Central Health Collaborative

- Meeting Minutes -

August 7, 2018

Mission: *To organize healthcare stakeholders by providing a structured forum for sharing valuable knowledge, finding common solutions, and identifying resources to improve health outcomes, improve quality and patient experience of care, lower costs of care, and improve joy of practice in our region.*

Member Attendees: Dr. Kevin Rich, Lyle Nelson, Ashley Knight, Deena LaJoie, Russ Duke, Kelli Badesheim, Luis Lagos, Melissa Mezo (phone), Samantha Kenny, Melissa Dilley, Kim Thurston, Tara Fouts

Guests: Jaime Aanensen, Rob Howarth, Michelle Arnett, Cristina Froude, Mark Nail, Ashley Havlicak, Amy Mart (phone), Kendra Witt-Doyle (phone), Conner Sheldon-Modrow (phone), Dr. Sarah Redding (phone), Bob Harnach (phone)

Agenda Items:

- **Pathways Discussion – Dr. Sarah Redding**

  Dr. Sarah Redding, Director of the Pathways Community Hub Institute provided a brief overview of the Pathways Community Hub model and targeted presentation for how the model may be implemented in the Treasure Valley community. The following is a summary:

  - The mission of the Hub is to bring in funding to support community care coordination. "Risk" would be one word to summarize the model. Reducing risk for populations served by the Hub is the overall goal.
  - The Hub is generally small and lean in terms of staffing. It is there to put an infrastructure in place to assist in connecting agencies to one another and to the at-risk population.
  - Payment for closing a Pathway – 50% of the payment for closing a Pathway has to be tied to the outcome. Many Hubs are contracting with Medicaid managed care plans and payment is tied to billing codes. Many Pathways programs contract with United Way and state funded public foundations as well. Payers need to be interested in funding the population.
  - The national certification process is critical to sustaining the Hub. Direct service providers, like clinics with Community Health Workers (CHWs), need to be involved in the conversation from the beginning. CHWs and Care Coordinators need to have strong supervision from their agencies throughout the process.

- **Care Coordination Systems Demo – Bob Harnach**

  Bob Harnach, CEO of Care Coordination Systems provided a demonstration of the software, called Pathways HUB Connect. The following is a summary of that demonstration:

  - The Pathways HUB Connect software uses a Community Health Record (or CHR) as a repository for social determinants of health services and Pathways.
  - It is a mechanism that allows community services to bridge data to clinics.

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- Includes mobile applications, allowing the CHW or Care Coordinator to take a tablet into the community to perform assessments of risk.
- Data is received within 5-15 minutes of inputting and reporting is done in real time. The software performs behind the scenes risk stratification with hospital admissions and populations accessing the emergency department.
- Software allows the agency to interface with the entire family unit, not just the patient or client. The CHW or Care Coordinator is able to record information on a person by person basis, allowing for understanding of family relationships and identifying risks for the entire family.
- HealthBridge.care is available within the HUB Connect software. This is an informational referral platform that interfaces with community resources and provides referrals. It has the ability to be a public facing website as well, for resource referral. In Washington state, their HUB Connect software is hooked into their 2-1-1 program and it pulling information from that site.
- Interoperability – currently the HUB Connect software is connected to eClinicalWorks and NextGen. Working on connections with Epic, Athena, Cerner, etc. to promote a single sign-on button. It will eventually have the ability to be accessed via the web and the EHR.
- The software has risk stratification and risk management capabilities. There is a feedback loop for payers but it is highly underutilized. Health plans are able to have read only access for health plan members specifically.
- Care coordination notes allow CHWs or Care Coordinators to write one note and then attach it to multiple forms. There is a regular checklist at every visit. The system evaluates what payer would be attached to each Pathway and automatically initiates an invoice once the Pathway has been completed.

❖ **Question/Answer Debrief – All CHC Members and Guests**

All CHC members were provided the opportunity to ask questions and debrief the software demo. The following is a summary of that group discussion:

- Payment for Pathways – How does the money flow?
  The Hub contracts with any funder (i.e. health plan) who is interested in paying for certain Pathways. The Hub also contracts with the community organization providing the service (i.e. local FQHC). The Hub then invoices the health plan and pays the FQHC for its services, acting as a middle man. This allows for small organizations, with only one CHW to participate along with larger organizations. There are both normal and high risk status levels for each Pathway. It is an outcome based unit model, where there is a higher weighted factor or units for a person that is at high risk.

- Referrals – How does the referral process work?
  The Hub has a detailed and transparent referral policy that is review upfront before contracts are signed. There is a clause that states that if a CHW or Care Coordinator finds someone in the community, that they are assigned to them in the Hub. Policies are open to review of geographical service areas as well. The PCMH clinic and the school all check-in with the Hub to see if a patient, client or student is already assigned and then the client is able to choose who they would like to work with as well.

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- Tips for Success
  The Hub agency should get Medicaid involved in the discussion right away. The discussion with Medicaid should be focused on understanding that the Hub is an avenue for transition to value-based payment and addressing social determinants of health.

- CHW Feedback
  CHWs interested in reimbursement for services. There are concerns with the CCS system as a whole, including duplicative reporting in the CCS system and FQHC EHR, interoperability, potential for Medicaid reimbursement. ROI is also a concern, time spent working in the system vs. overall cost of the system. Does this really make CHW work more efficient?

❖ Next Steps

1. CHC Executive Committee members, Russ Duke, Dr. Rich, Dr. Watts and Melissa Dilley to meet to discuss follow-up and potential next steps.

2. Melissa Dilley to work with Bob Harnach and Dr. Sarah Redding to get a price quote/cost breakdown of the CCS software.

3. Russ Duke to reach out to Medicaid to discuss potential reimbursement for the Pathways Community Hub model and what a partnership may look like.

4. Melissa Dilley to follow-up with Kendra Witt-Doyle with the Blue Cross of Idaho Foundation to discuss feedback and thoughts on CCS software demo.

5. Melissa Dilley to work with Missy Goode to schedule a Community Schools room tour at one of the local Community Schools.

❖ Next Meeting:

Tuesday, October 2, 2018
1:00 p.m. – 2:30 p.m.

❖ Location:

Central District Health Dept. /Syringa Room
707 N. Armstrong Pl, Boise, ID 83704

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