

III. Learn about and Discuss 3 CPAA Project Areas

Bi-Directional Care Integration

Kyle Roesler described the Bi-Directional Integration of Care project. The terms “care integration” and “integrated care” mean the same thing. The goal of such care is to take a whole-person approach to care, rather than treating individual symptoms separately. For example, putting the focus on children and adults who are dealing with physical ailments, as well as behavioral health and chronic disease. Care generally takes place in two types of settings.

1. A primary care setting (internal, family, pedes medicines).
2. A behavioral health setting (therapy, counseling, standalone services like psychologists or psychiatrists).

The shift we hope to see is from usual care to collaborative care. Usual care is defined as going to see a doctor for an annual checkup or when feeling sick. Patients with depression or anxiety may see a different provider. The two providers are not connected whatsoever, but the idea is to get all care management working together. The system would be drawn like a triangle, with the patient in the middle acting at the connecting piece, and the medical doctor and mental health provider coming together at the top.

The goal is for Primary Care Providers to start screening for mental health disparities. This will create a shift by holding providers more accountable in the care they provide. CPAA hopes to move to a system that rewards doctors through their quality of care, rather than the services they provide. This idea is ultimately to make mental health care and physical health care available in one area and at one time. Mental health doctors will also be able to implement basic health screenings during their care as well, such as lipid screenings and chronic disease checks to track progress over time. The goal of this setting is to have team-based care. While the behavioral health doctor will be the main doctor in this setting, the hope is that they’ll consult with a Registered Nurse or Primary Care Provider for the more physical side.

The following is a list of questions committee members asked following the lesson, along with Kyle’s answers and explanations:

1. What about the patient’s choice in providers? Will this matter?
 - The ability to switch providers is dependent upon your insurance, but you should be able to switch providers if need be. You should also be able to stay with your current providers, given they are part of the integrated care model.
2. Is the patient able to advocate for themselves in regards to which team they get, or are they assigned a team?
 - These teams will be set up as doctors A, B, and C, which means they will be pre-set up. But considering there is a patient-centered approach, there should be active engagement in the consumer’s say in whom they work with. This could be a challenge in the beginning as the plan rolls out, due to a limited amount of provider engagement in this model. But once it’s implemented, it should be no problem to adjust as necessary. Providence, SeaMar, and Cowlitz Family Health Care already participate in the integrated care model. The plan is to build on their expertise moving forward.

3. I have Medicaid. I have a pinched nerve and need an MRI, but insurance doesn't cover it. Will integrated care address this issue at all?
 - This is a situation that happens outside of primary care, in a way in that it moves into the specialty setting. The collaborative care model has not reached the specialty setting quite yet. The current emphasis is mainly on mental health and chronic disease, but we hope it moves into other areas of care, as well, such as specialties.
4. It would be interesting to move this integrated care model into the jail system, which really needs revamped and addressed. Is this something that could happen?
 - This is more in the area of transitional care, which is an idea that will be addressed in future meetings. However, Medicaid definitely needs brought into the jail systems, which is hard to do.
5. Will there be new jobs created to address the integrated care model needs?
 - There are shortages in providers, so yes, some new positions will be created or filled to help with collaborative care. At the same time, organizations will try to adapt and re-train some members of their own workforce, or see how they can use what's existing to fit this type of care. One aspect is tracking patient outcomes over time and doing follow up, which requires data entries through registries and track screening.
6. What is the plan for expanding this into more rural areas?
 - One idea is using tele-medicine and tele-psychiatry for distances that can't be feasibly traveled. "Tele" is essentially calling in and offering video conferencing. We are also encouraging some small health systems to work together because larger health systems usually aren't available in rural areas. A voice for the need of coordination in these small areas is definitely being spoken for and heard.

The following is Kyle's list of questions for committee members and their responses.

1. What is the primary way people currently access health information?
2. What is the preference for receiving health information about your own situation?
3. If you have a chronic disease now or in the future, what would be your preference for receiving information?
 - Preference for phone if not in person, and prefer to hear from the doctor directly rather than the nurse so you know it's coming from a trusted source and there is less doubt and/or wait time.
 - Some already have a patient portal with the ability for the patient to type a question, to which the doctor replies quickly. This is a great service.
 - I personally use the VA system, where I can set up appointments with my provider through emails. Secured messaging works really well. I can also request specialty care and set up appointments easily. Providence uses a messaging system, which is effective. For my kids, the system I use is ineffective because of lag time in response.
 - It would be cool to see continuity of care somehow across patient portals, so information doesn't have to be different, and I don't have to remember several different logins and passwords.
 - Use of an app would be effective and helpful.

- One committee member has an app with their doctor and finds it effective.

Opioid Response

Malika Lamont introduced herself and described the Opioid Response program. She referenced the [handout](#) she gave each committee member for review. She explained that the U.S. is in a named heroin epidemic and has been for about seven years, including the state of Washington. The areas outside of urban areas have been affected the most by the heroin epidemic. CPAA's plan is reflective of the state plan, which contains the four parts listed below.

1. Prevent opioid misuse and abuse.
2. Identify and treat opioid use disorder.
3. Prevent deaths from overdose.
4. Use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.

Malika asked questions related to these four areas of focus, for which consumers provided feedback, listed below.

1. Have you ever had an issue with accessing alternative pain treatment in your area with your Medicaid insurance?
 - Nothing is covered by Medicaid. My naturopath has gone above and beyond to accept Molina, but other treatments, like massage, acupuncture, and physical therapy (which allowed only six visits), are not covered.
 - Others have problems with provider stigma, such as being treated like drug seekers for broken fingers and broken knees, or other broken bones.
 - Malika included trauma-based care, stigma training, and bias in the project plan. Her project plan also has over prescription addressed to try and limit the issue of 90-day prescriptions following in-house procedures. The state is putting new rules in place regarding this issue.
 - Consumers would like to see doctors get education around prescriptions to avoid children, teens, and others from becoming addicted to opioids, and possibly offer non-traditional medicine rather than traditional medicine as an alternative.
2. Do you know of any opioid use disorder treatment providers in your area?
 - Yes, I'm currently taking suboxone. Back in the day, I hurt my back and only got prescribed pain killers: 120 Vicodin. After doing this month to month to month, I got addicted. There is a treatment provider right in Lacey. You can find them on the internet and most of them are pretty helpful. It's found right on Google; it's pretty easy. I personally use Evergreen Treatment Services, but there are several others.
 - Dr. Samantha Ritchie in McCleary, who is super nice.
 - For the most part, the group wouldn't know where to send someone if they were to ask. Others would suggest going to Google.

Below are questions the consumer advisory committee asked Malika, followed by her responses.

1. What about for pregnant women? Is there special training for those providers?
 - These are special cases and usually taken in at Grays Harbor or Seattle at Swedish. This is ideally began as inpatient care. If a person who is pregnant wants to get medically assisted treatment, they bump them up to the top.
2. Is there outreach or education for these women?
 - Yes, but it's not as broad as it should be.

3. Is there a flag in the system to prevent over prescription?
 - There is the prescription management system, but not every prescriber participates. About 33% of prescribers currently participate in this. We would like more people to get enrolled in this program and use it.

Care Coordination

Michael O'Neill explained the community-based Care Coordination Project. The basic idea is to assign someone who can help a patient connect with the many different types of things they need. This definitely benefits people who have complex issues going on. Some agencies have this in place, like housing agencies. However, there is a lot of variation in how this is addressed since it's based on individual agencies. CPAA is well aware it could be better.

We are using a specific community HUB model for the project plan. The idea is to limit the amount of care providers in order to coordinate care down to one point of contact rather than several people, especially within families. So, how do we create this model? Part one is the formulation of the community HUB where all of the different providers, payers, and everyone else interested in seeing this work come together decide to focus on a certain population of need. This prospective group neutrally agrees on how referrals will be made, then tries to figure out what the value of these care coordination services is. Based on this assessment, people will get assigned a Pathway. There are twenty different Pathways and they work as a checklist or list of steps to cover.

As a patient, you'll get an individual list based on your most important needs and the care coordinator works through it with you, keeping in mind what you feel is most useful for you. This information gets put into a system to keep all the needs of a person in one place and easy to access. It's helpful because you get a different look at what's going on with people, and it also helps pinpoint where the problems in your area lie since everything is documented. Our tactic in this project is the take a two-phased approach. First, small implementation; second, take it to scale. This will include a one-year pilot to kick off the model with six different care coordination agencies and up to 400 people. This will help us see if, and how, the model works. In the second phase, we intend to build up the initial partners to see more clients, then branch out and build up the remainder of the community to follow this model. After five years, we hope to have a client base of over 2,000 people and truly address the needs of people in our community. Our current target populations are listed below.

- Folks that have behavioral health and other health issues going on simultaneously. We also hope to prevent issues and address risk to get to the problem before it starts.
- Pregnant mothers.
- Homeless people and people at risk of becoming homeless.
- Frequent EMS (calling 911 over and over) users.
- Challenge: Need for more information to see who to really zero in on for care.
- Challenge: Need for issues to be addressed within the current workforce situation.

For right now, we are picking prospective target populations and organizations to participate in this program model. The assessment is needed so we can see what's already available and what's needed.

The following is Michael's question for committee members and their responses.

1. What is it like for people to get care coordination and what is needed to make it happen?

- I had an experienced team approach due to my chronic illness, but at the same time, I have severe depressive mood disorder. It was good to have a behavioral health provider in touch with my PCP. The only problem is that I go to SeaMar where they frequently change providers. My behavioral health provider left, and my team fell apart. It was a great thing when it was working, but it too easily fell apart.
- Others find it incredibly difficult to coordinate care especially for youth and elderly. These are two populations who don't really have a voice (because it's difficult to address and understand their needs).

The committee members then presented questions and ideas of their own, to which Michael responded. This dialogue is listed below.

1. What if someone doesn't need all of the steps that are involved with these set paths?
 - The goal is to have basic steps for anyone who will coordinate services. For example, if I'm on a chronic disease Pathway and someone else is on the same Pathway, we will both have a care provider, both have a screening, both have treatment. This is more on the side of the skills with the care coordinator working with you. The idea is that this person will listen to and care about you as the patient. The customization is in that one-on-one relationship and supporting patients in what they need. Ultimately, doctors won't be assigned unless someone needs that service.
2. There was a general concern amongst the group for availability of services.
 - Michael said this is something that the region knows needs to be addressed, but this is what the HUB is for. We can be made aware of where these resources are lacking and provide those needed services. We plan on getting together the best list possible about what's available already, but if something is not available that you need, we hope to provide the best support we possibly can. Pathways will be available for housing, transportation, educational, and other goals. These aren't just medical.
3. The committee made it clear that doctors need educated on who accepts insurance. If there is a path, we need to make sure that path is actually connected. Sometimes the problem isn't actually solved when doctors believe it is.
 - This is where the care coordinator steps in to be on your side in terms of advocating to your insurance provider to coordinate those needs.
4. Will these resources be provided?
 - Yes. What is going to happen as we roll out this model is we will see where Pathways are lacking or aren't being met. We need to do this to calculate gaps in resources for our partners. We hope to get all of these different providers to donate to a fund (the Wellness Fund) to address the missing resources and build up met needs. It would be an investment to build what's not there.
5. Care Coordination sounds great, but all they can do is be the voice back to the system, and in the meantime there are still people who aren't getting care.
 - We know there are going to be lacking resources, and it will take a long time to get access to those resources. If we can't access a specific area of needs right away, we hope there are additional things we can work on that will limit the stress in your life. We hope that value can be added in other areas, like education or job training to help with bill juggling or other struggles.

Michael invited consumers to join his work group if the interest is there. Michael told the committee he would email them the results from the Ohio care coordination model. He also told them he would coordinate an email with Justin containing questions around what consumers would like to see happen in care coordination.