Summary of Yakima Provider Focus Group
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How can we improve coordination of care?

- Care Coordinator needs to have a special skill set
    - Flexible
    - Knowledge of motivational interviewing (possibly credentialed in this)
    - Knowledge of behavioral activation
    - Need to be able to work in the home and on the fly
- CHPW said have to have dedicated staff as cc (care coordinator)
- MSWs are preferred
- Training for cc-behavioral aspects-medical, MH, DD, Long Term Care (LTC), Chemical Dependency (CD)
- Care Management tool PAM
- Care Coordinator works with health home
- Not health plan based, home based
- Cc needs to have cultural competence and work on interdisciplinary team
- Community needs to work together managing entity oversees health home
- Expertise changes depending on where person is at in their journey
- Use Evidence Based Practices
- Coleman (non-nurse and scalable) and Nieler models (should look at other models)
- Chronic care management has worked well in AAA, need to expand to a more multidisciplinary model
- Have contracts with specialty care-example of PACE contracts
- Example-women who has developmental disability, is 60, has MH diagnosis and early dementia, no wanted to care for her except hospice and she eventually died
- Should have 1 assessment for basic core set of service
- Options to be reviewed by objective entity

- Conflict free cm
- Team communicate regularly (weekly or daily) and staff clients, could be conference calls
- Integrated, seamless, non-duplicative
    - 1 assessment
    - Easing enrollment
    - 1 membership cared
    - 1 phone #
    - 1 person to contact
    - 1 benefit package
    - Inform beneficiary of what options are
    - Health fairs similar to private sector
- Use motivational interviewing, goal setting, involve advocates
    - ER Frequent Flyer program at YVH
    - ER doc refers to MSW, (social worker) MSW verifies history, meds, providers, and comes up with care plan
    - Works with ER director and instructs docs on protocol
    - Flagging system at the ER that has info on frequent flyers

How can reduce fragmentation of the system?

- Benefit package should the same for all
    - Best of both Medicaid and Medicare
    - Facilitative
    - Housing
    - Living skills
    - Employment
    - Transportation
    - Adaptive technology
    - Preventative care
    - Care Coordinator as a benefit
- Focus on high utilizers
- Look at Caremore in California
    - Adaptive technology
    - Uses chronic disease management

    - Have lowest amputation of diabetics in county
    - Cm makes home visits
    - Interdisciplinary team
- Use Chronic Disease self management
- Address legal system doesn't understand MH systems, docs and attorneys should sit down and talk about how legal issues affect care for Involuntary Treatment (ITA)
- Avoid ITA in the first place
- What is data on Telehealth outcomes?
- Consulting cc across state have Telehealth for consults
- Since Washington Medicaid 3 max visit rule, ER visits have decreased
- Urgent care may meet need of gap for services
- Link hospital with clinics electronically
- Spokane and Wenatchee have similar models
- PACE has dietician, MSW, DR, RN, Physical Therapy (PT), Occupational Therapy (OT), and Activities Therapist on team

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

- Shared savings
- Capitated fully at risk model
- Pace financial model
- Incentivize to provide care in community
- Incentives for clinical outcomes
- Provide the best care so it costs the least
- Conflict free (competition free) cm
- Health plan could stipulate in contract that benefits be offered objectively
- Some concern about standard benefit package, be more creative
- Ensure there is not underutilization
- Track these outcomes and use for performance
    - Least restrictive setting
    - Hospital days
    - Health status
    - How do they feel?

    - Real time client registry for this
- Managed fee for service potentially could end up with the same silos
- Money should go into 1 bucket
- Pay Medicaid providers Medicare rates
- Clients have incentive up front for prevention
    - Oriented on what is urgent, emergent
    - Nutrition
- Financial model that support prevention, do not use fee for service
- Build adaptive service (like Caremore) into rates
- Single entity will manage system, don't' have too many administrative layers
- Entities may be different per population
- Strong outcome tracking throughout not just early on
- Transparency of supports
- Get data for baseline prior to integration
- Have visible scorecards for client choice

What is the first step?

- Make risk adjusted rates (use Medicare data)
- Identify what community partners need to be at the table to be incentivized
- Communities should have conversation, community assessment, and design for community
- Assess what works well
- Develop map of service
- Make sure Accountable Care Organization (ACO) or Managed Care Organization (MCO) knows what the map of community is
- Look at infrastructure at provider level; some should go some should stay
- Do SWOT of system (strengths, weaknesses, opportunities, and threats)
- Indentify where duplication is
- MCO does not need to recreate provider structure
- Look at PAM and PRISM to what has been saved and outcomes
- Make sure you use what has worked LTC, PACT (assertive community treatment)
- What are the care pathways and options in communities
- Phase in, be able to make adjustments don't do it all at once

- Remember LTC is #2 in nation
- Try rural area, lots of opportunity to streamline (again, do community assessments)
- Don’t underestimate to get electronic medical record, this is critical, hit this hard
- Really important for community to know what is available and how to integrate
- Medical and human services need to work closely
- Loosen fed regulations on PACE