

Washington State Dual Eligible Beneficiaries Innovation Grant
September 2011 Stakeholder Engagement Meetings
Summary of Feedback

Stakeholder Engagement is an integral part of the development of a design plan under the state's Dual Innovations Grant. To address this need, the state developed an engagement [framework](#) that included four large meetings held in September 2011. A total of 112 individuals attended these meetings held in Lacey, Everett, Yakima and Spokane. Invited participants represented a broad range of stakeholders including beneficiaries and family members, providers, community based agencies, advocacy organizations, health plans and health systems. At the beginning of each meeting, participants were briefed on the [grant project and goals, the state's health reform goals, dual beneficiary demographics](#) and the Centers for Health Care Strategies presented a [national perspective](#) on why there is an emphasis on improving outcomes and integration of services for individuals who are dually eligible for both Medicare and Medicaid. Following the opening presentations, participants spent a majority of the day in two break-out sessions that were facilitated to gather feedback on core elements and consumer protections of an effective delivery system. Although the foundation of these discussions were the same in all four meetings, the types of probes used during the break-out sessions differed at each meeting to address feedback received through meeting evaluations and to achieve an overall progression between meetings one through four.

Participants were asked to provide the following types of information in the break-out sessions:

- identification **core elements** and **consumer protections** necessary in an effective service delivery system (more detailed discussion of consumer protections occurred during the first two meetings)
- Define components of each core element
- Identify ways to gauge or measure success
- Strategies to improve care coordination in the next 12 months (more detailed discussion occurred during last two meetings)

Participants were very engaged, provided insight and comments reflecting a wide range of perspectives. Questions and issues raised that were outside the scope of the grant were documented at the meeting, but are not included in this summary document. A summary of the participants and the meeting evaluations can be found in the appendix of this summary.

The following information summarizes the feedback gathered during the four September engagement meetings.

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Identified Consumer Protections of an Effective Delivery System (not listed in order of importance)

- **Information that is simple and clear, of high quality, adequate to inform decision making, reflects what is really available and is unbiased.** Individuals need clear information about the full range of care options including what is covered and what is not, options, risk, and cost. Information must be available in the languages spoken by beneficiaries.
- **Beneficiary choice and voice** present at all levels of the service delivery system. Beneficiaries have the central role in making decisions about their daily lives, managing their health, services and supports. Choice of providers, setting, of who participates in care team and how, of what services will be received and to self-direct care with the support necessary to do so.
- **Access and service equity** is assured for all Medicare and Medicaid covered services and networks ensure choice of primary, specialty and community based care providers. Services are culturally and linguistically appropriate. Access and equity based upon clearly defined standards and a uniform assessment of need. Systems are put in place to ensure that access and service equity are not significantly impacted by geography or inconsistent eligibility interpretations from provider to provider.
- **Beneficiary rights including clear and understandable appeals and grievance processes** must be comprehensive giving the beneficiary the ability to appeal decisions related to eligibility, provider assignment, denial of service, second opinions and plan of care issues. In a fully integrated system there should be a single appeals and grievance process. Beneficiaries have access to a neutral third party who is available to help problem solve and ensure their rights.
- **Oversight and quality of care measures** in place to ensure that contractors are accountable, that beneficiaries have timely access to care, are receiving high quality services, services are integrated and coordinated and that evidence based/evidence informed practices are used when appropriate.
- **Adequate controls to ensure confidentiality and privacy** beneficiaries are able to say who has access to information and who does not. Beneficiaries have access to their own records.
- **Transparency** in coverage and cost.
- **Simplicity** in forms, information, access and navigation.
- **Emphasis on preventative, health promotion and other services that are targeted to assist beneficiaries to live in least restrictive and appropriate setting with ability to attain/retain maximum level of functioning.**
- **Alignment of incentives** done to ensure outcomes and integration are achieved and incentives to deny or delay necessary care or serve only those beneficiaries who are low need/low cost are identified and minimized.
- **Continuity of care** is of particular concern if provider networks, health plans, etc. are changing. Beneficiaries would like to see ways that changes made to the system do not result in loss of critical services or delays in access or service delivery. One

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suggestion was requiring continuation of current services, medications and providers for a period of time to allow for continuity of care.

Identified Core Elements of an Effective Service Delivery System (not listed in order of importance)	
Core Elements (not in order of importance)	Description
Least Restrictive and Most Appropriate Setting	Strong primary care and home and community based options provide cost-effectiveness, allow beneficiaries to receive services in a setting of their choice and to take part in their community to the greatest extent possible.
Comprehensive Data Systems	Facilitate communication across providers, improve care transitions, identify gaps in care, reduce duplication, and improve the patient care experience and outcomes.
Evidence-Based/ Informed Practices and Outcomes	Provide tested information about strategies that deliver results. Observable and measureable indicators of success. Progress is measured on a routine basis.
Personalized Plan of Care	Uniquely tailored with beneficiary voice and choice laying the foundation for individualization. Strengths based, with customized strategies, supports and services recognizing health and social care outcomes are interdependent
Beneficiary Voice and Participation	These elements are key to quality of life and engagement in goal setting and outcomes achievement. Beneficiary voice and participation are intentionally elicited and prioritized. Options and choices reflect values and preferences. Ability to self-manage is respected and if necessary supports are provided to assist with self-management.
Multi-Disciplinary Team	Team members actively engage beneficiaries in planning and implementation of the care plan. The composition of the team is based upon the beneficiary's goals and care plan and may change over time. Complexity of care plan will inform whether or not a multi-disciplinary team is necessary.
Care Coordination	Serve as the primary point of contact for the beneficiary to assist with system navigation, understanding and accessing services, integrating health and social services care. Care coordination is necessary for every beneficiary and plays a key accountability role to integrate services across the broad array of physical health, behavioral health, long term services and supports and supports to beneficiaries with developmental disabilities.

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Core Element	Components	Measures of Success
<p style="text-align: center;">Least Restrictive (Most Appropriate) Setting</p>	<ul style="list-style-type: none"> • Services provided in the least restrictive and appropriate setting • Funding pays for community based care rather than funding sources restricting care to medical or the most expensive settings. • The full continuum of care and choice of settings is present and available • “home-like setting” closest setting to normal life while still addressing unique care needs of the beneficiary • Individuals can hire family and friends as caregivers • Level of need to be determined by an assessment; must be reviewed by care team at identified intervals • Beneficiary voice included in all elements of care • Dignity, independence and social support are preserved • Holistic 	<ul style="list-style-type: none"> • Documentation of review by care team • Appropriate use of acute care setting as supplement to community care • Reduction in inappropriate use of acute care setting • Three day required hospital stay change could eliminate silos (nursing home to home based) Remove regulation inhibiting appropriate level of care • Reduced risk profiles in PRISM show progress in self management • Someone is listening to family and needs are addressed, not just those of beneficiary but also caregivers • Providing supports in home to help family stay as unit – (services appropriate to supporting that outcome, i.e. respite care) • Decisions made outside silos and self interest i.e. low medical need and high social need.
<p style="text-align: center;">Comprehensive Data Systems</p>	<ul style="list-style-type: none"> • Include state level and provider level data (billing, encounter and prescription data) • Ability to share among providers with beneficiary consent • Assessment and care plan information could feed into the system • Personalized plan of care included. User friendly, available to beneficiary with ability for entry of data by beneficiary • Ability for providers (formal and informal) to input information (i.e. volunteers, family caregivers, etc.) • Portable and integrated across service delivery silos • Need ability to stratify populations, identify care opportunities, track outcomes, see billings and interventions • Need to work toward real time data (Discussion of how timely and real time would be defined depending on data and data user needs) • Need to determine if system would include full Electronic Health Records or Bits and Pieces that can be spun off to appropriate systems • Individual Trend Analysis i.e. diabetes data generate critical alerts • Comprehensive complaint tracking – complaint resolution system 	<ul style="list-style-type: none"> • Better care decisions. Real time information is available to providers and care team • Appropriate data available as needed (survey users, usage tracking-monitoring) • Beneficiaries could access their own data • Algorithms create alerts. (Monitor - Do plans change as result of critical alerts)

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Core Element	Components	Measures of Success
	<ul style="list-style-type: none"> • Healthcare Technology Assessment (HTA) • Whatcom County has a good system, what is potential to replicate? • Use aggregated data for trend analysis and forecasting across programs. Break down geographic barriers and minimize difficult physical moves by using user friendly home monitoring and information feedback. Have systems generate critical alerts for follow-up. 	
<p style="text-align: center;">Evidence-Based/ Informed Practices/ Outcomes</p>	<ul style="list-style-type: none"> • Factual, quantifiable, reliable • Do not use just a single source of information • Standardized across sexes - diversity • Use core principles of Evidence Based (EB) practices to enable implementation • Need to stratify to the population • Promising practices, outcomes cross silos. EB develop in silos. • Could do useful evidence based without doing it to full fidelity in an expensive university setting. Can do best practices. • Example - Movement exercise programs to keep people healthy – prevention and ongoing 	<ul style="list-style-type: none"> • Are we getting the same results time after time • Good Health Outcomes – Improve, stabilize or slow deterioration of health status (fewer meds, changes in meds, redirection of care plans)
<p style="text-align: center;">Personalized Plan of Care</p>	<ul style="list-style-type: none"> • Beneficiary voice-participation, choice and accountability • Full disclosure of risks and outcomes • Comprehensive single assessment including social, health, environment, culture, psychological, spiritual, housing. Includes beneficiary personal emergency or disaster pre-planning. Plan is updated and revised or changed as needed. • Everyone communicating and keeping information current • Personalized Goal Setting - Based on beneficiary not provider needs • Population based plan of care suffers from being too general, need to make sure it is customized to the individual beneficiary. • Care plan is shared, multiple providers can see it. Electronic Personal Health Record • Health Action plan – include individual/family responsibility and support system, advocacy, peer support, beneficiary motivation. Include way to manage when everyone does not agree. • Cost of plan – alternatives – evaluation of outcomes • Transitional support when care settings change or when service is new or 	<ul style="list-style-type: none"> • Uniform comprehensive assessment is completed • Beneficiary Perspective Documented • Main contact is Identified • Documents support treatment history • Staff trained and credentialed • Clear, well defined plan, with objectives and benchmark information. Measure against that. Integrated, shared data. Ongoing monitoring, system and tracking • Person understands plan, knows options, appeals, self management. (could be measured through use of survey, ask beneficiary and advocates specific questions to confirm) • Identify the beneficiary’s issue(s) and related goal. Break goal down to steps. Benchmarking. (Interviews, monitoring progress and results. Goal achieved within planned time period) • Care conferences include beneficiary/family, could be self-directed (check attendance)

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	<p>individual graduates from a service or it is changed to a different service</p> <ul style="list-style-type: none"> • Realistic, actionable, practical, provider capacity, beneficiary status, Plan determines who is involved • High touch model-check in with beneficiary regularly for self management support • Wellness and prevention • Flexibility in benefits package • Supports integrated care for seamless transitions; various players understand what each other do. Cross systems education • Continuity of care across Medicare /Medicaid regardless of spend down status “comparable benefits” • Timeliness of authorizations for discharge plan Peer Supports (Social connections in community-neighborhood, Others in recovery groups, Caregiver supports) • Incorporate the individuals’ ability for self-care 	<ul style="list-style-type: none"> • Percentage of beneficiaries completing treatment, the beneficiary completes treatment if identified in care plan (i.e. chemical dependency) • Beneficiary satisfaction – surveys • Readmission rates – medical claims data, diagnosis data on readmit. Less ER, less crisis, check ER and Crisis services • Use of Clinical assessment tool of beneficiary activation (i.e. Patient Activation Measure) • Use of Motivational Interviewing by care team • Good outcomes based on beneficiary and provider actionable plan of care. Plan may include transitions which slow decline, not just getting better (not too much care if beneficiary wants less). • Improved health and daily functioning level of beneficiary • Decreased numbers of mentally ill addicted, DDD beneficiaries under 65 on Medicaid • Decreased arrests and incarceration of Behavioral Health and DDD beneficiaries • Behavioral Health increase engagement, reduce % of no shows • Increased social connections outside of home • Beneficiaries have less costly intervention services – they access services at the right time and place • Better job performance, attendance family happier, situation better (survey) • Travel between different support and case models without having baseline impacted • Timely Access to care – measure days to service • Reduction in spending – per person \$ \$ by group, by cost, by metrics • Appropriate medication use – prescriptions refilled • Numbers of regulations reduced/ Waivers • Incentives for appropriate quality improvement activity for community partners. Share cost savings – align incentives • SF 36 Quality measure tools

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		<ul style="list-style-type: none"> • Increase in beneficiaries with a named primary care physician • 800 number or feedback tool for poor care/lack of documentation of follow up steps • Mortality rates • Check if beneficiaries are dying where they want to die – not being kept alive beyond their wish
<p>Beneficiary Voice and Participation</p>	<ul style="list-style-type: none"> • Consumer voice important to all elements • One spot shopping – palace for beneficiary or advocate to access that will give overview on beneficiary eligibility for various programs. Also a spot to enter the needs of the beneficiary. • Use of motivational interviewing techniques • Services allow self-management and self-direction 	<ul style="list-style-type: none"> • Well constructed beneficiary survey. We must ask our beneficiaries what they think/thought about the care they received. Even a handwritten note or voicemail will be better than not receiving their input. • Beneficiary Perspective Documented • Measure quality of life and satisfaction • Beneficiary, family are satisfied with program
<p>Multi-Disciplinary Team</p>	<ul style="list-style-type: none"> • Includes medical and social service practitioners to focus on overall beneficiary health and functioning. Holistic. Beneficiary and beneficiary family, advocate, peer counselor/support included. Hospice or other care volunteers. Person closest to beneficiary, such as home care provider or home health provider included. As many disciplines as needed but not more than is necessary. • Recognize the time and dollar cost of Multidisciplinary Teams. Determine circumstances where it is wisest to convene and use a team – such as the highest cost beneficiaries, or those with most frequent medical incidents. Have team be cognizant of non-medical issues such as housing or transportation that may need referral for follow-up. • Different agencies work together planning, decision making, accessing data • Use technology to communicate, monitor plan of care • Care team needs to be accountable for outcomes and dollars spent/saved • Think broadly about who is included in the care team (community agencies such as Diabetes Association, AIDS groups or other broader scope of agencies) Don't limit to just Medicaid paid • Organize around chronic disease management rather than a specific medical issue • What triggers the Multi-Disciplinary Team (MDT)? What indicates a need for intervention? Managing cost of MDT 	<ul style="list-style-type: none"> • Review of team documentation • Provider familiarity with beneficiary status

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Core Element	Components	Measures of Success
	<ul style="list-style-type: none"> • Changes to Laws, rules and regulations may be needed - Revised Code of Washington (RCW), Washington Administrative Code (WAC) 	
<p style="text-align: center;">Care Coordination</p>	<ul style="list-style-type: none"> • Having clear, accurate, timely, and accessible information and communication available is critical. • Single Comprehensive Health Risk Assessment and uniform care assessment and care plan ensures portability across geographic areas and multiple providers. • Person, who is a translator, advocates for the beneficiary so the beneficiary can understand and navigate systems. Develop beneficiary trust – person working with beneficiary can go between systems. Should not be a new layer. • Communication – single point of contact during changes. Communication and communication channels known and understood by beneficiary. Highlighting the changes so the others will understand Collaboration – relationship based • Tiers of case management depending on “where individuals and their advocates are, and how much they already know about the systems.” Again should not be one size fits all • Transition planning and follow up is critical • If an individual is receiving care from several sources those sources are aware of one another and working in harmony. The patient is not being hurt by missing information on medication etc. Beneficiary should be at the table. Person closest to daily care is a first line in reporting • Place where conflicts in care are communicated and resolved. Known structure, methodology, or system where that happens and is documented • Primary care providers can refer to specialists and have more interaction when the person goes in and out of specialty care. Primary care provider can provide close to home follow up • Education – compliance • Wrap around system – use natural systems • Use of motivational interviewing techniques • Triage – allocating resources (process) across silos 	<ul style="list-style-type: none"> • Beneficiaries and families less opposition – they don’t feel like they have to fight for services • Description of care plan consistent across providers • Less time to transition between providers • Better integrated care – professionals would know who was doing what with beneficiary care • Administrative systems complementary (not first name first on some forms and last name first on other forms) • Uniform comprehensive assessment with follow up tracking – across the continuum of care (medical and social supports) • Access the service system through any door

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During the meetings in Yakima and Spokane, participants were asked to identify what could be done to improve coordination of care in the next 12 months. The following ideas were generated:

Next Steps with Care Coordination

- Host discussion on discharge planning why does it sometimes not work, what problems need to be addressed - alignment of care, coordination, roles – find what could improve outcomes.
- How can information be shared when individuals transition between hospital and nursing home. What does nursing home need to know. How can they most effectively get that information?
- Manage medication transitions and overall comprehensive medication list
- Define components of care coordination. Share best practices in WA care coordination. Build on partnerships
- Update personalized care plans and share updates.
- Get care coordinator assigned to hospital/facility
- Provide clear information on the full/graduated range of care options. Education about what's available particularly for younger beneficiaries with more serious needs
- Identify and articulate clear expectations
- Develop protocols to have shared expectations for timing on follow up to provider calls.
- Honor beneficiary choice to self manage
- Share lists of beneficiaries w hospitals – hospitals notify social supports network of admissions
- Formalize Information sharing in care/Medicaid. Get beneficiary informed releases for information sharing
- Facilitate education and communication. Plan for trusted advisor, ombudsman, advocate roles and relationships
- Common Language – Develop and use terms consistently (including client, beneficiary, customer, patient)
- Expand existing chronic care management program. Expand Chronic Disease Self Management Training
- Shared data base with Health Care systems such as FQHC, Aging and Adult, Triple A's
- Expand Aging and Disability Resource Centers (ADRC's)
- Use available social networking technology. Users could log on and ask questions. Sections would be protected; other sections could have data entered by users.
- Expand care transitions, Coleman model to other areas, provide training for people from different entities who see the model value
- Utilize multidisciplinary teams as needed
- Assess how we transmit data
- Be open to joint ventures, agreements, partnerships to continue services, unusual partnerships (what is not normally considered such as having a psychiatrist in hospital), nontraditional, mergers, redesign, radical, faith based, wellness –Begin to create ongoing coalitions of providers for case coordination at higher levels
- Improve collaboration and partnership – ask around – where are the connecting points locally, identify these points
- Get involved in Accountable Care Organizations (ACO's) as they are developing
- Assure people are supported in a reasonable human way

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- Support family supports facilitator for family to go to. Provide 1-800 number for family and advertise available resources
- Longer term funding support for family caregivers
- Develop common demographic boundaries – fewer overlapping regions for different service systems such as VA, DSHS, Counties
- Align incentives
- Case/care planning for individuals with severe medical or behavioral issues. Don't overlook one set of issues due to the other.
- More accessible providers – address issues impeding access, assumptions, reimbursement rates, no show rates
- Culturally competent follow-up communication with beneficiary
- Get a population to work with address Portability - Equity in Services not multiple geographic program boundaries
- Partner for Accountable Care Act (ACA) grants for care transitions
- Comparison group, Pilot project, Partner with Higher Ed to assist with studies of evidence based

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Appendix 1

September Engagement Meeting Participants

September 7th Duals Engagement Meeting attendance -- Lacey

Participant Represented

Mental Health Transformation Partnership
Community Protection Providers Association
Senior Lobby
Washington Association of Area Agencies on Aging
Washington Association of Day Services, Full Life Care
Centers for Independent Living
Washington State Association of Local Public Health Officials
Veterans Administration
Beneficiary
Washington Community Mental Health Council
Service Employees International Union Healthcare 775 NW
Mother of beneficiary
Arc of Washington
Home Care Association of Washington
Group Health Cooperative
Long Term Care Ombudsman
Centers for Medicare and Medicaid Services
Amerigroup
Community Residential Services Association
AARP
Washington State Association of Public Health Officials
Aging Services of Washington
Developmental Disabilities Council
Washington State TBI Council
Washington State Homecare Coalition

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Regional Support Network
Parent Coalition
CHOICE Regional Health Network
Public Health and Social Services, Thurston County
St. Joseph Medical Center
Home Care Association of Washington
Department of Veterans Affairs
DSHS - Home and Community Services
Capitol Club House, beneficiary

34 Participants

September 13th Duals Engagement Meeting attendance -- Everett

<u>Representative</u>	<u>Organization</u>
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National Association of Mental Illness – Washington	
Washington State Residential Care Council	
National Association of Mental Illness- Eastside	
Service Employees International Union, Healthcare 775 NW	
King County Mental Health Advisory Board	
Rural Health Care Association of Washington	
DSHS -Home and Community Services	
Washington State Home Care Coalition	
Community Residential Services Association	
Centers for Medicare and Medicaid Services	
Washington Association of Area Agencies on Aging	
Optum Health Pierce RSN	
Qualis	
ARC, beneficiary	
Snohomish Health District	
Centers for Medicare and Medicaid Services	
Community Health Plan of Washington	
Disability Rights Washington	
Mental Health Action	

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DSHS- Developmental Disabilities Division
Long Term Care Ombudsman
State Council on Aging
Association of Public Hospital Districts
Janet Michaelsen Community Residential Services Association
Washington Association of Day Services
Molina Health Care
Washington State TBI Council
United Health Care
Association of County Human Services
Whatcom Health Care Alliance
Beneficiary
PACE, Providence Health System
AARP, beneficiary
Washington Community Mental Health Council

34 Participants

September 28th Duals Engagement Meeting attendance -- Yakima

Garden Village Nursing Facility, Memorial Hospital
Comprehensive Mental Health
Washington Association of Area Agencies on Aging
Washington State Independent Outpatient Providers Association
Yakima County Human Services
Washington State Home Care Coalition
Greater Columbia Behavioral Health
Parent of beneficiary
Migrant Health Clinic
DSHS - Home and Community Services
Community Residential Association (DD)
Washington Association of Day Services
Parent Advocate/ PAVE

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Washington Community Mental Health Providers

State Council on Aging/Yakama Nation

Beneficiary

Parent of beneficiary

United Health Care

Benton County Human Services

19 Participants

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September 30th Duals Engagement Meeting attendance -- Spokane

Spokane County
Washington Association of Area Agencies on Aging
State Council on Aging
Association of County Human Services
Community Residential Services Association
ARC of Spokane
Family Home Care and Hospice
Independent Services Corporation
NDP
Community Health Plan of Washington
Providence Health Systems & Washington Adult Day Services Association
SRHD
Spokane Regional Support Network
DSHS-Developmental Disabilities Division
Long Term Care Ombudsman
AARP & retired family physician
Washington Home Care Coalition
Frontier Behavioral Health
DSHS – Home and Community Services
Evergreen Club, Spokane Mental Health
Washington State Hospital Association
Service Employees International Union Healthcare 775 NW and Individual Provider
Adams County
State Council on Aging & Republic Hospital Board Member
Washington Academy of Family Physicians

25 Participants

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Appendix 2

September Duals Engagement Evaluation Summary

Evaluation Responses	Lacey 9/7/2011	Everett 9/13/2011	Yakima 9/28/2011	Spokane 9/30/2011
5= strongly agree 4=agree 3=neutral 2=disagree 1=strongly disagree				
Overview session provided good background information	4.12	4.21	4.59	4.64
Amount of information provided in the meeting was sufficient to help me contribute to the conversation	4.17	4.21	4.59	4.64
Breakout sessions were helpful in facilitating dialogue	3.96	4.3	4.65	4.86
Participation was encouraged and supported	4.38	4.65	4.82	4.93
I understand how information gathered at today's meeting will be used	3.28	3.96	4.53	4.5
Group member's needs and differences were respected	4.08	4.64	4.76	4.86
Number of Participants	34	34	19	25

The following open-ended questions were asked on the meeting evaluation. The comments received were grouped by theme and the number of comments received on each theme is reported below:

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	Lacey	Everett	Yakima	Spokane
What did you like most about this meeting?				
A. Information Presented	4	7	3	9
B. Diversity of participation and perspectives	7	13	4	2
C. Break-out sessions	1	2	2	3
D. Organization	2	2	2	0
E. Opportunity to provide feedback/interactive dialogue	11	10	5	2
F. Facility/food	0	2	0	0
What would you change about the meeting?				
A. More/different information prior to meeting	2	1	1	0
B. Clarity of information	7	2	0	0
C. Facility/Food	0	2	0	2
D. Nothing	1	7	2	2
E. Agenda and length of agenda items	8	3	1	2
F. Composition of meeting participants	3	2	2	1
Do you have any additional information you would like to add to today's discussion?				
Focus Group Topic Ideas				
Rural	0	0	0	2
Developmental Disabilities	1	0	0	1
Medical community	0	0	1	0
Other comments				
Consumer Protections	0	0	0	1
Would like to see Medicare/Medicaid combined				1
Additional ways to gather feedback (wiki)	0	0	0	1
Expand on existing systems that work in WA	1	3	2	1