. It's important that we caught the attention of Qualis Health. Qualis wants us to branch out to skilled nursing facilities, and with Qualis' help that is be feasible.

Directors Report
&
Pre-DRAFT Waiver Toolkit Discussion
	• Carol thanked Lena for driving over the pass to join us for the meeting in person!
	• Carol presented December's Director's Report, which focused on the Waiver Toolkit Pre-Draft
	  • The HCA has been working on this toolkit to create a narrowed scoped of work for all ACHs. There are 3 required projects plus one optional project. (Update since this meeting: in the Draft Waiver Toolkit released on 1/3/17, there are 2 required projects plus ACHs are required to select one of the optional projects from Domain 2 and one of the optional projects from Domain 3). In addition to the projects, there is also foundational planning work, which is Domain 1. Under Domain 2 we have mandatory projects and a Diversion Interventions project (our SIM project). Under Domain 3, the Addressing the Opioid Use Public Health Crisis is a required project. No one knows right now when Special Terms & Conditions (STCs) is going to be approved, but it is expected to be approved by inauguration of the new president on January 20th. There is going to be a public comment period probably before then. (Update: the public comment period is from January 3rd to February 2nd, 2017).
	  • Carol talked about the Toolkit requirement of the Regional Health Needs Inventory (RHNI). Carol said that GCACH completed a great, thorough Regional Health Improvement Plan (RHIP), but it will take more information to complete the RHNI. Sue Jetter also did a lot of work to determine resources in our region. When you look at the Toolkit, the RHNI sets the standard for what needs to happen for the rest of the Toolkit work.
	  • Bill Hinkle asked about how ACHs are interfacing with PH departments and needs assessments in their community. Carol replied that that's another great resource we should be accessing. Dr. Amy Person said that when we did the original RHNI, we did look at the assessments from the counties. Carol said that the State has created the dashboards that are informing our ACHs. Our common measure set that we'll be judged on that data. There's a Division within DSHS called RDA that allows access to data on social determinants, recidivism rates, incarceration rates, homelessness, substance abuse, HS education, poverty, etc.
	  • Carol talked about the required project of Toolkit, the Pathways Community HUB model, which is based on work that Dr. Sarah Redding did in Ohio. With this model, you can track patients and fit them into a pathway for care. (Update:

HCA & GCACH are bringing Dr. Redding to Ellensburg for a Pathways Community HUB training on Friday, January 27th! Let Carol & Aisling know if you want to attend this free training).

- Carol talked about the Workforce Transformation Plan (part of Domain 1). We may be striving for bi-directional integration of care, but need to have sufficient capacity, therefore you need to have more workforce training in your area. Maybe we can start a program for licensed social workers in the Tri-Cities, similar to residency training in our hospitals. Think about what type of capacity is appropriate in different parts of the GCACH region, for example, more telehealth, training for peer counselors for in-home care for patients with MH, etc. Regarding the opioid use PH crisis, Kittitas county is already doing work in this area and Franklin county has started to do some work with Consistent Care and RDA data will be helpful.
- Dr Donald Ashley talked about the data dashboard demonstration. Klickitat has some of the best follow-up with patients with depression. Yakima has best follow-up with diabetes despite obstacle with SDs. Let's learn from other examples in the country. Look at 6-month follow-up for people on antidepressants. Healing is cut by half if BH is added and it also cuts down medical costs. Rural Nebraska did work on. Nebraska found that when they put BH person in the clinic it dramatically improved patient outcomes. The Toolkit seems to push interventions that are complicated, but there are also other ways to get to the same outcomes.
- Dan Ferguson said that as the Director of the Center of Allied Health, he is involved with statewide workforce issues. There is a call this afternoon at Governor's office for an agenda for this year and they will be evaluating workforce. The Osteopathic school in Yakima, and the Heritage school are looking at developing a BH primary care graduate degree (a masters-level program.)
- Lena said that organizations involved in Medicaid transformation will contract with ACH not with HCA. Part of the money is a broader public participation process. Under the SIM grant, Carol has done a fabulous job with budget provided so far! With more money, there will be more support for staff and contractors to do a broad public participation process. One application for our vision for a transformed system includes the Medicaid transformation waiver as well as other grants for a broader vision for a transformed system. ACHs will with a broad swath of people to come up with a vision. Think about how qualitative and quantitative data support projects we're going to undertake.
- Lena talked about the third-party assessor. When you turn in the Waiver application, the HCA and a third-party assessor will review the application, validate the plan, and do some of the valuation. There will be a formula for financing ACHs. The HCA has final say. It would be controversial if HCA went against advice of assessor. **There will just be one Waiver application/plan so it's a whole system and the plan is cohesive.**

Carol stated that we'll contract with existing organizations to deliver services. The RHIP work is very valid but we may not get to some of that work right away.

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Priority Workgroup Breakouts	• All five PWGs met (Oral Health, Diabetes/Obesity, Care Coordination, Healthy Youth & Equitable Communities, and Behavioral Health) to discuss the Medicaid Waiver Toolkit pre-draft.
Adjournment	• The meeting adjourned at 11:30AM.
2016 Meeting Schedule	The GCACH Leadership Council meets the Third Thursday of the month. • Location: Greater Columbia Behavioral Health, 101 N Edison St, Kennewick • Time: Leadership Council: 9-11:30 **Thank you for your time and engagement with the Greater Columbia Accountable Community of Health!**