Medicaid Demonstration Project Selection Feedback Summary

Project Selection Outreach:

To gather continual survey results an online Survey Monkey was created with a recorded webinar presentation to gather feedback from all community partners. This survey was sent out to the 494 members on our partner list. We also encourage local partners to send the survey link to members of their partner lists that may not be part of the NC ACH.

In-Person presentations were made available to individuals in the 3 Coalition for Health Improvements and the North Central Hospital Council meeting. Each area had a total of 2 presentations in person where people could attend. A paper survey as well as a link to the survey monkey was provided for people interested in filling out the feedback form. Presentations were as follows:

March 6th	Wenatchee, WA (Chelan-Douglas CHI)
March 8th	Twisp, WA
March 21st	Brewster, WA (North Central Hospital Council)
March 23rd	Moses Lake, WA (Grant CHI)
March 24th	Omak, WA (Okanogan CHI)
April 10th	Moses Lake, WA (Grant CHI)
April 13th	Wenatchee, WA (Chelan-Douglas CHI, also available by webinar)

Feedback Received

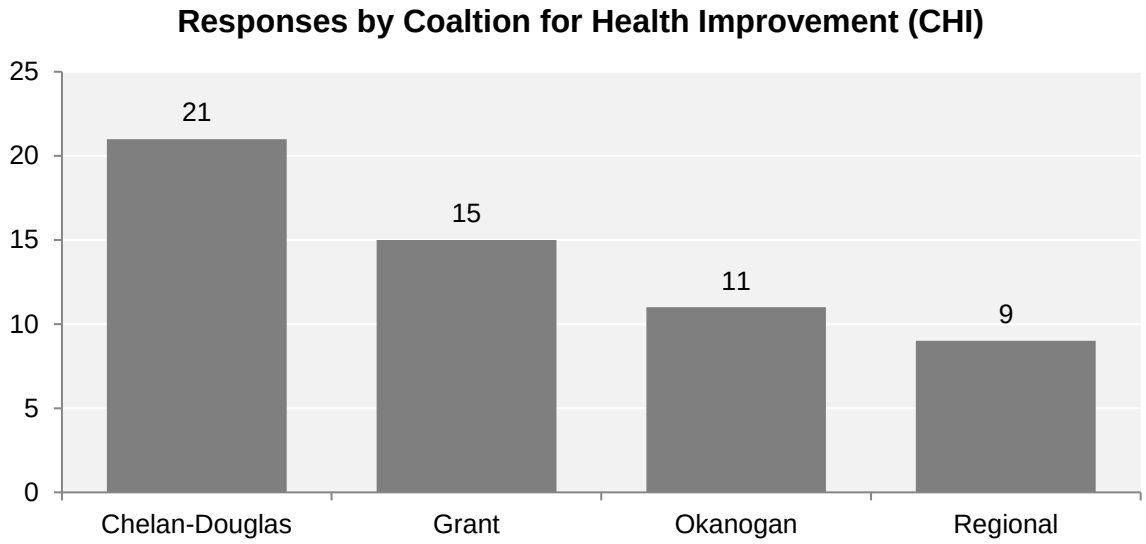
The following items were received and available on the following pages.

- Medicaid Demonstration Project Survey Summary (n=60)
- North Central Hospital Council endorsement of projects
- Grant County CHI roundtable report out
- Methow Valley Health Care Network response letter

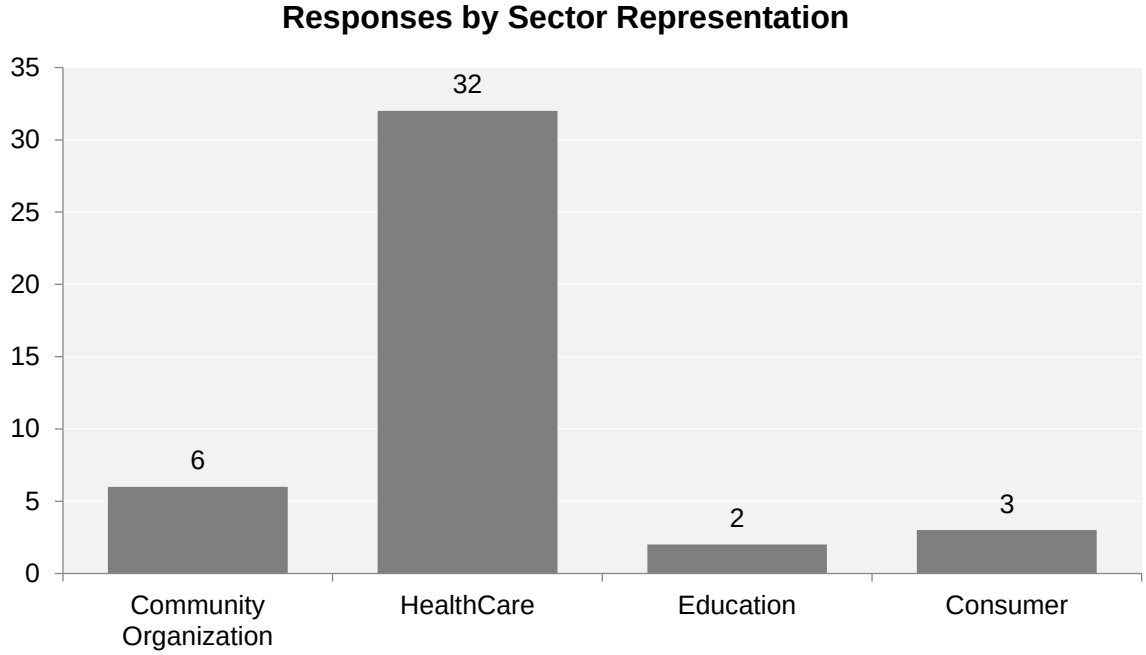
Medicaid Demonstration Project Survey Summary

Number of Surveyed Individuals: 60

56 respondents (93%) identified what Coalition for Health Improvement they represented. Of responses: 38% where Chelan-Douglas, 27% where Grant, 20% were Okanogan, and 15% identified as regional partners.

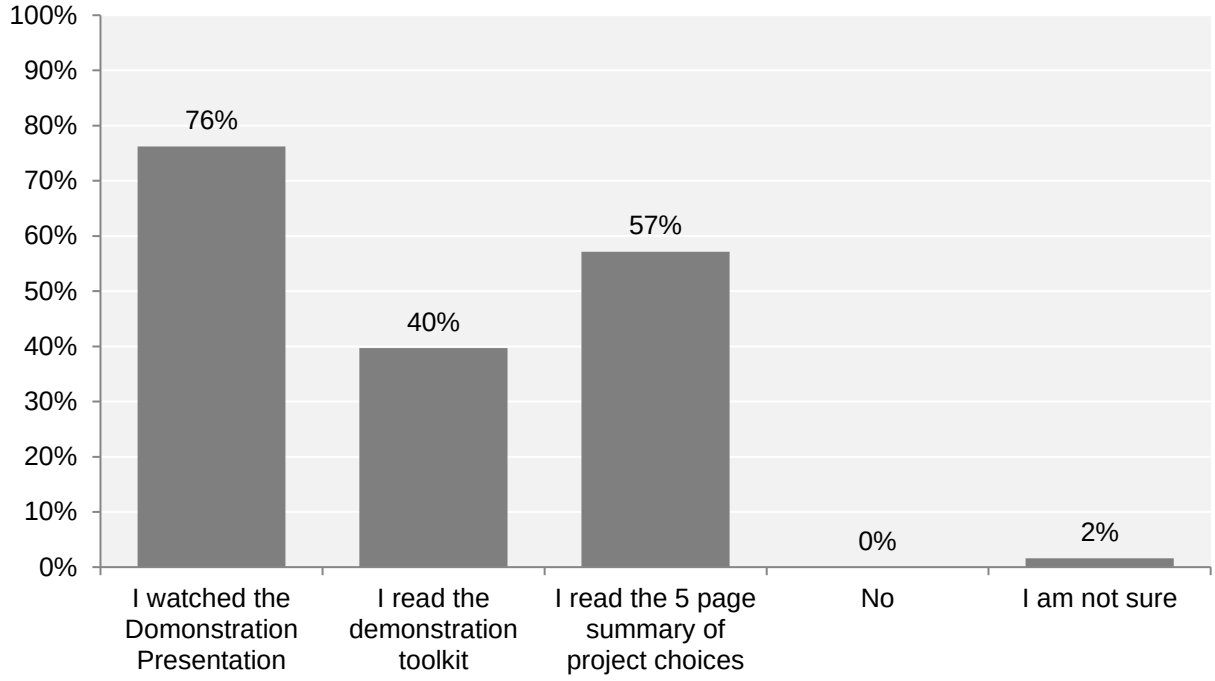


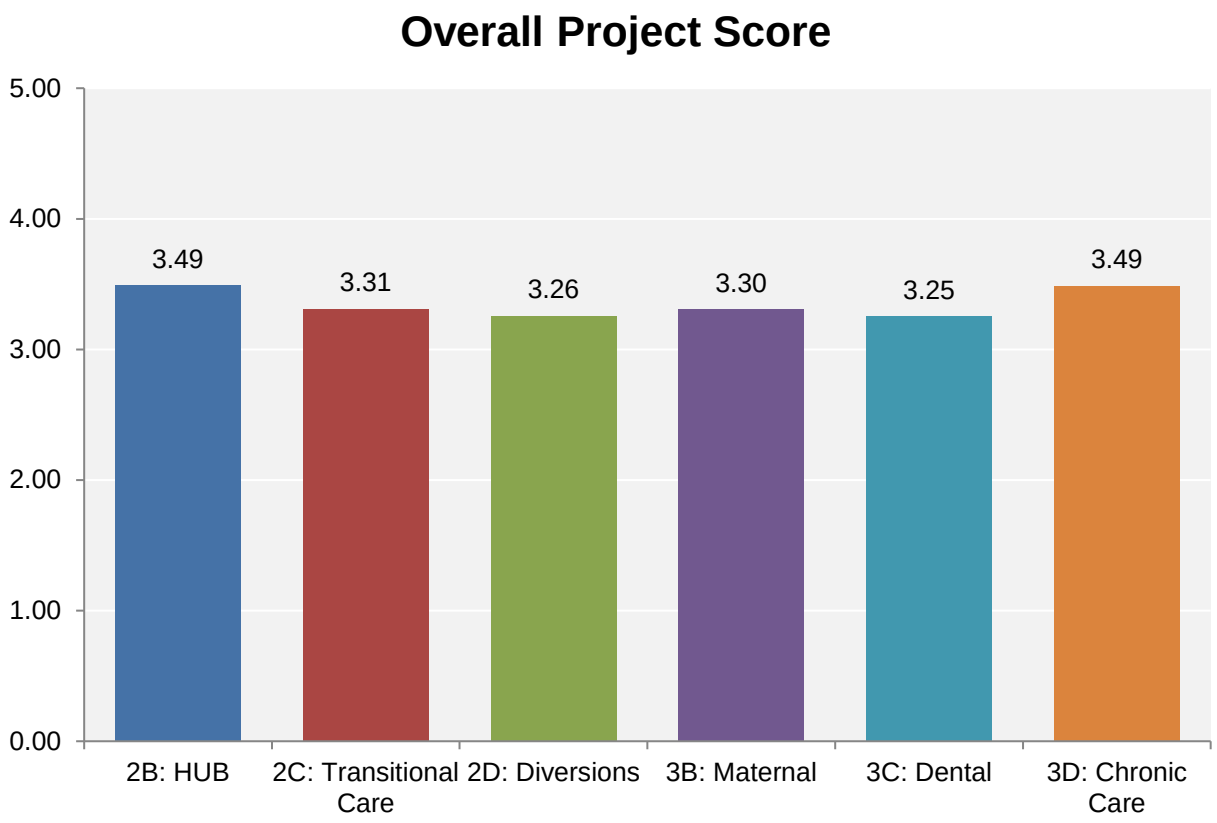
43 respondents (72%) identified what sector they represented. Of responses: 74% where Healthcare, and 26% identified as a representative outside of the Healthcare sector.



The table below demonstrations the level of basic knowledge respondents had about the Medicaid Demonstration project prior to competing the survey.

Have you watched the demonstration presentation or read the demonstration toolkit or 5 page summary of project choices? (n=60)





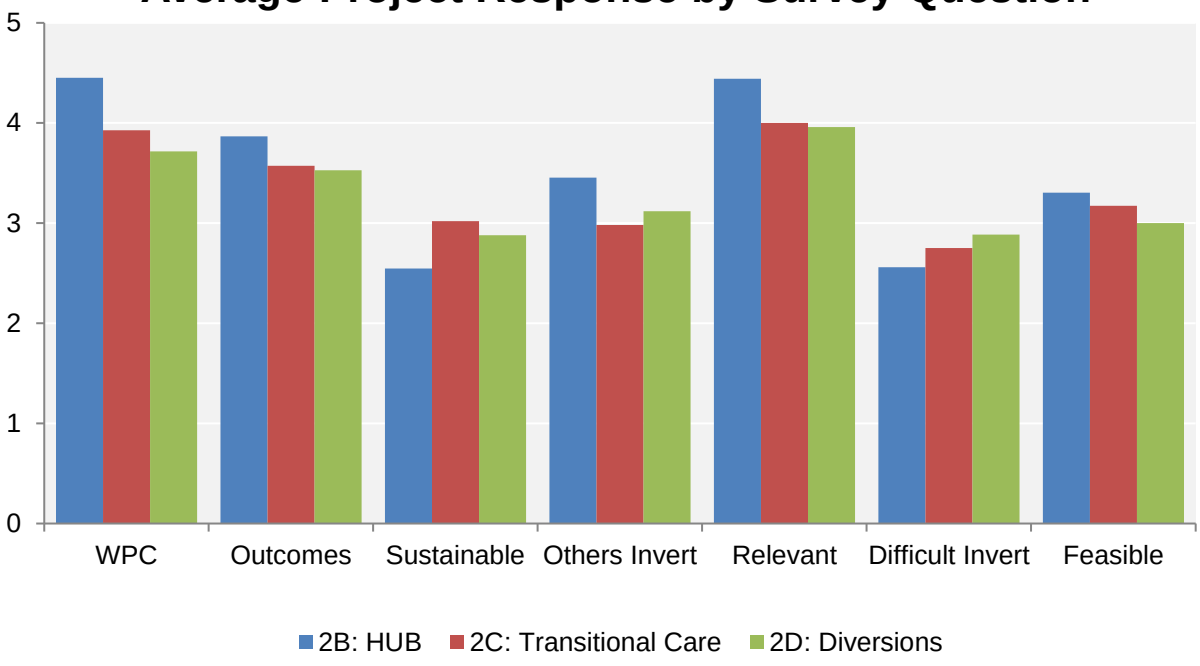
Overall project score is the average of the responses to all seven questions.

The below table is a key to correlate results for the Domain 2 and Domain 3 graphs on page #4 to the survey questions:

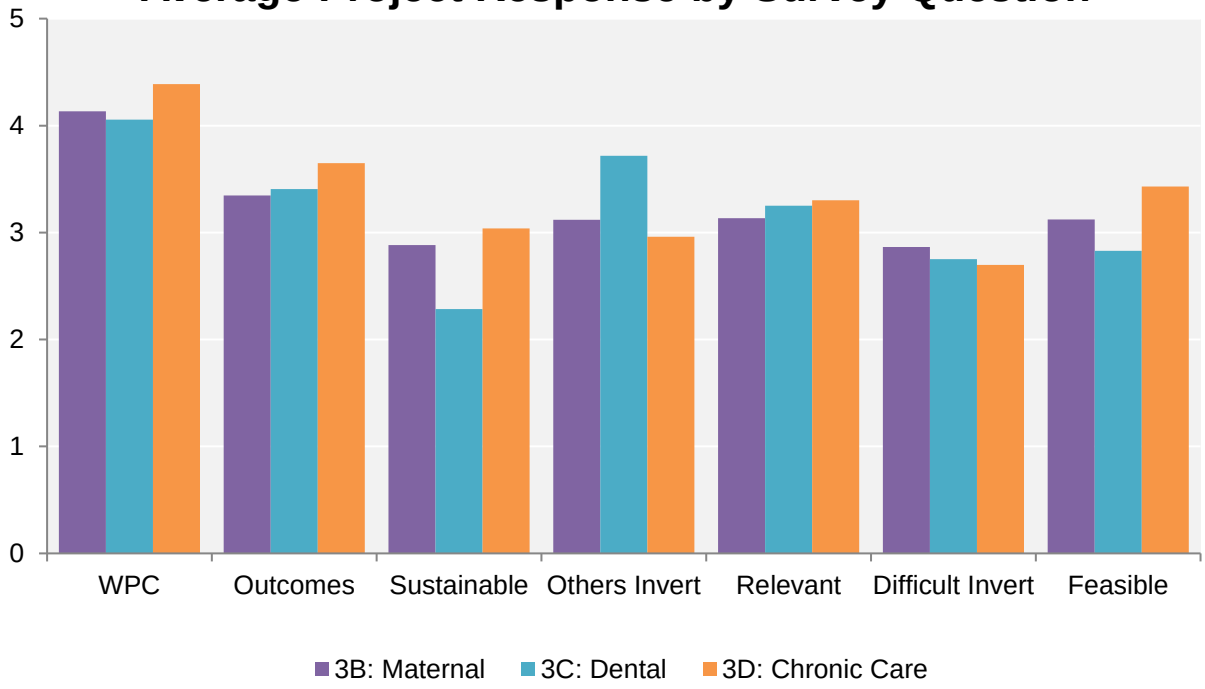
Graph Key	**Survey Questions:**
WPC	1. How critical is this project to the establishment of Whole Person Care in the region?
Outcomes	2. How likely is it that we will be able to improve outcomes in 4 years of implementation?
Sustainable	3. Would changes be sustainable after Demonstration dollars are gone?
Others Invert*	4. Is this project addressed in part by other projects, making a separate project of this kind less necessary?
Relevant	5. Is this relevant and needed in all 4 counties?
Difficult Invert*	6. How difficult would it be to implement this project on a region-wide basis? (The whole region will be judged and funded on the basis of each project's region-wide success. So a project effective only in a limited area could affect funding negatively for the whole region.)
Feasible	7. How feasible is it to successfully address this problem with the relatively limited funds available through the Demo?

***Response scores were inverted to maintain consistency of 1 to 5 rating score (i.e. 1 least desirable, 5 most desirable)

Domain 2
Average Project Response by Survey Question



Domain 3
Average Project Response by Survey Question



Survey Comment Results Summary:

30% of Survey responses included comments. Main themes of each project are summarized below. Full comments are attached in separate PDF document.

Project 2B: Pathways HUB (n = 29)

- Ability to implement HUB, measure, and meet outcomes required by state in 4 years
- Need to be a dynamic partner in the community and not just a referral source
- Ability to sustain the HUB model after the Demonstration
- Comments are generally positive

Project 2C: Transitional Care (n = 19)

- It could be addressed through programs such as care coordination (i.e. Project 2B Pathways HUB)
- Hard to address due to rural nature of counties
- Already being addressed through current programs

Project 2D: Diversion Intervention (n = 18)

- Could be addressed by other toolkit projects (i.e. Project 2B Pathways HUB)
- It would be a high cost project to implement
- Current financial incentives do not align with project
- Not generally positive about project

Project 3B: Reproductive and Maternal/Child Health (n = 16)

- Focusing on childhood interventions has the biggest impact on health
- Long term ROI hard to demonstrate in 4 years
- It would be very expensive to implement
- Could be addressed by other projects in the Toolkit (i.e. Project 2B Pathways HUB)

Project 3C: Access to Oral Health Services (n = 19)

- Do not have the local dentist willing to accept Medicaid patients
- A lot of agreement this is a big need and very important, but unlikely to achieve.

Project 3D: Chronic Disease Prevention and Control (n = 19)

- Needs coordination and partnerships to be successful
- Complements other projects (i.e. 2A Bi-Directional Integration & Project 2B Pathways HUB)
- Good long term ROI, but concerned that would not be achieved during demonstration.
- Needs to be different than previous chronic disease prevention projects if it is to be successful.

Q3 Comments on Project 2B: Pathways HUB

Answered: 29 Skipped: 39

#	Responses	Date
1	I understand that in Southwest, there are now care coordinators managing care for the individuals who are the high utilizers. They are in their second year with a much simpler system as far as implementation and it is not yet working well from the provider perspective. While not the same model, that model is less complex. The Hub model may be a better model, but how long has it taken to get it up and running well in the states that are using it? I would guess that it would take a minimum of 2 years, but likely 3 to get it fully operational, and it would be fledgling for the first year. That data (along with what was done to get it up and fully functional) could be valuable in determining the projected timeline, but only if their work force mirrors the workforce in central WA. The workforce issues we face here could substantially delay full implementation of the model when you get to the hiring and training part. When does the Medicaid Transformation Demonstration period begin? Where would the funding come from for the hub after the demonstration project is over? Don't know if one hub is needed in each county...seems like it would be easier to do a smaller area than it would hubs that cover the entire region.	4/17/2017 3:52 PM
2	Great concept!	4/14/2017 3:21 PM
3	The 3 means I don't know. I know a lot about our area, but not some of the other areas in the region.	4/13/2017 12:22 PM
4	211 is a key partner that needs to be at the table in order to meet goals, create healthy outcomes for clients and for sustainability after the demonstration funding is gone. 211 has the infrastructure in place to connect clients to the social determinants of health and to continue to build, update and sustain the regional database of resources. With 211 there is no need to recreate this aspect of the project.	4/13/2017 9:01 AM
5	Care traffic controllers models only work if there are resources to direct traffic too.	4/12/2017 4:34 PM
6	Can't exactly picture what the HUB will look like. Concerned about the viability of the program after initial funding is expended. But I like it (as I picture it anyway)	4/12/2017 2:05 PM
7	My biggest concern is that we invest in technology that will help to "coordinate the coordinators" as opposed to hiring people. A centralized data bank of community resources and shared info about who has interacted with specific patients is what I feel is most important.	4/12/2017 1:46 PM
8	On how difficult it would be to implement - I think this depends largely on who will be taking on the "hub" -- what experience they have and how well connected they already are to the four county area.	4/12/2017 9:47 AM
9	This project should be implemented with careful consideration of how to blend it with the existing care coordination model in our region/state. There has been significant investment in the regional Health Homes program with many lessons learned that can help inform an improved implementation of a second care coordination model. While Health Homes is now realizing a shared savings model based on the Medicare savings from the Duals demonstration project, it has been slow to come to fruition based on slow data reporting and other factors. I highly support this project.	4/11/2017 8:05 PM
10	due to how money/contract would funnel funds through the hub, the sustainability is dependent on the payment reform possible during the demonstration being 'retained' afterwards. If payors see ROI and savings by paying for the services of the HUB coordinators through the HUB, they would need to be ready to continue that methodology after the demonstration period.	4/11/2017 11:10 AM
11	Sustainability is dependent on reimbursement through the development & implementation requires start up (project funds)	4/11/2017 10:47 AM
12	This project is key to NCW success for the goal of the triple aim.	4/10/2017 9:09 AM
13	The NCACH should strongly consider initiating this proven system for addressing social determinants of health.	4/8/2017 9:35 PM
14	If left only to the healthcare sector to accomplish this, it will fail its intent and less likely to be sustainable. Other policy making bodies in the region need to have buy in.	4/8/2017 6:23 AM
15	Many questions about implementation so feedback is limited at this time.	4/7/2017 12:16 PM
16	Pathways presentation at Chelan conference indicated that implementation process takes at least 5 years. Very labor intensive and intensive communication - base process will face difficulty over such a large geographic area with home base services & mulitple agencies.	4/7/2017 12:13 PM
17	How difficult is it for a HUB to connect with a variety of BHR's?	4/7/2017 12:09 PM

18	If done effectively, this project could provide the medical & mental health professionals with needed coordination. Providing both diversion & transitional guidance . If not effective, it would create another layer on medical/mental health team. There is alot of potential with this project to cover the needs of all 4 counties, focusing on specific needs of their residents and available resources.	4/7/2017 12:04 PM
19	Difficulty depends on 1. resources available in each area. 2. Degree of cooperation in communities. If few resources, it is challenging to complete the referral process.	4/7/2017 11:56 AM
20	A single source is smart…4 seems a bit burdensome and might promote inefficiencies with technology, high speed connectivity would be anywhere. Retail facetime unnecessary.	4/7/2017 11:42 AM
21	"Primary Care Case Managers are not nearly as effective as staff providers who know their patients and have strong relationships. PT's need access to a person more than just phone calls & layers of filters. *What stands out as needed & evidence-based is the community health worker, home visits. *Baseline population assessments can be done through collaboration with social service agencies, primary care clinics & school districts. This is more than ""Healthy Youth"" data and census data, more specific that county health assessment data. Aces questionnaire at well child visits, at risk seniors ID's with Medicare Wellness HUB concept needs to have some decentralization of implimentation. Regional and cultural population characteristics have a bearing on who & how care coordination & service delivery is done. So #6 needs to be flexible with room for several regional modes of delivery. The immigration/refugee population will be more challenging to reach. The spiritual community should be tapped into! "	4/7/2017 11:33 AM
22	Barry Kling's comments in the recorded webinar appeared to favor this model of an intervention. To me most important will be to design a system that will show measurable and achievable treatment and outcomes. Where I put a "3", it was my next-best selection to a "don't know." I marked 3s in cases where I'm not clear how important it is for our entire state to improve performance vs. our region v. each of the four counties within NC ACH.	4/6/2017 1:47 PM
23	The idea behind this HUB is brilliant. This implementation and design, as well as hiring highly qualified employees will be key. The idea of the air traffic controller is incredible; it would allow those with specialized care coordinating positions, such as nurse case managers, health homes care coordinators, early headstart home visitors,BH, ECEAP, CPS, DD, APS, Section 8, have a place to go when each position is at the limitations of what the positions can/cannot do. It would free up a nurse case manager to let someone else do housing, or help a 0-3 home visitor refer for a parent of the child s/he is working with. However, what worries me is to be effective and trusted in a community, the person/people running the HUB will need to be Mary Poppins and crew. They will need to really know their communities, be easy to work with across agencies, trusted, and knowledgeable in a variety of ways. My concerns is the HUB would end up an office full of brochures and a glorified receptionist pushing referrals through rather than a dynamic coordination center for the needs of a community.	4/6/2017 1:25 PM
24	Needs more definition between clinical case management and home-based, face to face, care coordination. The MCO's have not bought into the Care Coordination model but continue to try and provide clinical case management. The model needs to include the Predictive Risk Model related to how client access their care instead of clinical measures. These savings are easier to measure than clinical outcomes over a 4 yr period.	4/6/2017 9:27 AM
25	Pathways is solid and flexible enough model. It provides standardization and a data platform that solves key problems.	4/5/2017 2:44 PM
26	THE PATHWAYS HUB WIL BE DIFFICULT TO SHOW roi IN JUST 5 YEARS	4/5/2017 2:24 PM
27	This would be my choice.	4/5/2017 1:50 PM
28	The idea of the Hub would bring (maybe mandate) together agencies and services that are already available. It is important with limited funds to get ALL the players working for the individuals. Agencies need to work in concert and understand what each client needs. smaller numbers may be served, but if it is more holistic it will be better. And NOT creating new efforts and jobs and housing, but using the current experts is much more efficient.	4/5/2017 12:47 PM
29	Due to our ruralness - it may be difficult to coordinate programs. Transportation is a challenge that may not have been fully addressed yet. Many in our community don't have access to transportation nor internet/phones to coordinate these needs.	4/5/2017 11:49 AM

Q5 Comments on Project 2C: Transitional Care

Answered: 19 Skipped: 49

#	Responses	Date
1	Need to have a good understanding of how the systems work in order to address challenges. For example, there is funding for transition services for individuals who are incarcerated, but there are so many barriers to how the jail works that it is next to impossible to work with someone prior to their transition out of jail. However, in theory it is a great idea. BTW the link to the APIC information in the document does not work.	4/17/2017 4:04 PM
2	3= I don't know	4/13/2017 12:22 PM
3	in both this group and the last, the question about difficulty in implementing the project makes the answers 1-5 kind of hard to judge what is meant. I put in 5s because i think it would be very difficult.	4/12/2017 3:37 PM
4	We are very rural in our region and don't have real access to Interventions or Acute Care Transfers. Mental health office is open only a couple of days per week.	4/12/2017 2:07 PM
5	I think that the potential for saving money is significant but because of that, there may be varying degrees of interest in this project.	4/12/2017 1:49 PM
6	Transitional Care is already a priority (specifically in hospital and nursing homes) in the Health Homes program which demonstrates the ability to address the issue in part by other projects such as Pathways HUB.	4/11/2017 8:10 PM
7	this has care coordination at its core. And the pathways hub has the structure to implement this as a pathway.	4/11/2017 11:12 AM
8	Sustainability is dependent on reimbursement through the development & implementation requires start up (project funds)	4/11/2017 10:47 AM
9	I believe there are already systems in place that address this. Using the Pathway HUB will improve those systems.	4/10/2017 9:11 AM
10	Transitions of care could be strengthen by NCACH sanctioned multi-sector agreements demonstrating commitment and accountability to measurable actions supporting transitions of care.	4/8/2017 6:27 AM
11	This effort could be accomplished by a strong hub that focused on both physical & mental health needs. Personal experiences had me to believe that transitional services from intensive services into the community are poor for elderly clients and certainly not reflective of whole patient care or the specific needs of elderly population. The need behind transitional care should be addressed, but could be done with an effective HUB rather than a stand alone project.	4/7/2017 12:05 PM
12	I don't know much about transitional care.	4/7/2017 11:42 AM
13	The problem population does not get discharged to nursing home, home health, or even follow through with following up on outpatient care. They just go "home" so case managers (CHW's) need to go to where they are, their home, etc. Behavioral health services would help.	4/7/2017 11:34 AM
14	Can some of these outcomes and measures be included as part of project 2B?	4/6/2017 1:54 PM
15	For the most part, the changes in health care have focused on transitional care, and it's one of the peices working better than some of the other transformations. IT could still use work, but is being addressed by clinics, hospitals, and insurances.	4/6/2017 1:27 PM
16	The use of Transitional care RN's is expensive and not necessary. Care Coordinators with specific training and abiility to provide home-based visits has proven more effective. Health Homes is a good example.	4/6/2017 9:30 AM
17	NOT SURE WE COULD SHOW THE TYPE OF ROI THE STAE IS LOOKING FOR WITH JUST THIS PROJECT	4/5/2017 2:26 PM
18	The four county area might be challenged by trying to implement this plan. While transition is important there are not always places available for that to happen. I am not as familiar with this area.	4/5/2017 12:49 PM
19	The coordination of these types of needs may be difficult if the services and programs are too distant (rural)	4/5/2017 11:50 AM

Q7 Comments on Project 2D: Diversion Interventions

Answered: 18 Skipped: 50

#	Responses	Date
1	I think diversion interventions can save the system a lot of money, but it is not clear how that would work in terms of sustaining the project when there is not project funding...funding for diversion activities (all of which are not Medicaid reimbursable to do it right) has to be built into the system, and it is not clear if it would be possible under the CMS regulations. I think again, work force issues are a consistent challenge across all the project options.	4/17/2017 4:08 PM
2	Our location within the region is multi city, multi county, multi jurisdictional and has many moving parts. Lincoln County, Grant County, Okanogan County Sheriff's, Colville Tribal Police, Homeland Security (Dam), Electric City, Grand Coulee, and Coulee Dam Police Depts - just to name some - oh and Washington State Patrol.	4/12/2017 2:16 PM
3	As with transitions, entities that do well financially in the status quo will be less inclined to embrace changes that will reduce their reimbursement.	4/12/2017 1:52 PM
4	Seems to need more approaches listed. Not completely sure what Community Paramedicine entails, but I think social service agencies could be instrumental here	4/12/2017 11:53 AM
5	Similar to Care Transition, Diversion Interventions (ER Diversion) are happening in existing programs and therefore should easily be incorporated into another project.	4/11/2017 8:13 PM
6	This is also a key care coordination and non-traditional referral pathway that can be significantly addressed and measured through the pathways HUB system. Once again, the workforce of the pathways HUB system needs to be grown and a means to pay them agreed upon. And that funding stream, which is itself a diversion of $ spent in high cost services over to care coordination resources(which should be lower $).	4/11/2017 11:15 AM
7	This is a heavy lift	4/11/2017 10:47 AM
8	See comments in previous project.	4/10/2017 9:12 AM
9	This low hanging fruit is probably already addressed to a large degree. This and much more would likely be addressed by the pathways model.	4/8/2017 9:42 PM
10	Attention must be given to address the current underlying perverse financial incentives that drive the system. Otherwise, system will not engage meaningfully.	4/8/2017 6:30 AM
11	#4 OBHC & juvenile court system are already engaged in diversion program in our county. I don't know how successful this is.	4/7/2017 12:14 PM
12	The rationale for this project is almost identical to the Transitional Care project definition (NC ACH PPT Demonstration Decisions). Diverting the community from services through the use of EMS is a way to reduce costs, but does not necessarily help the community member or address underlying causes for requests for help.	4/7/2017 12:06 PM
13	In response to the last question, I can see the argument for selecting fewer options to increase the likelihood of a targeted plan for sustainability to occur after the demo ends.	4/6/2017 4:41 PM
14	To have a coordinated effort in this direction is needed. IT's possible the HUB would do this agenda too?	4/6/2017 1:29 PM
15	This will be an expensive and difficult project, best done on a community basis instead of regionally. I do not have enough knowledge of this to have good input.	4/6/2017 9:32 AM
16	COST OF ER DIVERSION WTIH PARAMEDICINE COLD BE LINMITED WITH A BIG IMPACT IN OVERUSE OF THE ER. IT SHOUILDEASILY SHOW AN ROI AND WOULD ALSO DOVETAIL WITH ANOTHER PROJECT OF POST HOSPITAL FOLLOW UP BY PARAMEDICAINE THAT COULD BE ROLLED OUT IN CONJUNCTION OR AFTER THIS PROJECT IS SHOWING SUCCESS	4/5/2017 2:28 PM
17	If there was enough money, this project might be doable, but what are the risks of regular relapse. Again the number of individuals served might be small to do it right.	4/5/2017 12:51 PM
18	These may be added to other projects at a much lower cost as an add-on then a stand alone project.	4/5/2017 11:53 AM

Q9 Comments on Project 3B: Maternal and Child Health

Answered: 16 Skipped: 52

#	Responses	Date
1	Longer term return, but I think you will see a spike in the problems and costs if resources for women's reproductive health are cut by Congress if you don't do something in this area. In that case a static outcome might actually reflect a higher degree of success than you otherwise might think.	4/17/2017 4:12 PM
2	Nurse Family Partnership is very expensive and unless the "requirements" were less stringent, it may not be feasible at this time. Home visit programs could be done and outcomes achieved without the hoops that one needs to go through to provide NFP	4/14/2017 3:28 PM
3	I don't have enough knowledge in this area to honestly answer the questions.	4/13/2017 12:24 PM
4	Wellness and population health begins at birth. Healthy Mother's Healthy Families	4/12/2017 4:36 PM
5	While the long term savings from a program such as this are possible, the savings would likely be minimal in the demonstration project period.	4/11/2017 8:15 PM
6	This is very much a front end early intervention with long term ROI. It can easily piggy back on the pathways HUB care coordination program as a specific pathway.	4/11/2017 11:17 AM
7	Research shows this has the biggest impact on maternal & child health.	4/10/2017 9:13 AM
8	Probably represents a relatively small portion of health cost. This would largely be addressed by the pathways model.	4/8/2017 9:47 PM
9	Engagement of child care providers, Head Start, preschools, schools led by primary car providers and supported by WPC wrap-around services to families will be needed.	4/8/2017 6:33 AM
10	The effects of poor family planning & teen pregnancy, poor prenatal care, lack of parental engagement and lack of prevention & health maintenance create lifelong negative impacts on health & well-being . We should focus on helping the current generation of teens & young adults produce the next generation of healthier adults.	4/7/2017 12:06 PM
11	There is no better investment than zero to 5 years old. Building the brain architecture (neural synapse), early learning, mental, physical and relationships is the very best return on investment. A win in this optional will have an impact on the other optionals and will give these children a chance to escape poverty, incarseration, drag on social services & physically, mentally and spiritual whole success for their entire life.	4/7/2017 11:44 AM
12	Part of outreach needs to be sensitive to the concerns of undocumented individuals and families. This is a key group in addressing and educating parents about adverse childhood experiences and partnering with them to mitigate these risks, which are social determinants of health. It would also help address the teen pregnancy prevention for young mothers, sequelae of post partum depression if unchecked/untreated.	4/7/2017 11:36 AM
13	I believe home visiting programs are effective, but if chosen, measures such as vaccine adherence, better birth outcomes, and other short term measures would be needed. There are home visiting programs in existence, and it would likely be better to coordinate those existing programs than to add more.	4/6/2017 1:31 PM
14	A pathways HUB could include this piece nicely.	4/6/2017 9:33 AM
15	this area of health care is extremely important, but I am not sure how it would be implemented over the whole area.	4/5/2017 12:53 PM
16	The ruralness of our area would make something like this almost impossible.	4/5/2017 11:54 AM

Q11 Comments on Project 3C: Access to Oral Health Services

Answered: 19 Skipped: 49

#	Responses	Date
1	It would seem that dental services would be feasible, as Medicaid at least will pay for services for children, so if screening could be implemented in a cost effective way that can be integrated with health (can a pediatrician be taught a quick screening process that can be incorporated with the well child check-ups?) it would seem to be more sustainable over the long term.	4/17/2017 4:15 PM
2	While adult oral health is a huge concern, private providers accepting Medicaid adults is an ongoing problem.	4/14/2017 3:30 PM
3	3= I don't know	4/13/2017 12:24 PM
4	I am not sure what providers are currently available to provide the resources to the project.	4/12/2017 4:37 PM
5	The region struggles with a sufficient number of dental professionals willing to work with underserved populations.	4/12/2017 1:55 PM
6	I think it would take longer than the demonstration period to show savings with this program. Building the provider capacity to fit the need would take most if not all the allowed time.	4/11/2017 8:18 PM
7	Oral health can also be a pathway in the HUB model. But this is a high $ resource and slow to grow provider base that will be difficulty to show 4 year return. Dental capacity is a concern.	4/11/2017 11:18 AM
8	Need dentists	4/11/2017 10:52 AM
9	Relevant and important, but ability to effect change and to achieve sustainability are not clear to me.	4/8/2017 9:48 PM
10	With continuation of ACA expansion funding, there is a good chance this can be achieved.	4/8/2017 6:35 AM
11	#6 Very difficult	4/7/2017 12:12 PM
12	"#2 - Depends on strategy Poor dental care & dental maintenance lead to many other conditions. But without changes in dental insurance, it would be hard to implement and sustain. Would be good to have some dental input on NC ACH. Even if this is not the selected project, the dental professionals may have good ideas on regional efforts/needs. "	4/7/2017 12:07 PM
13	I can see this being a priority for kids based on community fundraisers/donations. It shouldn't be funded by government agencies.	4/7/2017 11:44 AM
14	Need to recruit more family dentists, mobile dental services, sliding scale for non-covered services. Basic dental assessment/screening in primary care pediatrics (long term outcome). Adults - catch it early, prevent chronic inflammation and chronic disease.	4/7/2017 11:36 AM
15	It's unlikely the demonstration dollars can "fix" oral health. There are several efforts currently out there, but the sustainability of the demonstation project for oral health is dismal.	4/6/2017 1:34 PM
16	Dollars best spent on high risk medical populations to see most savings along with a prevention program through primary care.	4/6/2017 9:35 AM
17	GREAT PROJECT BUT THAT COULD BE ROLLED OUT TO AL PCP CLINICS ADN INSTITUTED WITH RELATIVE LOW COST BUT NOT SURE HWO WELL IT WOULD SHOW ROI IN JUST 4 YEARS	4/5/2017 2:30 PM
18	I do believe that oral health care is critical to the medicaid population and would help with over all health. Again, not sure how many people can be helped across the entire area.	4/5/2017 12:55 PM
19	We have absolutely no dental office in our community that take Medicaid. It is a huge issue for us, but I believe it can be added to other projects as an add-on at a lower cost.	4/5/2017 11:55 AM

Q13 Comments on Project 3D: Chronic Disease Prevention and Control

Answered: 19 Skipped: 49

#	Responses	Date
1	This is a huge undertaking--it will take generations to educate people to take charge of their own health. As people are socialized health care costs should decrease, but it is a long term venture. The health care systems have begun implementing this, but considerable public education is going to be required over the long term. That doesn't mean it isn't a good idea to foster productive interactions between informed patients who take an active part in their care, and providers with resources and expertise.	4/17/2017 4:20 PM
2	Not my area of expertise	4/13/2017 12:25 PM
3	The Department of Health and 211 are key partners for chronic disease prevention. Both agencvies have been partnering statewide since 2103 to expand self management resources and awareness of resources through community outreach. The expansion of the statewide 211 database of services has opened and opportunity for community health outreach workers to expand information and resources into more rural areas. Through the use of the new DOH CHART software program that connects to the 211 database of services, community health outreach workers will have more immediate access to resource information to make referrals for clients.	4/13/2017 9:17 AM
4	I think that this is a project with almost universal support. It also has the potential to reduce the cost of healthcare through reduced specialty and inpatient costs. This will result in the State viewing this project as a success.	4/12/2017 1:57 PM
5	Coordination of the existing chronic disease programs across agencies in our region, improvements on patient incentives for participation and the initiation of a bi-directional communication system could result in a successful project.	4/11/2017 8:22 PM
6	This is one of the most widely pursued opportunities for improvement in health care. But it continues to be a silo approach in need of relationship based, patient specific, locally trusted, care coordination. The structures and measures of the pathways HUB model create the most relevant workforce (CHW's or ?) to build the Behavior changing/influencing engine needed to affect change.	4/11/2017 11:22 AM
7	Chronic diseases are preventable and controllable. Improving our health systems and community involvement is much needed.	4/10/2017 9:17 AM
8	Dovetails with Patient Centered Medical Home efforts.	4/8/2017 10:06 PM
9	Success in this project is a must, as it has the highest probability to generate system savings that can be applied to sustaining other efforts.	4/8/2017 6:37 AM
10	Our primary care delivery system is not really designed to support the CCM effectively, especially in regards to prevention. Unless the system itself is redesigned (HUB, Home Visiting Models), we will just get the same result we've been getting.	4/7/2017 12:08 PM
11	Community Choice & WSU Extension have a diabetes prevention program at this time.	4/7/2017 12:02 PM
12	My feeling is that messaging marketing should mostly be communicated at young age (middle school up) in schools, in churches, etc. (sporting events). I don't believe older demographics should be the targets for messages.	4/7/2017 11:45 AM
13	How do we get folks to allow community health workers in their homes? I suspect a local, established, trusted team of individuals is necessary, preferred to "outsiders".	4/7/2017 11:37 AM
14	so so many programs are tried via current medical outlets. So many have low participation or adherence. I truly believe coordinating these current efforts and offering trainings to social service and medcial staff would be much more effective than throwing yet another diabetes, SAIL, foot care, etc into communities.	4/6/2017 1:37 PM
15	Would need to be measured by a predictive risk model and not clinical model to see outcomes in 4 yrs.	4/6/2017 9:37 AM
16	AGAION THE 4 YEAR WINDOW OF SHOWING IMRPOVED OUTCOMES AND roi IS VERY DIFFICULT	4/5/2017 2:31 PM
17	This would also be my choice	4/5/2017 1:54 PM
18	shine a light on SUD as a chronic disease.	4/5/2017 12:13 PM
19	This combined with Project 2A makes the most sense to me as a Community Health Worker. It is doable and trackable. Those two combined make this a viable project.	4/5/2017 11:56 AM

Email Verifying North Central Hospital Council Project Endorsement

From: Kevin Abel [mailto:kabel@lcch.net]
Sent: Thursday, March 30, 2017 8:43 AM
To: Linda Parlette <Linda.Parlette@cdhd.wa.gov>
Subject: RE: NCWACH Project Options

Hi Linda,

I agree we have what we need to make our decision and the detailed information can go to the board members.

I heard back from some that were not at the meeting and we are at a point where we have consensus on Chronic Disease Prevention and Control and Community Based Care Coordination Pathways HUB as the two optional projects for our region from the hospital standpoint. We still need the input from other community groups but it is a start.

Kevin Abel
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Grant County Summary of CHI answers from April 10th.

Pathways HUB

Concerns	Excites
Data sharing-patient consent (Health Info Exchange)	Relationship with the person
Pathway resources lacking (mental health access to care)	Connecting people to resources
Operationally how it will work	Key to other projects; essential service
Educating CHW's; recruiting good CHW's→not making training too rigorous	Partnership with 211
Making appointments- delays in starting CC	Address social determinants of health
Caseload restrictions?	Measurement-tracking success and failures, lack of resources to be tracked
Who will make referral to HUB?	Focusing on specific population, i.e. ER utilizers
Health homes role?	
Who is the HUB?	

Chronic disease

Concerns	Excites
We do not have people in community that currently do this follow up/tracking	You can measure some of the successes in certain clinical settings
Poor compliance with chronic disease patients	Possible home monitoring would be beneficial since limited transportation in this area
Lack of transportation in rural area	This would have to work/would work well with the Pathways HUB
Once you diagnose a chronic disease, how do you know there will be follow up?	This would be getting ahead of the curve, finding root cause, different than current clinical model
4 years is a short time to measure chronic disease improvement	This will hopefully keep the diagnosis from developing/getting worse
The provider will need a team, who will provide the team to make this possible?	This will provide relief for providers seeing same patients with same issues over and over
How will data be shared?	Hopefully reduce repeat ER users

MCH/Oral Health

Concerns	Excites
Will primary care take on oral health?	Outcomes of home visits
Resources?	Prevention focus, early intervention
See results, but perhaps not savings	Both address transportation issue
What has worked well in other communities?	Support for whole family/outreach for whole family (MCH)
Increased needs in rural areas; mobile unit prepared?	Mobile visits (dental)
Dentist at the table	Addresses children (most vulnerable group)
Who will (MCH) it be open to?	Will collaborate with HUB
Home visits must be culturally relevant	Oral health crosses over with MCH, chronic disease
Cost over time	
You would need care coordination/care coordinator	

ED Diversion/Transitional Care

Concerns	Excites
Very circular, what is the difference?	Types of services are not as big of a concern
Diversion will take a lot more resources/investments to address	Diversion sounds more appealing for work
Still addresses people with acute situations, want to reach them prior to preventative services.	Overlaps with HUB
Cannot do this without care coordination	Transitional interventions would be best to achieve outcome→payment on admission
Resources available in community for this?	Long term care→ other initiatives
Not successful without HUB	Focus on opioid work
	Addresses areas of high cost of medical care
	Potential for high cost savings
	It is a more proactive approach

Most groups agreed that in order for each option to succeed, the Pathways HUB would need to be implemented.

Methow Valley Response to Survey
Community Based Care Coordination & Diversion Intervention

Background

The Methow Valley Health Care Network has identified **Community Based Care Coordination** and **Diversion Intervention** as significant health care gaps in our region, with Diversion Intervention being of highest priority for implementation. We believe that a more integrated health care approach is needed to address these specific issues hence an initial partnership has been established with the following valley health care providers: 1) Aero Methow Rescue Service; 2) Lookout Coalition; 3) Frontier Home Health & Hospice; 4) Family Health Centers, Twisp; and 5) Three Rivers Hospital (plans are to extend the network to a broader range of local providers). In addition, the network has recently submitted a revised grant application to the *Rural Health Network Development Planning Program*, (HRSA-16-017) to obtain support to develop a detailed plan to address these specific needs. For the Methow Valley community the planning grant outlines in detail the following: valley history, demographics of target populations, relevant community services, unmet needs, barriers and challenges, project objectives including performance metrics, and roles and responsibilities of network partners. This planning grant funding is for a 12 month period (initiation June 2017 if funded) but will only support the development of a strategic plan; whereas, plan implementation will occur in 2018. The planning grant is directly focused on the need for community based coordination to alleviate loss of local services and better access to care by enhancing emergency medical services with an overarching goal of improving the quality of essential health care services. Although this planning grant was developed specifically to address the needs of the Methow Valley, we believe it is highly relevant to the North Central Accountability Community of Health. (*If you would like a copy of the grant contact Cindy Button*)

Comments to survey questions (1-7), ranking score range- 1 (not at all), 5 (very much)

1. We believe that it is critical to establish "Whole Person Care" in the Methow Valley and the region. To accomplish this, well integrated community networks are vital. The overarching "unmet need" can be summed up as, a lack of health care gap management to fully address chronic, mental and behavioral health needs. Health care needs can be broad in scope where patients may be dealing with a range of short- and long-term health issues. These patients may also be struggling with numerous confounding factors such as poor compliance with medicines, lack of family support, lack of primary care, difficult living conditions among other factors that further compromise their overall health status. Hence, effective strategies need to be developed to address "Whole Person Care". **Ranking (5)**
2. Once care coordination and diversion interventions are established, and assuming the appropriate performance metrics are developed and used, then health outcome improvements will be realized (in less than 4 years). We believe this is particularly true in the Methow Valley since we've already made progress via our Network. **Ranking (5)**
3. A critical component of both care coordination and diversion intervention is network communication. We envision limited resource allocation will be needed to maintain efficient care coordination and ongoing efforts focused on community paramedicine with available resources should enable sustainability with limited additional cost. **Ranking (4)**
4. At this point in time we do not believe that the goals of the HUB and diversion intervention would be addressed by other projects. The HUB as a care coordination strategy in an important health care integrating tool. For example, when we consider diversion intervention, care coordination is a critical component needed for successful integration. Depending upon the scope of the care coordination efforts (local vs. regional

focus) it may or may not be appropriate to integrate into other projects. However, from our perspective we wish to stress the need for a local HUB strategy, since we believe it will best facilitate addressing the unmet needs of our community. **Ranking (2)**

5. We believe it is critical for the Methow Valley and potentially Okanogan County (**Ranking 5**). It may likewise be equally critical to all counties in the region since they share similar issues with regards to rural health care needs; however, we lack adequate information to fully assess. **Ranking (3)**
6. The care coordination could readily be integrated region wide. However, we believe that local coordination is critical since there are unique differences within various communities. For example, in Okanogan County Methow Valley demographics are quite different than those in Omak or Eastern Okanogan County; hence, local coordination is important. However, it is envisioned that the entire region would benefit from care coordination and diversion intervention but how that would look may vary from community to community. **Ranking (3)**
7. The demo project will establish the proof of principle, and once appropriate metrics are developed and measured long-term and broader feasibility can better be assessed. Since each community is unique the results from the demo project will need to be tailored to other communities within the whole region. **Ranking (4)**