Whole Person Care Collaborative

April 5, 2021
Introduction

Welcome

Introductions

Consent Agenda
  March Minutes
  April Agenda
<table>
<thead>
<tr>
<th>Proposed Agenda</th>
<th>Time</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>11:00</td>
<td>Introductions</td>
</tr>
<tr>
<td>Wendy Brzezny</td>
<td></td>
<td>Consent agenda</td>
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<tr>
<td></td>
<td></td>
<td>Agenda</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Minutes</td>
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<tr>
<td>2. Columbia Basin Health Association</td>
<td>11:05</td>
<td>Coordinating Chronic Care + Behavioral Health through COVID</td>
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<tr>
<td>Hayley Middleton</td>
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<tr>
<td>3. Amerigroup</td>
<td>11:25</td>
<td>Supporting Integrated Care</td>
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<tr>
<td>Caitlin Safford</td>
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<tr>
<td>4. HCA/Comagine</td>
<td>11:45</td>
<td>Behavioral Health Performance Measures</td>
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<tr>
<td></td>
<td></td>
<td>Study: Presentation and Provider Input</td>
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<tr>
<td>5. Announcements &amp; Updates</td>
<td>If time</td>
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<td>6. Adjourn</td>
<td>12:45</td>
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**Minutes**

<table>
<thead>
<tr>
<th>Location</th>
<th>Attendees</th>
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<tbody>
<tr>
<td>Virtual</td>
<td>Deb Miller, Kate Haugen, Whitney Lak, Jamie Hilliard, Dusti Rocha, Deborah Dettman, Samantha Krumdiek, Alejandra Gonzalez, Mary Louise Jones, Tessa Timmons, Stephen Johnson, Shoshannah Palmanteer, Tawn Thompson, Mike Lopez, Becky Corson, Dianna Osborne, Afton May, Vicki Evans, Jackie Weber, Donny Guererro, Misti Queen, Pam Tupling Zwiegle, Stephanie Dowland, Lisa Apple, Chenia Flint, Joe Ketterer, Kristen Stagner, Consultants: Roger Chauffenier, Christina Clark, Connie Davis. NCACH Staff: Wendy Brzezny, Mariah Brown, Linda Parlette, Caroline Tillier, John Schapman, Sahara Suval, Teresa Davis – Minutes</td>
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<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Minutes</th>
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<tbody>
<tr>
<td>Introduction</td>
<td><em>Tessa Timmons moved, Lisa Apple seconded the motion to approve the consent agenda, motion passed.</em></td>
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</tbody>
</table>
| Announcements & Updates      | - Mid Valley – They are in Cohort 2 of UW Aims grant that starts next week.  
- Rural Facilities Capital Grants Partnership Fund opens today from Empire Health Foundation, $25K grants available.  
- Reports are due Wed, March 3rd, please upload to portal.  
- Mariah Brown will oversee all practice facilitation in NCW. This is a change for Grant County. |
| Children’s Home Society of Washington | Samantha Krumdiek opened her presentation by reviewing the services that Children’s Home Society of Washington offer and her role and function as the Whole Person Care Coordinator. She proceeded to discuss their BMI project and their journey with collecting the challenges and opportunities to collect the data the COVID shutdown. Finally, Samantha outlined CHS depression screening and follow-up improvement project and the success they are experiencing. For full presentation, please see the slides and/or recording at ncach.org. |
| Molina Health Care           | Team members presented a picture overview of Molina Collaborative efforts to meet community and member needs. For full overview, please see the slides and/or recording at ncach.org. |
“Homegrown Health Care.

Big-City Innovation”
HAYLEY MIDDLETON, MPH, CPHQ, PCMH CCE
Director of Quality

OUR MISSION:
To provide equal access to quality healthcare to all persons regardless of age, sex, color, ethnicity, national origin, or the ability to pay.
OVERVIEW

CHRONIC CARE STRATEGY
Changes to the Care Delivery + Proactive Outreach

BH UPGRADES
Identifying Gaps + Improving the Process

BUILDING POP HEALTH
Building strategies to improve community health

NEXT STEPS
Ramping up after COVID
CHRONIC CARE STRATEGY

Identify Patients with Highest Risk
Gather Data + Create Strategy for continuity of care in the safest way for our highest risk.

Contact Patients + Address Needs
Outreach to Specific Populations + Create Next Steps Plan

Coordinate Next Steps for Care
Scheduling Office Visits/Drive-Up, Order Labs, Linkage to Other Services, Medication Refills, etc.
DM Care: Poor HbA1c >9% or Untested

CBHA WIDE

2019: 29%
JAN: 32%
FEB: 30%
MAR: 30%
APR: 32%
MAY: 31%
JUN: 33%
JUL: 29%
AUG: 30%
SEPT: 29%
OCT: 29%
NOV: 31%
DEC: 31%

Compliance Goal 25%
DM Care: BP Control <140/90

CBHA WIDE

<table>
<thead>
<tr>
<th>Month</th>
<th>Compliance</th>
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<tbody>
<tr>
<td>2019</td>
<td>79%</td>
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<tr>
<td>JAN</td>
<td>78%</td>
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<tr>
<td>FEB</td>
<td>81%</td>
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<tr>
<td>MAR</td>
<td>75%</td>
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<tr>
<td>APR</td>
<td>73%</td>
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<tr>
<td>MAY</td>
<td>74%</td>
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<td>JUN</td>
<td>75%</td>
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<tr>
<td>JUL</td>
<td>74%</td>
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<tr>
<td>AUG</td>
<td>79%</td>
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<tr>
<td>SEPT</td>
<td>74%</td>
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<tr>
<td>OCT</td>
<td>72%</td>
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<tr>
<td>NOV</td>
<td>70%</td>
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<tr>
<td>DEC</td>
<td>73%</td>
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</tbody>
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Goal: 70%
Controlling High BP <140/90

CBHA WIDE

<table>
<thead>
<tr>
<th>Year/Month</th>
<th>Compliance</th>
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<tbody>
<tr>
<td>2019</td>
<td>76%</td>
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<tr>
<td>JAN</td>
<td>72%</td>
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<tr>
<td>FEB</td>
<td>73%</td>
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<tr>
<td>MAR</td>
<td>66%</td>
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<tr>
<td>APR</td>
<td>64%</td>
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<tr>
<td>MAY</td>
<td>70%</td>
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<tr>
<td>JUN</td>
<td>68%</td>
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<tr>
<td>JUL</td>
<td>68%</td>
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<tr>
<td>AUG</td>
<td>70%</td>
</tr>
<tr>
<td>SEPT</td>
<td>65%</td>
</tr>
<tr>
<td>OCT</td>
<td>66%</td>
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<tr>
<td>NOV</td>
<td>62%</td>
</tr>
<tr>
<td>DEC</td>
<td>61%</td>
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Goal: 70%
BH UPGRADES

INTERNAL REFERRAL + DOCUMENTATION

IMPROVED ACCURACY OF SCREENING

ADDITION OF MH INTAKE PROCESS
Medicare Annual Wellness Visits

- Pre Visit Chart Audit
- Health Risk Assessment
- Office or Virtual Visit

Chronic Care Management

Patient Referred/Offered
CCM with Clinical Pharmacist + Creation of Care Plan.

Target Cohorts + ED Utilization

Ability to prioritize by Risk + Educate patients on alternative care for acute needs.

Gare Gaps + HCC/RAF Coding

Identify Gaps in Care as well as Coding Opportunities for Conditions being addressed elsewhere.
Track Scheduled visits, due for specific exam + how many contacts it takes to schedule.

CARAVAN COACH: MEDICARE

- TRACK: Specific Initiatives
- VALIDATE: Patient Records Prior to Visit
- PIN POINT: Care Gaps
- IDENTIFY: Coding Opportunities

Pop Health Coordinators validate and pull in medical records, provide pre-visit call and document necessary information for provider review.
NEXT STEPS

IMPROVE WORKFLOWS + DOCUMENTATION
• BH Referral Process additions
• BH Documentation + Location of Info
• Utilize new Medicare Opportunities Doc.
• Test CCM Note + Tracking

LAUNCH PILOT POP HEALTH TEAM
• Pilot AWV + Pre Visit Process
• Assign Roles + Regroup in 2 Weeks

COMPILE DATA FOR VISIBILITY
• Build Dashboard for tracking measures
• Audit Billing/Coding Info for CCM
• Update HCC Coding Opportunities Form

ENHANCE ACCESS FOR CHRONIC CARE
• Open schedule out 3 months for Chronic Patients
• Clinical Pharmacist CCM partnership
QUESTIONS ?
Questions/Discussion
Supporting Integrated Care

Amerigroup Washington
Integrated Managed Care—Lessons Learned

• Challenging Operationally
• Learned from every (10) region’s approach
• Wrap our arms around the financing and provider experience
• Still working out internal processes to better serve members and providers
• Hosted virtual IMC provider forums in every region in the summer/fall 2020
  • Continually hosting quarterly Town Halls and Office Hours for updates and during small implementations
Supporting Integrated Clinical Care

• Partnering with UW’s CoLab and Better Health Together
  o Why Spokane you ask?
• Identified three dyads of providers that can support/work together towards integrated care
  o Focus on behavioral health provider as “lead” provider
• The CoLab will be work to tailor integrated care trainings to the needs of these three dyads
Contractually and Financially Supporting Integrated Care

- Focus for 2020: refining a new contracting model—hope to deploy late 2020/early 2021 with interested providers
Behavioral Health Performance Measures Study

North Central Region
April 5, 2021
Agenda

- Meeting kick-off and introductions
- Present data
- Share study background and review timeline
- Introduce survey and attendees complete survey
- Post survey discussion
- Share project next steps and adjourn
# 12 Performance Measures for Study

<table>
<thead>
<tr>
<th>Population</th>
<th>Measures</th>
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<tbody>
<tr>
<td>Overall Adult Medicaid</td>
<td>% Homeless – Narrow Definition (HOME-N)</td>
</tr>
<tr>
<td></td>
<td>% Employed (EMP)</td>
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<tr>
<td>Adult SMI Population</td>
<td>Psychiatric Inpatient 30-Day Readmission (HEDIS-PCR-P)</td>
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<tr>
<td></td>
<td>Follow-up After Hospitalization for Mental Illness Within 7 Days of Discharge (HEDIS-FUH-7D)</td>
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<tr>
<td></td>
<td>Follow-up After Hospitalization for Mental Illness Within 30 Days of Discharge (HEDIS-FUH-30D)</td>
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<tr>
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<td>Follow-up After ED Visit for Mental Illness Within 7 Days (HEDIS-FUM-7D)</td>
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<tr>
<td>Adult SUD Population</td>
<td>SUD Treatment Penetration (SUD)</td>
</tr>
<tr>
<td></td>
<td>Follow-up After ED Visit for Alcohol and Other Drug Dependence Within 7 Days (HEDIS-FUA-7D)</td>
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<tr>
<td>Children Ages 6-17 With Mental Health Needs</td>
<td>Mental Health Treatment Penetration – Broad Definition (MH-B)</td>
</tr>
<tr>
<td></td>
<td>Psychiatric Inpatient 30-Day Readmission (HEDIS-PCR-P)</td>
</tr>
<tr>
<td></td>
<td>Follow-up After ED Visit for Mental Illness Within 7 Days (HEDIS-FUM-7D)</td>
</tr>
<tr>
<td>Children Ages 10-17 With SUD</td>
<td>SUD Treatment Penetration (SUD)</td>
</tr>
</tbody>
</table>
Results Summary

Regional view of three years of data ending June 30, 2020
Statewide, trends are stable or improving on 4 of the 12 measures in the study

1. Adult Medicaid, Homeless, Narrow Definition
2. Adult Medicaid: Percent Employed
3. Adults With SUD Treatment Needs: Substance Use Disorder Treatment Penetration
4. Adult SUD: Follow-up After ED Department Visit for Alcohol/Other Drug – 7 Day

(Also improving but not in the study: Opiate Use Disorder Treatment Penetration; Antidepressant Medication Management)
Statewide, trends are worsening on 6 of 12 measures

1. Adults With SMI: Follow-up After Hospitalization for Mental Illness – Within 7 Days
2. Adults With SMI: Follow-up After Hospitalization for Mental Illness – Within 30 Days
3. Adults With SMI: Follow-up After ED Visit for Mental Illness – Within 7 Days
4. Children/Adolescents (6-17) With Mental Health Needs: Follow-up After ED Visit for Mental Illness – Within 7 Days
5. Children/Adolescents (6-17) With Mental Health Needs: Mental Health Service Penetration (Broad)
6. Children/Adolescents (10-17) With SUD Treatment Needs: Substance Use Disorder Treatment Penetration

For future study: Psychiatric Inpatient 30-Day Readmission Among All Age Groups
Adult Medicaid, Homelessness Narrow
(Excludes “Homeless with housing in ACES”)

Statewide 2020 Q2 Range: 3.0% - 6.6%
Adult Medicaid: Percent Employed

Statewide 2020 Q2
Range: 39.7% - 55.6%
Adults With SMI: Psychiatric Inpatient 30-Day Readmission

Statewide 2020 Q2
Range: 8.2% - 18.8%
North Central data suppressed due to low numbers
Adults With SMI: Follow-up After Hospitalization for Mental illness – Within 7 Days

Statewide 2020 Q2
Range: 40.9% - 66.9%
North Central Highest Rate
Adults With SMI: Follow-up After Hospitalization for Mental Illness – Within 30 Days

Statewide 2020 Q2
Range: 61.7% - 79.7%
North Central Highest Rate
Adults With SMI: Follow-up After ED Visit for Mental Illness – Within 7 Days

Statewide 2020 Q2
Range: 44.2% - 71.5%
North Central Highest Rate
Adults With SUD Treatment Needs: Substance Use Disorder Treatment Penetration

Statewide 2020 Q2
Range: 30.4% - 42.9%
North Central Lowest Rate
Adult SUD: Follow-up After ED Department Visit for Alcohol/Other Drug – 7 Day

Statewide 2020 Q2
Range: 12.9% - 38.9%
Children/Adolescents (6-17) With Mental Health Needs: Mental Health Service Penetration (Broad)

Statewide 2020 Q2
Range: 61.3% - 70.1%
North Central Lowest Rate
Children/Adolescent (6-17), Psych 30-Day Inpatient Readmission

Statewide 2020 Q2
Range: 5.6% - 18.5%
North Central data suppressed due to low numbers
Children/Adolescent (6-17) With Mental Health Needs: Follow-up After ED Visit For Mental Illness – Within 7 Days

Statewide 2020 Q2
Range: 55.3% - 82.1%
(North Central highest rate)
Children/Adolescent (10-17) With SUD Treatment Needs: Substance Use Disorder Treatment Penetration

Statewide 2020 Q2
Range: 17.6% - 38.8%
North Central Lowest Rate
Questions?

Other sources of performance measurement information:

Contact Glory Dole or Teresa Claycamp for follow up if needed:
- [Glory.Dole@hca.wa.gov](mailto:Glory.Dole@hca.wa.gov)
- [Teresa.Claycamp@hca.wa.gov](mailto:Teresa.Claycamp@hca.wa.gov)
Behavioral Health Performance Measures Study

Objectives:

1. Understand how behavioral health performance measures vary across region (ACH), by MCO, and over time
2. Identify factors contributing to desirable outcomes that can be expanded, and factors contributing to lower performance in need of intervention

Project Timeline

- March
  - HCA provides DSHS RDA data for 12 measures
  - Comagine Health uses RDA data to design surveys and interviews
  - Coordinate with ACHs to allow surveying at regional provider meetings
- April
  - Meetings with providers in each region to present data and collect survey data
  - Comagine Health interviews with ACHs/MCOs
- May / June
  - Survey and Interview Analysis
  - Final Report & slides

Project ends 6/30/2021
Provider Survey

Survey is divided into four areas and includes 15 questions:

- Demographics & Workforce
- Coordination of Care Post Integration and Access
- Availability of Health Information Technology
- Measurement

Complete the provider survey
- Link will appear in Chat
- 15 minutes to complete survey
Wrap Up

Are there other topics that were not included in the survey that you would like to discuss?

Results of the study will be shared in July 2021.

Thank you for your participation!
Announcements/Updates
Partner Updates

• Managed Care Organizations

• Community Based Organizations

• Clinical Partners
Reports are due Wednesday, April 7th by COB. Please upload to the portal.
Next meeting: May 3, 2021