Bi-Directional Care Integration Work Group Meeting

Meeting Summary, 07/31/2018

Support and Backbone Staff: Kyle Roesler – *CHOICE,* Abby Schroff – *CHOICE*, Madi Tanbara – *CHOICE*
In Attendance: David Stipe – *Qualis* , Rene Hildebrand – *CHOICE,* Christina Garcia – *Molina Healthcare,* Dr. David Meyers – *Cowlitz Family Health Center,* Stephanie Shushan – *CHPW,* Alicia Ferris – *Community Youth Services,* Mattie Osborn – *Amerigroup,* John Kern- *AIMS Center,* Mike McIntosh – *Catholic Community Services*, Dian Cooper- *Cowlitz Family Health Center* , Mario Paredes - *Consejo Counseling and Referral Service,* Jennifer Mooney – *Summit Pacific,* Vicky Brown – *Morton General,* Annie McGuire – *Providence,* Anne Shields - *AIMS Center*

I. Executive Summary & Next Steps

- The next meeting will be on August 28, 2018 from 9:00am -10:30 am at Fairfield Inn and Suites, 6223 197th Way Southwest, Rochester, WA 98579.
- 56 organizations submitted a RFP. They are currently being scored by OHSU, and partnering providers will be selected and notified mid-August.
- Dian Cooper from Cowlitz Family Health Center presented about their process of developing behavioral health integration. Her presentation can be found here.
- Work group members discussed the implementation plan and key indicators to measure performance progress. Qualitative and quantitative metrics were discussed for both primary care settings and behavioral care settings. A draft of the metrics can be found here. These will be finalized over the next several months. Partners will likely select a subset of final metrics.
- Kyle informed the workgroup of a psychiatrist in SW WA interested in serving in the psychiatric consultant role as defined in the Collaborative Care Model (CoCM). He is available up to 15-20 hours per week to serve in this role for partners implementing the CoCM. CPAA is considering covering the consulting costs so this service would be no cost to partners. Please email Kyle if you are planning to implement the CoCM and need psychiatric consultation services.
- Due to time constraints, the workgroup was unable to discuss the Bi-Directional Training program. Kyle will send out an email to update members on the process of enrollment.

II. Welcome, Introductions & Pre-Meeting Updates

Kyle welcomed the group and facilitated introductions. Kyle reviewed the agenda, which included: a presentation by Dian Copper from Cowlitz Family Health Center, key performance indicators from the Implementation plan, reviewing a psychiatric consultation opportunity, and the AIMS Center Bi-Directional Care Integration training program. Other updates include:

- CPAA is currently developing tools for accountability and reporting between partners. CPAA is developing a change plan, similar to a work plan, which partners will be required to fill out.
- Workgroup members are encouraged to take HCA Value based payment survey to measure the use of VBP among Washington State providers. It should take no

more than 30 minutes to fill out. If you have not done so already, please click here to access the survey.

- RFPs scores should be finalized by August 15th, and the first round of funding will be distributed in October.

III. Cowlitz Family Health Center- Dian Cooper

Cowlitz Comprehensive Health Care Group began as a unique partnership of three nonprofits with the goal to provide integrated care. Referrals were being made between organizations, but no connections or follow ups were being provided. Together, they spent over a year learning each other's processes to make a total connection or "no wrong door policy."

Goals established for Cowlitz Family Health Center included improved access to care, streamlined communication and referral processes, increased provider education, and increased medical outcomes with a decrease in cost. Things that worked well included a standardized screening tool, increased patient access to a Psych ARNP, hiring more nurse practitioners with MAT waivers, and warm hand-off work flow between organizations due to medical assistants being able to access behavioral health professionals on site. Initial barriers included more patients being screened positive for BH conditions and not having the capacity to support increased case load, patients not being ready to accept treatment, and patients dropping out of treatment.

Multiple projects and studies support the alliance of organizations and found that primary care satisfaction and productivity increased as a result. Dian continued on to discuss the history of CFHC, which began operating as an integrated organization in 2014. During the next year, CFHC incorporated outpatient and residential substance use disorder treatment services into service lines, contracting through Cowlitz County for reimbursement. Since the integration and coordination of care, CFHC has been much more successful getting people into treatment.

Since offering Substance Use Disorder Continuum of Services, there has been little pushback from clients. Dian made the case that when different lines of service communicate with each other and use the same health records that health care can be provided quickly and with quality. This type of integrated treatment will also help to normalize addiction and mental health disorders. When asked how restrictions apply to integrated PCP records, Dian responded by explaining the process they used including charting form development into different record systems and having assistance from attorneys help with legal wording and consent forms of information being shared. Although some clients are listed as confidential for billing and coding purposes (e.g. SA/DV survivors, STI positive teens), clinicians can still review their health information.

After her presentation, Dian answered questions from the workgroup. Additional discussions included how productivity was measured by providers each month. Through a Washington Department of Health grant, they were able to measure pre and post productivity and satisfaction. Availability of behavioral health professionals was also a concern. Clinician availability was addressed by changing scheduling of appointments to have built in flexibility seeing patients as needed, trying to accommodate same day appointments. The responsibility of

MAT billing through health plans was also briefly discussed, as BHOs become integrated with MCOs.

IV. Key Performance Indicators- Implementation plans

Key performance indicators for the implementation plan must be submitted by October 1, 2018. This is a key deliverable for CPAA to receive funding for year 2 of the Transformation, and will contain more specific information about the project work being implemented in the region. The workgroup reviewed a table of draft metrics that may be used to track project implementation progress. Partners will not be responsible for all of the metrics, only a small selection. The document discussed can be found here.

Feedback from review of Primary Care Setting:

- Measured HbA1c over 9 instead of 7
- Change standard BP measurement to 130/80 instead of 140/90
- More about what you are doing and why (value based contracting), and if clients are getting better and healthier. Checking back in to see if there is still a need.
    - Makes it difficult to measure stability when you are just looking at symptoms rather than broad outcomes perspective
    - Should incorporate social determinates of health
- Pay for performance- looking more at substance use disorders in terms of social determinants of health. Important to look at needs and outcomes.
- What can you look at for outcomes that can be measureable that all partners can use?
    - Can measure functional impairment - already clinically laid out and can measure if it is improving
    - Additional Tools for behavioral health
        - CANS- multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.
        - SDoH is in the next rollout in epic, will be incorporated into the chart – pilot program
    - Discussed leaving the tool used up to the individual providers to utilize it and to show outcomes (ex. Depression remission-below certain threshold over entire population, or improvements in individual chronic conditions for populations served measured with pre and post data)

Feedback from review of Behavioral health setting:

- Remember the point of what we are trying to measure – collaboration; the goals and plans that are created, the exchange of information. Should have providers/partners be able to demonstrate that in their plan
- Using population based care: should be adaptive. Are they being evaluated that that strategy is effective for that population?
- Evidence Based Care: important to integrate with existing BH agencies that will impact their physical health

- Some organizations have selected to do multiple projects so finding a balance of metrics to measure is important.
    - One suggestion was for CPAA to specify what type of measurements want to be taken, and hopefully data already being measured can be used to reduce program workload.
- Important to ask "How do we measure progress when each organization is measuring different metrics and reporting on different items?" ACH has a list of common measures - more physical health when compared to behavioral health

V. Review psych consultation role in collaborative care:

Kyle announced that there is a Psychiatrist who is currently in the Community-Based Integrated Care Fellowship at UW. He has 15-20 hours available to serve as a psychiatric consultant as defined in the CoCM, starting in Nov-Dec. Kyle is in communication with him to form a contract that will use Domain 1 funding to cover costs for organizations that are interested. For groups who are interested in utilizing this service, Kyle will send out an email with more information about next steps.