

## WPCC Workgroup Meeting Notes

Thursday, April 12<sup>th</sup> 2018, 1-2:30 PM

<p><b><u>Location:</u></b> Webinar AND <b>Chelan Douglas Health District</b> 200 Valley Mall Parkway, East Wenatchee, WA 98802</p>	<p>GoToMeeting Info:  <a href="https://global.gotomeeting.com/join/358682781">https://global.gotomeeting.com/join/358682781</a>            Meeting Access Code: 358-682-781            No computer audio? Dial in using your phone.            United States: +1 (786) 535-3211</p>
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### Attendees

Workgroup members: Dulcye Field, Blake Edwards, Courtney Ward (in lieu of Julie Lindberg), Deb Miller, Amy Webb

Staff and consultants: Peter Morgan, Caroline Tillier, Kathy Reims

Absent: David Kolde, Molly Morris, Julie Lindberg, Kim Fricke

<p><b>1. Welcome &amp; Introduction</b></p>	<p>Briefly reviewed main recommendations that came out of our last meeting on February 20<sup>th</sup>. Also pointed out where meeting notes are posted on website (<a href="https://ncach.org/wpcc-workgroup/">https://ncach.org/wpcc-workgroup/</a>)</p>
<p><b>2. Revisit prior requests for input</b></p>	<p>Discussed assessment (e.g. MeHAF), change plan, and reporting to flesh out pros and cons of completing this information at the organization vs site level. If different teams are in different places, how do we want to address that? For assessment scores, should data be averaged, or should there be a representative sample for the whole organization. One thing to message is that if an organization decides to average or select a representative PCMH-A, we should request that they list the methodology so they do it the same way every year. Progress measurement should be consistent year-to-year. Organizations may parse out their change plans differently (teams may work on different sections of change plan at different times). There are reasons that organizations may want to monitor at site level.</p> <p>Change plan is what organizations intend to do, and progress to date is what sites/orgs have actually done. Site level progress is important, and spread is also important. Amy only has one site, but operationally, if had more than one site, would be critical to know how individual sites are performing against measures. At minimum, progress reporting and assessment data would need to be recorded at the site level with the ability to roll it up to the organization level.</p>

Measure reporting with numerators and denominators would also be at site level and would provide measures over time. Should change plans be submitted at the site level, since it might be hard to set an organization-wide target if have sites at different places? Dulcye pointed out that she has 3 sites in 3 different ACHs – how will this change plan translate for BHT and Greater Columbia? NCACH is further ahead on this front, but Dulcye is getting the sense that as long as making improvements, toward end of the day may not matter. Kathy suggested that may need learning activities around spread.

Action Item: Peter to reach out to David Kolde separately. He was unable to join today's meeting but has an important multi-site perspective. Might be worth reaching out to other multi-site orgs as well (Moses Lake, FHC and CVCH).

We are already moving forward on asking providers to complete MeHAF annually, but should PCMH-A also be updated annually? These assessments were done at the site-level. While a lot of tactics are going to link back to workflow processes within PCMH-A, it would be helpful to demonstrate that have made progress through the tool itself. Primary care providers on the call didn't have any concerns with requiring primary care to update PCMH-A and doing so annually would be sufficient (more frequently is not necessary.)

Action Item: Make recommendation to broader WPCC group that PCMH-As be updated annually to measure progress.

Revisited preliminary recommendation that providers use a standardized tool to screen/assess social determinants of health (SDOH). Dulcye mentioned that her organization uses PRAPARE, which already allows for EHR integration (it was suggested to FQHCs). Kathy has a white paper comparison of various SDOH tools. Good news is that most of the fields are very similar across tools, and being able to integrate into an EHR is a big deal (templates for major EHRs already available). In the spirit of recommending tools that are already in use rather than asking providers to use multiple/duplicative tools, workgroup members were supportive of recommending PRAPARE screening tool without further review of other tools. For behavioral health providers who generally do much more screening around social needs, we could give them option to either use the tool or just incorporate the questions into their existing screening questions. Amy concerned about lack of community resources (e.g. no point in screening if there is no follow up action) and also asked for clarification on whether Pathways HUB is still coming online and could serve that purpose (yes, but probably not until 2019). Will have power in numbers if all providers are using same SDOH screening tool, in that we will be able to identify shared gaps/needs, and resource gaps that require capacity investments.

	<p><u>Action Item:</u> Make recommendation to broader WPCC group that providers use PRAPARE screening tool as they work to identify/address SDOH needs (SDOH section in change plan). Staff need to sort out how this would interface with Pathways HUB.</p>
<p><b>3. Health Information Technology, Value Based Purchasing, and Workforce (aka Domain I)</b></p>	<p>Reviewed questions and issues related to Domain I. For example, where are providers on their progression towards value based payment, and what more do they want to know or do? Providers briefly shared their experience with alternative payment models, and capitated contracts. Amerigroup has established VBP on primary care side, but right now don't have any established with behavioral health providers. Should we explore a regional workgroup on this topic? Courtney in support of that. MCOs and providers and ACH are all not clear on VBP and would benefit from getting on same page. Dulcye agrees that need more eyes on this. How are things measured and monitored? For organizations that have limited data extraction ability from EMR, will be a big challenge to succeed under VBP. Agreed that need to get a sense of where people are on this Domain I continuum.</p> <p><u>Action Items:</u> Peter and Caroline will propose and draft a provider survey to help us assess the full picture of gaps/needs so we can identify a path forward. Will also identify existing resources in our region on VBP and other topics, to assess whether distinct ACH workgroup is most efficient use of time/resources or whether another means of engagement would be more efficient.</p>
<p><b>4. Stage 2 Funding options</b></p>	<p>Reviewed stage 2 funding questions and goals. Revisited the funding model shared at the January WPCC meeting, and presented another potential model as a way to illustrate how some of the funding variables could be adjusted. Workgroup members discussed implications and leaned towards Model 1 for the following reasons:</p> <ul style="list-style-type: none"> <li>• Like base funding of first model because smaller providers have fewer resources to begin with, despite having large goals to achieve and approach with base funding helps get them to sustainable level.</li> <li>• Being able to predict/know funding projections and having funding stability is important – providers are wrestling with how best to plan and budget for this work.</li> <li>• Base level of funding important for smaller organizations and also recognizes that there's a certain hurdle that everyone needs to get over</li> <li>• Reducing complexity will simplify the management of the funding process.</li> </ul> <p>Some caveats and comments with respect to Model 1 require further attention:</p>

	<ul style="list-style-type: none"> <li>• In Model 2, like the concept of something tied to measurement; holding organizations accountable to outcomes, and helping them work through barriers. Payment for performance is important to make sure people are achieving outcomes.</li> <li>• For payment per learning activity, how do we account for resource utilization and how long learning activities last?</li> <li>• Base amount shouldn't be same for everybody – could be based on Medicaid population.</li> </ul> <p>There is a recognition that within our WPCC Learning Community, we will have every spectrum imaginable in terms of need for funding; smaller providers may need more because they are under-resourced, while larger providers also need more to impact their volume of patients. Workgroup needs to be cognizant of overall budgeted amount for WPCC, and simplicity and predictability are important criteria to honor as we fine-tune funding model. Also need to think about the fact that we may need to set capacity building funds aside to support HIT and linkages to CBOs. Staff noted that NCACH budget includes regional/capacity building funds outside of the project/workgroup budgets (though exact amounts are still being fleshed out with our Board.)</p> <p><u>Action Item:</u> Staff to fine-tune Stage 2 funding variables and present updated model to workgroup based on today's observations (will be focus of May meeting).</p>
<p><b>5. Next Meeting</b></p>	<p>Next Meeting – May 10<sup>th</sup>!</p>