Bi-Directional Care Integration Meeting

Meeting Summary, January 30, 2018

Support and Backbone Staff: Christina Mitchell - *CHOICE*, Kyle Roesler- *CHOICE*, Laura Spoor- *CHOICE*, Megan Moore- *CHOICE*
In Attendance: Julie Nye – *Child and Adolescent Clinic*, David Meyers – *Cowlitz Family Health Center*, Stephanie Shushan – *Community Health Plan of WA*, David Stipe – *Qualis Health*, John Lanning – *Providence*, Jen Houk – *Providence*, Marc Bollinger – *Great Rivers BHO*, Christina Garcia – *Molina*, Nancy Holman - *Physicians of SWWA*, Adam Marquis – *Willapa Behavioral Health,* Liz Cattin – *PeaceHealth*, Kevin Haughton – *Providence*, Laura Johnson – *United Healthcare*, Mattie Osborn - *Amerigroup*, Kay Savage – *Physicians of SWWA*

I. Executive Summary

The Bi-Directional Care Integration Work Group met to discuss finalizing target populations, the Current State Assessment milestone, and identifying the main intersection points of bi-directional care within other project areas.

- The group feels that the target population should be more specific by dividing mental illness into specific categories such as PTSD, depression, anxiety, etc.
- Also, CPAA will explore analyzing data that shows the health disparities of communities in the most need and focus efforts there.
- One strategy for the 2018 State Assessment is that each project area will have individual questions but also questions that overlap with other project areas compiled into one assessment.
- The assessment may have two phases. The group discussed the first phase to include the IPAT tool and customized questions pertaining to all project areas. This may change if we can improve efficiency. The second phase will allow partnering providers to choose an integrated care assessment that works best for their organization. The goal would be to use an integrated care assessment as a means for ongoing quality improvement. A final decision was not made and survey strategies are still being modified.
- When identifying overlap in other project areas, the group focused on the Pathways HUB model. Care Navigators/Case Managers who are involved with primary care can help bridge the gap between primary care and behavioral health.
- Also, they discussed overlap with Transitional Care when discharging patients from the hospital or psychiatric facilities.

II. Welcome and Introductions

Kyle Roesler welcomed participants and facilitated introductions, then reviewed the desired meeting outcomes, listed below.

- Review previous meeting
- 2018 Milestones
- Updates

- Target Populations
- Discuss first Milestone for 2018: Current State Assessment
- Building an Integrated Portfolio – Focusing on Bi-Directional Care at the next Council meeting

III. Updates from CPAA & Review Last Meeting

After the Project Plan submission and first write back, we did not receive a second write back. From this, we are expecting a high score, and we should know the score by end of next week. Our score will determine how much funding our region will receive, and CPAA hopes to receive funding by mid-May.

Kyle reviewed the work plan timeline and milestones for 2018. The primary focus is on the Current State Capacity Assessment milestone, but there are several things to complete over the next six months of 2018.

Kyle then informed the group about updates from the Clinical Advisory Committee. The members represent primary care, behavioral health, pediatrics, oral health, public health, MCOs, and BHOs. Each county (except Wahkiakum) in the region is represented and meetings are held once every other month.

The previous meeting focused on technology/systems improvements, value based payment, and securing formal commitments from providers. Some key points from the meeting were the Committee discussed creating a group focused only on data/technology investments because it requires the right kind of expertise. Potential partners need clarity on the format of commitment letters, developing a regional strategy for value-based payment, and incentives to support transformation goals.

Kyle then informed the group that the next council meeting is Thursday, February 8, 2018 from 12:00 pm – 3:00 pm. He encouraged anyone from the group to come because there is going to be a shared learning on bi-directional care integration, mainly focusing on an overview of the project, what we are working on, and what we are trying to achieve. Kyle would like to present success stories of behavioral health integration and ways in which the other projects overlap in primary care.

IV. HCA Updates

Kyle shared that HCA has given CPAA an update on pay for reporting deliverables but it is still under development. The slides can be found here.

Our first semi-annual report covers the first 6 months of this year and is due July 31st. The template is being released in March. More importantly, the implementation plan template is being released in April. Although we broadly know what to include in the plan, HCA's new guidance should be more specific. Also, we are expecting to receive more specific information for the 2018 milestones in March.

V. Finalizing Target Populations

Our current target population:

- In primary care and behavioral health settings, children and adults:
  - Dx w/ mental illness
  - Dx w/ serious mental illness

- SUD treatment need
  - ❖ Also that have co-occurring chronic conditions (diabetes, asthma, heart disease, obesity)

Kyle asked the group if we should we be more specific?

- Right now it's an and/or diagnosis, but maybe we should be just and to narrow it down
- Analyze data that shows health disparities for those in the most need
- Should mental illness be broken down to be more specific? Such as PTSD, depression, and/or anxiety?
- Levels of functioning to be more specific, some data is in the Prism system
- RDA has the potential to combine encounter data with claims data (State has access to both data as well)

VI. Current State Assessment

One strategy for the 2018 State Assessment is that each project area will have individual questions but also questions that overlap with other project areas. The assessment will also have two phases, the first will be the IPAT tool and the second will be our partnering providers' choice from a list of integrated assessments (yet to be determined) that work best for them.

Kyle divided the group into smaller groups to analyze the first 8 questions in the IPAT.

Feedback from the group:

- Be really specific when delivering the assessment that each primary care clinic/behavioral health clinic should answer questions individually, and not holistically as a system
- #10 needs more clarification: what is a clinical care team? Include the framework the IPAT uses for definitions as a reference tool
- Historically dental and medical have been left out of each other's work, currently there's no mention of dentistry at all on the IPAT
- Language/Terminology barrier between different providers
- Allow for specific drop down boxes to expand, add a comment box for feedback
- Adding directions on how to answer questions, define terms used
- Simplicity is key
- Emphasize confidentiality
- Ask for feedback on challenges faced/concerns for the future

Kyle informed the group that there will be questions integrated from other work group areas, along with some skip logic as well. The assessment piece will be built into commitment letters and will be a tool to continue monitoring success after implementation.

VII. Building an Integrated Portfolio

When identifying overlap in other project areas, the group focused on the Pathways HUB model. Care Navigators/Case Managers who are involved with primary care can help bridge the gap between primary care and behavioral health. Group members shared that currently, patients are facing hurdle after

hurdle to try and get access to resources. The group also conversed about the type of training that will be provided to navigate the Pathways HUB.

The group then discussed overlap with Transitional Care when discharging patients from the hospital vs. the psychiatric facility. The meeting ran out of time so the group will discuss project overlap further during the next meeting.

VIII. Next Steps & Closing

The group discussed having a joint quarterly meeting, then breakout sessions for each project area, instead of meeting monthly.

- The group was concerned that momentum will be lost going to quarterly meetings
- Many people are in different work groups so they will have to miss certain breakout sessions
- The group wants to keep the same meeting format on a monthly basis
- The next work group meeting will be February 27th, 2018 from 9:00 am – 10:30 am and will be a webinar/phone call
    - Call in info: 1-872-240-3311
    - Access code: 942-416-725