Combined Chronic Disease and Transitional Care Work Group Meeting

Meeting Summary, 06/26/2018

Support and Backbone Staff: Evan Clayton – *CHOICE*, Shannon Linkous – *CHOICE,* Alexandra Toney – *CHOICE*
In Attendance: Jen Houk – *Providence*, Steve Brooks – *Lacey Fire District 3*, Katie Strozyk – *Lewis County Public Health and Social Services*, David Stipe – *Qualis*, Nancy Holman – *Physicians of Southwest WA*, Stephanie Shushan – *CHPW*, Christina Garcia – *Molina Healthcare*, Kyle Roesler – *CHOICE*, Rene' Hilderbrand – *CHOICE*, Kelli Sweet – *AAA Cowlitz County*, Kate Cross – *DOH*, Jim Reinhardt – *Camano Island First Responder*, Mattie Osborn – *Amerigroup*, Renee Smith – *Summit Pacific Medical Center*

I. Welcome and Introductions

Alex welcomed the group and facilitated introductions. Then, she reviewed agenda items, which included program updates, a guest speaker, and discussion.

II. Program Updates, State Capacity Assessment, and Discussion

Alex reviewed program updates, listed below.

1. RFP was released May 30th, and will close on July 16th with instructions
    a. Send any corresponding questions to rfp@cpaawa.org. Answers will be posted on our website FAQ page weekly.
    b. Second Virtual Town Hall meeting for addressing RFP related questions will take place on July 9th from 2 – 3PM. An invitation will be send out via email.
2. CPAA received 65 LOIs.
3. Will select partners by 8/15
    a. Process: CPAA will work with a third party for scoring RFPs and rating partners. There will be a ratio range of Behavioral Health providers, Community Based Organizations, and Clinical Providers selected. There will also be a specific pool of partners that CPAA will select that may score low in the RFP, but will be integral to the process.
4. CPAA Implementation Plan will be completed in October.

Alex introduced James Reinhardt, from Camano Island fire rescue, who presented to the group about Camano Island's community paramedicine program.

III. James Reinhardt: Community Paramedicine – Camano Island

James introduced himself to the group. He is a WA state community health worker and FTE community paramedicine. He implemented the entire community paramedicine program on Camano Island, and wanted to share some of what works, and what doesn't work, to help others address barriers within their own programs. He shared about a community health needs

assessment completed on Camano Island. On Camano Island, only 15% of the population is Medicaid, so community paramedicine is really used to address the issue of aging. The population is not highly diverse; the depression rate is really high and the exercise rate is really low. One of the issues the population is facing is the amount of disability in the population and especially falls. Over the timeline of four years, the amount of life assists the Fire/EMS have done has quadrupled. This takes them away from being available for other emergency calls, and part of the problem is that there is no fall prevention measure in place. Jim is trying to secure funding for a falls prevention program.

Camano Island Fire Department has 20+ firefighters/volunteers. The amount of calls isn't the problem; it's that access is limited to other calls while they're happening. On the island, there is no direct access to medical, dental or mental health. Patients have to go outside the county to get care, and there is not enough volume to address the need. Additionally, travel and transport time is too long, and a major issue, if there is an emergent need. Camano Island faces several obstacles to better outcomes and barriers to patient-centric care, listed below.

- No shared health records
- Lack of PCP/hospital referrals
- An obsolete "scope of practice"
- Remaining in "silos"
- Cultural and professional biases
- Protection of perceived "market share"
- Fear of changing familiar models of care

Jim shared failures and successes of the program with the group. These are listed below.

Failures:

- Complaints with no follow up ideas for addressing what needs fixed
- Unrealistic perception of personal bandwidth – can't do it all
- Don't underestimate the over resistance you will get to this model of care
- Overestimated the level of acceptance he would receive
- Overestimated the amount of value PCPs would see in having a community paramedic participate in the line of care
- Push back because an ambulance driver is not a community health worker
- If you're going to create a community paramedic model that coordinates with other players in the healthcare industry, you have to have the right model. Referral model or clinical model? This needs to be identified/established ahead of time.
- Case load was underestimated – have a manageable load and be realistic based on capacity

Successes:

- Need to have a community paramedic that gets on it early in order for this model to work – this will mitigate a lot of issues that could arise down the road

- Need to be able to identify the patients who will call 911 repeatedly or high risk patients before they start to utilize services too much

IV. Next Steps & Closing

- Next meeting will be July 31, 2018 from 10:45am – 12:15pm at Fairfield Marriott in Rochester
  - **Call In:** +1 408 740 3766
  - **Meeting ID:** 623 945 277
- Next Virtual Town Hall meeting will be July 9th from 2 – 3PM with invitiation to follow
  - Join from PC, Mac, Linux, iOS or Android: https://zoom.us/j/648215161
  - US: +1 669 900 6833
  - Meeting ID: 648 215 161
- Email for FAQs: rfp@cpaawa.org
- RFP due 7/16 and partnering providers selected 8/15
- Submit any requested work topics or collaboration meetings to: toneya@crhn.org
- Next work group will still remain combined (Chronic Disease and Transitional Care)
- Implementation Plan will be completed in October