Whole Person Care Collaborative

March 1, 2021
Introduction

Welcome

Introductions

Consent Agenda
  February Minutes
  March Agenda
Announcements/Updates
Partner Updates

• Managed Care Organizations

• Community Based Organizations

• Clinical Partners
Empire Health Foundation is proud to partner with Premera Blue Cross on the Washington State Rural Facilities Capital Grants Partnership Fund. The Fund supports the advancement of quality healthcare in under-resourced communities by making grants to hospitals, clinics, health centers, and other healthcare providers in rural areas of Washington State.

Grants will support equipment purchases and small capital projects that rural healthcare facilities may have difficulty funding due to capital constraints. Investments in the infrastructure of rural clinics can contribute to increased access to services for patients by adding new technology or equipment that may have been previously unavailable. Improvements to health facilities and equipment also have a proven positive impact on physician retention and recruitment.

 empirehealthfoundation.org/our-programs/rural-facilities-capital-grants-partnership/
Reports are due Wednesday, March 3 by COB. Please upload to the portal.

Mariah Brown will oversee all Practice Facilitation in NCW. This is a change for Grant County.
Announcements
Behavioral Health Services

- We provide a solid foundation for children and families through services:
  - Therapeutic Foster Care
  - Child and Family Therapy
  - WISe (Wraparound Intensive Services)
  - Parent Education: Incredible Years Parent Training, Triple P
  - School Success: Readiness to Learn, Truancy Intervention Program
  - Triple Point-LGBTQ Group
This role has developed over the last two years starting with simple referrals to primary care providers to now an integral part of developing and implementing a change plan to better address our client's whole care needs.

Coordinators Role:
- Started with PCP referrals, transportation referrals, dental referrals, and sleep study referrals
- Moved to a more hands on focused change plan of tracking High BMI scores and depression screening and follow up
- Collaborative work with the Child and Family therapist supervisor developing the change plan
- Collaboration with the Child and Family therapist team in collecting and analyzing data
Our agency chose High BMI Scores as a focus as we do not have the capabilities of collecting A1C and BMI is a health risk factor associated with diabetes in youth.

- Childhood obesity affects more than 18% of children making it the most common chronic disease of childhood (Obesity Action Coalition, 2018)

- Pre-covid days we were weighing and measuring youth in the office to collect BMI scores.

- Today (virtually) we are asking the parent or youth their height and weight to collect this data.

- Our EHR system calculates the BMI number and percentage.
Clients that score above the 85th percentile at intake are then referred to the WPC coordinator.

Coordinator tracks each client in an excel spread sheet with the client’s name, BMI score, letter and resources sent, and follow up outcomes.

Each client is sent a letter informing them of the high BMI and resources for addressing health along with the contact information for the PCP to discuss nutrition services.

Coordinator follows up with the client 3 months later to answer any questions and to confirm utilization of resources.
Resources

10 tips
Nutrition Education Series

be an active family

Physical activity is important for children and adults of all ages. Being active as a family can benefit everyone. Adults need 2½ hours a week of physical activity, and children need 60 minutes a day. Follow these tips to add more activity to your family’s busy schedule.

1 set specific activity times
Determine time slots throughout the week when the whole family is available. Devote a few of these times to physical activity. Try doing something active after dinner or begin the weekend with a Saturday morning walk.

2 plan ahead and track your progress
Write your activity plans on a family calendar. Let the kids help in planning the activities. Allow them to check it off after completing each activity.

3 include work around the house
Involving the kids in yard work and household activities is a great way to get them moving.

4 keep a supply of healthy foods
Make sure your family has healthy snacks and meals easily accessible. Stock the pantry and refrigerator with fresh fruits, vegetables, and low-fat dairy options.

5 plan for all weather conditions
Choose some activities that do not depend on the weather conditions. Try mall walking, indoor swimming, or active video games. Enjoy outdoor activities as a bonus whenever the weather is nice.

6 turn off the TV
Set a rule that no one can spend longer than 2 hours per day playing video games, watching TV, and using the computer (except for school work). Instead of a TV show, play an active family game, dance to favorite music, or go for a walk.

7 start small
Begin by introducing one new family activity and add more when you feel everyone is involved.

8 be an active family
Fatigue is no excuse — use all that extra energy to find a family activity you can do together.

What is Childhood Obesity?
Childhood obesity affects more than 18 percent of children, making it the most common chronic disease of childhood.

Today, more and more children are being diagnosed with diabetes, hypertension and other co-morbid conditions associated with obesity and severe obesity.

A child is affected by obesity if their body mass index-for-age (or BMI-for-age) percentile is greater than 95 percent. A child is affected by excess weight (or classified as “overweight”) if their BMI-for-age percentile is greater than 85 percent and less than 95 percent.

Causes of Childhood Obesity
Although the causes of childhood obesity are widespread, certain factors are targeted as major contributors to this epidemic. Causes associated with childhood obesity include:

- Environment
- Lack of physical activity
- Heredity and family
- Dietary patterns
- Socioeconomic status
Depression Screening and follow up

- We are utilizing the PHQ-9 to assess clients 12 years and older for depression and progress.
- Therapists are assessing initially at intake and then monthly with assigned therapist.
- If the client scores 15 and above the intake therapist administers the Columbia Screener at intake and a safety plan is created upon clinical judgement.
Columbia Depression Assessment Tool

Ask questions that are in bold and underlined.

<table>
<thead>
<tr>
<th>Past month</th>
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<td>YES</td>
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Ask Questions 1 and 2

1) *Have you wished you were dead or wished you could go to sleep and not wake up?*
   Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

2) *Have you had any actual thoughts of killing yourself?*
   General non-specific thoughts of wanting to end one’s life/die by suicide without general thoughts of methods, intent, or plan.

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

3) *Have you been thinking about how much you might do this?*
   Person endorses thoughts of suicide and has thought of at least one method.
   e.g. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.”

4) *Have you had these thoughts and had some intention of acting on them?*
   Active suicidal thoughts of killing oneself and reports having some intent to act on such thoughts.
   e.g. “I have the thoughts but I definitely will not do anything about them.”

5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*
   Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.

6a) *Have you done anything, started to do anything, or prepared to do anything to end your life?*
   Examples: Collected pills, obtained a gun, gave away valuable, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
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<tbody>
<tr>
<td>1) Seek behavioral health counseling services and/or contact crisis line.</td>
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<tr>
<td>2) Seek behavioral health counseling services and/or contact crisis line.</td>
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<tr>
<td>3) Seek behavioral health counseling services, psychiatric services/evaluation, and/or contact crisis line.</td>
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<td>4) Seek psychiatric services/evaluation by behavioral health intake/emergency room/EMT.</td>
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<tr>
<td>5) Seek psychiatric services/evaluation by behavioral health intake/emergency room/EMT.</td>
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<tr>
<td>6a) Seek behavioral health counseling services, psychiatric services/evaluation, and/or contact crisis line.</td>
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<tr>
<td>6b) Within 3 months: Seek psychiatric services/evaluation by behavioral health intake/emergency room/EMT.</td>
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Any YES indicates that the person should seek behavioral health counseling and/or contact crisis lines at: National Suicide Prevention Lifeline 1-800-273-8255, text “Home” to 741741, Behavioral Health Response (BHR) 1-800-811-7466, Provident Crisis Services (PCS) 314-647-4357, KUTO 1-888-644-5886, Trevor Project (LGBTQ) 1-866-488-7386. However, if the answer to 4, 5 or 6 is YES, seek immediate help: contact behavioral health intake, go to the emergency room, or call 911.

Missed depression screening & follow-up

Provider

- Staffing changes
- High Caseload
- Forgetting to screen regularly

External factors

- Lack of working resources: internet/phone/tablets
- COVID limited appointment availability

Patient

- Refusal to complete screener
- Minimizing symptoms
- No show appointments

System / organization

- Lacking training
- No/unclear tracking system or workflow to screen regularly
- Slow progression to access Zoom
Nominal Group Technique

A. Clinician: Staffing changes
B. Clinician: High Caseload
C. Clinician: Forgetting to screen regularly
D. Client: Refusal to complete screener
E. Client: Minimizing symptoms
F. Client: No show appointments
G. Client: Lack of education on depression
H. Client: Doesn’t understand how to complete screener
I. External Factors: Lack of working resources such as phone, internet, tablet
J. External Factors: COVID limited appointment availability
K. System/Organization: Not providing training to administer assessment
L. System/Organization: No/unclear tracking system or workflow to screen regularly
M. Slow progression to access zoom for telehealth appointments
Nominal Tool Findings

Top 3 Findings:
C. Clinician: Forgetting to screen regularly
F. Client: No show appointments
L. System/Organization: No/unclear tracking system or workflow to screen regularly
Plan of Action

- We updated our workflow for all assessments to include when to screen and where to record the results.

- We created individual excel tracking sheets for therapists to track the monthly PHQ-9 scores with the youths age, diagnosis, score, and follow up plan if applicable.

- A reminder was set in our EHR system at the beginning of each month for all clients 12 years and older.
Workflow example:

- **PHQ-9**
  - When: Intake, monthly, as needed to monitor depressive symptoms
  - Where: ICANotes>Client face chart>Forms/Assessment>PHQ-9 modified for Teens.
  - Reporting: tracking sheet on H drive

- **CATS**
  - When: Intake, at treatment planning, as needed to monitor trauma symptoms
  - Where: ICANotes>Client face chart>Forms/Assessment>select appropriate version based on youth/caregiver and age.
  - Reporting: tracking sheet on H drive

- **PSC-17**
  - When: Intake, as needed to monitor symptoms
  - Where: H drive>Child and Family Counseling>Clinical Assessment Tools and Data> PSC-17>choose appropriate version
  - Reporting: none

- **Columbia Suicide Screener**
  - When: PHQ-9 score > 14
  - Where: ICANotes>Client face chart>Forms/Assessment>Columbia Suicide Screener (CSS)
  - Reporting: none
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>dx</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
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<tbody>
<tr>
<td>14 Other conduct</td>
<td></td>
<td>Score: 0, Follow up: n/a</td>
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<tr>
<td>12 Generalized anxiety</td>
<td></td>
<td>Score: 1, Follow up: n/a</td>
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<tr>
<td>15 Intermittent explosive</td>
<td></td>
<td>Score: 5, Follow up: n/a</td>
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<tr>
<td>15 PTSD, unspecified</td>
<td></td>
<td>Score: 10, Follow up: n/a</td>
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Next Steps

- Our Plan is to continue collecting data to see improvements of our efforts.
- Survey our therapist for feedback on administering assessments
- Take action according to our survey findings
Questions
NCACH Whole Person Care Collaborative

3/1/2021

North Central Region & Molina
Collaborative Efforts to Meet Community and Member Needs

Victoria Evans, WA State Director Behavioral Health
Whitney Howard, WA State Director IMC Implementation
Misty Queen, HCS Director
Jackie Weber, Care Management Supervisor
Donny Guerrero, Community Engagement Specialist
Pam Tupling, Contract Manager

MOLINA HEALTHCARE
## Supporting Members

**Connecting Members to Needed Care & Services**

- Encouraging & Promoting use of Telehealth by Molina Providers & 24/7 Virtual Urgent Care (when Molina Providers are not available)
- Reaching out to all Members impacted by COVID & Members impacted by recent wildfires. Targeted outreach to at risk members with unmet care needs. Providing Pandemic Care Kits
- Providing home delivered meals to Medicaid & Medicare members diagnosed (or living with someone) with COVID
- Molina is waiving all COVID-19 related out-of-pocket medical expenses for all Members: Marketplace, Medicare & Medicaid
- Coronavirus Chatbot self-help tool with information about COVID-19 risk factors and recommended next steps
- Providing smartphones and offering 90-day prescription refills & encouraging use of mail order Rx
- Promoting Food Access through *Amazon EBT & free delivery of other essential services via our PRIME on Us* benefit

*3 months of Amazon Prime to adult Medicaid enrollees*
Supporting Providers

Responding to Urgent Needs & Providing Support to Maintain Health Care Delivery

$15M in Direct Payments to PCP & SUD Providers. Accelerated claims & incentive payments. Offered $8M in Advance Payments to BHAs.

$1M in PPE, Food, & financial supports enabling Telehealth Access. Significant deployment thru Provider Partners.

Routinely updating & sharing both administrative guidance & updated Provider & Member Resources.

Partnering with Providers to outreach & educate Members about the importance of continuing to obtain needed care: care for chronic conditions, preventive care & immunizations.

Numerous changes to support frontline care providers including relaxed Prior Authorization requirements, extending current Treatment Authorizations thru December; supporting expedited Care Transitions thru expanded staffing coverage to support timely Provider Support & Discharge.
## Supporting Communities

<table>
<thead>
<tr>
<th>Providing Financial &amp; Supply Donations</th>
<th>Supporting Frontline Partners Across the State</th>
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<tbody>
<tr>
<td>Donating $200K from Molina’s <em>COVID Community Response</em> to 100+ Food Banks in each &amp; every County in the State</td>
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<tr>
<td>Donating thousands of PPE items from Molina’s <em>COVID Community Response</em> through frontline community partners</td>
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<tr>
<td>Supporting Molina employees who are licensed medical professionals with “Volunteer Time off” to allow their support of local COVID treatment and relief efforts</td>
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<tr>
<td>Ongoing donations of personal hygiene items, food, clothing, and monetary support to Tribal &amp; community partners across the state</td>
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*Lean on Molina*
Site of Care Shift: Pre & Post COVID-19

2019 Telehealth Trend

2020 Telehealth Trend
Telehealth Providers & Visit Types

**BH Top Diagnosis**
- Post-Traumatic Stress Disorder
- Generalized Anxiety Disorder
- Major Depressive Disorder
- Opioid Dependence Uncomplicated
- Alcohol Dependence Uncomplicated
- Other Stimulants Dependence Uncomplicated

**PH Top Diagnosis**
- Opioid Dependence Uncomplicated
- Contact Exposure Other Viral Communicable Disease
- Encounter Screening for Other Viral Disease
- Anxiety Disorder Unspecified
- Mix Receptive - Expressive Language Disorder
- Autistic Disorder
Molina Healthcare COVID-19 Vaccine Efforts

**Members**
- Text and automated calls to possible vaccine eligible members and those due for 2nd dose
- Vaccine Education Promotion insert added to Member Mailings
- Internal Dashboard tracking vaccination rates for Members
- FAQs maintained & posted to website

**Providers**
- System configured for vaccine administration billing
- Partnering with skilled nursing /long term care facilities on vaccination plan for members
- COVID provider website updated with latest vaccine information

**Community**
- Supporting Vaccine Education Outreach via Social Media
- Molina staff volunteering for vaccine administration
- Mobilizing efforts to leverage Molina mobile unit to assist in targeted vaccine administration
- Exploring opportunities to leverage MolinaCares Foundation to support vaccine outreach for high disparity populations
Molina has a variety of Care Management Programs that are voluntary for members in order to improve health outcomes, assist members with managing their conditions, and provide members with needed resources and referrals.

www.spokesmanreview.com
During 2020 Case Management focused on COVID and Fire Response in North Central WA

**Fire Response**
- Calls made to members in zip codes most heavily effected by fires
- Calls made to areas that had secondary smoke due to fires
- Calls focus on ensuring members had medications, DME and other basic needs

**COVID Response**
- Calls to members that are COVID positive
- Partnership with Confluence to call their COVID positive members
- Call focus on member needs including food insecurities
- 2-week meal kits can be delivered to Medicaid and Medicare members
Supporting NCW Communities

Financial donations supporting local food banks

Donated $200,000 Statewide
100+ Food Banks in each & every County in the State
$18,000+ in NCW food Bank Donations
Supporting NCW Communities

**Wildfires** Molina partnered with multiple Community Partners in response to the Wildfire during the 2020 pandemic.

**COVID 19 Kits** *Stress less Kits:* Kits for Adults and kids to help reduce anxiety and stress,.

**COVID Care kits:** Hand soaps, Hand Sanitizers, face masks, literature on how to keep safe and healthy
Supporting NCW Communities

Flu Prevention

**Drive Through Clinics**
Molina Partnered Family Health Centers to create Drive though flu clinics.

*Walmart and Molina*
Provided Flu Vaccinations for Molina Members in Grant and Okanogan counties
Supporting NCW Communities

Our Work Continues

**Molina Care Baskets:**
Molina provided $5K to the Quincy school district to help fill food insecurity during the holidays.

**Mobile Unit Support:**
$25K Mobile unit donation
Supporting NCW Communities

Homeless and unsheltered support

Moses Lake, Washington - Municipal Government is with Donny Guerrero.

January 4

A big thank you to Molina Healthcare for their $2,500 sponsorship donation (two checks, one for $800, another for $1,700) and 50 sleeping bags to the City’s Open Doors Sleeping Center. For those interested in donating, more information can be found here: https://bit.ly/3plKmv4

Photo: Donny Guerrero, of Molina Healthcare, with a check and five boxes of sleeping bags.
Supporting NCW Communities

Our Work Continues

• Current coordination with Chelan/Douglas Counties at the Quality Mental Health Meetings & taking the lead on expanding this to Grant and Okanogan Counties
• Community and Social Media outreach and engagement
• Call focus on member needs including food insecurities
• 2-week meal kits can be delivered to Medicaid and Medicare members
SUPPORTING PROVIDERS / NORTH CENTRAL WA REGION

Responding to Urgent Needs and Providing Support to Maintain Health Care Delivery

• $10 Million for statewide Primary Care Support
  – North Central providers included FQHCs, RHCs and hospital systems with Molina paneled members
  – In Chelan, Douglas, Grant & Okanogan Counties
  – Molina’s North Central PCP Support Payments were made to 13 providers which covered 90% of our North Central members.
  – North Central PCP Support payments: $714,700
  – 13 Provider Groups
    • Lake Chelan Community Hosp, Cascade Medical Ctr, Columbia Basin Health Assoc, Confluence, Coulee Community Hosp & Coulee Family Med, CVCH, Family Health Centers, Quincy Valley Medical Ctr, Columbia Basin Hosp, Mattawa Community Clinic, Moses Lk Community Health Ctr, Mid Valley Hosp, Samaritan Hosp

• $10 Million annual investment for Substance Use Disorder (SUD) providers across the state, with an emphasis on inpatient/residential SUD services.
Thank You!
Discussion
Next meeting: April 5, 2021