Location	Attendees
Chelan Douglas Health District 200 Valley Mall Pkwy East Wenatchee WA 98802	**Workgroup members:** Eric Skaansgard, Elaine Bandy, Laina Mitchell, John McReynolds, Rhonda Piner, Chenia Flint, Kelly Steffens, Nicole Tabort, Kate Haugen, Ray Eickmeyer, Misty Queen, Beth Goetz, Shoshannah Palmanteer, Molly Morris **NCACH Staff**: John Schapman, Wendy Brzezny, Linda Evans-Parlette, Tanya Gleason, Caroline Tillier – Minutes **Myers and Stauffer (Independent Assessor):** Catherine Snider, Leslie Barron
Agenda Item	**Minutes**
Minutes	Ray Eickmeyer moved, Elaine Bandy seconded the motion to approve the minutes, motion passed.
TCDI Hospital Partner Updates	John quickly previewed the agenda for today, including 2 partner updates. Background is that our providers are interested in peer sharing and allowing opportunity for questions. As part of agreement with NCACH, plan on including partner updates during next 2-3 meeting. Partners were asked to take 5-10 minutes to share best practices, lessons learned, and successes and challenges. **Lake Chelan Community Hospital** Ray shared information about community paramedicine model that LCCH is using for a lot of their transitional care and diversion intervention work. They have combined 3 existing community paramedicine models to broaden improvements to their relatively small population (not just restricted to hyper utilizers.) Shared a list of skills community paramedicine staff are developing in the field (e.g. wound care, fluid replacements, A1c testing). Always use primary care provider as lead; not operating in silo, but EMS skills and labor can be a contributor to this work. Do lots of assessments for patients, navigation, education and connecting to resources. Reach out to primary care providers when identify hyper utilizers. Social determinants of health are assessed via LEAD score on every single patient when they are discharged (e.g. housing, financial issues, food.) Everyone, including well-to-do patients, appreciates being asked these questions. Contact patients in their home, also do phone call follow-ups, and send written report to PCP including needs. Inpatient, ER, and PCP all refer to community paramedicine program. Leverage local groups like Tender Living Care (TLC) and local Rotary to assist people with cleaning, going to grocery store, building ramps or handrails. Visits last about 60-90 minutes, and second to third visits are also about 60 minutes long – this would be impossible for PCPs. They are fortunate to have a lot of resources in their valley. Have seen about 150 patients, and close to 100% of them were very satisfied or satisfied with the service and majority likely to recommend to others. Linda mentioned that Representative Cody is very interested in community paramedicine work, and she will connect Ray with her. Kate asked whether this would become a billable service. Trying to work CDT codes for transition/diversion work on referrals, and all LCCH EMS staff are community health workers and working on certification to work at top of license and increase reimbursements. Elaine asked whether community paramedics had ongoing relationship with patients (how many times are they seen?) – really depends on the person, and also resources that patient is connected to for follow-up. *Workgroup participants requested copies of Ray's presentation.* **Coulee Medical Center** Kelly provided overview of how they are doing Transitional Care Management (TCM). It has involved a lot of trial and error. Started a TCM process a few years but never took off. So revamped the process after spending time with Confluence, which was quite helpful. Would call patients being discharged within 48 hours, and then within 30 days, kept calling until they were reached. This population is typically unreachable so took a lot of time. Current process – tries to call within 24-48 hours, and only try twice with note in chart. Works closely with scheduling to ensure that follow-up appointments match level of complexity. Usually routes a note to the provider prior to their provider visit. MCO and Health Homes care coordination – Kelly estimates that probably ¼ to ½ of discharged clients would benefit from some sort of chronic care management. Don't have resources to refer patients to. Ray asked about using Patient Activation Measure (PAM) to assess patient's motivation and engagement in their health care, and also suggested Chronic Disease Self-Management classes can make a difference. For CMC, however, the lack of community resources, and transportation challenges contribute to high no-show rates (very high poverty rates.) Patient population is very complex and have very few resources in area. CMC catchment area is about 9000 patients; they are only hospital for 60 miles. Nearby towns include Grand Coulee, Coulee Dam, Electric

	City, Elmer City, Nespelem, Coulee City, Elmira, Wilbur, Mansfield. Surrounded by federal and state lands and Colville Reservation – very low tax base. Someone suggested that motivational interviewing (MI) could bridge the gap around cultural divides. Kelly noted that program like Health Homes (where care coordinators go to people's home) and MI is great, but when it comes to Native population, it really comes down to trust given historical trauma and past experiences with health care. CMC staff also noted that some non-native patients in the area are very anti-establishment, so this makes home visits a challenge. Specific to ED diversion work, Beth shared that Coulee Medical partnered with Colville Behavioral Health on direct referrals for tribal members (because Grant County Mental Health program usually took 4 hour minimum if they could come at all). If someone is enrolled, can refer to tribal behavioral health more quickly. In the past, could not work with Grant Integrated Services due to insurance/geographic barriers, but this is slowly improving. Beth noted that if patients have IHS insurance only, the Coulee Medical clinic can't see them, though ER/hospital can.
2020 TCDI Budget	John shared feedback based on partner check-ins and surveys to see what they've found beneficial and what work to prioritize for 2020. Surveyed hospital partners and also initiated discussion with NCECC. Recommendations from TCDI Hospital partners – want to continue the work with a focus on improving connections to outpatient care as immediate next steps, especially outside organizations (not clinics within hospital/ED system.) Funding recommendation is to provide $65,000 to hospital partners (budgeting for total of 8 organizations.) Encouraging partners to focus on key issues that are unique to their areas. Total of $520,000. Recommendations for EMS partners – invest in additional trainings (documentation, WEMSIS, reporting), separate funding stream to incentivize those who want to develop more robust community paramedicine programs, expand treat and referral programs, and offer quality improvement/motivational interviewing trainings. Funding recommendation is total of $395,000. Training and consulting funds are designed to be flexible. Grant total budget for TCDI projected at $980,000 for 2020. John asked for feedback from workgroup members, including concerns or ideas about what's missing. Ray likes the proposal. No other comments. Erik encouraged funded partners to keep Catholic Charities posted around crisis/law enforcement overlay since they have funding and resources available for MH follow-up in the field. Motion to approve 2020 budget for TCDI in total of $980,000. Rhonda Piner moved, Ray Eickmeyer seconded, no discussion, motion passed.
Next Meeting:	Business portion of meeting was adjourned at 11am given special session with Medicaid Transformation Project Independent Assessor (Myers and Stauffer) who joined call to gather input from TCDI Workgroup members on current status of work. Date: Thursday November 21st Time: 10 AM – 11:30 AM Location: Chelan Douglas Health District 200 Valley Mall Parkway East Wenatchee, WA 98802