Summary of Bellingham Provider Focus Group
November 16, 2011

Participants: Chuck Benjamin-RSN; Jackie Mitchell-Whatcom County Chemical Dependency (CD), Victoria Doerper-AAA; Julie Johnson-AAA; Dean Wight-Whatcom Counseling & Psychiatric Clinic; Tom Sebastian-Compass Health; Larry Thompson-Whatcom Health Alliance; Teresa Litton-Whatcom Health Alliance; Scott Livengood-Developmental Disabilities Providers; Anita Tallman-Christian Health Care Center; Carina Kroll-PACE; Desmond Skubi-Interfaith

How can we improve coordination of care?

- Electronic health records
  - All hard wired in Whatcom, Primary Care (PC) can access
  - Electronic Medical Record (EMR) has a 60-70% adoption rate, still have gaps
  - Gaps in connection with social services
  - Lack analytical ability
- PACE
  - Ability to combine Medicare and state funds
  - Long Term Care (LTC) and acute care
  - Full at risk
  - 1 pot of money to use for individual needs
  - Interdisciplinary team
  - Can get eye glasses, Occupational Therapy (OT), etc, based in individual needs
- Use state money to keep spendown from not affecting care
- Take capitation for capitation
- Take Medicare and Medicaid benefits packages and combine them
- Hospitalization/surgeries in Pennsylvania model are not at risk for hospitalization, this works for DD system
- Chronic Care Management model (AAA) works
  - Nurse Care Manager (CM) has coaching role
  - Activation plan
  - Navigate system by cm
  - Positive impact on Emergency Room (ER) use
- Disability Life Line
  - Statewide case management system-WEB based client registry (Community Health Plan of Washington and Interfaith)
  - Chronic Care Management could be integrated into this
  - This is similar to electronic medical record but can use to coordinate care

    - Population based management tool to reach out, can see service in data
    - Only includes care coordinators for CD and mental health (MH)
    - HIE-CM system has services listed
    - Needs to be real time data
- Cross organization interdisciplinary teams should be used for the highest acuity and have funding to allow time for this
- Have only one care plan
- Create something like PACE that meets all needs
- Can use Accountable Care Organization (ACO), Health Maintenance Organization (HMO) or both
- Need to an organizing body
- Require community assessments
    - Take advantage of good things going on
    - Still try to be as consistent as possibly across state
    - Having the conversation really brought providers together and it is helpful to have these as ongoing
    - Communitywide plan for providers
- Whatcom County would take on a demonstration project, has been discussions about this and it would be a unique opportunity
- Have a series of demonstration projects around state
- Use Wrap Around care model for adults
    - Multidisciplinary teams
    - Fidelity based
    - Already have them for kids
    - This is a philosophy, not a program
    - Involved all disciplines
    - Peer members
- Single group of providers to contract for responsibility for defined group of duals, provide all services
    - Have financial incentives
    - Capitation
    - Accountable
    - 20-20 organizations
- AAA would expand care coordination to reside where there is the primary need, not necessarily be with PC
- WMIP
    - Blended funding
    - Buy-in for risk
    - Care coordination is improving
    - Needed more CM, outreach-only telephonic and it didn't work for everyone

    - Medical clinic in BH setting, this is very complex, can't just co-locate, need infrastructure
    - Just putting money in one pot doesn't make it work, need to clinically integrate
    - Everyone needs to share risk
    - Have to integrate information to a care plan that makes sense
    - Need to look at NOT being able to drop clients when they get expensive or go into WSH
    - Poor enrollment structure, it allowed for cost shifting
    - Molina is not knowledgeable outside of basic healthcare
- An ACO or HMO needs to partner with LTC and MH
- Need to have this knowledge
- Don't carve out, integration needs to go all the way to the system of care
- PACT Model (assertive community treatment)
    - Seen 2-3 times per day
    - Fidelity based
    - Intensive outpatient is a step below PACT but for those who still need intensive care
- Support for family care givers should be given on an ongoing basis
    - Education
    - Respite
    - Support groups
- LTC benefits need to include in home care, adult day health
- Keep in least restrictive settings
- Housing providers, facilities like for those coming out of WSH

How can reduce fragmentation of the system?

- There is a group that no one wants to work with, high utlizers, what happens with them in a new system? They are getting older.
- Not opt out, can have choice of healthcare home but can't opt out
- Whatcom Health Alliance has many sharing agreements
- If there is enough choice, should be able to opt in, have support/info for choice
- Neutral party should assist with choice, like SHEIBA
- Can decrease fragmentation with shared savings, medical groups are much more comfortable with this
- Won't necessarily decrease fragmentation with full capitation
- Washington Medicaid Integration Project (WMIP) had no savings
- Have to have 2 tracks
    - Incentive
    - Integrated care coordination

- Transformation has to produce savings
- Good EMR, can improve possibly of decrease in fragmentation
- CD, will have other issues, need the integrated MH and CD WAC
    - Problem with federal laws
    - State should ask for waiver on these CD laws
    - Need to integrate CD into system of care
    - Include CD screening in the assessment
    - Need to have providers that have skills and ability to pay for it
    - Currently a state grant, pilot in King has no CPT code for CD, looking at allowing PCs to turn on punctuality
    - Going on in ERs around country
- CHPW, has developed a system on this
- Create a system within a hospital
- ER use in Whatcom is fairly reasonable
- Addressing shortage of geriatric practitioners
- Parish nurses attend discharge planning and follow up
    - Keeps down readmission
    - Care transition need to be more coordinated
- What keeps people living independently?
    - Provide home health
    - Adult day heath
    - Transportation
    - MSW to do discharge planning
    - PC in system could have round rights at hospitals
    - Medicine recognition program
    - Fall prevention
- Need to include those in Residential Habilitation Centers (DD)
    - This could be efficient
    - Keep money for 14,000 that can't get services
    - Better access to PC, make it more consistent around state

How can we increase accountability? What incentives should be used?

- Incentivize for
    - Preventative care
    - Programs for Chronic Care Management

    - Self Management
    - Chronic disease care management
    - Fall prevention
    - PC doing more in regards to prevention
    - Intervention
    - Provide education
    - Podiatry regularly
    - Send out home health for care checks
    - Dieticians for prevention
    - Med management
    - Smoking cessation
    - Deliver meds
    - Incentive to be proactive
- Use data to drive program
- What is high cost now?
- Combine funding streams
- Make change according to communities needs
- Transparency, score cards, make sure the right people are in the conversation reviewing these
- Outcomes
    - Increase satisfaction
    - Look at other states health homes outcomes
    - ER utilization
    - Hospital rates
    - Decrease inpatient overall
- Baseline services that need to be offered
    - LTC
    - Peer support, outreach, crisis services, step downs from inpatient
    - Supported housing
    - PC
    - Care coordination sufficient capacity
    - Employment
    - Transportation
- Be careful that services are consistent across state
- Measureable assessment that is conducted in a consistent manner

- Keep in mind to recognize partners within the system
- Use services that are working, don't get rid of them

What is the first step?

- Ask for waivers
- Demonstration project in Whatcom
- RFQ or RFP (contract) listing principals and outcomes and them responders would tell ACO how they would do this
- Have a truly organized system that the community will respond with
- Providers need to understand exactly what this entails
- Similar to current proposal, grant with CMS(FEDS)
- HMO should be non-profit
- Actuaries need to analyze costs with Medicare data
- Determine where duals are living and what services are they getting