Chronic Disease Meeting Summary

Meeting Summary, March 27, 2018

Support and Backbone Staff: – CHOICE, Megan Moore, Shannon Linkous, Alexis Sullivan
In Attendance: Mattie Osborn – *Amerigroup*, David Stipe – *Qualis Health*, Vicky Brown – M*orton General*, Julie Nye – *The Child and Adolescent Clinic*, Carlos MejiaRodriguez – *Molina Healthcare*, Laura Johnson – *UHC*, Stephanie Shushan – *CHPW*, Annie McGuire, Lesley Price – *Thurston County*, Jennifer Luna – *SeaMar*, Nancy Holman – *PSWIPA*, Ashley Taylor – *Summit Pacific Medical Center*, Steve Brooks – *Lacey Fire Department*, Dean Counts – *Wahkiakum County*, Elise Reich – *Molina Healthcare*, Amy Kleine – *Peacehealth*

I. Welcome and Introductions

Alexandra Toney welcomed and facilitated introductions. She reviewed the agenda items, which included the following.

1. Domain one investments
2. Target population
3. Core elements of Chronic Disease Control and Prevention
4. Questions for the group
5. Implementation of Wagner's Pillars of Chronic Care: Group Discussion
6. Next Steps

II. Project 3D Logic Model & Domain 1 Investments

Alex reviewed the project 3D logic model, which can be accessed here. Then, she initiated an open discussion about potential Domain 1 investments. She asked the group the following questions. Responses and feedback are listed below each.

1. How can we support partnering providers in the development/expansion of HIE and/or the implementation of evidence based approaches, specific to chronic disease?
    a. Separate ideas, like chronic disease prevention and management. They can be associated, but there will be two separate populations.
    b. EBP based on EMR
2. Which Domain 1 investments should be highest priority and which may be a lower priority?
    a. All of them are important
    b. Community should be invested in more because healthcare often happens outside of the traditional setting
3. What change management software or high-level reporting toolkits are organizations using? Potential barriers and gaps in data practices of potential partners?
    a. Organizations are using Innovaccer and IBM Watson, but they find Innovaccer is the best option so far.
    b. One Healthport and Innovaccer will be interconnected through data links.
    c. One major advantage of Innovaccer is that it does reporting for you.

III. Target Populations

Alex reviewed the target populations that were established by the work group. She compared them against the pay for performance metrics for this project. Work group participants gave feedback on target populations.

- Involve a care coordinator to limit ED visits.
- Implement target populations across projects.
- Request to get more specific on cardiovascular disease and heart disease because they are both broad diagnoses.

IV. Core Elements of Implementation

Alex reviewed the core elements of implementation, which include the six pillars of Wagner's Chronic Care Model in primary care and chronic care support from the community. This generated a discussion based on the following questions. Feedback is listed below each.

1. How is population-based care being implemented in your practice?
   - Picking populations where the most need is seen and going after them.
   - SCHF Work Group within Summit Pacific Medical Center's organization.
   - Expansion of workforce through EDIE registry.
   - Implementation of multi-level system where social determinants of health is considered before chronic disease prevention.
2. What does implementation of the chronic care model look like for your organization?
   a. Most beneficial to implement?
      - ❖ Target CBO's to offer support to patients and generate more engagement
      - ❖ Target motivated and engaged clients who aren't Medicaid patients

   b. What would require the most support/change to implement?
      - ❖ Pre-managed care system
      - ❖ Collaborative care agreements with CBO's, no formal process
      - ❖ Stanford Model – partner with other organizations such as Molina

   c. What would be the easiest pillar to implement or perhaps is already implemented?
      - ❖ WSU implemented diabetes self-management support management system, similar to the Stanford model

V. Next Steps & Closing

- ❖ Topics for next month:
  - Further discussions into subpopulations
- ❖ Develop LOI/RFP
  - RFQs are being reviewed
  - Format to follow
- ❖ Potential chronic disease event in collaboration with Qualis taking place early May
- ❖ Group follow-up to Alexandra Toney toneya@crhn.org
  - Submit any requested training or work group
  - Feedback on logic diagrams
- ❖ Next Meeting: April 24, 2018
  - Fairfield Inn and Suites, 6223 197th Way Southwest, Rochester, WA 98579