Chronic Disease Prevention Meeting

Meeting Summary, January 30, 2018

Support and Backbone Staff: Christina Mitchell - *CHOICE*, Kyle Roesler- *CHOICE*, Laura Spoor- *CHOICE*, Megan Moore- *CHOICE*
In Attendance: Leslie Jones – *Department of Social and Health Services*, Julie Hurlin - *Providence*, Stephanie Shushan – *Community Health Plan of WA*, Dean Counts – *Wahkiakum County*, Phil Jurmu – *Longview WA*, Christina Garcia - *Molina*, Sally Soundgar, Nancy Holman - *Physicians of SWWA*, Kay Savage – *Physicians of SWWA*, Liz Cattin - *PeaceHealth*, Julie Nye – *Child and Adolescent Clinic* , Laura Johnson – *United Healthcare*, Mattie Osborn - *Amerigroup*, Tina Lomeyer – *Mason General Hospital*, Virginia Ramos - *Seamar*, Douglas Spingelt - *Seamar*

I. Welcome and Introductions

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

- Review application acceptance
- Discuss assessment
- Finalize target population
- Updates from the Clinical and Consumer Committee meetings
- YMCA overview by Sally Sundar
- Integration of Chronic Disease Prevention with other project areas
- Restructure of work groups
- Next steps

II. Updates from CPAA & Review Last Meeting

Christina announced that CHOICE has hired a program manager to take over the chronic disease 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 Assessment

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 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 Chronic Disease, we will look at the shared learnings, work groups, RFQs, and meeting with providers/organizations.
The group made the suggestion of being particular with who you contact and how the survey is sent to partners to make sure CHOICE is receiving the needed information.

IV. Finalizing Target Population

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

- Look at ED use for specific chronic diseases; who has the most/highest use?
- Identify if it is a clinic transformation, is it referral patterns, etc.
- Target population will need to be finalized in June, but also depends on partnering providers and their commitments to move the assigned metrics

V. Clinical Advisory Meeting Update:

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 ideas to have patient incentives for getting chronic disease screenings done. This could be done with things like gift cards, gas cards, free haircuts, etc. Also, they discussed holding events dedicated to health screenings more than once a year. Another concern they brought up was that people do not have access to supplies. For example, diabetic Flex pens (don't need refrigeration) for homeless people instead of regular insulin.

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. Sally Sundar, YMCA

Sally Sundar, Director of Health Integration and Transformation, gave a presentation on how the YMCA has successfully worked with other ACHs throughout Washington State. The presentation can be found here.

Integrating YMCA chronic disease programming that focus on equity, families, and community will improve population health in both the clinical and public health fields. The YMCA has a Diabetes Prevention Program, Youth Obesity Prevention, Weight Management, and other programs that overlap with CPAA Chronic Disease Prevention.

The YMCA is also working on ways to set up a referral process of medical providers for clients. The Y has electronic data to share and is currently working with Medicare, increasing involvement with Medicaid, and reaching out to employers.

Group feedback:

- Cost is a factor for people
- YMCA does do discounts, some scholarship opportunities
- Trying to lower cost but also maintain stability
    - Y is seeking alternative payers to maintain sustainability of programs

VII. Integration of chronic disease with other project areas

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 Chronic Disease Prevention.

2A –Bi-Directional Care Integration

- Preparation for surgery, smokers, diabetic patients, etc.

2B-Care Coordination

- Care Coordinators
- Triage with nurse practitioner, ems, and counselor
- Patients age 60+ fall risk

2C-Care Transitions

- Post discharge follow up,
    - Cooking classes, group support, physical therapy
- Screening for depression and anxiety, pathways HUB

3A-Opoiod Response

- Task force, behavioral health, and opiates

3B-Maternal and Child Health (ACEs)

- Outlier, if not included in target population
- Asthma and diabetes diagnosis
- Pregnant women/ Trying to get pregnant with chronic diseases

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 10:45 am – 12:15 pm
    - Call in info: 1-646-749-3131; Access Code: 982-276-437