Whole Person Care Collaborative

April 1st, 2019
Introductions & Roll Call
Approve Agenda & Minutes
Announcements
Announcements

• VBP Discussion with HCA right after WPCC Meeting

• NCACH Summit
  April 12th
  See additional info in packet

ADDRESSING THE ROAD BLOCKS TO WHOLE PERSON HEALTH

North Central Accountable Community of Health

2019 Annual Summit
Friday, April 12, 2019
Moses Lake, WA
9:00 am - 4:30 pm

NCACH.ORG/ANNUAL-SUMMIT

OPEN TO ALL
Learning Activities
• Motivational Interviewing Workshop
  • April 2-3rd in Okanogan
  • April 4-5th in Moses Lake

• QI Affinity Group: value stream mapping
  • April 25th 12-1pm, Virtual

• Motivational Interviewing Train the Trainer
  • June 10-13th in Wenatchee
Workshops cont.

• Team Roles for Primary Care Integration in Behavioral Health workshop
  • May 8\textsuperscript{th} in Moses Lake
  • *Training agenda in packet*

• Patient and Family Voice in QI workshop
  • May 30\textsuperscript{th} 8:30am-4pm, registration on portal to open soon
WPCC Peer Sharing

Catholic Charities Crisis Data
CRISIS SYSTEM DATA

Catholic Charities Serving Central Washington
EASTERN STATE HOSPITAL UTILIZATION RATE 2014 TO 2017

**ESH Utilization Rate**
June-July 2014

- Spokane: 83.2%
- Greater Columbia: 49.3%
- Chelsea-Douglas: 150.0%

**ESH Utilization Rate**
8-15-17

- Spokane: 80.2%
- Greater Columbia: 81.0%
- North Central: 40.7%
SELECTED DATA POINTS IN ESH CENSUS HISTORY
2018 CRISIS PROGRAM DATA: HOURS AND CONTACTS

CC Crisis Programs Hours and Contacts 2018

- DCR: Hours - 1848, Contacts - 1495
- Diversion: Hours - 1988, Contacts - 3322
- MCI: Hours - 937, Contacts - 3601
ITA DETENTIONS AS A % OF TOTAL DCR ACTIVITY

- ITA Detentions: 10%
- DCR Contacts: 90%
WHERE ARE SERVICES PROVIDED?

Sept-Dec 2018: Activity by Location (N=3651)

- CMHC: 51%
- Emergency Dept: 11%
- Diversion: 21%
- Other: 17%
- Homeless Shelt: 1%
- School: 1%
- Temp Lodging: 0%
- Other Med/Behav: 1%
- Jail: 2%
- Inpatient hosp/psych: 3%
- Home: 4%
- Other: 4%
- Nurse/Group Home: 0%
2019 –
JAIL AND EMERGENCY ROOM DIVERSIONS
2019 - FOLLOW UP TO CRISIS INTERVENTION

Referred and Contacted in 7 day follow up

- Referred for 7 Day follow up: 556
- Seen in 7 day follow up: 556
y = -0.2328x + 7.8603
TIME SERIES – INTEGRATED CRISIS/DIVERSION
WHAT SERVICES WERE NEEDED – SINGLE CASE

Intervention Doseage by Domain

- Mental Health: 11
- Psychotics: 5
- Housing: 23
- Substance Abuse: 1
- Healthcare: 4
- Income Support: 2
- Food Clothing: 16
- Transportation: 27
- Legal: 5
- Motivational: 2
- Divorce: 4
DIVERSION CASE MANAGEMENT BY DOMAIN QTRS 1-3 (MAR THROUGH NOVEMBER 2018)

Linkages by Need Type

<table>
<thead>
<tr>
<th>Need Type</th>
<th>Linkages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>680</td>
</tr>
<tr>
<td>Substance use</td>
<td>270</td>
</tr>
<tr>
<td>Psych / med management</td>
<td>322</td>
</tr>
<tr>
<td>Housing</td>
<td>554</td>
</tr>
<tr>
<td>Transportation</td>
<td>421</td>
</tr>
<tr>
<td>Healthcare</td>
<td>217</td>
</tr>
<tr>
<td>Healthcare benefits</td>
<td>217</td>
</tr>
<tr>
<td>Food and Clothing</td>
<td>326</td>
</tr>
</tbody>
</table>
2019 ESTIMATED DIVERSION SAVINGS $148,000
QUESTIONS OR COMMENTS?
Pathways HUB Update

Deb Miller

Also see additional info in packet
PATHWAYS COMMUNITY HUB UPDATE

- Program Overview
- Highlights to Date
- Challenges
- Next Steps
<table>
<thead>
<tr>
<th><strong>AHP Care Coordination Network HUB</strong></th>
<th>The AHP HUB represents a network of agencies that provide evidence-focused care coordination and the professional work needed to identify and address risk factors.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Programs</strong></td>
<td>Action Health Partners currently manages two programs in the Care Coordination Network HUB: Pathways and Health Homes</td>
</tr>
<tr>
<td><strong>Contracted Network</strong></td>
<td>These community partners contract with AHP HUB to deliver care coordination services. Community Specialist Services Agencies (CSSA-Pathways) and Care Coordination Organizations (CCO-Health Homes) employ the boots on the ground staff that serve clients directly.</td>
</tr>
<tr>
<td><strong>Community Partners/SDOH Services</strong></td>
<td>Boots on the ground staff (Pathways Community Specialists or Health Homes Care Coordinators) work out in the community with clients to identify health, social, and behavioral barriers to health and wellness through a comprehensive assessment.</td>
</tr>
<tr>
<td><strong>Balanced Wellness</strong></td>
<td>When Physical, Emotional, Social, Spiritual, Environmental, Financial barriers are mitigated, balanced wellness can be achieved.</td>
</tr>
<tr>
<td><strong>Whole Person</strong></td>
<td>“Individuality is only possible if it unfolds from wholeness.” – David Bohm</td>
</tr>
</tbody>
</table>
PATHWAYS PROGRAM OVERVIEW

Referral Partner

Community Specialist Services Agency CSSA

Community Services Partner

SDOH Services
(Identified Pathways)
PATHWAYS PROGRAM OVERVIEW

- Samaritan ED
- Community Specialist Services Agency CSSA
- Community Services Partner

- Client Referred
- Pathways
- Action Health Partners Care Coordination Network HUB

- SDOH Services (Identified Pathways)
- Moses Lake Community Health
- Rural Resources
- 1 PCS
- 2 PCS
# HIGHLIGHTS TO DATE

## CLIENTS

<table>
<thead>
<tr>
<th></th>
<th>Assigned</th>
<th>Enrolled</th>
<th>Total Enrollment Percentage</th>
<th>Due Diligence List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>187</td>
<td>33</td>
<td>18%</td>
<td>250</td>
</tr>
<tr>
<td>Pediatric</td>
<td>13</td>
<td>3</td>
<td>23%</td>
<td>136</td>
</tr>
<tr>
<td>Pregnant</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>1</td>
</tr>
</tbody>
</table>

## Top 5 Pathways Initiated

**Oct 2018-Feb 2019**

- Social Service Referral: 54
- Medical Referral: 36
- Education: 24
- Tobacco Cessation: 16
- Housing: 13
- Medical Home: 12
- Adult Learning: 6
- Immunization Screening: 4
- Health Insurance: 3
- Medication Assessment: 2
- Employment: 1
- Behavioral Health: 1

## Pathways Risk Scorecard-All Pathways

- Oct-18
- Nov-18
- Dec-18
- Jan-19
- Feb-19
HIGHLIGHTS TO DATE
CHALLENGES

- **Client Outreach and Engagement**
  - Finding clients
  - Engaging once found

- **Mastering client management in the CCS platform**
  - Defining efficient workflows (HUB Staff and PCS)
  - Bidirectional referrals between Care Coordination programs
  - Utilizing the CCS Referral Tool for electronic referral process
CHALLENGES

• Pathways Community Specialist training
  • Limited access to available training
  • Working with statewide ACH HUBS to develop a standardized training program is slow
NEXT STEPS

- Increase program reach
- Region zoning
## NEXT STEPS

<table>
<thead>
<tr>
<th>Zone</th>
<th>Coverage Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Potential Clients</td>
<td>Grant A: 1390, Grant B: 244, Chelan-Douglas A: 1178, Chelan-Douglas B: 143, Okanogan A: 169, Okanogan B: 616</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Engagement Rate</th>
<th>Potential Clients</th>
<th>Total PCS-A</th>
<th>Potential Clients</th>
<th>Total PCS-B</th>
<th>Potential Clients</th>
<th>Total PCS-A</th>
<th>Potential Clients</th>
<th>Total PCS-B</th>
<th>Potential Clients</th>
<th>Total PCS-A</th>
<th>Potential Clients</th>
<th>Total PCS-B</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>139</td>
<td>3.1</td>
<td>24.4</td>
<td>0.5</td>
<td>117.8</td>
<td>2.6</td>
<td>14.3</td>
<td>0.3</td>
<td>16.9</td>
<td>0.4</td>
<td>61.6</td>
<td>1.4</td>
</tr>
<tr>
<td>20%</td>
<td>278</td>
<td>6.2</td>
<td>48.8</td>
<td>1.1</td>
<td>235.6</td>
<td>5.2</td>
<td>28.6</td>
<td>0.6</td>
<td>33.8</td>
<td>0.8</td>
<td>123.2</td>
<td>2.7</td>
</tr>
<tr>
<td>30%</td>
<td>417</td>
<td>9.3</td>
<td>73.2</td>
<td>1.6</td>
<td>353.4</td>
<td>7.9</td>
<td>42.9</td>
<td>1.0</td>
<td>50.7</td>
<td>1.1</td>
<td>184.8</td>
<td>4.1</td>
</tr>
<tr>
<td>40%</td>
<td>556</td>
<td>12.4</td>
<td>97.6</td>
<td>2.2</td>
<td>471.2</td>
<td>10.5</td>
<td>57.2</td>
<td>1.3</td>
<td>67.6</td>
<td>1.5</td>
<td>246.4</td>
<td>5.5</td>
</tr>
<tr>
<td>50%</td>
<td>695</td>
<td>15.4</td>
<td>122</td>
<td>2.7</td>
<td>589</td>
<td>13.1</td>
<td>71.5</td>
<td>1.6</td>
<td>84.5</td>
<td>1.9</td>
<td>308</td>
<td>6.8</td>
</tr>
</tbody>
</table>

- **Grant A:** Beverly, Ephrata*, 98823 George, 98824 Mattawa, 98837 Moses Lake*, 98848 Quincy, 99357 Royal City, 98851 Soap Lake, 98857 Warden, 98860 Wilson Creek, 99321 Mansfield, 99115 Coulee City, 99123 Electric City, 99133 Grand Coulee, 99135 Hartline, 99116 Coulee Dam, 99124 Elmer City, 99155 Nespelem, 98815 Cashmere, 98821 Dryden, 98826 Leavenworth, 98828 Malaga, 98836 Monitor, 98847 Peshastin, 98801 Wenatchee, 98807 Wenatchee, 98802 East Wenatchee, 98843 Orondo, 98850 Rock Island, 98858 Waterville, 98811 Ardenvoir, 98816 Chelan, 98817 Chelan Falls, 98822 Entiat, 98831 Manson, 98814 Carlton, 98834 Methow, 98856 Twisp, 98862 Winthrop, 98812 Brewster, 98813 Bridgeport, 98846 Pateros, 98819 Conconully, 98827 Loomis, 98829 Malott, 98840 Okanogan, 98841 Omak, 98844 Oroville, 98849 Riverside, 98855 Tonasket, 98859 Wauconda.
NEXT STEPS

- **Increase referral partners**
  - Primary Care*
  - Walk-in Clinics*
  - Behavioral Health Providers*
  - Expand Emergency Department partners
  - TCDI Partners
    - EMS Partners
  - Other Community Based Organizations
NEXT STEPS

*Increasing referrals:

- Referral Partners have Providers/Staff view online tutorial
- F/U with onsite presentation by HUB staff
- Sign Referral Partner Agreement (Agreement Contract, HIPAA BAA)
- Build referral process into SDOH screening
- *If available*- Tailored EDIe reports to identify patients eligible for HUB services
Sustainability

• Why don’t things stick?
CONE OF LEARNING

After 2 Weeks we tend to remember:

10% of what we READ
20% of what we HEAR
30% of what we SEE
50% of what we HEAR & SEE

Nature of Involvement:

Reading
Hearing Words
Looking at Pictures
Watching a movie
Looking at an Exhibit
Watching a Demonstration
Seeing it Done on Location

Passive

Participating in a discussion
Giving a Talk

Active

Receiving/Participating

Doing

SOURCE: EDGAR DALE
Sustainability Key Principles

- Clear workflows (process map and procedures)
- Clear roles (swim lane diagrams)
- Clear policies
- Training Systems in place
- Reinforcement systems in place
- Measures of performance and reliability
- Owner established for long term quality control
- Audits- secret shopper

- This is where high reliability principles come in!
Reliability Principles

• Standardize processes
• Use reminders that are conspicuous; contiguous, contextual, informative and complete
• Make the desired action the default
• Replace opt-in with opt out
• Tie the desired action to existing patterns of habits
• Reduce complexity-reduce # options and steps
• Make failures difficult
• Smooth workflow
- Use visual cues to drive time-dependent processes
- Forcing functions: require completion of the action before the next step is permitted
- Promote clear communication
Advanced Access Procedures for Implementation

May 14, 2010 version

PLEASE DISCARD ALL PREVIOUS COPIES / VERSIONS!!!

Advanced Access Procedures were implemented at CareSouth Carolina, Inc. on Monday, March 1, 2010. The following is an overview of the principles.

1. In order to address problems of no-shows, over booked schedules, complaints from patients, hospitals, and other organizations of being unable to get an appointment and increasingly growing numbers of patients “lost to follow up”, CareSouth Carolina is implementing an evidence based and proven system re-design called Advanced Access.
   a. No-shows: evidence has shown that no-shows are predominately the result of patient’s being given an appointment too far in the future and not at a date and time of their choosing
   b. Schedules become over booked with double and triple appointment bookings as a result of no shows and walk in patients who have learned that if they cannot get an appointment, the best thing to do is just “show up”.
   c. Addressing the chaotic need of daily unpredictable schedules leaves little or no time for planned care, follow up and tracking.
   d. After years of diligent work, the CareSouth Carolina average Third Next Available Appointment measure is in excess of a week and, for some providers, a month. This is a significant barrier to access.

2. The core key process for the CareSouth Carolina implementation of Advanced Access are as follows:
   a. In order to address problems around extremely high no-show rates, schedules filled up and overbooked, and patients unable to get appointments, patients who have been “told” by the provider to follow-up in a certain time will be given an appointment card that says, call us the week of Monday, XXXXX to get an appointment that is convenient to you.

   1 These patients for follow up will be entered onto the provider’s Sunday schedule. The tables on the following pages give examples of situations,
## SCRIPTS AND PROCESSES FOR APPOINTMENT AND SCHEDULE MANAGEMENT BY FRONT OFFICE & OTHERS

<table>
<thead>
<tr>
<th>THIS APPLIES TO WHOM</th>
<th>WHEN</th>
<th>SCRIPT</th>
<th>OPERATIONAL PROCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Front Office</td>
<td>When a patient who is on the “Sunday” schedule calls in (as they were told to do) OR just shows up</td>
<td>Welcome them</td>
<td>The Sunday schedule appointment will be re-scheduled (moved) from the Sunday schedule to the requested appointment date and time during the current week OR the date and time when the patient shows up. Use reason code RESCHEDULE. When a Sunday scheduled patient shows up and there are no more available appointment slots, this is the only time you can “double book” (use reason code RESCHEDULE). This patient will still be given “priority” over non-scheduled walk-in patients.</td>
</tr>
<tr>
<td>2. Front Office</td>
<td>When making an appointment for follow up as requested by the provider: the appointment for follow up is NOT in the provider's schedule (insert name of provider) would like to see you back in (insert time frame), if you will call us the priority for the following week for which follow up is requested.</td>
<td>Since (insert name of provider) would like to see you back in (insert time frame), if you will call us the provider's name on the following Sunday schedule.</td>
<td>Front office enters the patient's name on the priority for the following week for which follow up is requested.</td>
</tr>
</tbody>
</table>
Aim: To maintain a comprehensive and accurate registry of our patients with Diabetes in order to perform appropriate and timely care.

| Diabetes Registry Measures: | Average A1c | % of patients with two A1cs in the last 12 months | % of patients with last BP < 130/80 | % of patients with last LDL < 100 | % of patients are current smokers | % of patients have an annual foot exam | % of patients have an annual eye exam | % of patients with an annual self-management goal documented |
|---------------------------|-------------|-----------------------------------------------|--------------------------------|
|                           |             |                                               |                                 |                                  |                                        |                                 |                                 |                                                     |

### Operations

**Print off Diabetes registry and workflow the first Tuesday of every month.**

**Review registry for last visit, blood pressure, eye exam, foot exam, lipids, and A1c.**

#### Front Desk

- **Visit**
  - If more than six months, make appointment.
  - Otherwise, review Blood Pressure, Lipids and A1c for follow-up guidelines.

- **Blood Pressure**
  - If blood pressure <130/80 use other risk factors to determine follow up needs.
  - If BP Systolic is >130 or BP Diastolic is >80 follow up at least every month.

- **Eye Exam**
  - Add patients without eye exam in the last 12 months to wait list for eye clinic.
  - Contact patient when slot opens with date of clinic.

- **Foot Exam**
  - If no foot exam in the last 12 months, schedule an appointment.

- **Lipids**
  - If LDL <100 use other risk factors to determine follow up needs.
  - If LDL >100 but <130 follow up should be at least every three months.
  - If LDL >130 follow up should be at least once a month.

- **A1c**
  - If Hgb A1c > 9, follow up every month. If Hgb A1c >7 but <9 follow up should be at least every 3 months. If Hgb A1c <7 follow up should be every three to six months.

### Case Manager

**Review registry for risk stratification, tobacco, and self-management goal. Note: For patients who do not have information populated in the flowsheet, CM will open NextGen and determine if patient is actually a diabetes patient. Alert clinical team to patients on huddle report.**

#### Tobacco

- If current smoker, review for tobacco cessation counseling. Advise patient to quit at next contact.

#### Self-Management

- Monitor patients on registry for annual goal. Responsible for connecting with patient to set goal when in for a visit.

#### Group Visits

- Determine which patients/providers do groups. Coordinate DM group visits for pod by doing the following:
  - Determine provider availability
  - Denise's schedule availability
  - Coordinate with NTM on support staff availability
  - BHP schedule availability
  - Call pts and schedule for DM GV as needed.

### Provider

**Review the flowsheet every visit and enter any new data. Review registry for any patients for which there are concerns and patients who are MOGE. Provide information to CM.**

### MA

**Review the flowsheet every visit and enter any new data. Responsible for patients on registry who are in for visit today.**

### Nurse

**Reviews copy of registry given by CM to ensure all follow-up has been completed and is accurate.**

Source: Clinica Campesina, Lafayette Colorado
Use visual controls

• Flag specific tasks, statuses, or emails with a color.
• Use shadow boards and outlines for tools and equipment.
• Set triggers and alerts for issues.
• Use labeled bins and folders.
• Create a task board with categories (e.g. To Do, Doing, Done).
• Create reports with red, yellow, and green colors for quick status summaries.
• Consider your customers and how you communicate with them (e.g. easy website navigation, signs to direct people where to go, etc.)
• Put a flag in each inventory supply when it’s time to reorder. When the supply gets low, someone will see the flag and place an order.
• Add pictures to work instructions.
Visual Controls
Planning Ahead

Learning activities feedback
Please rank these potential topics for learning activities in order of priority for your organization.
Other topic areas not listed that are of high priority for your organization to effectively implement your Change Plan

• Gathering data through conversations and encouraging patient story telling.
• Data extraction for measurement and reporting.
• Integrating treatment plans to include both behavioral and physical health and teaching behavioral health clinicians how to address physical health coaching.
• Successful outreach techniques and strategies.
• Billing/coding and reimbursement for CAH and RHC facilities: generating revenue, denials management, prior authorizations.
Please rank the following content areas in order of priority for your organization.
Other Conditions

Other conditions not listed that are of high priority for your organization

- Preemie care, failure to thrive, and autism evaluations
- Chemical dependency; lack of mental health resources in our area.
- Outside of the obvious mental health conditions we are also interested in obesity as it relates to a variety of physical health conditions.
- Trauma
- COPD
- Colorectal cancer screening
- Obesity, dementia
- Heart Failure
- Sepsis
How much do you agree or disagree with this statement? "Face-to-face meetings with peer organizations are valuable to accelerate our learning and improvement work."

- **Strongly agree**: 20.00%
- **Agree**: 60.00%
- **Neutral**: 20.00%
- **Disagree**: 0.00%
- **Strongly disagree**: 0.00%

*Notes:*
- **Responses**
Annual face-to-face meetings and quarterly virtual meetings are expected within WPCC partner contracts. Would you be willing to attend more face-to-face meetings in a year?

- Yes, only 1: 10.00%
- Yes, 1-2: 50.00%
- Yes, 3 or more: 10.00%
- Unsure: 10.00%
- No: 20.00%
How many team members would you be willing to send to a face-to-face meeting?
Proposed Implementation for 2019-2020

Capacity Building Pre-Work LAN on Team-based care

The Proposed WPCC Learning Activity

- LS 1 FtoF
- LS 2 Virtual
- LS 3 FtoF
- LS 4 Virtual
- LS 5 FtoF

What is the Commitment?
- Commit a care team to participate
- Monthly all team/org call
- Quarterly learning gathering (3 days and 2 half days over 15 months)
- Care teams agree to report on common measures for the track they choose
Dialogue