Summary of Spokane Provider Focus Group
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Participants:

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How can we improve coordination of care?

- Look at lessons from before 2005 in the MH system, did hospitalizations increase
- Be careful to not make access to care so restrictive that they have to go to acute care
- What is data prior to 2005
- AAA, chronic care manager, need access to all data that comes to hospital, need access to med records electronically
- Single assessment, single tool for all primary care (PC), Chemical Dependency (CD), MH & DD
- Card with medical record on it like in Europe
- Bill goes out and gets paid in one day
- Work around CFR (federal codes) on making info available
- Look at RCW around "separate and discrete" language
- Keep working on co-occurring WACs
- Indentify high utilizers and have care coordinators have access to their history, etc.
- Train MH case managers as care coordinators
- Patient advocate that goes with patient to hospital and then to home
- Healthcare System, not Medical System
- Have case manager move into Community Health Clinic to help
- Use wrap around, train natural supports like Children's Warp Around Evidence Based Practices
- In home care givers need to be involved with care coordination
- Make sure DD services/habilitation model doesn't get watered down to medical model
- Keep the following for DD
    - Employment supports
    - Residential supports
    - Case Management does coordination
    - More services for waiting list of DD
- If an Managed Care Organization (MCO) takes all program/services then they take the risk
- Services for everyone in home

- Run by states
- Regional health alliances
- Physical homes to keep people out of hospital
- Provide teams prior to discharge and after
- ECS, works. This is Extended Community Services
- Identify with client before they go in to inpatient setting
- Skilled Nursing Facility asks MH to have ARNP do case staffing (this occurs in Grant County)
- Core benefits increase
- Care coordinator has to have spending authority
- Self directed care, client has money
- Care coordinator can be coach
- Care Team:
    - Medical environment in charge
    - Specialists for DD , Long Term Care (LTC), CD , MH
- Have providers cross boundaries
- Least restrictive options used

How can reduce fragmentation of the system?

- DD   families do not see system as fragmented except with MH
- Coordinate by DD Case Manager
- DD   is #1 in US for employment
- LTC isn't fragmented, it is with medical services and is #2 in nation
- Do same services in LTC & DD, not broken, don't change services
- Keep options home-based
- Use the Case Manager to coordinate care, does assessment and develop care plan
- AAA in Spokane uses MH case managers at Spokane Mental Health, has a contract
    - They combine data systems
- Create Gate Keeper system, someone is identified like postal carrier to report to Case Manager if they aren't picking up mail and/or paper
- Rural areas should not be punished for lack of resources
- Telehealth, Greater Columbia RSN (Regional Support Network)has a contract
- Formulary for meds can vary so need to make sure that duals stay covered
- PCs better trained at managing psychotropic medications and providing geriatric care
- Have healthcare providers be salaried, no fee for service

How can we improve accountability?

- Make sure these are built in to keep people healthy
- Chronic care Case Management
- System that pays for better communication between providers
- Benefit package to include prevention
- Have UM function also doing discharge from hospital
- Research other models other than capitated, etc., even those outside of US
- Maximum profit margin such as 5% and then MCO or other for profit would have to reinvest profits in care
- Take into account other systems not in control of such as courts, corrections (multiple assessments and legal teams driving up costs)
- Disinsentivize Involuntary Treatment (ITA)
- Have funding stream/payment system align with care coordination
- Money goes to non-profit, reinvested in system
- MCO left when this was tried before
- Example Optim Health has had good outcomes
- Combine both public and private
- Focus on prevention
- Maybe only need a meal (example of prevention)
- Captivated model promotes more prevention
- Managed fee for service, can't fund all but start with EBP
- Accountable Care Organization (ACO) assuming risk, should include institutional settings
- Look at PACE models for financial system
- Captivated model
- Incentives for self prevention/care
- Chronic disease self management
- Smoking cessation
- Total capitation
- Change the message that beneficiaries are entitled to everything rather than just what they need
- Savings needs to go back into system, example, LTC never sees savings
- Disincentivize Emergency Room(ER) visits
- Better triage at ER, see who person is getting services from
- TR Reid, Keeping America Healthy
- Use shared savings to wrap care

- Erase the color of the money, don't make people wait until they are worse to get services
- Lump sum payment
- Look at data to identify cost savings, there were efficiencies prior to 2005
- Incentives for love hosp. rates
- Training others in best practices
- Feedback loop from clients saying it is working
- Funding formulas that take into account lack of resources in rural areas (care costs more in Grant County than King but King's MH rates are higher)
- Hosp. and Nursing Home can use savings to develop/enhance other services
- Incentive for not readmitting and/or keeping people longer than needed
- Entity to talk to itself, all records, all info (example: Optim Health in Pierce RSN and Group Health)
- See if risk is varied by population and location
- Jarvis model, "factor for increase risk or decrease risk"
- 45 part D plans in Spokane, single payer would take that away and have much less admin overhead
- Why does out of state cost more?
- Reciprocity out of state, have same treatment cost the same
- Invest in rural benefit
- Local buy-in requirement
- Incentive for local buy in-counties, be able to choose how to spend it
- PCs should have special population training
- MH council is providing medication practice management
- Not prescribing durable medical equipment in excess
- Outcomes
    - Maintain in home setting
    - Use of least restrictive
    - Maintain community setting
    - Increase employment
    - Decrease mortality rates
    - Decrease costly medical care and services that don't work
    - Decrease intensive interventions
    - Increase healthy and happier days (self report)
    - Decrease ER visits
    - Decrease PC visits

What is the first step?

1. Values and Principles (done)
2. Pilot project anywhere but Spokane and King County
    a. Rural are, make it challenging
    b. All or nothing, can't exclude any part of system
    c. No opt out
    d. All systems at one time
3. Design payment system
4. All parts of system need to be involved in data decisions
5. If contracting with MCO then providers want input on data and other issues
6. Start on return on investment, data to show projected impact, go back and look at this
7. Design benefit package that includes transportation, employment
8. Deal with how to limit the impact of employment income for SSI (Supplemental Security Income)