CPAA Consumer Advisory Committee Meeting

Meeting Summary, 08/14/2018

Support and Backbone Staff: Madi Tanbara – *CHOICE*, Rene' Hilderbrand – *CHOICE*, Caroline Sedano – *CHOICE*, Kyle Roesler – *CHOICE*
In Attendance: Doug Levitt – *Pacific County & Great Rivers*, Heather Ristow – *Thurston County*, Gary Sweet – *Thurston County*, Erin Oly – *Thurston County*, Sam Silvestro – *Thurston County*, Michelle Richburg – *Thurston County*, Kevin Haughton – *Providence Medical*, Luanne Serafin – *Northwest Justice*

I. Welcome, Introductions, Review of Meeting Minutes

Rene' welcomed the group and facilitated introductions. Due to last-minute relocation, the meeting started later than expected. Rene' explained that the agenda would be shifted to accommodate this change and started with the guest presentations. Other items on the agenda included: CPAA updates, chair/co-chair discussion, open discussion, and next agenda items.

II. Bi-Directional Integration of Care

Kyle Roesler, Bi-Directional Care Integration Manager at CHOICE, began with a brief review of integrated care, including the state of mental health in America.

- Washington State ranks in the bottom 10, indicating poor access and care.
- Average 26-year gap in life expectancy between a person with no mental disorder and a person with any mental disorder in the public sector. Physical health consequences, such as hypertension, can be a factor.
- The greatest percentage of people with mental disorders (40%) seek treatment in primary care, but most do not receive formal treatment at all.
- Whole-person care integrates biological, psychological, and social facets.
    - The biopsychosocial approach includes physical health, medications, life experiences, peer support, and social determinants of health.
- Care integration is on a continuum from low-level intervention (primary-specialty care collaboration) to higher, more complex intervention in a hospital/residential setting. All levels require support from community partners.
- Collaborative Care Model utilizes screening, tracking, and collaboration between a medical provider and behavioral health care manager.
    - Team-based care, psychiatrist consulted as needed, systematic follow-up and measurable outcomes are in place.
- Six levels of integration (AIMS Center) measures the level of integration between behavioral and primary health in a given organization, ranging from level 1 (minimal collaboration) to level 6 (full collaboration in an integrated practice).
    - Most ranked level 2 or 3, meaning coordination could be done more effectively. Some larger healthcare organizations ranked 5, in part due to greater resources.

- Mental health screening – when a patient scores high, the goal is to reduce this score overall and eventually have a patient graduate out of enhanced services. If the score is not improving, treatment plan may need to be adjusted.
- Bree Collaborative Standards outline 8 common elements of integrated care, including:
    - Integrated care team, patient access to behavioral health (BH), accessibility & sharing of patient information, practice access to psychiatric services, systems & work flows to support population-based care, evidence-based treatments, patient involvement in care, and data for QI.
- Integration of BH into primary care (including pediatrics) and chemical dependency setting means the potential for new team roles (care manager, onsite clinician, psychiatric consultant, etc.).
- Other important aspects of BH integration includes implementing mental health screening & follow-up, routine checking of clinical outcomes & altering treatment as needed, medication adherence, accountability for BH quality measures, routine preventative care (such as annual checkup, immunizations), and treatment for co-occurring physical health conditions (diabetes, heart disease, etc.).
- Sample workflow model guides care and implementation in a given medical setting.
    - Diagram Example: Depression in Primary Care, communication among staff (MA, doctor), formal assessment, and referral to mental health service.
- Not all integration strategies are effective, including screening for BH without adequate treatment, referral to BH service without coordination & follow-up, co-located BH specialists without systematic outcome tracking or evidence-based treatments.
- Make efforts to close the loophole so patients do not “fall through the cracks” and get lost in the referral zone, instead get in immediate contact with necessary resources.
- Triple Aim of Healthcare Reform: Better access to care, better health outcomes, and lower overall healthcare costs.
- Where are we now? Kyle provided some program updates to the group.
    - We know our partners (available to view here on CPAA Website)
    - Plans and contracting w/AIMS Center – webinar series to discuss models, integrated care training program in the works
    - Contracting w/a psychiatrist, high demand and short supply of providers
    - Writing implementation plan
- What lies ahead? Kyle gave an overview of what’s to come in the field of bi-directional care integration, including workforce development, clinical practice change to integrate managed care, more emphasis on medication assisted treatment (MAT) in the context of whole-person care, and ensuring care is reimbursed through value-based payment.
- 2020-tasked with being facilitator for transition of healthcare services under one roof, emphasis of quality over quantity in the rollout.
- Kyle concluded his presentation and opened the floor to questions:
    - Would current provider be part of the care team, or does provider have to be changed to participate in integrated care?
        - Capacity will depend on the facility, warm hand-off to physician if care has to be transitioned.

- Has the integrated care program been piloted?
  - Yes, Providence has a clinic, Pediatric Clinic for adolescents in Centralia, Valley View Medical Center. Once funds flow merge, optimistic that programs will be more widely adopted.
- Is the integrated care program fund or outcome driven?
  - Since funds are independent from the structures, there is a better care provided, more early screening and prevention efforts. BHR partnership with Valley View to provide mutual access to patient health record, collaborate on treatment plan for best possible outcome.
- Plan in place to incorporate consumer voice?
  - Consistent part of care models, patients outcomes tracked, patient satisfaction measured by surveys, focus groups, also built into standards, up to organization to transition care, refer to counselor.

III. Reproductive, Maternal & Child Health Project

Caroline Sedano, Maternal & Child Health and Oral Health Programs Manager at CHOICE, provided an overview of the maternal & child health program, specifically the information shared at the last work group meeting about vaccines.

- Adverse Childhood Experiences (ACEs): set experiences with lasting negative health consequences, often leads to trauma, early intervention and care is key to implement during developmental milestones.
- CPAA region is below state average for immunizations, exemptions range from personal, medical, religious.
- High rate of children out of compliance, meaning that immunization series is not complete based on recommendations, documentation may be incomplete due to reasons such as changing providers or barriers that hinder access to available services; includes lack of transportation, parents working multiple jobs, etc.
- Marketing – consumer education, place information in non-medical settings such as grocery store, WIC.
- Friendly, non-threatening promotions that counter vaccine myths like autism link, decision of vaccinating vs. risk of disease.
- Parents and providers undergo training to be local champions, connect with local community to inform and promote vaccinations.
- Policy recommendations include implementing reimbursements, an incentive-based program, and effective patient recall system
- Caroline then opened up the floor for discussion and questions, where the following points were brought up by committee members:
  - Concern over side effects of vaccines, some parents opting for delayed schedule to space out recommended doses. Important for providers to note this in the child's medical chart.
  - Overload of vaccine information provided to parents, often in the form of paperwork. Instead, take the time to sit down with patients and discuss, provide other alternatives.
  - Inform parents on the outcome of their choice to not vaccinate, affects the surrounding community and puts other kids at risk.

- Social media campaigns, Facebook sharing, can be a useful tool for reaching families, keep the message short and to the point.
- State immunization registry – My IR allows individuals to access their records, what vaccines are recommended for you, conduct research at home
- Address supply issues, vaccines constantly changing, new combined vaccines – make sure patients are kept informed.
- Potential for clinical facility embedded within schools, help to address not only vaccines, but the variety of medical services required to improve access.
- Have PCP in school setting, parental consent to treat form.
- Back to school immunization clinic good reminder, prompting for parents to update each year.
- Counselor cross-trained in mental health? Integrated care model has been proposed in schools.

IV. CPAA Updates

Rene' provided committee members with the following CPAA updates:

- Chehalis Tribe – MAT Project and possible syringe program agreement with bordering counties.
- Staff transitions – Executive Director (ED) Winfried Danke has taken on a new role at Providence, and Opioid Program Manager Malika Lamont accepted position in Seattle. CHOICE is currently contracting with an outside source to find an executive director, and application accepted for a new Opioid Program Manager.
- In the meantime, Jennifer Brackeen, Samantha Tatum, and Christina Mitchell will jointly manage operations, and John Masterson, current board member and formerly from BHR, will step in as interim ED.
- Connie Whitener new Squaxin Island Tribal Health Director – all tribes on board for agreement, internal signatures – next steps to determine technical assistance if needed.
- Partners selected – 44 total, 10 reserve capacity building, see link in above notes. 7 were not selected, additional care coordination agencies to come on in 2019.
- Fair & objective selection process, some input from program managers, mostly 3rd party
- New partners kick-off event – afternoon welcome reception planned in September, Rene' will send out invitation to CAC members with further details.

V. Open Discussion, Chair/Co-Chair Decision

Rene' transitioned the meeting into an open discussion about additional topics concerning the committee. The following points were discussed amongst attendees:

- Consumers expressed strong interest in advocacy training, possibly with Vic Coleman, who has done policy & systems training with other organizations.
- Rene' proposed to have the training at regular committee meetings so there is less concern with time constraints.
- Rene' brought up the possibility of a separate 3-day training, however room & board, meal costs would have to be factored in. Another option is a 4-hour training. Rene' stated that more information will be sent out in this week.

- Members expressed that as consumers, they are encouraged to be change agents, and to do so, it is important to be equipped with the proper tools and provided resources.
- Still recruiting CAC members in other counties, 7 total counties served by CPAA, currently the committee membership is very Thurston-heavy.
- Consumers expressed their desire to have more diversity on the committee, including racial, gender identity, younger representation before CAC Chair and Co-Chair selections.
- Consumers shared their frustration that Rene' is the only program manager running both the consumer group, county forums, and tribal relations, while other single CPAA programs have one program manager.
- Members questioned that if CPAA values those being served, why Rene' is split between two programs, suggested one person dedicated to overseeing CAC. While Rene' acknowledged members' frustration, much of the decision making in that regard is above her and would involve ED.
- Statewide youth liaison – request to get younger CAC members at the table.
- Chair/co-chair decision – look at charter again. Committee members stated that taking on either role would be a significant time commitment right now.
- Members stated that they would request additional compensation to serve as chair or co-chair, would like to increase members and diversity before final decision is made.
- Hold off on chair and co-chair right now; Rene' will follow up with consumers, possibly over the phone.

VI. Next Agenda Items

Rene' provided an overview of what's to come for the CAC and upcoming meetings.

- Consumers were frustrated with the last-minute location change to a completely different building and confusion, having to walk through the emergency room to reach the conference room.
- Rene' proposed changing the next meeting to Pacific County, and rotating locations from time to time as a way to provide exposure to other regions and diversify membership. CAC members were fine with location changes to other counties if needed.
- Rene' proposed shifting the October meeting date to include consumers in a webinar, more details and follow-up to come.