HUB Advisory Committee (Care Coordination) Work Group

Meeting Summary, December 4th, 2018

Support and Backbone Staff: Michael O'Neill- *CHOICE*, Madi Tanbara – *CHOICE*, Abby Schroff - *CHOICE*
In Attendance: Robyn Hansen – *Physicians of Southwest Washington*, Kirsten York – *CAC of Lewis, Mason & Thurston Counties*, Jennifer Anderson – *Mason General Hospital*, Karla Cain – *ANSWERS Counseling*, Lesli Scarbrough – *Molina HealthCare*, Lynette Gregory – *Providence Health & Services*, Katie Strozyk – *Lewis County Public Health & Social Services,* Cole Magley – *Gather Church*, Patti Howard – *Gather Church*, Laura Johnson – *United Healthcare*, Mattie Osborn – *Amerigroup*, Ophelia Noble – *Noble Foundation*, Lynn Nelson – *ESD-113*, Jason Hoseney – *Costal Community Action*, Cash McCollum – *Costal Community Action*

I. Welcome and Introductions

Michael facilitated introductions and reviewed the objectives for the meeting, which included:

- Review CPAA & Pathways HUB Updates
- Discuss Statewide Care Coordination Landscape
- Input on Next Steps for Community CarePort Implementation

II. Review CPAA & Pathways HUB Updates

Michael shared CPAA updates with the workgroup, as well as program-specific updates relevant to Pathways HUB.

CPAA Updates

- New CEO, Jean Clark, will be staring her position December 10th, and will be attending the December CPAA Council Meeting as well as future workgroup meetings.
- CPAA has two open positions: Community Outreach Coordinator and Pathways Referral Coordinator, both listed on Indeed.com
- December 14th – Formal Change Plan approval, which will initiate reporting payment, dispensed before the end of 2018.
- CPAA released a RFP for Local Forums to receive additional funding for hosting regular meetings.
    - RFP open through Jan. 11th, Q&A webinar December 14th, 2019.
    - Please visit www.cpaawa.org/cpaa-news/ for more information on upcoming events.

Pathways HUB Updates

- CPAA's Pathways project has been titled, "Community CarePort", to better capture the vision and work of the project. For more information, please contact Michael O'Neill (OneillM@crhn.org).
- Logic model depicts Community CarePort's workflow, including inputs, main infrastructure, and client & system outcomes.
- Strategize methods for data sharing to reduce duplication across care coordination services.
- Technological tools and EMR data linkage are two key parts of the infrastructure that create a foundation for the care coordination strategy.

- Pathways platform provides flexibility to adapt for additional care coordination efforts in the region.
- Two types of outcomes – individual and system-level.
    - Individual: Increasing access to care services, mitigate identified risks, and connect with an advocate to support them in meeting their health objectives.
    - System: Integrating into one streamlined system with data sharing and gap analysis.
- Focus efforts on developing a regional policy agenda amongst partners.

- Community CarePort started its soft launch on November 5th!
- 2 week training is underway for care coordinators – week 1 took place in October, followed by a practicum period for trainees to get familiar with the system and begin seeing clients.
- December 10th – final week of training, wrap-up period.
- Pathways training involves utilization of software tools, practice clients, education on skillsets for care coordination (safety, personal boundaries, MI), and basic health literacy education.
- The intake process consists of an initial profile and checklist to screen the client, which automatically generates 20 standard pathways.
- More care coordination agencies are in development, the first cohort is in training, and 8 more agencies to come on board within 2019 to develop a more robust network.

III. Discuss Statewide Care Coordination Landscape

Michael provided the group with an update on the current state of care coordination on the state level, including ongoing conversation and upcoming opportunities to engage in care coordination efforts.

- There has been continued statewide conversation about the sustainability of Care Coordination, including after the Medicaid Transformation.
- **October 30th** – Meeting with ACHs/MCOs
    - Continue system evaluation, and discuss effective measurement strategies.
    - Create a straightforward, standardized process to connect partners with local care coordination agencies.
- Implement a shared community inventory with up-to date resources.
    - Partners noted disconnect in referrals for home visiting programs, and expressed interested in further discussion.
- Community Health Worker (CHW) Taskforce provides training and education for CHWs.
    - State wide CHW taskforce reconvening in 2019

    - **December 29th** – Regional CHW Listening Session to gather input from CHWs.
        - Location: Youth & Family LINK!, 907 Douglas St., Longview, WA
        - Child care is available.

    - **Action:** Michael will follow up with main contact information for the CHW Taskforce.

IV. Input on Next Steps for Community CarePort Implementation

Michael shared what's to come in the implementation of Community CarePort, and provided prompting questions to receive workgroup feedback on these next steps.
    - Focus on expanding referral network, developing QI system, further aligning w/other MTP activities, and coordination for Cohort II onboarding.
- Continue increasing growing overall capacity and systems, communicate progress.

Feedback & Discussion

- Plan for monthly care coordination agency meetings starting Jan. 2019 to review data, identify opportunities to strengthen practices, share skills, and support collaborative efforts.
- Include integration of care coordination into future contracts.

- **Which topic is most relevant for you and your organization?**
- Potential opportunities with nurse case management program, and True North, which supports homeless and at-risk youth.
- ESD-113: Navigator program that supports students, and often times their families are also in need of resources. **Action:** Michael to follow-up with ESD-113.
- Further development for youth and families is critical, possible insight from Youth & Family LINK
- Care Coordination portal will be a critical tool for busy case management staff.

- **How do we leverage our tool to support other care coordination programs?**
- There are organizations in multiple tiers with varying capacities that utilize CarePort tools, from full-on care coordinating agencies to other community partners.
    - What can be done to meet their individual needs?

- **What supports are needed to help your organization engage in the HUB?**
    - Natural referrals occur through coordinated entry, integrate pathways into existing infrastructure vs. being a separate entity.
    - Refer clients back out to partnering agencies, integrate with Community CarePort.
    - Consider an organization's capacity to grow, including identification of possible barriers.
    - Avoid duplication or hindrance if a system designed for coordinated entry is in place.
    - Coordinate a system that accounts for crossover between clients.
    - Care traffic control – examine community need, co-pilot patient's journey, create an effective workflow between providers to form a dynamic team.
    - Have an individual serve as the "point of contact" to provide client support.
    - Allow client notes to be accessible across agencies, walk client through resources.
        - Currently, there is greater need than capacity, which is why the focus remains on expanding the network of care coordinators.
- **How would you or your agency make use of Community CarePort communication tools (e.g., flyer, one pager, website, etc.) and what program element of CarePort would you focus on?**
    - Two levels of support materials—one for agencies, one for consumers
    - Focus on the selling points of why utilizing a care coordinator is valuable, using evidence-based support.
        - Increased access to care, speak with client to identify their individual needs, simplify, prioritize and engage in their care management.

- Utilize EMR system for care coordinators to follow client's progress.
- Develop a system where there is a solidified business relationship that allows the care coordinator to advocate for their client.
- Ensure the client's healthcare provider is aware of the care coordinator's role and maintains clear communication between all parties.
- Distribute one-pager to agencies, include the "who, what why, where, when."
- Share ROI and other consent forms with providers.
- Build client care team, send regular updates via dashboard to providers to capture client's progress and outcomes, and patient notes, results of screenings, etc.
- Use "Pathways" tab to track standardized pathways, and dashboard to indicate when client begins working on and completes different pathways.
- Care team dashboard
- Utilize checklists, determine any changes from last visit, and capture additional information shared by the client.
- Other system options include risk screening, home safety assessment, healthy changes tool, patient activation measure (how engaged a client is in their own care).
- Lessons learned from focus groups – tools and processes to apply in the broader community?

V. Next Steps

- December 10-14: Final week of Cohort I Training
- Building out referral network
- Starting up regular QI/QA activities
- Continue state-wide care coordination discussions
- Next workgroup meeting is **January 29th, 2019**, from 3:15-4:45 PM at Fairfield Inn & Suites, (6223 197th Way Southwest, Rochester, WA, 98579).