North Central Accountable Community of Health

WPCC Workgroup Meeting

Tuesday, February 20th 2018, 8-10 AM

Location:	**Conference Information:**
Webinar	https://global.gotomeeting.com/join/895704941 (669) 224-3412 Access Code: 895-704-941

Attendees

Workgroup members: Blake Edwards, Dulcye Field, Kim Fricke, Dr. David Kolde, Julie Lindberg (and Courtney Ward as backup) Deb Miller, Molly Morris, Amy Webb,
Staff and consultants: Roger Chaufournier (CSI Solutions), Kathy Reims, Connie Davis, Caroline Tillier, Linda Parlette

Agenda

1. Introductions	Workgroup members and consultants introduced themselves. Workgroup members described their current quality improvement efforts and/or linkage to whole person care. Workgroup composition per charter is well represented though we may want to recruit a representative from Emergency Services.
2. Medicaid Transformation Overview	Since the WPCC preceded this work, provided an overview of the Medicaid Transformation including goals, vision, and overview of our ACH region. Walked through the three domains of "Initiative 1" of the Medicaid Transformation (aka Care Transformation through ACHs). Domain 1 is focused on infrastructure (Health Information Technology, Value Based Purchase and Workforce), while Domain 2 and 3 include projects related to Care Delivery Redesign, and Prevention and Health Promotion. Explained how these projects relate to the WPCC and Change Plan.
3. WPCC in the Transformation	Reviewed an organizational chart showing how the WPCC fits into other workgroups and partners involved in the NCACH Medicaid Transformation. WPCC Workgroup is one of a number of workgroups helping to plan our projects. Outside of the WPCC Learning Community (partners receiving funding and doing work on the ground) other partners will be receiving funding to work on opioid related initiatives of transitional care and diversion interventions. WPCC

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	Workgroup is a technical subgroup of the broader WPCC which meets monthly. WPCC workgroup's role is to guide planning and implementation of Bi-Directional and Chronic Disease projects, and help connect providers to other NCACH projects. Reviewed timeline of tasks for the workgroup including what's ahead through August 2018. Fast tracking change plan development since trying to roll it out at March 24th Kick-Off, which is why we are asking the workgroup to provide input into evidence-based approaches and reviewing target population today.
4. Change Plan Overview	Purpose is to document what clinical partners can accomplish to support whole person care in our region. This is a deliverable for Stage 1 funding, but it's not a static deliverable. It's a template that will get updated/added to every year (some work may need to be sequenced). Trying to create structured template so it's easy for providers to build a roadmap. Learning Activities will provide support to providers as they work on process improvements outlined in their change plan. Based on the original evaluation criteria described in the draft change plan template (aim, measure, baseline, goal and action steps), walked through how action steps are getting deconstructed into primary and secondary drivers and tactics. Also reviewed the 8 topics in the change plan which correlate to the 6 Medicaid Transformation projects as well as 2 additional important topics (addressing social determinants of health and access to care). There are things that clinicians can do within their clinic walls to impact the objectives of all of our selected projects. What can clinics do on their end? Today, focusing on Bi-Directional Projects and Chronic Disease Prevention and Control because those are the projects the WPCC is taking leadership of. Some providers have used Collaborative Care model and others have used Bree Collaborative, though not everyone was familiar with both or clear on how they did or did not align. Chronic Care Model is the only evidence-based approach that was available under the Chronic Disease Prevention project.
5. Review of Supporting Data	Workgroup reviewed data that was included in NCACH's preliminary project plan applications for both Bi-Directional and Chronic Disease projects. Looked at this data in the context of target populations and chronic conditions. The data generally resonated with workgroup members. Recognized that prevalence of chronic conditions may vary by region. Also spent some time walking through Medicaid Transformation performance measures, including definitions (e.g. antidepressant medication management). Workgroup Recommendations/Discussion: In addition to targeting diabetes, respiratory issues and heart disease as chronic conditions, the workgroup recommended that we add depression to the list since it is one of the leading and most disabling chronic conditions. Also begins to shape idea that chronic conditions are also behavioral health in addition to medical. Workgroup asked about Substance Use data which was not shown in slides. Workgroup members asked about measures for respiratory issues and heart disease since those are big and broad (diabetes measures are already pretty well-developed). This is exactly something we want to explore with the workgroup. Workgroup member suggested that we use the term "mental health condition" or "behavioral health condition" instead of illness (as presented in the HCA data). In our region, hospitalizations around diabetes may have to do with cultural barriers. Chronic Care model is applicable across all chronic conditions, but tactics will vary depending on the condition. We are

	trying to build those tactics into the template, including high-leverage changes that we know work. Cardiovascular bucket is really broad so may want to narrow the focus on what's most important. Community health centers already track a measure related to cardiovascular disease, aspirin utilization for patients who have been diagnosed. May also want to track Beta blocker use post MI, ace inhibitors. Hypertension in primary prevention is where you want to be when it comes to cardiovascular disease. Workgroup would like to see measurements that providers already track (CMS and MIPS) to be leveraged rather than coming up with new measures. Suggested cross-walking with HEDIS measures that might already be tracked. We have the opportunity to recommend standardized measures, but we can also let organizations measure what they are already tracking (mitigates measure burden). There should be a standard around measurement as it relates to evidence. Would think that we would want to compare and hold ourselves to the same standards, though EHR limits for some providers may prevent ability to provide requested measurements. There may be minor variations across type of provider but would be great to find alignment/overlap across what is already being measured and include those as high-leverage measures. For those with limited EHR capacity, would hope that we could help people build towards better systems. Everyone seemed on board with that. Action Item: Caroline will send a template with the performance measures and ask workgroup providers to identify what measures they are already tracking (including source e.g. HEDIS) and what they think should be tracked. Will also include a separate tab for specific input into measures for chronic conditions that we are focusing on (which may not be included in the HCA performance measures). Measure specifications will be important to clarify, and include measures in the change plan template that are already being used.
6. Change Plan Deep Dive a. Bi-Directional Integration Project b. Chronic Disease Project	Dug into some of the action steps for the two main projects, specifically the driver diagrams which are being used to structure the development of the change plan template. Looked at 5 levels of integration which will be included in the change plan. Tactics are different depending on where you are on the integration continuum, so challenge is to create a template that is consistent yet flexible. Looked at 7 principles of Bree Collaborative (as primary drivers) which representation consolidation/summary of how to think about integration – providers shouldn't these principles surprising, though language might be a little different than what some providers are used to. Also reviewed elements of Chronic Care Model (as primary drivers). Discussion: Two questions for the group: (1) Bree Collaborative is mapped to the MeHAF assessment, and we could ask all providers to complete MeHAF annually so we could have serial data to look at level of integration over time. This will give us a metric to measure movement towards integration in our region, without saying that full-fledged integration is best for everyone. Where people are accessing acute care for behavioral health, it probably has to do with access to care (unmet need). And (2) for those already on that journey, what would be helpful in terms of change ideas/tactics to support providers based on where they already are and where they want to go. Note that PCMH-A, which many of our primary care providers completed, looks at readiness to be a full-fledged Patient Centered Medical Home (some

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	provider orgs are already certified). There are 2 types of measures we will want to track - level of integration, and then efficacy for those integrated program (e.g. PHQ-9). For chronic diseases, wondering how BH providers are thinking about opportunities to monitor/facilitate care for patients with SMI. What kinds of linkages to physical health should be included in the template? Co-managements seems to be making a difference, so we'll try to include those ideas in the change plan template (and make it clear to BH providers why things about diabetes might be included in their template). For change plan template, workgroup felt that things were heading in the right direction in terms of the "roadmap" approach to our template. Members did suggest that we also include text boxes to freely type (not just check-boxes). There were also questions about where the measures would be documented. Any measures that we agree to all report, and additional measures that teams would like to report would be in a separate section that was not depicted in screen shot shared. Some members wanted to know if there would be shared/transparent dashboards where providers can see each other's work for purposes of peer sharing and collaboration. Action Item: Send workgroup link to MeHAF so members can better understand this tool, consult with their behavioral health colleagues, and answer Kathy's question. Caroline and Kathy will look into potential standard measures of success around integration.
7. Input on Project Measures	This was addressed as part of prior discussion of data (item #5 above).
8. Input on Driver Diagram Framework	Finally, walked through a mock-up of an existing portal to see how the primary drivers, secondary drivers and tactics come together into the portal form and how to show progress (aka change status). This is designed to ease reporting. Clarified that none of these portal reports will be rolled up to the state (HCA), but it will help us with summarizing information for our own NCACH narrative reports to HCA.
9. Wrap Up	**Closing comments from members** • Appreciate peek into what portal will look like • Interesting to be moving from a more internal quality improvement journey to more external/shared journey • Strategy of looking at what is already being reported and incorporating it into process and adds value is worthwhile even if it will add more admin burden • Quality improvement work is not something CBOs. Seems very clinically-focused right now, so figuring out where CBO fits would be helpful. • How do community-based education pieces fit into this template, so health systems don't have to do everything? • Like the idea of a portal to track progress

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	• Simplifying approach and demystifying integrated care helps pave the way for greater change. • Identifying the measures is easier than actually figuring out how to report the measure (complexities around population, baseline, what's in, what's out). Support principle of using measures that are currently being used by providers. • Data seemed very adult driven so hope the workgroup doesn't lose sight of adolescent population as well. • Lots of evidence-based practices and opportunities for partnership across community-based and clinical orgs – need to leverage those programs to promote integrated care. • Given map of our large ACH, which underscores that this is a big undertaking • Hope that we will crosswalk what is already being measured • Appreciate difficulty getting things out of their system for reporting (or don't have EHR). Underscores the need for single or cross-communicative platforms. Wish there was money for that. o Caroline clarified that ACH is setting some investments aside for "Domain 1" investments and HIT is a big part of trying to connect our system). We will ask this workgroup to chime in on this at some point. • Linking tribal health programs and Indian Health Services (IHS) will be an important piece as we think about bi-directional integration • Lots of potential, and input from providers is critical since we primarily facilitators as an ACH