Care Coordination Meeting Summary

Meeting Summary, April 24th, 2018

Support and Backbone Staff: Michael O'Neil – *CHOICE*, Megan Moore – *CHOICE*, Shannon Linkous - *CHOICE*
Attendance: Rene Hilderbrand – *CHOICE*, Mary Zozaya-Manahan, - *Providence*, Catherine Monterio - *Seamar*, Julie Nye – *Child* & *Adolescent* Clinic, Jennifer Luna - *Seamar*, Shannon Saegar - *DSHS*, Samnatha Waldbauer – *DSHS*, Phyllis Cavens – *Child* & *Adolescent Clinic*, Apple Martine - *Thurston County Public Health and Social Services*, Carlos Martinez - *Seamar,* Jennifer Houk – *SW* Providence, Jennifer Anderson – *Mason General Hospital*

I. Welcome and Introductions

Michael facilitated introductions and reviewed the agenda items for today's meeting.

- Review Logic model
- Begin to Operationalize Target Population
- Discuss Issues Related to Health Homes
- Discuss Relation of Peer Support to the Pathways Workforce

II. Review Logic Model

Michael reviewed the draft logic model, found here. He asked the group to review the model and give their feedback.

Feedback:

- The goal is to have selected and trained CCAs this year
    - Hope to be up and running by November
    - Start sharing data and tracking progress
    - RFP process will be released soon in May for agencies to apply to become one of the 6 selected agencies
- CCAs have not yet been identified
- Up at the top of the dates, there is a big gap between 2018 and 2021
    - Are you going to redefine some of those targets to create a more detailed timeline?
    - Will help partnering organizations to look at and gain a clear picture
- Will continue to work on the right size of the target population as a group

III. Begin to Operationalize Target Population

During the last meeting, the group decided on a set target population, so now Michael wants to begin to operationalize the selected target population. Michael reviewed the Target Population, found here. After reviewing the document, there was a suggestion to organize the selected population by most populated/severity. Also, the group wanted to change "high blood pressure" to "cardiac" and add tobacco use listed as a substance.

After review of the Target Population, Michael asked the group to think about a potential referral process: where are these people most likely to show up?

There are two ways people are referred to the HUB.

1. Seeking help at partnering organizations that meet HUB criteria
2. Organizations such as managed care partners/hospitals/other organizations that have data on their patients already

Seamar explained their process of referrals. They have really focused on engagement and outreach by having a Community Health Worker (CHW) go out and screen clients that are active in Medicaid and seeing a provider. They also reference past addresses and phone numbers. It is time consuming but very successful. Seamar believes their CHWs will spend most of their time engaged in outreach efforts, especially in more rural areas. One idea that needs to be developed is how to create an identifier by a specific Point of Entry.

Michael then asked the group, "From your organization's perspective, how you would go about identifying folks that fit our criteria? What is the best way to operationalize?"

Michael passed around some index cards to each person to write down their ideas and feedback.

- Emergency Department patients
    - Mom delivering baby, moms who have used substances
- Community Care Centers
- Both in patient/outpatient psych clinic
- Could we have health workers in that setting where people are at?
    - hard to follow up with some people after they leave care
- Could tie into Transitional Care
    - Such as the EDIE system to find patients and see where they're at
    - Seems to increase engagement
    - Find some motivation/incentives to get people to engaged
        - Health Homes is free so they experience a lot of no shows, lack of dedication by utilizers
        - Opportunity for us to talk to health plans to adjust incentives structure with HUB
- Connecting with clients, really listening to their needs, identifying barriers, and building trust
    - Biggest complaint is feeling impersonal connection with primary doctor
    - Patients value what their doctors tell them what to do (it's an AND not an OR)

IV. High Rates of Death

Michael referenced a census document, found here. This list is looking at each census tract with a high mortality rate. This could be used as another layer to the target population per 100,000 people. The group could target these geographical locations as a filter to apply to our target population. The group liked the idea but would like to see a geographical map of these census tracts. They would also like to know the cause of the mortality rates, and they want to add the population next to each census tract as a better visual.

V. Discuss Issues Related to Health Homes

During the previous meeting, group members wanted to discuss the overlap of Health Homes clients with our target population. Due to technical difficulties, Kathie Olson was unable to join the call but will discuss this further at the next Care Coordination meeting.

Michael did reference a document from HCA, found here, which discussed some frequently asked questions and answers about the Pathways HUB Model and DSRIP.

The group had some discussion around this topic as well. They determined that Maternal and Child Health would have the least overlap with Health Homes. Patients with a behavioral health issue as a primary diagnosis are less likely to be Health Homes eligible. Michael did clarify that HCA stated that people who are eligible for Health Homes need to be enrolled into Health Homes over Pathways. Pathways needs to follow HCAs guidelines for Health Homes with overlap of clients.

The group then discussed two issues with Health Homes criteria:

1. People can have a rising prism score but still not be eligible, could be introduced into the HUB
2. Declining Risk – ability to take patients off the program but they still have needs that could be addressed in care coordination

Michael asked how do we create a beneficial/healthy relationship with Health Homes? We will revisit the Health Homes piece during the next meeting.

VI. Discuss Relation of Peer Support to the Pathways Workforce

There is alignment for Peer Support in Washington State, and Michael wants to continue to get a clearer expectation on what that means for Pathways. Michael referenced a Peer Support document, found here. Part of the role of a Peer Support's work is talking about their own experiences as a way to connect with people they are working with. Could this be criteria for developing a work force?

- Some agencies require an associates or a bachelor's degree, which is limiting
- Successful in building trust and getting people to engage
- Could be too limiting to require this level of staff who don't have required supervisor
- There is a Medicaid billing code for peer counselors

VII. Environmental Scan

Michael referenced an Environmental Scan, found here. Michael wants the group to determine what the right level of workforce is. Community Health Workers and Peer counselors are potential options.

He asked the group if they are thinking of specific criteria for hiring staff?

- Fit for Hire - People have to feel comfortable in trying to engage people
- CHW position in heavily dominated RN and Social Worker field
    - Will have to have a lot of supervision
        - Training on setting work boundaries
        - Clear communication with the care team so issues are not missed
    - CHWs could fill out paperwork; that takes work load off of other care team members

- The HUB has very direct pathways so it helps with setting work boundaries

Summary and Next Steps

- May 29th, 2018 3:15pm- 4:45pm
  - Fairfield Inn and Suites
  - 6223 197th Way Southwest, Rochester, WA 98579