Domain 2 Combined Work Group Meeting

Meeting Summary, 8/29/2017

Support and Backbone Staff: Megan Moore – *CHOICE*, Justin Wagaman – *CHOICE*, Jennifer Brackeen – *CHOICE*, Shannon Linkous – *CHOICE*, Winfried Danke – *CHOICE*, Kyle Roesler – *CHOICE*, Liz Argen – *HMA*, David Hanig – *HMA*, Michel O'Neill – *Cowlitz County*
In Attendance: Christina Pegg – *Longview HA*, David Stide – *Quales Health*, Larry Horne – *BHR*, Jennifer Simmons – *PSWIPA*, Jon Tunheim – *Thurston County*, Mattie Osborn – *Amerigroup*, Diane Hurley – *Morton General*, Leianne Everett – *Morton General*, Kat Latet – *CHPW*, Stephanie Shushan – *CHPW*, Tina Edlund, Doug Spingelt – *Sea Mar CHC*, Federico Cruz – *Sea Mar CHC*, Melissa Taylor – *Lower Columbia CAP*, Crystal Billings – *Providence*, Dian Cooper – *CfamHC*, Marc Bollinger – *Great Rivers BHO*, Ophelia Noble, Addie Spencer – *Nisqually Health*, Liz Cattin – *Peace Health*, Julie Nye – *Columbia Well*, Julie Heerlyn – *Providence*, Phil Jurmu – *Longview*, Samantha Waldbauer – *DSHS*, Mikayla Springob – *DSHS*, Leslie Jones – *DSHS*, Kelli Sweet – *DSHS*, Vicky Brown – *Mason General*, Laura Johnson – *UHC*, Yvette York, Ed Mund – *Lewis County (LCPHSS)*, Steve Brooks – *Lacey Fire Department*, Greg Deblanco, Michelle Wilsey – *Cascade Mental Health*, Angela Niday – *CfamHC*, Lynette Gregory – *Providence*, Caitlin Safford – *Amerigroup*, Ashley Taylor – *SP-MC*, Susan Shepherd – *DSHS*, Kathy Miller – *SP-MC*, Mary Goelz – *Pacific County*, Adam Marquis – *WillaPABH*, Janelle Sorelle, Kate Cross – *DOH*, Carolina Lucen – *Sea Mar*, Penny Cooke – *VVHC*, Carolina Lucen – *Sea Mar*, Angie Bennett – *VVHC*, Melanie Matthews – *PSWIPA*, Kim Nuesse – *Cowlitz County*, Angie Ferner – *Cascade Mental Health*, Patrick O'Neill, Jen Houk – *Providence*, Kevin Haughton – *Providence*, Kathie Olson – *Molina Healthcare*, Dr. Phyllis Cavens – *Cowlitz County*

I. Welcome and Introductions

Michael O'Neill started the meeting and facilitated the welcome & introductions. Michael reviewed the agenda.

II. CPAA Compass and RFQ Review

Winfried Danke reviewed the CPAA Compass, which contains the following:

Three key overarching goals:

1. Health Improvement, specifically to vulnerable populations
2. Whole person care
3. Smart Spending Goal

And Five CPAA Goals:

1. Improve Healthcare Access
2. Improve Care Coordination & Integration
3. Prevent & Manage Chronic Disease
4. Prevent and Mitigate Adverse Childhood Experiences (ACES)
5. Enhance Educational & Economic Opportunities

Winfried and Jennifer talked about the RFQ and what it's trying to achieve. Key points are:

- What kind of partners might be interested in leaning into this work?
- What kind of ideas do said partners have?

The whole process is very informal. It is just to assess who is interested and what those parties are interested in. **There is a deadline for RFQ submissions set for September 1, but it will remain open. As new ideas arise, all parties should feel free to send in thoughts, even if it's after the deadline. Although, keep in mind that the sooner your ideas are submitted, the better. This will allow for more time to review and develop projects.** The idea is to get the project description in the RFQ and think about what partners would be most beneficial to these projects. Jennifer added that any questions involving the RFQ should be directed to her. She also offered to brainstorm any ideas with people who feel stuck. She emphasized that RFQ submission is NOT a guarantee of funding. The hope is to submit a rich and well-developed project plan overall in the end.

III. Role of Domain 2 Work Group and Review of Project Plan

Liz Argen reviewed how the Medicaid Transformation Demonstration supports the region's priorities. Funding is dependent on meeting the clinical performance metrics, and if this is done, this money will be flexible. Although this funding is dependent on clinical metrics, this does not mean it's completely dependent only on input from clinical groups or that the money will only be spent in these areas. Liz reviewed how dollars are earned through metrics and performance. Interventions have already been chosen in prior work group meetings, so the next step is selecting target populations. Several projects share metrics, so review of that is essential so each group can see which providers can help meet their own metrics. Liz reviewed metrics (statewide and project-specific) for Bi-Directional Care and the selected strategy, which is the collaborative care model. She reviewed Care Coordination metrics and that strategy, which is Pathways Community Hub. This touches multiple populations, which will be reviewed at a later time. She then reviewed Transitional Care metrics and the selected strategies, which are Interact 4.0, Transitional Care Model and Care transitions intervention. The Diversion metrics were reviewed and the associated strategy is Community Paramedicine. The Chronic Disease and Prevention metrics were reviewed and the associated strategy, which is the Chronic care model. Liz then reviewed the two necessary sections to the project application, which are listed:

1. ACH level: Domain 1 and funds flow
2. Project level: project selection and outcomes (i.e. what does this project look like, who is the target population?) This is high level thinking – how will this be carried out over the next three years? Partnering providers will be determined especially from the RFQ. This will help determine provider gaps in our region. What kind of HIT or workforce do we need to help support this project and our population's success?

Liz reviewed key dates to keep in mind:

- August 29: Develop target populations
- September 26: Discuss providers (based on RFQ) & Domain 1 investments based off of populations decided on today – develop strawman proposal
- October: more completed project application
- October 23: completed level project applications

IV. Addressing Domain 2 Target Populations

David went over the Target Population document. This was an overview of the general universe of target populations, so the intent for this was to be broad. This group was meant to bring specificity to the target populations. Each project addresses specific populations of interest. David facilitated the breakout of five different groups in which discussion about target populations took place. Facilitators rotated between groups and represented different projects so each group had a chance to address and discuss each project. Each group was allotted 15 minutes of discussion time per project. Facilitators directed a report out of the small group discussions, which are reviewed in the chart below:

Different colors represent similarities in identified target populations across projects

Collaborative Care Model (Bi-Directional)	Pathways Hub	Transitional Care	Diversion (Community Paramedicine)	Chronic Disease (Chronic Care)
Homelessness	Homelessness	Homelessness	Prescription drug confusion	Family Intervention
Elderly population/High-density senior living without adequate care available on campus	Senior citizens and folks 45-65 who are not eligible for Medicare with increasing health concerns	Different age break-outs	Seniors	High density senior populations receiving Medicaid
Different subpopulations with mental healthcare needs	Mental Health Penetration	Mental and Behavioral health and chronic illness	Mental/Behavioral Health	Children on Medicaid with CPS involvement
Those using ER as a safe place or to seek shelter	Those with co-occuring disorders	Dual-eligibles	Co-occurring conditions	Adults with two or more co-morbid conditions
Hispanic parents who ensure their children receive adequate care but neglect their own	Folks with high isolation	Rural/isolated population - where are people transitioning to? Do they have access to different things?	Social isolates	High social isolation populations

Those with transportation barriers	Limited English proficiency	Kids coming out of the juvenile justice system - is there something we're doing right there that could apply to transitions for adults out coming out of jail?	Post jail and juvenile rehab and those on probation and transitioning out of jail/rehab	Populations transitioning out of jail
People in end of life care or hospice or those with hospice services who are not using that network	Folks with medication management issues, substance abuse disorder and IV drug users	Frequent urgent care users	Substance abusers, including babies exposed to opiate addictions	Schools with high absenteeism rates and high school drop-out rates
People who go to one appointment and have difficulty with readmission	ACEs score of 6 or higher	Multiple ER users and multiple hospital stays	Victims of domestic violence	Areas with ACEs score of 6 or higher
Those without an existing care provider	Folks with limited follow up care		Unstable living situations and looking for immediate gratification	Those coming out of conditions without an assigned PCP
Those with a fear to access care	Children and school-aged youth		Families of young children with low health literacy	Tribes
Moving between providers	Rural geographies targeting the more rural counties and helping people to access services		People with babies who do not know how to address the illnesses	People of color, specifically those with heart conditions and diabetes
Young parents (18-24)	High risk OB			Registered PCMH's in the state

Those in poverty	Thurston Urban Core			Those living in Pacific, Grays Harbor, Lewis and Mason counties
Kids in transition between childhood and adulthood (managing their own care)	Culturally specific group that may have access issues to care			
New to area - moved out of state or to a new county	EDIE system (frequent utlizers)			
People seeking service not wtihin 8-5 timeframe (i.e. restricted working hours) - specifically in East Lewis and Mason County				
Kids in after school programs				

CPAA will talk with the CORE data team to discuss zeroing in on target populations. This will allow the establishment of target populations that should be focused on. David will send out the unduplicated list of target populations, which will be integrated into later drafts of the project.

V. Next Steps & Closing

- Next Meeting: September 26
- Identify partnering providers – Based on RFQ results, including gap analysis of missing providers (not just clinical, but the big picture of CPAA)
- Identify Domain 1 investments – Based on workforce, population health management, value based payment
- Identify sustainability & alignment – Both of which will help with development of the strawman proposal
    - Project specific – 6 or 8 projects being deliberated by CPAA council & board
        - Will these address the needs in the community? Why is this project needed in the area? What are the resources needed? Who are the partnering providers?
        - Strawman is an outline of the project, which will make it easier for work group members to respond to
- David will create an unduplicated list of the developed Target Populations that will be sent to the work group