# Transitional Care Integration Meeting

## Meeting Summary, January 30, 2018

**Support and Backbone Staff**: Christina Mitchell, Kyle Roesler, Winfried Danke, Laura Spoor, Megan Moore
**In Attendance**: Jim Jackson – *Department of Social and Health Services*, Jennifer Mooney – *Summit Pacific*, Tina Lomeyer - *Mason General Hospital*, Liz Cattin – *PeaceHealth,* Nancy Holman – Physicians of SWWA, Kay Savage – Physicians of SWWA, Christina Garcia – *Molina*, Janelle Sorrell – *United Health Care*, Carlos Martinez – *Seamar*, Mary Zozaya-Monohon – *Providence*, Marc Bollinger – *Great Rivers BHO*, Terri Camp – *Morton General Hospital*

### I. Welcome and Introductions

Christina Mitchell welcomed the work group participants and facilitated introductions. She reviewed the agenda for the meeting:

- Review project application
- Discuss state capacity assessment
- Finalize target population
- Committee updates
- Discuss integration with other project areas
- Future of the work group
- Next steps and closing

### II. Updates from CPAA & Review Last Meeting

Christina announced that CHOICE has hired a program manager to take over the Transitional Care work and hopes that person will start mid-February.

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 we can disperse, and CPAA hopes to receive funding by mid-May.

### III. Current State Capacity

After receiving an update from HCA, CHOICE has learned that there is no strict format for the assessment and that it can be used to inform and guide planning and implementation of the different project areas. CHOICE wants to use the assessment piece to learn what we need to know, where should we focus or services, and what do we do next. The survey will be released in March. The semi-annual report based on that assessment and will be due to HCA by July 31st.

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. As part of the assessment for Transitional Care, we will look at the shared learnings, work groups, RFQs, and meeting with providers/organizations.

## IV. Finalize Target Populations

Christina reviewed the current target population and asked the group if we should be more specific. Group feedback:

- How do we differentiate between CPAA and Health Homes and not duplicate efforts for narrowing target population?
- Health Homes has very specific criteria; there are many people who are just under that criteria who need care, and CPAA should identify this gap
- Difficult to collect data when you are inclusive; help those who do not fall into criteria but don't use them in data that helps us meet our metrics
- Prism score is delayed data, very restrictive; many people need help but technically do not qualify
- There is a need for increasing provider capacity to serve the population and lower ED visits

The group also noted that there are more risks for smaller communities to take on projects, so how can CPAA help support those communities? One concern is that hospitals can't discharge patients because there is nowhere to release them: where can CPAA help with that?

The Seattle Crisis Respite Center has a successful model to look at as an example. They are using motel room blocks for short term medical stabilization and working with community workers helping to find long term housing during the patients' stay.

## V. Clinical and Consumer Committees

Christina shared updates from the Clinical Advisory Committee (CAC). 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 payments, and securing formal commitments from providers. Some key points from the meeting were the CAC decided to create a group focused only on data/technology because it is too big of a topic, needing clarity on the format of commitment letters, developing a regional strategy for value-based payment, and incentives to support transformation goals.

Christina also shared updates from the Consumer Advisory Committee. They brought up creating a model like Camp Quixote as emergency housing during transition out of the hospital.

Group Feedback:

- Were there RFQs surrounding housing?
    - Are the counties involved in these types of conversations?
- One concern currently is that people have vouchers but there is no housing available
- Patients in rural areas struggle with access to care/appointments
- Transportation is offered through Medicaid
    - Takes all day, up to four-hour window waiting period
    - Require doctor's notes
    - Easy to get blacklisted

  - Very challenging for patients to use
- CPAA could bring vendors to the table, offer education
  - Find vendors from HCA, Christina Garcia could help reach Johnny Schultz
- Limited minutes on people's phones, limited access to a computer to schedule transportation
- Certain counties have a medical bank for medical supplies

The Consumer Advisory Committee expressed that they do not want to be tokenized and asked if someone from the CHOICE Council or Clinical Advisory Committee would attend their next meeting. Dr. Kevin Houghton has volunteered to go to future committee meetings.

## VI. Transitional Care Integration

Christina informed the group that the next council meeting is Thursday, February 8, 2018 from 12:00 pm – 3:00 pm. The council would like to have more shared learnings that identify overlap between project areas. Christina asked the group to identify ways in which the other projects overlap with Transitional Care. Christina also shared that Community Health Workers are written into all ACH plans and there is a legislative bill that defines their role.

2A Bi-Directional Care Integration:

- Depending on primary care or behavioral health, referral process to meet patient needs

2B Care Coordination:

- Care Transitions and Pathways HUB model dealing with transitional care
- Social service referrals
- Behavioral health referrals
- Follow up appointments
- Creating an after care plan, but also implementation of that plan

## VII. 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 10:45 am – 12:15 pm
  - Location TBD
  - Conference Number: +1 (646) 749-3122
  - Access Code: 726-347-661