# Bi-Directional Care Integration Meeting

## Meeting Summary, February 27, 2018

**Support and Backbone Staff**: Kyle Roesler- *CHOICE*, Alexis Sullivan - *CHOICE*, Megan Moore- *CHOICE*
**In Attendance**: David Meyers - *Cowlitz Family Health Center*, Christina Garcia – *Molina*, Terri Gushee - *Mason General Hospital*, Stephanie Shushan – *Community Health Plan of WA*, Julie Nye – *Child and Adolescent Clinic*, Vicky Brown - *Morton General Hospital*, David Stipe – *Qualis Health*, Laurie Tebo – *Behavioral Health Resources*, Amber Gelargrange – Cowlitz Family Health Center, Marc Bollinger – *Great Rivers BHO*, Larry Horne – *Behavioral Health Resources*, Frank Morrison – *Core Health*

### I. Executive Summary and Next Steps

- The work group will finalize target populations with more specific criteria in the next couple of months. **Think about what populations you plan to serve with your model of integrated care.**
- The State Capacity Assessment will be sent out March 5th and will close March 26th, it is very vital that CPAA get partner participation in completing the survey. **Please complete the survey.**
- CPAA scored 100% on the project proposal from HCA
- CPAA Milestone 2 for bi-directional care integration, found here
- Draft Logic Model for Bi-Directional Care Integration, found here
    - Which integrated care practices can your organization commit to implementing?
- Organizations should be thinking about a LOI/RFP for an integrated care program

### II. Welcome and Introductions

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

- Review Last Meeting
- Programmatic Updates
- Milestone 2: Discuss Domain 1 Investments
- Project 2A Logic Model
- Next Steps

### III. Review Last Meeting

The assessment questions have been finalized after all the group feedback. Kyle thanked everyone that responded because it was extremely helpful in the process.

The group decided previously that the target populations needed to be more specific because they were too broad in the toolkit.
Target populations with a narrower focus:

- Adults/children w/ or at-risk for behavioral health conditions
    - Dx w/ mental illness (depression, anxiety, PTSD) and/or low behavioral health needs

- Dx w/ SUD treatment need: alcohol use disorder, opioid use disorder, tobacco use disorder
- Dx w/ SMI (bi-polar disease, schizophrenia) and/or high behavioral health needs
- Co-occurring chronic illnesses: obesity, diabetes, CVD, asthma

The group will continue to review the target populations as we collect more data and will finalize them in the next couple months.

## IV. Programmatic Updates

All ACHs received a score of 100% from HCA for their project plans. CPAA also received a 10% bonus for pursuing six projects instead of four. CPAA will receive a tentative total of $15,855,032 for year one funding with two types of funding, DSHP and IGT. The first installment of funding will be between March and May and the Finance Committee is continuing to develop a method to distribute those funds.

CPAA is also continuing to expand providers in the financial portal so all partnering providers will receive a detailed letter on the registration process. Although we are sending a letter to all partners, it does not guarantee funding.

**HCA update**:

First year funding was based on the project plan that was submitted at the end of the year but this coming year funding will be determined by meeting milestones that lead into implementation plans.

Next year we will earn money primarily through pay for reporting metrics which are still in development by HCA. Some examples of P4R metrics for years 3-5 are listed below:

- Practice/clinic site is actively sharing information (via HIE) to coordinate care
- Providers are trained on project selected evidence-based approach(es)
- Providers who are trained actively implementing evidence-based approach(es)
- Medicaid Providers are defined as clinic/practice sites who provide physical and behavioral health services paid by Medicaid.

**Community Based and Social Service Organizations All Projects - Examples**

- Organization site is actively sharing information (via HIE) to coordinate care
- Organization staff trained on project selected evidence-based approach(es)
- Organization staff implementation of project selected evidence-based approach(es)

These metrics should be finalized by the end of March.

**State Capacity Assessment**:

The State Capacity Assessment will be sent out March 5th through Survey Monkey. It will have skip logic based on the type of provider/organization, and instructions on how to complete it. There will be a PDF of the questions available for reference and the survey will also be on the CPAA website. It will be open until March 26th.

Kyle also informed the group about a meeting between CPAA and P-TCPI. The two organizations are coordinating activities to build on each other's behavioral health integration activities. Currently, they are developing a learning collaborative event with the AIMS center.

- In person/webinar event late spring early summer – topic: how collaborative care Is implemented on the ground
- Yearlong Bi-Directional training starting fall 2018 – 3 phases

1. Planning your model of integrated care (3-6 months)
2. In-person training for integration (2 days)
3. Virtual coaching and additional training (Over 6-9 months)

## V. Milestone 2: Discuss Domain 1 Investments

Kyle created a document for Milestone 2: Domain 1 Investments that support the 2A project. The three Domain 1 areas are Financial Sustainability through value based payment, Workforce, and Systems for Population Health Management, found here. He asked the group for feedback on each document.

**Financial sustainability:**

- Moving from fee for service to value based payment, there's opportunity to incentivize that shift
- HCA created different billing codes to support the Collaborative Care Model
- One concern around training teams/ caregivers
    - How are we going to hire, identify, and place people needed in the work force?
    - How do we create funding for these positions?
    - Locating FTEs, shortage of behavioral health providers
- Kyle suggested trying to create incentives to create these types of teams
    - Use existing work force- ways to offset costs for training or absence from work force
    - Creating new teams will lead to salary shopping and poaching between organizations

**Work Force: Training and Technical Assistance**

- Who's interested in AIMS Center Bi-Directional training – Core Health, Mason General (already using some AIMS), Child and Adolescent Clinic, and Providence
    - Yearlong program, hoping to have all care teams identified so they can participate in it
    - Start dates for the AIMS Center training can be staggered but hoping for all care teams to be completed by the end of 2019
- The TCPI website has a list of training events

**Work Force: Capacity**

- How can we use incentives to draw more family medicine residents to serve underserved areas?
- Should add cost sharing aspect amongst several organizations to strategies
- Need to add support staff to support additional clinicians being added
    - Medical assistants, care coordinators, receptionists
- Look at real cost of the providers
    - Current estimates are lower - add benefits and cost of recruiting to salary
- Reach out to colleges to let administrators know what degrees are short in the medical field/behavioral health
    - UW is doing some of their own recruitment
    - Something for CPAA to look further into

**Systems for Population Health Management**:

- Will continue to share updates and continue to brainstorm more

## VI. Project 2A Logic Model

Kyle created a draft logic model that he shared with the group, found here.

- The partner inputs are still a bit incomplete and need additional input from partners
- All organizations will have their own way of implementing, so just use the core principals of collaborative care as a guide to your implementation
- Metrics: will they be linked to what the requirements are?
    - Do have more information regarding the baseline percentage for these metrics
    - Pay for Performance metrics are listed in the logic model and are the most prominent way of earning funding in Years 4 and 5.

Kyle asked the group if this draft logic model reflect the groups commitment to the work? Does this help think about implementation and what types of changes need to made over the next year and half, and what might be missing?

- Dr. Meyers requested that dental be added
- Rural areas, how do we get the people to help us do this?
    - Such as behavioral health staff, etc.
    - Could telehealth or tele psych help?
        - Telehealth company wants to sell you a block of time but that doesn't match the needs of the hospital
        - Other organizations have had better success partnering with individual providers that offer telehealth services due to lower costs and more flexibility
    - Partner with other organizations to gain support
        - Partner organizations have challenges with capacity as well, not enough man power even if willing to help
    - Creating a bridge between behavioral health degrees, internships
    - School locations not near rural areas
        - Apprenticeship programs through employers
        - Similar to trade school but people can get a degree as well through their employers
        - Shelton has 3 people that have certifications to earn hours to get independent clinician status
    - Contract with clinical providers that provide supervision hours for people to get licensure
- Need to realign Medicare reimbursement with state reimbursement in order to fix pay differential

Kyle shared the need for both Clinic Champions and Administrators to create collaborative care programs and excitement around change. What tools would help build that interest?

- There is a video from the AIMS center called Daniel's story to help paint what collaborative care can do
- Create some kind of a rotation into different medical offices to understand the operations of different providers

  - Example: Dentists in medical clinics and vice versa
  - Training incorporated into schools for training new medical providers
- Some identified stake holders on both sides, identify what's important to them, how is this type of work going to help them meet the metrics, how does this help move patients move into wellness, impact on population health, etc.
- Incorporate personal stories into continued education development taken by providers so they can see the effects and personal case studies
- Have clinic champions that have personal experience act as the "sellers" that can speak the lingo of fellow providers
  - Serve as examples of success of the models
  - Help ease the fear of startup costs, etc.
  - Highlight organizations that have had success implementing their own models of collaborative care

## VII. Next Steps & Closing

- Next meeting is March 27th, 2018
- Finalize Domain 1 strategies
- Continue developing logic model
- Organizations should be thinking about a LOI/RFP for an integrated care program
- Did this webinar work well?
  - In-person is preferred, creates transparency, interaction, and strengthens relationships
  - Suggestion of holding council meetings and work groups in the same day
    - Break into smaller work groups simultaneously