Whole Person Care Collaborative
August 2, 2021
Introduction

Welcome

Introductions

Consent Agenda
  June Minutes
  August Agenda
## Whole Person Care Collaborative (NCACH) Agenda

August 2, 2021
11:00 AM – 12:45 PM Monday

| Confluence Technology Center | Conference Dial-in Number: (669) 900 6833  
| 285 Technology Center Way Suite 102,  | Meeting ID: 568 190 9332  
| Wenatchee WA 98801             | One tap mobile: +16699006833, 5681909332#  
|                               | Join Zoom Meeting: https://zoom.us/j/5681909332 |

### Proposed Agenda

<table>
<thead>
<tr>
<th>Proposed Agenda</th>
<th>Time</th>
<th>Goals</th>
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</table>
| 1. Introduction | 11:00   | Introductions  
| Wendy Brzezny   |         | Consent agenda  
|                 |         | Agenda Minutes  |
| 2. Announcements & Updates | 11:10 | Population Health LAN  
|                           |         | QI Affinity  |
| 3. Annual Wellness Visits | 11:20 | A Journey by Mid Valley Clinic  
| Diane Osborne       |         |                 |
| 4. PHQ Implementation | 11:45 | Using process improvement to implement PHQ  
| Tessa Timmons      |         |                 |
| 5. Future of WPCC  | 12:10   | Moving forward into 2022  
| Wendy Brzezny      |         |                 |
| 6. Adjourn        | 12:45   |       |

Next Meeting: September 13th, 2021
<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Minutes</th>
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<tbody>
<tr>
<td><strong>Virtual</strong></td>
<td>Attendees: Whitney Lak, Dusti Rocha, Paul Hadley, Loretta Stover, Duane Duncan, Lizabeth Snow, Chris Tippett, Aileen Morelos, Christina Harvil, Hayley Middleton, Mary Louise Jones, Tessa Timmons, Stephen Johnson, Shoshannah Palmanteer, Tawn Thompson, Becky Corson, Jackie Weber, Donny Guerrero, Misty Queen, Lisa Apple, Cherla Flint, Connie Mom-Ching, Chrystal Eshelman, Jan Sternberg, Kat Latet, Sara VanHorn, Stephanie Dowland, Victoria Evans, Virginia O’Kelly, Jamie Hilliard, Joe Ketserer; Consultants: Roger Chauvornier, Christina Clark, Kathy Reims; NCACH Staff: Wendy Brzezny, Mariah Brown, Linda Perlette, Caroline Tillier, Teresa Davis – Minutes</td>
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| **Announcements & Updates** | • Monthly reports and homework is tied to payment  
• Population Health LAN – tomorrow, June 8th (reminder July 13th is half day session 8:30-12:30)  
• OI Infinity group June 23rd – if you have a topic, send Wendy or Tina an email  
• No July meeting  
• Will plan to resume in-person meetings in August with virtual as an option (plans can change if COVID rates or Governor mandates change).  
• The portal is migrating to a new site. Mariah will be available to assist along with the admin from the site. |
| **The Center for Alcohol and Drug Treatment** | Lizabeth Snow presented on CFADT’s journey with diabetes screening by educating staff, sharing personal stories and understanding how diabetes can affect an individual’s recovery journey. Staff were involved with the plan and revamping diabetes data collection. Chris Tippett shared how The Center started using a PHQ9, how the focus on screening was diverted and then the team refocused. The staff were involved with developing a plan and incorporating other tools to assess suicide risk and plan for positive screening. The team developed tools to better track PHQ9 scores because they are unable to get those scores readily out of the EHR. Chris shared a story on how the front desk staff have been an integral in identifying patients with high PHQ9 scores or when PHQ9 score does not match behavior. Please visit ncach.org/wpcc for the recording of this presentation. |
| **Community Health Plan of Washington** | Kat Latet shared CHPWs equity journey and how it is built in their DNA. CHPW is connecting the dots across internal and external efforts and recognizing the impact of COVID-19 and the racial awakening, they developed a 3-year strategic plan strategy with specific equity goals. Kat also shared the learning collaborative they are participating in and early lessons learned. Please visit ncach.org/wpcc for the recording of this presentation, PowerPoint and handout. |
| **WPCC Improvement Data** | Tina Clarke discussed variation in data and using knowledge of variation to make better decisions for improving your process and systems. Next she discussed how WPCC recommended strategies for measurement are designed to create the conditions for better decision making. This information led to looking at WPCC data points over time and group discussion. |
Announcements/Updates
Announcements

• Monthly Reports due Wednesday, Aug 4th.

• Population Health LAN – August 10\textsuperscript{th}
  • Wendy Bradley: Equity, Population Health Management, Patient-Centered Care

• QI Affinity - Cancelled in August

• September meeting – 2\textsuperscript{nd} Monday due to Labor Day
Partner Updates

• Managed Care Organizations

• Community Based Organizations

• Clinical Partners
Mid Valley Clinic
- Fall of 2019: Implementation of NEW EMR (Cerner)

- Spring 2020: Population Health Nurse Vacated position (minimal teaching of current workflow/spreadsheets etc.)

- Summer/early Fall 2020: Minimal work done to help float clinic with Metrics/reporting/participation, however the CQIT (Clinical Quality Informations Team) was developed
  - Initial implementation of pursuing AWV w/emphasis on workflows and patient interactions, bulk AWV’s completed

- Late Fall 2020: New Population Nurse Hired (whirlwind training begins)

- December 2020: Covid Vaccines rollout and become top priority

- January 2021: Rollout long term plan for AWV continuity/sustainability
* FINAL YTD FOR ANNUAL WELLNESS VISITS FOR 2020

**AWV 2020**

- Dec: 83
- Nov: 103
- Oct: 31
- Sept: 29
- Aug: 0
- July: 1
- June: 0
- May: 0
- April: 0
- March: 8
- Feb: 17
- Jan: 4

TOTAL= 259 completed 2020

Goal was 50% = 26% end result * we were at 15% Nov
Where do we go from here?
    - devise long term, more sustainable system to ensure we meet expected benchmark for reimbursement

How do we do this?
    - initially bringing CQIT team together, we brainstormed and asked what was/ was not working for each provider team and their process for getting patients scheduled. This enabled us to look at the different processes and see if we could find some common ground to help standardize the process.

What was the result?
    - the process started ok, however failed in the long run. The provider teams found it difficult to do the “same” process with the patient base they had, it did not seem to “flow” smoothly throughout.

Now What?
    - Moving forward, we took the basics and made the process more simple that left room for each provider team to have the flexibility they needed to fit the patient needs, as well as their own similar but different workflows.
AND WHERE ARE WE NOW……

2020- GOAL 50%, ENDED YR AT 26%

2021- GOAL 50%, CURRENTLY AT 22%
Moving Forward:

- We continue to further breakdown by provider teams and re-evaluate processes. We’ve noticed we have 1 provider team who is not as successful and we’re looking into that specific team’s process to help ensure the best possible outcomes.

- We “praise” our staff on the amazing job they’ve done thus far and ensure we are supporting their efforts and make it known how much we appreciate them. We may incentivize this down the road to make it just a little more fun/competitive.

- We utilize “coach” Facesheets daily to help give us additional information so we have a better understanding of the Whole Person at every appointment, not just AWV.
Mid Valley is proud of how far we have come in the many challenges and hurdles put before us. From a new EMR, to lost staffing and minimal coverage to new faces and ideas…. all in the most challenging time Healthcare has experienced with Covid.
Questions/Discussion
Confluence Health
PHQ Implementation

Tessa Timmons, LMHC
Behavioral Health Service Line Director
 Agenda

• Background & “The Why”
• Process Improvement: A-3 Kaizen Form
• Strategy
• Outcomes
• Next Steps
Background and “The Why”

- **Screening is important**
  - 64% of individuals that die by suicide present to a medical appt within a month of the attempt
  - 95% have presented to a medical visit within a year prior to their attempt

- **CH Primary Care**
  - 20,000 visits/month
  - 170+ medical providers
  - Every Patient, Every Time

- **Kaizen – 2018**
  - Kaizen: Kai = Change  Zen = For the better
  - PHQ-2 plus the suicide question given at patient check-in.
  - MA give follow-up assessments if needed and enters data into EPIC

- **Personal Story - 2019**
1. **Strategic Priority**
   - MIPS Quality Measure
   - Deliver Best practice of Medicine

2. **Department Goal**
   - The use of PHQ in Primary care is below target

3. **Root Cause Analysis**
   - Lack of Training
   - Different viewpoints
   - Lack of understanding
   - Staff turnover
   -Staff unsure how to explain
   - Confused about the "why"
   - Staff not consistent w/promo

4. **Action Plan**

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<th>Action</th>
<th>Owner</th>
<th>Due</th>
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<td>Process different across depts</td>
<td>Retrain depts on the Kaizen work</td>
<td>Tessa Timmons</td>
<td>April 2020</td>
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<tr>
<td>Lack of consistent training</td>
<td>Retrain IBH staff</td>
<td>Kasey Grass</td>
<td>Mar/April 2020</td>
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<tr>
<td>Staff Buy in</td>
<td>Gamification</td>
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<tr>
<td>Staff Buy In</td>
<td>Re-explaining the why</td>
<td>IBH Staff</td>
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5. **Results**

- **PHQ 2019**
  - **Trendline**
  - **April**: 46%
  - **May**: 52%
  - **June**: 51%
  - **July**: 63%
For departments that do not have an Integrated Behavioral Health Provider:

In Grant County, schedule the patient with Dr. Kelley Drayer.
In Chelan, Douglas and Okanogan Counties, schedule the patient with Dr. Tim Day.

The BH provider is responsible for completing the patient safety plan, as clinically appropriate, using the .bhsafetyplan SmartPhrase in Epic.
## Moses Lake – Internal Medicine

### April 2019

<table>
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<th>Last Visit</th>
<th>PHQ9 YN</th>
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PHQ 2021

Jan: 56%
Feb: 58%
Mar: 60%
April: 59%
May: 61%
June: 61%
Next Steps

• Ensuring Accountability
• Treatment and Remission Standardization
  • Clinical Decision Support Tools
• Specialty Departments
  • 150+ providers
Thank you!

Tessa.Timmons@confluencehealth.org
Questions/Discussion
Future of WPCC
Historical Context

2017 Medicaid Transformation Project began
  • 8 areas of focus – NCACH chose 6:
    • Bidirectional Integration of Physical and Behavioral Health
    • Chronic Disease Prevention and Control
    • Community-Based Care Coordination
    • Transitional Care
    • Diversion Interventions
    • Opioid Use Disorder
    • Reproductive and Maternal/Child Health
    • Access to oral Health Services

2018 WPCC Summit and Initial Change Plans created
Historical Context

2019: Learning year

- Several learning activities including learning and action networks and sprints
- EMR implementations
- Learning how/when to use data in the work
- Population Health LAN I

2020: COVID-19

- Telehealth
- Population Health LAN II
- Pared down the change plan
More Context

2021: Depression & Diabetes Improvement

• PH LAN II
• Using data to drive improvement
• Strengthening QI Skills
• Moving towards Value-Based Care

End of the COVID tunnel or is that Delta?
Advance whole-person health and health equity in North Central Washington by unifying stakeholders, supporting collaboration, and driving systemic change, with particular attention to the social determinants of health.
Why does NCACH exist and how does it serve the region?

• NCACH addresses health equity and improves the wellbeing of all people in the North Central Region.

• NCACH advances social, emotional, physical, and behavioral health as embodied in the principles of whole-person care.

• NCACH catalyzes the success of other entities by making complementary efforts and maintaining an environment of collaboration and community benefit.

• NCACH unifies regional efforts by coordinating and promoting collaboration across sectors.

• NCACH helps groups focus on cross-cutting priorities, pursues durable solutions, and prioritizes efforts that deliver systemic improvement.
Three Pillars* of NCACH’s Future State

1. Advance Transformation with a Regional Portfolio
   We will use distributed leadership to develop a vision for equitable system change and implement it through a far-sighted regional portfolio.

2. Anchor in Shared Measurement
   We will root our decisions in quantitative and qualitative data that depicts the health and wellbeing of residents.

3. Build Through an Inclusive Process of Distributed Leadership
   Our pursuit of equitable system change will reflect the aspirations of the entire region, not just the concerns of certain groups or sectors.

*You can find more information on the 3 pillars on the NCACH website under July (retreat) meeting resources: https://ncach.org/board-meetings-minutes/
Future State Planning Process

- Mission
- Guiding Principles & Value Streams
- 3 Pillars
- Regional Portfolio and Strategies
- Operational Plan (How to Implement Strategies)
- Programmatic Goals (Executing Initiatives)
What does our bridge look like?
2022 Ideas to Continue

• Equity

• Cross-sector collaborations and integrated partnerships

• Care Coordination

• System development to support behavioral health needs
How would you describe the WPCC?
What do you want to work on next year?
What activities do you want to continue next year?
What role would you like NCACH to play in your transformation work?
Determinants of Health

- Healthcare: 10%
- Genetics: 30%
- Behavior: 40%
- Social Status: 15%
- Environment: 5%

Last 3 year building foundations:
• QI Process
• Empanelment
• Team-base Care
• Population Health management Process

Moving forward:
Funding model to incentivize cross-sector collaboration
  Clinical ‹—› clinical collaboration
  Clinical ‹—› non-clinical collaboration

Build on the work you are doing, yet help us move in the right direction
Proposal

2+ Organizations collaborate to build integrated partnerships and break down silos.

Applications would outline:
• what you want to accomplish
• how you plan to address SDoH and health equity
• specific steps each organization must take to achieve the goal
• how you will measure progress
• individual budgets

Idea: incentivize cross-sector partners by paying BOTH partners to work together to change/improve how they work together
What is your initial reaction to this proposal? Please note details have not been worked out.
Convene a workgroup
• 2 meetings ~1.5 hours each

Idea:
1. Create a plan on how WPCC envisions cross collaboration
2. Ask CBO’s/non-clinical stakeholders to opine on the plan
3. Refine the plan based on feedback

Chat in if you would like to help shape 2022
Questions/Discussion
Next Meeting: September 13th

We will plan in-person, but if COVID rates are too high, we will transition back to virtual only.