Attendees: Morgan Linder, Meghan DeBolt, Megan Toliver, Doug Logan, Liz Fraser, Mike Denny, Sam Werdel, Everett Maroon

Welcome: Mike Denny started the meeting at approximately 2:00 pm.

Service Provider Presentation (slides in meeting packet): Everett Maroon, Blue Mountain Heart to Heart (BMH2H)

- BMH2H is a co-manager for GCACH opioid demonstration project
- The opioid epidemic is largely due to overprescribing
    - Increase in heroin overdoses concurrent with decrease in Rx opioids
    - Our ACH is the third most severely affected region in WA State
- BMH2H provides case management for people addicted to opioids (help access other programs to help) through a trauma informed approach
    - BMH2H is low-barrier: Focused on informing patients of services available
- Models of Care
    - They utilize medication assisted treatment models, used in combination with other behaviors
        - BMH2H would need to go through a specific waiver process to be able to prescribe buprenorphine. They work with doctors already in community because it is difficult to recruit specialists to rural areas.
    - Harm reduction (mainly on individual level)
        - Result of HIV crisis – reduce harm from shared syringes, cottons, spoons, etc,
        - Participants more likely to go into recovery and engage in preventative behaviors (testing drugs, etc)
        - Syringe exchange point of entry for 93% of patients in BMH2H program (helps start recovery process)
    - Care delivery
        - Personal empowerment focused, social work foundation
- Demographics: BMH2H will be increasing Latino outreach in next few months to increase trust and participation in programs
- Collaborations: BMH2H is conscious of projects focused on improving people's lives because so much money becoming available to address issue

Local CHIP Update: Meghan DeBolt, Behavioral Health Council

- HANDOUT: BH Retreat update and charter
- First BH Council meeting this Thursday (meeting third Thursday of every month)
- Will have priorities/sale tax recommendations ready by march for fall RFP cycle
- Aiming for community forum in February

Regional CHIP Update: Sam Werdel, Greater Columbia Accountable Community of Health

- Sam reviewed the milestone reporting schedule handout (summary of practice transformation workbook/portal)
- Milestones have helped improve culture by increasing reporting organizations' openness and interaction with providers (Pharmacists, etc)
- Quality improvement categories have introduced quality improvement efforts into may reporting organizations

Discussion, Follow-up, and Next Steps

- We discussed if organizations receiving Community Health Funds need to provide specific budget/show BMCF what funds were used on. We will discuss this issue further following the September GCACH Leadership Council.

Adjournment: The meeting was adjourned at approximately 3:30pm

Next Meeting –
December 17th, 2019 | 2:00pm
Walla Walla County Training Room
314 W Main St., Walla Walla

Organization Name	Project Name	Proposed Grant Amount
The Health Center (Walla Walla)	General Operations	$30,000.00
Columbia County Public Hospital #1 dba Columbia County Health System (Dayton)	Transport Van Purchase	$18,000.00
Valley Residential Services (Walla Walla)	Specialized transport to increase healthcare access and navigation for disabled adults	$23,000.00
Helpline (Walla Walla)	Screening & Referral Services	$19,252.00
SonBridge Community Center (Walla Walla)	General Operations	$19,252.89
Providence St. Mary Foundation (Walla Walla)	Good Samaritan Program	$25,000.00
	Total:	$134,504.89

APPENDIX C – MILESTONE REPORTING SCHEDULE

Milestone	Category	Description	Reporting Quarters				Reporting Method			Terms and Conditions
			Q1	Q2	Q3	Q4	Selection	Data	Narrative	
1A.1	Budget - Proposed	A proposed budget to perform the required work in 2019	✓				X	#		A. Submit proposed budget no later than February 15, 2019
1A.2	Budget - Reconciled	A reconciled budget to the pre-budget for 2019				✓	X	#		B. Submit reconciled budget from PY 2019 by Jan 15, 2020
2A.1	Access and Continuity	Empanel all patients to a care team or provider.	✓	✓	✓	✓		#		A. 95% Empanelment in comparison to the appropriate care team or MCO assigned provider list.
2A.2	Access and Continuity	Risk-Stratified Care Management	✓	✓	✓	✓	X	#	N	B. Out of 75% of the empaneled patients; provide care management to at least 80% of patients you identified as those at highest risk.
2A.3	Access and Continuity	2-Mandatory - Reference the Toolkit for menu of items.	✓	✓	✓	✓	X		N	C. Select additional opportunities from the Toolkit to enhance your care team to care for those at highest risk.
			✓	✓	✓	✓	X		N	D. Select additional opportunities from the Toolkit to enhance your care team to care for those at highest risk.
2B.1	Care Coordination	Bi-Directional Integration of Behavioral Health		✓		✓	X		N	E. Implement Bi-Directional Integration: Choose one evidence-based model of care and an evidence-based instrument or tool to systematically assess patients and monitor or adjust care.
2B.2	Care Coordination	Self-Management support for at least three high-risk conditions (Choose one of the four options)	✓	✓	✓	✓	X	#	N	F. All members of the care team have basic communication skills to support patient self-management. The practice routinely uses tools and techniques that reinforce patient self-management skills. The practice routinely and systematically assesses the self-management skills and needs for patients with chronic conditions. The practice has a systematic approach to identifying patients with a need(s) for additional support in self-management. The practice has a training strategy to develop staff/care team capacity to support self-management.
			✓	✓	✓	✓			N	G. The practice is able to measure how self-management support strategies affect target conditions or diseases, and adapts and improves these strategies to improve care outcomes.
			✓	✓	✓	✓			N	H. The practice uses tactics and tools that support self-management across conditions and supports patient acquisition of specific skills for management of target conditions or diseases: Conduct routine interval follow-up with patients about their goals and plans.
			✓	✓	✓	✓			N	I. The practice develops and maintains formal and informal linkages to external resources to support self- management. The practice will develop infrastructure and planning via narrative reporting in quarters 1-2, and a systematic narrative for reporting in PY 2020, quarters 3-4.
2B.3	Care Coordination	Medication Management and Review	✓	✓	✓	✓	X	#	N	J. The practice has a systematic approach to reconcile all patients' medications and identify high- risk patients that would benefit from medication management. Selection and narrative quarters 1-2 and data quarters 3-4.
3A.1	24/7 Access by Patients and Enhanced Access	Expand patient access to the practice by providing care and consultation outside the office visit.	✓	✓	✓	✓			N	A. Attest that the patients continue to have 24/7 access to a care team practitioner who has real-time access to the EHR.
			✓	✓	✓	✓	X		N	B. Enhance access by implementing at least one type of opportunity for care provided outside of office visits.
			✓	✓	✓	✓		#		C. Staff time spent on care provided outside of visits
			✓	✓	✓	✓	X	#		D. Commitment to timely responses
4A.1	Patient-Centered Interactions	Place the patient and family at the center of care. Your practice will use the Patient and Family Advisory Council and/or brief, in-office surveys to understand the patient perspective and engage patients and families as valuable partners. (Choose 1)	✓	✓	✓	✓	X	#	N	A. Conduct practice-based survey - monthly0.
				✓	✓	✓	X	#	N	B. Create Patient and Family Advisory Council - quarterly.
				✓		✓	X	#	N	C. Survey and PFAC - semi-annually.
4A.2	Patient-Centered Interactions	Shared Decision Making- support patients as engaged, informed and effective partners in their own health.	✓	✓	✓	✓		#	N	D. Identify and implement shared decision-making tools or aids in at least 2-5 health conditions, decisions or tests. Make the decision aid available to the appropriate patients and generate metrics for the proportion of patients who received the decision aid.
			✓	✓	✓	✓		#	N	E. Provide quarterly counts of patients receiving the decision aids and show growth in use of the aids using graphs or run charts.
5A.1	Quality Improvement	Your practice will implement a "transformation project" quality improvement team to implement transformation work.	✓	✓	✓	✓	X			A. A quality improvement team defined in the Practice Transformation Implementation Work Plan to drive quality improvement efforts.
5A.2	Quality Improvement	A systematic approach to using data about your practice to drive quality improvement. You will begin to work toward metrics related to the project areas and metrics related to the success of value-based reimbursement	✓	✓	✓	✓	X	#		B. The Clinical Quality Metrics for the projects as identified by your organization in Appendix B.
5A.3	Quality Improvement	Practice Transformation Implementation Workplan. Develop a framework and plan for achieving all milestones and self-identified goals and/or projects. This is a "living" document that will be updated regularly.	✓	✓	✓	✓	X			C. Actively engage with your Practice Transformation Navigator to implement and update document throughout the demonstration. (PTIW)
6A.1	Care Coordination across the Medical Neighborhood	A systematic coordination of care across the medical neighborhood. Practice will take a more systematic approach to working with Emergency Departments, specialists, hospitals, etc. to bridge seams of care between settings. (First Quarter - Select two of the three options for milestone 6)	✓	✓	✓	✓	X	#		A. ED Care- quarters 1-4 you will implement EDIE and actively engage with PreManage to track - ED discharge data. In quarters 3-4 you will report tracking data on patients that had follow-up contact within one week.
			✓	✓	✓	✓	X	#		B. Follow up on hospitalization- Implement EDIE, and actively engage with PreManage to identify patient hospitalizations and obtain discharge information. In quarters 3-4, report on those receiving hospital follow-up contact within 72 hours of discharge, minimum 75% of inpatients.
			✓	✓	✓	✓	X		N	C. Enact care compacts/collaborative agreements with at least two groups of high-referral specialists in different specialties to improve transitions of care including primary care to cardiology, gastroenterology, orthopedics and sub-acute services (for example, a skilled nursing facility).
7A.1	Learning Collaboratives / Trainings / Mentoring	Participation in the Medicaid Transformation Project Team Learning Collaboratives, Training and for Exemplar clinics- mentoring.				✓	X		N	A. In Quarter 4, your practice will attest to having participated in at least one learning session/webinar per month.
						✓	X		N	B. Attended at least four Leadership Council Meetings.
						✓	X		N	C. Attended at least 4 learning collaboratives with at least one provider present.
8A.1	Health Information Technology	Develop a framework for optimal use of your electronic health record in the care of your patients, meeting metrics and use IT dollars to invest in resources where necessary.	✓				X			A. In the first quarter, your practice will work with the Practice Transformation Navigator to identify infrastructure, resources, etc. that will be required for the period of the Medicaid Transformation Project.