Introduction

Welcome

Introductions

Consent Agenda
  May Minutes
  June Agenda
<table>
<thead>
<tr>
<th>Proposed Agenda</th>
<th>Time</th>
<th>Goals</th>
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| 1. Introduction | 11:00 | Introductions
Wendy Brzegny       |       | Consent agenda
Agenda              |       | Minutes                                                             |
| 2. Announcements | 11:05 |                                                                      |
| & Updates        |       |                                                                      |
| 3. The Center    | 11:15 | CFADT journey through depression and                               |
| for Alcohol &   |       | diabetes screening and collecting data                             |
| Drug Treatment   |       |                                                                      |
| 4. Community     | 11:35 | CHPW’s health equity journey                                       |
| Health Plan of   |       |                                                                      |
| Washington       |       |                                                                      |
| 5. WPCC Improvement Report & discussion | 12:00 | What is our monthly reporting data telling us?                     |
| 6. Adjourn       | 12:45 |                                                                      |
### Agenda Item

**Introduction**

- **Tessa Timmons moved, Lisa Apple seconded the motion to approve the consent agenda, motion passed.**

**Announcements & Updates**

- Population Health LAN – half day session planned for July 13th.
- QI Infinity Group April 26th.
- Single Topic Webinar – Brief Interventions that Build Resilience – recording & resources available.
  - If there is a topic you are interested in, please let Wendy know and she will try to find faculty to present on it.

**Columbia Valley Community Health**

Mary Louise presented CVCH’s success on improving depression screening and monitoring in their clinic. She discussed the PDSA that was designed by the Operation team, timeline set, obstacles faced and how they overcame them and rethought their original plan. Please visit ncach.org/wpcc for the recording and PowerPoint.

**Coordinated Care**

Coordinated Care: Symone, Ryan and Marissa presented on Coordinated Care’s process for screening for behavioral health needs, followed by the Zero Suicide project. As the sole MCO who provides insurance to foster children, the Zero Suicide project helped them focus on assisting this population to interrupt the intention for intentional self-violence resulting in death by suicide. Finally, they presented on Coordinated Care’s role in telehealth, experience and belief that it is here to stay. Please visit ncach.org/wpcc for the recording and PowerPoint.

**WA DOH Behavioral Health**

Dr. McGuire reviewed the monthly behavioral health monthly forecast and trends that have been measured for the last year including key incites. Mary Franzen discussed the weekly forecast, including Washington State syndromic data and Behavioral health data from other sources. To see the monthly reports and weekly forecasts, please visit https://www.doh.wa.gov/Emergencies/COVID19/HealthcareProviders/BehavioralHealthResources. Please visit ncach.org/wpcc for the recording and PowerPoint of this presentation.
Announcements/Updates
Partner Updates

- Managed Care Organizations
- Community Based Organizations
- Clinical Partners
Announcements

• Monthly Reports and Homework tied to payment

• Population Health LAN – tomorrow, June 8th
   Reminder: July 13th LAN is half day 8:30-12:30pm

• QI Affinity - May 26th

• No July Meeting

• Resume in-person meetings – August with virtual as an option
The Center For Alcohol & Drug Treatment
Questions/Discussion
Our Equity Journey
Equity: In our DNA

We are a local, Washington-based Health Plan.

- With nearly 30 years of experience and long-established roots in health equity for underserved communities.
- We were founded by, and are still governed by, community organizations (Community Health Centers) which, in turn, are governed by community members.
- Born out of social justice movements and created for equality in healthcare.

The health of our members is our primary concern.

- Our programs are designed to proactively identify and address the behavioral, social, and medical needs of our members and to recognize the whole person’s needs.
- CHPW’s aim is to advance health equity and improve the lives of the people it serves by addressing the barriers to health and well-being.

Foundational attitude of cultural humility.

- As an organization and as individuals we approach each member as someone deeply deserving a healthy life. It means seeing them as experts on their own health, and prioritizing their voices over our own. It means listening, understanding and avoiding assumptions. But most of all it means trusting that they know best what they need to be healthy, and working relentlessly to help them get it.
Who Do We Serve?

234,400+

members with unique needs
(Medicaid, Medicare, and BHS0)

53,000

25% of members list a
language other than English as preferred
CHPW’s Health Equity Journey

- Impacts of COVID-19
- Racial Awakening
- Connect the dots across all internal and external efforts
- 3-year strategic plan strategy:
  - To be a leader in the pursuit of whole person care and health equity.
Equity Goals:

- Apply an Equity Lens to all our work
- Reduce Health Disparities
- Become an Anti-Racist Organization
- Create an Equitable Work Environment
Some of CHPW’s Equity Work

Apply an equity lens to all of our work
- Equity Assessment Tool
- Center to Advance Consumer Partnership (CACP)
- Embedded in strategic planning

Reduce health disparities
- Learning Collaborative Grant Program
- Equity Data improvements and transparency
- Review risk stratification algorithms for bias

Become an anti-racist organization
- Focused staff training and resources
- Health Equity Fund Initiative
- Immigrant Refugee Health Alliance
- General advocacy work

Create an equitable work environment
- Diversity & Inclusion Advisory Group
- Equity Survey to staff to gain an organization wide baseline
- New consulting support and commitment to training
- AHE Culture of Equity
Catalyst: Advancing Health Equity Initiative (AHE)

- CHPW, CHNW, and Health Care Authority (HCA) are participating in a national, 2-year learning collaborative project called **Advancing Health Equity**.
- Supported by University of Chicago, Center for Healthcare Strategies, Institute for Medicaid Innovation and Robert Wood Johnson Foundation
- One of 7 state teams (Medicaid Agency + Medicaid Health Plan + Medicaid Provider Organizations).
- Focused on health equity and **implementing a care transformation** and payment model to address equity.
Catalyst: Advancing Health Equity Initiative (AHE)

Learn a bit more about the initiative following these links:

- [https://www.solvingdisparities.org/](https://www.solvingdisparities.org/)
Learning Collaborative Grant Program

- This program is the Washington AHE team’s care transformation.
- **$50,000 grants** available to CHNW CHCs for projects to advance equity. Grants are an advanced payment from quality withhold.
- 15 CHCs participating:

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<tr>
<th>Advance Health Equity within:</th>
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<tr>
<td>Member Experience with Access to Care</td>
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```
Monthly Cohort Calls

- Goals
  - Reporting on progress
  - Problem-solving
  - Shared learning

- Resources
  - CHC colleagues
  - CHPW subject matter experts
  - National Advancing Health Equity technical assistance team

- Quarterly Learning Series:
  - Equity in Program Design
  - Patient Partnership
  - Racial Justice in Healthcare
### Early Lessons from AHE: Cross Cutting Factors

<table>
<thead>
<tr>
<th>Root Causes</th>
<th>Analyze root causes of disparities, including structural racism, explicit/implicit bias, and historic underinvestment and neglect</th>
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<tbody>
<tr>
<td>Partnership</td>
<td>Partner with patients and communities, community-based organizations, and care teams to identify causes and craft solutions</td>
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<tr>
<td>Language</td>
<td>Establish shared definitions of equity, health disparities, and related concepts</td>
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<tr>
<td>Data</td>
<td>Strengthen quality, completeness, and use of data to more accurately measure disparities, engage providers, and assess progress</td>
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<tr>
<td>Culture</td>
<td>Cultivate an internal culture of equity to strengthen approaches so colleagues understand the need to advance health equity</td>
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Questions and Discussion
Questions/Discussion
May 2021 improvement data

All data processed on June 3, 2021
Objectives

• Use knowledge of variation to make better decisions for improving your processes and systems
• Understand how WPCC recommended strategies for measurement are designed to create the conditions for better decision making
Real-life dilemma
AHA! The data

<table>
<thead>
<tr>
<th>Month</th>
<th>Bill Amount</th>
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<tr>
<td>Jun</td>
<td>$62.13</td>
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<tr>
<td>Aug</td>
<td>$60.89</td>
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<tr>
<td>Oct</td>
<td>$59.56</td>
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<td>Dec</td>
<td>$110.77</td>
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What should they do?

1. Think it over and write your response in the chat – don’t press send (1 min)
2. When directed, press send.
Here’s the last 3 years...

Electricity Consumption

Son moves home
Our ability to correctly interpret variation in data is fundamental to develop effective improvement strategies.

Queen Anne’s Lace (A), Poison Hemlock (B), Cow’s Parsnip (C), Giant Hogweed (D) – obviously, this should not be used to identify plants
What causes variation in our data?

**Common cause variation**
Stable system

**Special cause variation**
Unstable system
Common cause

Stable system

Good or bad

Improvement actions/strategy ideas:

• System will need process re-design to perform better or more reliably stable

• Learn about your population (e.g., segmentation) and processes (e.g., fishbone diagram)

• Identify aspects of the process to change (e.g. segmentation, process mapping, use change package, etc.)

• Test changes using PDSAs leading to implementation where appropriate

• Continue to monitor performance over time
**Special cause**

**Unstable system**

**Good or bad**

**Improvement actions/strategy ideas:**

- Identify when the special cause occurs – what happened around that time? (planned improvement? COVID-19 surge? Something unexpected?)
- Identify is the special cause good news (improvement?) or bad news?
- Learn about the special cause (Planned? Unexpected? Theories?)
- Take action based on what you learn
What is needed to identify variation

- Run chart or control chart (time-series charts)
- Use of run chart or control chart rules (and at least 10 data points)
- An initial denominator (population of focus) size of about 100-200 patients – appropriate given the planned improvement aim and timeline
- A reasonably stable denominator size over time (+/-10% and consistent use of 12-month look back periods)
Monthly vs. 12-month look back data: scenario

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<td>12 month look back</td>
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<tr>
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<td>90%</td>
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Based on a handout created by Dr. Kathy Reims
<table>
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<th>Run chart rules</th>
<th>Criteria</th>
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<tr>
<td>Rule 1: Shift</td>
<td>6 or more consecutive points <em>either</em> all above or all below the median</td>
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<tr>
<td>Rule 2: Trend</td>
<td>Five (5) or more consecutive points all going up or down</td>
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<td>Rule 3: Runs</td>
<td>Too few or too many runs crossing the median (see table)</td>
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<tr>
<td>Rule 4: Astronomical point</td>
<td>Used to detect an unusually large or small number. This rule is not probability based, though may be useful for learning</td>
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What questions do you have?
HEMOGLOBIN A1C POOR CONTROL (NQF0059 MODIFIED)

JUNE 3 2021

Cascade: HbA1c poor control

CBFM: HbA1c poor control

CBHA: HbA1c poor control

CFADT: Diabetes screening

Coulee: HbA1c poor control

Confluence: HbA1c poor control

CVCH: HbA1c poor control

FHC: HbA1c poor control

Grant Integrated: HbA1c poor control

Mid Valley: HbA1c poor control

MLCHC: HbA1c poor control

OBHC: HbA1c poor control

Samaritan: HbA1c poor control
Hemoglobin A1c poor control (NQF 0059 modified) (All teams)

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Notes:
- This is quality improvement data: It may be imperfect. It is not suitable for judgment or accountability. It is intended for learning, sharing, and improvement.
- N is the number of teams reporting in the given period. This may change the denominator in significant ways month over month.
- The median is calculated as the middle value of every month where data has been reported.
- The month of observation on the x-axis corresponds to the last month in a 12-month look back period. To illustrate, data reported in the July-2020 column corresponds to data from the measurement period June 1 2019 to July 31 2020.
- For the purposes of visualizing variation, the y-axis may not be presented as 0-100%.
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Depression screening and follow-up (NQF 0418) (All teams)

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Additional self-selected quality measures (depression, MI, SUD)

Follow up after ED visit for MI: 30 Day (NQF 2605)

Increase Access Mental Health

SUD Treatment Penetration (DSHS-RDA)

Increase Access - SUD

Serious MI: PHQ9 Score decreased by 5+ among clients with PHQ9 score >19

Patients with PHQ >19 who have not attended appointments

OUD Treatment Penetration
Additional self-selected quality measures (diabetes)

PC: Diabetes: Hemoglobin A1c (HbA1c) testing

Diabetes: Eye Exam (NQF 0055)

Diabetes: Blood Pressure Control (NQF 0061)

Diabetes foot exam (NQF0056)

Diabetes: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (HEDIS)

Diabetes: Medical Attention for Nephropathy (NQF 0062)

Diabetes: Blood Pressure Control (NQF 0061)

BMI Measure

"BUILDING HEALTHIER COMMUNITIES ACROSS NORTH CENTRAL WASHINGTON"
Reflection question

How has using improvement data over time helped you better understand your system? How has it helped you act to improve your systems/processes?
As leaders, what concrete steps can you take to help teams make better decisions from their data?


NO JULY MEETING

See you in August!