Combined Chronic Disease and Transitional Care Work Group Meeting

Meeting Summary: 12/04/2018

Support and Backbone Staff: Alexandra Toney – *CHOICE,* Abby Schroff- *CHOICE,* Madi Tanbara – *CHOICE*
In Attendance: Robyn Hansen- *PSWIPA,* Cheryl Moses-*PSWIPA,* Melissa Taylor- Lower Columbia CAPS, Davis Stipe – *Qualis,* Jennifer Luna- Seamar, Jennifer Anderson – Mason General. Kelli Sweet – Area on aging, Rachel Akins – Providence, Lesli Price – Thurston Co, Michael O'Neill – CHOICE, Karla Cain – Answers Counseling, Stephanie Shushan – CHPW, Kate Cross – DOH, Leslie Scharbrough – Molia, Elizabeth Schimper – Grays Harbor, Rene Hilderbrand – CHOICE, Christina Mitchell – CHOICE, Jennifer Anderson – Mason County

I. Welcome, Introductions & Pre-Meeting Updates

- CHOICE and CPAA has hired a new CEO, Jean Clark. She will be staring December 10.
- Change Plans were submitted on October 15th for review by CPAA. They were returned with feedback on November 1st and a final draft was submitted November 15th.
- The final draft will be approved by December 15th and will trigger a release of funds as partners' first deliverable.
- CPAA is beginning a value-based payment awareness campaign to share resources, educational materials, and VBP tools with partner organizations.
- CPAA will host a webinar in January to talk about the metrics data platform. More information will be provided later.
- More Information can be found in the PowerPoint Slideshow.

II. Community CarePort

Michael O'Neill, CPAA Pathways Program Manager, provided and overview of CPAA's care coordination project, and answered questions from members of the Committee. The project is implementing the Pathways Community Based Care Coordination model, and has adopted the title "Community CarePort".

The Pathways model can be simply defined as: Find, Treat, Measure. This design helps care coordinators meet all the possible needs of the client in a location that the client is most comfortable in. These services will be delivered by Community Health Workers in the communities they are serving. The target population for Community CarePort includes clients who have complex health needs such as co-occurring chronic conditions, behavioral health needs, and other risk factors such as homelessness, frequent emergency services utilization, or recent release from jail.

Care coordinators help clients prioritize their health, break goals down into manageable steps, and keep clients on top of their health through increased support and access to health care agencies. This is managed through the Community CarePort software platform. Referral Partners link appropriate clients to a care coordinator that can help navigate different systems. Care Coordinating Agencies document clients' journey through systems in the region, creating new data about bright spots and barriers that clients may face.

Community CarePort had a soft launch of services this month, and is currently working with five Care Coordinating Agencies that are starting to accept clients. Work will continue in the coming months to build a robust referral network, and to develop additional tools and strategies to better align a wide variety of care coordination services already provided across the region. There is especially work to be done aligning transitional services with CarePort. There are more opportunities for Transitional Care agencies to become Care Coordinating Agencies.

While the core care coordination services are up and running, it was clear there is more need than current capacity. There is also a need to carefully integrate with existing clinical services to avoid duplication of coordination efforts. If there are any further questions about Pathways collaboration or care coordination agencies, Michael can be reached at oneillm@crhn.org. For Michael's presentation, Please click here and here.

III. Next Steps & Closing

- Next meeting will be **January 29, 2018** from 10:45am – 12:15pm at Fairfield Marriott in Rochester
    - Call in information will be sent out with a calendar invitation
- Submit any requested work topics or collaboration meetings to: toneya@crhn.org
- Next work group will remain combined (Chronic Disease and Transitional Care)