**Grant County COH**

**Round Table Discussion Notes**

**10-28-2014**

Panel:

Sheila Chilson-MLCHC

* The big question is “what is different” about this? MLCHC is focused on IHI Triple Aim. The key is looking beyond the silos, look to collaboration, building good relationships and foundation. Looking together at the health of the population finding solutions as a group. How can we do it together?

Tom Thompson-Samaritan Healthcare

* With much attention on geographic boundaries of SHCIP it boils down to where do people seek care? The plan is about the people. Grant County is unique with 7 Public Hospital Districts. Interlocal agreements provide a vehicle to work together/collaborate. Care is best planned regionally and delivered locally. The advantage of integration of services is the ability to manage risk. Very excited about having a serious coalition, has been looking at a model at Mason General Hospital in Shelton, WA where a 501(c)3 was formed with cross sector partners.

Gail Goodwin-Grant Integrated Services

* Concern about the process to develop innovation plan might do damage to current system. There is movement to move to combine SUD and MH services into Behavioral Health and until now the two systems operate differently. It’s about the people. Co-occurring conditions is an expensive piece of the system. This population would be well served by socio-economic factors such as affordable housing.

Rep. Warnick-13th Legislative District

* Reiterates the regional “ways” that things are done. It is important to educate the legislators on rural health and its differences/challenges compared to urban health delivery. Grassroots is the way to accomplish this.

Commissioner Schwartz-Grant County

* Alignments/lack of alignments of different coalitions doing different work toward same outcome goals has been frustrating. There needs to be better collaboration/alignment with each other to be more effective/efficient with limited funds. The struggle at the county level is to get moving pieces moving together. Important to have a local/personal say, be the drivers of a local plan.

Tom Legel-Samaritan Healthcare

* 3 reasons healthcare is so high in the U.S.: 1. Tort Reform; 2. Pharmacy pricing/costs; 3. We don’t “ration” care. Some countries pay more for the primary care providers than for the specialty care providers. Social services and prevention are funded better in other countries.

Jeannette Wood-Confluence Health-Moses Lake Clinic

* Breaking down silos is working here in the medical community. Viewing community as a village, “it takes a village”. It’s important to take care of our own through education and holding them accountable; teach all of us the value of the resources. Keep the patient at the center of all we do. Access is an issue, getting patients to care when they need it. Need to be better about educating on WELLNESS and not ILLNESS. We need to think outside the box for integration of services.

LeRoy Allison-Grant Integrated Services

* As to the process of state for the SHCIP, hoping that perfect futures of regional planning don’t ultimately harm the smaller areas.

Debbie Bigelow-Coulee Medical Center

* How can CMC integrate with anyone? Challenges of geographic location often leaves them outside the reach of collaboration. Appreciative of the thought of finding answers locally. There is difficulty in integration with the Tribes from a Federal/Gov’t level, yet local level there is a good relationship built.

General discussion:

1. As an alternate on the MH Task Force, Rep Warnick asked the question about cross sector input, specifically regarding integration with law enforcement and MH services.
* Law enforcement has no way to take care of MH/SUD so often are bringing them to hospital.
* There is no “right place” at this time to care for these types of needs. Concerns regarding liability/responsibility for medical safety in these cases.
1. Payers need to be at the table. Medicaid payers are entering coming to the table in these discussions. Private insurance needs to be held accountable via legislative policy. Big employers are a good example of successful negotiations with payers.
2. Is there interest in convening a group like this regardless of ACH/Regional designation? What would an ACH look like?
* Continue to have decision makers that take action at the table. Learn as a group from communities like ours during this process.
* Moving toward best practices with non-traditional partners. Guiding and working with the “low-hanging fruit”.
1. Next meeting agenda items:
* Look at other models
* Work on inviting other partners
* Report/Discuss final RSA designation
* Report on outcome of SIM2 funding request and anticipated next steps by HCA