

Summary of Seattle Provider Focus Group

October 26, 2011

Participants: Rosemary Cunningham-AAA; David Stone-Sound Mental Health; Janet Michaelsen-Sunrise Community Living; Robert Moore-Americorp; Lynette Landenburg-Tacoma Lutheran retirement Community; Laura Hofmann-Warm Beach; Robert Hellrigel-Providence; Christi Sahlin; Swedish Hospital; Janet St. Clair-ACRS; Yoon Joo Han-ACRS; Bridget Folz-Harborview; Tom Lennon-Providence; Ken Stark-Snohomish County

How can we improve coordination of care?

- PACE model was created for Duals
- Providence PACE
 - Combing low income housing with service center/location
 - It is a closed network of care-PACE model-contract with ancillary services such as Swedish Hospital
 - Use a monthly capitated rate
 - Serves primarily over 50 with 400 enrollees
 - Primary care drive
 - Not appointment driven
 - Bring services to a service center/location
 - Make sure the demographics are diverse
- Need to loosen regulatory restraints that are on PACE currently
- Need to build strong relationships with hospitals and have staff at the hospitals, chemical dependency (CD) and mental health (MH)
- CD needs to have strong relationships with MH
- Molina and Compass Health are a good example
- Understand multiple issues
- Discover others in system
- Look at co-location
- Start with having plan of care coordination
- All need to understand all pieces
- Have MH get dual certification for CD services
- Send providers out to assisted living centers

- Send providers to adult day health, have PACE pay for adult day health
- Some partnerships can be developed to interconnect
- At hospital begin to talk about PACE
- Work closely with Adult Family Home (AFH) and provide training (again, PACE model)
- Use state PRISM system, predict who will be high utilizers
- Bring in expertise
- PEARLS program is a good example
- Expand long term care system
- Education with family needs to start with primary care management and add case management
- Everett Clinic Partners Program is a good example
- Have a shared care plan like U of W Harborview has built
- MHITS system, psychiatrist reviews care and this is done in coordination with AAA
- Health team would include RN, MSW, ARNP who makes house calls & peer supports
- Need to get more interconnected with hospitals (this is a repeat theme)
- Integrate the funding for all systems
- Remember non-English speaking people's needs
- Importance of exchange of health info, make it clear when HIPAA applies and when it doesn't
- Leverage electronic systems to exchange info
- ACRS and ICHS have a great system as examples
- Role of care manager:
 - Needs to coordinate all care
 - Using MH case manager like ACRS does
 - Understand the needs of each person
- Role of case manager needs to be recognized as crucial and adhere to their plan
- PACE model is patient centered
- Have a role for low income housing in the system
- Use PACE financial model but don't have the system primary care based, have it behavioral health based (I think they may have meant social service based)
- Make sure you remember there is a broad base of the population and build it for them
- LTC, Behavioral Health (BH), Primary Care (PC)-provide transportation for appointments

- Use a fully risk bearing model
- Put care coordination close to primary care
- Use patient centered approach to determine who is care coordinator
- Do not have one size fits all
- LOC-Tacoma Lutheran
 - Work with Evercare
 - Partner with hospitals
 - Have full coverage 24-7 at provider level
 - Look at ways to keep people out of the hospital
- At the hospital family has to be involved
- Palliative Care Model-talk about end of life, diagnosis (not sure about the spelling)
- HIE-use technology in homes and pay for this
- CMS (FEDS) has money in its innovation section, can use monitors in the home to walk the beneficiary through their day
- Add the care manager early on
- Swedish has a residential care team, they have calls at home following discharge
- Prior to discharge set up follow up appointment, medical respite program
- Care plan with return visitors and look at who provides care in community (more on this in the email pasted below)

How can reduce fragmentation of the system?

- Foundational that there has to be parity across all systems in capitated model
- Managed care implies controls, utilization management
- Whoever takes on the risk needs to be ready to meet those needs
- Opt out is important
- PACE is a 3 way contract
- Possibly have Fed take risk and take on program
- Whoever runs the model takes the risk and decides who takes the role of care manager
NOTE: it was stressed several times the whatever the entity was that carried the risk would be “smart and experienced” enough to know who to run the program
- Care coordination should be interdisciplinary
- Job description for case manger is effectively established through relationship

- Contractor would be the first point of contact
- Create new care manager that knows all fields
- Primary care case management model, Americorp
- How are pilots working so we expand with tweaks
- Use pilots and expand, that is the way to go for first step (LTC said this and others agreed)
- If PACE and or WMIP can provide good outcomes then use those models
- Pilot PACE for 55 and under
- Really hard to do this incrementally will be really hard without data system to make it work
- Contracting entity should develop criteria for eligibility for certain services
- There has been a lot of movement around PACE
- Put it back to the Feds to run pilot, model and take the risk
- Like Medicare Advantage Program
- This won't work with this population
- Community Health Clinics (CHC) are across the state and work well to coordinate care
- Social system is 90% of care and PC is 10%
- Key is getting advocates on social service side, they work on relationship
- Hot Spot video, use to focus on how to keep people out of the hospital
- Inventory what we are currently doing
- BH contracts to reduce hospitalization , used SAMSA grant
- Where is prevention?
- Pierce County Community connections....look at their model for LTC
- Make beneficiaries accountable
- Multi-Care doing great job on care coordination
- King County hospital has done good job on partnering, respite program

How can we improve accountability?

- Everyone has to share risk in model
- Have a stop loss provision
- Partner to get people up to speed and learn how to build capacity and use risk management
- Level of scalability

- Data of ACO should show outcomes, actuarial rates can show that
- Medicare Advantage-use HEIDS, “reach for the stars”
- LTC already has a lot of quality measures
- GH uses incentives for beneficiaries, check this model out
- AAA Pierce uses education
- Care Manger should provide health literacy
- Build criteria including prevention
- Preventive services should be free
- Whoever holds risk should chose provider that can provide most culturally competent services AND follow client to choose providers
- If you have someone at risk for illnesses prevention makes a lot of sense
- Incentive to reduce hospital days
- Look at shared savings
- Regulatory reform to reduce burden with technology
- Be offered gains at the end of the year
- MH-King would look very carefully at an offer from ACO
- Manage risk by payers being balanced
- Incentives to providers who see this population
- System needs to be portable to other states
- Total different feel if you get something at end of the year
- Review and change policies such as medical clearance for hospitals and Evaluation and Treatment Centers (E&T) (MH)
- Medicaid already has incentives for facilities (hospitals to bump rate when reduces ER visits
- Lots of Medicaid incentives
- Do away with observation days
- Reimbursement for phone work-30% can be done on phone
- GH has done good job on this
- Change language on order so that it doesn’t suggest going back to hospital
- Give more autonomy to nurses so you don’t pay higher for PCs
- Use PACE financial model but not primary care based, make it behavioral health based
- Make sure you include transportation in benefit design

Hi Kelly,

I really appreciated the discussion at the focus group on Wednesday.

I have continued to think about what we discussed and I wanted to e-mail you about a couple of other thoughts.

We had talked a lot about having a Case Manager/Care Manager role and I agree with this concept. In thinking about it more, I think that it would be helpful to have **liaisons** whose role it is to create an overall treatment plan for a case load of patients and that person would be responsible for checking in with the providers at each agency and holding them accountable for meeting the established treatment plan goals as well as assuring that the agencies are working together and not duplicating services, especially for patients who have multiple providers at a variety of agencies (MH, CD, PCP). The liaison would not be a direct service provider, but would be responsible for making the necessary referrals and initiating the connections with appropriate providers based on the patient's needs.

In addition, I think that it would be helpful to have a DSHS Home and Community Services Case Worker assigned to the hospitals who would work closely with ED and inpatient Case Management staff who was well versed in community services, who could determine what services that patients are eligible for, who could make the referrals to the those providers, and who could work closely with the Case Management staff to assist with discharging the patient back to the community in a timely manner, which will help to reduce length of stay in the hospital setting. Also, it would be helpful if this Case Worker could negotiate rates with the community providers. My experience is that when Home and Community has applied for "exceptional rates" for patients that providers are more receptive to taking the more medically complex patients as well as patients that need equipment for a safe discharge. However, the time frame for approving the higher rate has been very slow and patients wait in the hospital for several weeks pending these approvals which is much more expensive in the long run than Medicaid paying a higher rate at a SNF, AFH, etc.

At Swedish, we piloted a process where we created Care Plans for patients that we flagged in their medical record and we assigned one of the ED social workers as a "liaison" to follow a small group of patients with a high volume of ED and inpatient visits and whenever these patients presented to the hospital, the other social workers would call this "liaison" to discuss the current plan of care. This really helped to create continuity between visits and better connected the patients to community providers, which resulted in many cases to decreased ED and inpatient admissions. I would be happy to discuss this further if you are interested.