WPCC Workgroup Meeting Notes

Thursday, October 11th 2018, 1-2:30 PM

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

Attendees

Workgroup members present: Kim Fricke, Kathleen O'Connor, Courtney Ward, Molly Morris, Lisa Apple, Deb Miller, David Kolde
Staff and consultants: Peter Morgan, Wendy Brzezny, Caroline Tillier, Christina Clark (CCMI), Connie Davis (CCMI), Kathy Reims (CSI), Nicole Van Borkulo (Shift Results), Gwen Cox (Qualis)
Absent: Dulcye Field

Note that this workgroup meeting took place on the same day as a full-day retreat that NCACH staff were having with consultants involved in WPCC work, which is why many of these consultants joined the workgroup meeting.

1. Welcome & Updates	Wendy announced some changes to workgroup membership. Amy Webb moved on from Cascade Medical so Kathleen O'Connor will join this workgroup in her stead. Blake Edwards who had represented the BH sector but stepped down form workgroup when he transitioned from Children's Home Society to CVCH. Jim Novelli from Okanogan Behavioral Health was invited to join workgroup, though he could not make it today (Lisa Apple joined on his behalf). Julie Lindberg, representing the MCO sector, moved on from Molina and nominated Vicky Evans to replace her. She was unable to join today, so Courtney Ward is filling in as her back-up. Peter shared background about this workgroup for newer members and clarified that it was established to provide technical and logistical advice to the broader WPCC. Reviewed prior minutes and action items.

2. Learning Activities + Coaching	Workgroup members briefly shared how their colleagues are feeling about participation in current bi-directional LANs. Wendy reviewed updates to planned learning activities (based on discussion with consultants that morning) including an empanelment LAN and Cardiovascular Diseases (CVD) Sprint slated for December start date. Also planning on offering a team-based care LAN to help organizations understand different roles that staff can play. Connie explained the patient/family workshop which would encourage providers to include patient and family members in transformation effort, which helps accelerate change. Lisa supportive of topics and emphasized that access is an important topic. There will be information specific to BH access, but there is less evidence regarding solutions that work well. Lisa pointed out that BH access issues are very unique and may require policy fixes (e.g. requiring a 2 hour intake before someone can become a patient.) Discussed role of coaching network. Wendy explained that NCACH is leaning towards a local coaching network that involves coaches hired and managed by NCACH. Feedback from workgroup members included: • Kathleen underscored importance that anyone serving as a coach has real-world experience in the settings that our providers operate in (not just in change management or practice improvement) • Lisa has appreciated having an objective party who can help her team sort out and walk through ideas • David sees role of coaches as asking the right questions, not necessarily having to be experts in the field. Outside eyes are important Caroline added that NCACH staff and consultants discussed need to shift our support model. In addition to learning activities, recognizing need for more intensive coaching to help providers apply what they learn, tie it to their change plans, and promote more sharing across practices and coaches. Lisa mentioned that coaching received on change plan was very helpful and would appreciate more of that now that received feedback. Kathy, Tina and Gwen have been providing some coaching to serve immediate needs around change plan, and we are taking a leap to develop coaching network, which can be adjusted based on feedback as we go along. Discussed peer sharing opportunities. Lisa suggested that it's best to match peers based on their line of business. Also underscored how helpful it would be to see other organizations' change plans and allow for grouping by topic. Wendy clarified that all change plans submitted by end of December will be shared in the portal for all to see; we can look into grouping information by topic. Christina explained the role of affinity groups, which are less formal and open to all (e.g. QI affinity group). A facilitator holds to the open space for people to come together around a topic, which allows for people to drop-in/drop-out. A Medical Assistant (MA) affinity group may be really powerful when get to team-based care learning activity.

	Wendy asked group to chime in on the commitment we may ask of people who participate in the Motivational Interviewing Train the Trainer track coming up early 2019 (4 day training). Some people have been selected as good candidates based on their participation in Foundation of MI, others might choose to apply. Connie explained that those who complete the training will be asked to offer a small training (1:12 ratio) within 1 year of their training, since they must use the skill in order to maintain the skill. Deb mentioned that some of the Pathways HUB staff is interested in developing this capacity and underscored that care coordinators could really benefit from this kind of training. Highly desired skill set for community-based organizations. Should we require some of those trainings to be opened up to broader NCACH community (rather than just making MI training available to their agency)? Group discussed reasonable options; for example, potentially asking participants to offer 2 trainings in the first year.
3. Communications	Wendy solicited feedback on best way (content and frequency) to communicate out to the WPCC community. What has worked well, and where have people felt out of the loop? Most WPCC workgroup members felt that email is best way to communicate. Portal was intended to centralize communication and in hind sight, NCACH realized that notification settings are not automatically turned on for members of the portal. We have been working on flipping this "switch" so people receive email notifications when new content, calendar items, blog posts, etc have been posted (with a direct link to portal). How can we make portal more useful to users? Kim offered that everyone is extremely busy, so any additional systems that needs to be logged into presents a barrier. If emails can pull people into portal, then would be much more useful as centralized communication tool. The direct link to the new content is key, and a link at the bottom to adjust notification levels would also be helpful *[note: link to notification settings already included in all notifications].*
4. Change Plan Measures	Caroline explained philosophical decision made by NCACH around measures that WPCC providers will be reporting on. Because process improvements are broad an applicable to all patients (not payer specific patients), we are encouraging providers to submit broader measures for entire patient panel. The measures we are "graded" on by the Health Care Authority are going to be Medicaid specific, which adds a challenge in terms of connecting the dots between the HCA results and the data reported by providers. The idea was that this would be less of a reporting burden. <u>Comments</u> • Lisa really likes this approach because process improvements are not specific to payers • David asked if it's OK if provide Medicaid data only. Yes, we are trying to be flexible. • Gwen offered that EMR systems usually include payer identification. She suggested that Medicaid specific data from providers would be easier to match up to HCA data. • Nicole suggested that from an improvement perspective, separating out Medicaid only data would not lend itself to improvement especially for providers that have smaller Medicaid population • Kathy believes correlating the provider data to HCA should be doable • Christina offered that just enough good enough data is sufficient for quality improvement

	Kathy shared some brief insights specific to the optional measure set that was collected by end of September. Decreased the overall set of optional measures to about 100. Great to talk to the teams and focus them in on what actually will be working on in short-term. These measures will be ready to be reported on in December.
5. SDOH screening tools	Kathy had encouraged us to identify a core set of domains that we would ask all WPCC members to screen for. At one point, there was a suggestion that we recommend one SDOH screening tool for everyone to use. Providers pushed back because they did not want to be prescribed a tool (some are already using one) but rather guidance to reach consistency across providers who may be using different tools. Caroline presented a draft summary of SDOH screening tools for discussion. Is this is a useful summary? Are the suggested core domains (e.g. behavioral health, housing, etc) reflective of what providers are already asking? Anything missing? Every tool is different in how they ask questions specific to domains. <u>Comments</u> • Kim observed that many tools address these domains, but the wording is key. For example, housing instability can be asked in many different ways. Do you have adequate housing? Do you have housing that has running water? Are you couch-surfing? There is no perfect standardized question that would give us a data set that is comparable. The questions would have to be relatively the same for data to be comparable across providers. • Deb asked whether we had considered cross walking the SDOH screening tools with the HUB intake assessment. How closely are those aligning? Has to be more seamless from patient perspective. • Standardizing social determinants of health questionnaires may not be the goal. Are questions similar enough that we can distill important regional information, even if the data is not “apples to apples.” • We don’t need bull’s eye accuracy with respect to SDOH data acquisition, we just need to know how many people are hitting within the three rings. Could help with better understanding the regional need. • Intention of asking people about SDOH is to get people what they need. Have HUB as a lever, but we may need to strengthen connections to other community-based organizations. • Work out of Oregon on empathetic inquiry could really help in terms of sensitivity around these questions • How SDOH screening process is done will be important to address through learning activity. It’s less about the tool, and more about implementing the process. Long lead up but something is planned around SDOH learning activity late 2019. <u>Action Steps</u> • Deb will send HUB intake assessment and NCACH staff will cross-walk it with SDOH screening tools before posting to portal as resource.

6. Synchronizing Workgroup Strategies	Wendy asked for input on how best to synchronize other workgroup efforts (e.g. TCDI and opioid). David had suggested that their information would be posted on portal. Even within large organization, hard to track all the pieces. Gwen pointed out that the NCACH monthly newsletter does provider updates on what workgroups are working on. Beyond that, could we do a shared learning activity brining together funded providers through WPCC (outpatient) and TCDI (hospitals), especially where their respective processes interplay. Deb suggested a self-directed HUB powerpoint she has, which could be shared on portal. Kathy sees a great opportunity for a Q&A session with Pathways HUB staff and community specialists. Wendy suggested including workgroup updates on the broader WPCC agenda, on quarterly basis. Given that everything is interrelated, conversations and connections are happening organically. Kim uncertain that it's possible to report out on everything that is happening. Peter suggested that connections are not happening systemically; doing some updates can promote better information sharing, but queuing up a shared LAN may be more effective.
7. Other	Meeting adjourned. Next workgroup meeting – November 8th!