
Bree Collaborative | Social Determinants and Health Disparities Workgroup

February 18th, 2021 | 8:00 – 9:30 a.m.

Virtual

MEMBERS PRESENT

Phyllis Cavens, MD, Medical Director, Child and Adolescent Clinic, Vancouver
Yogini Kulkarni-Sharma, AVP, Health Plan Quality Improvement at Molina Healthcare
Ashley Lile, Director of Training & Technical Assistance, Washington Association for Community Health
Laurie Bergman, Quality Integration/Population Health/Cm Manager, Confluence Health
Kevin Conefrey, Vice Present, HR & Corporate Services, First Choice Health
Jessica Martinson, Director of Continuing Professional Development, Washington State Medical Association
Zandy Harlin, MPH, RN-BC, Quality Program Manager, Population Health, Kaiser

Permanente
Laurel Lee, VP Network Management, Molina Healthcare
Wes Luckey, Deputy Director, Greater Columbia Accountable Community of Health
Meg Jones, Director of Government Relations, PacificSource Health Plans
Karie Nicholas, GC, MA, Epidemiologist, Washington Association for Community Health
Abigail Berube, Director, Safety and Quality Washington State Hospital Association
Thomas Green, MD, Orthopedic Surgeon
Jon Ehrenfeld

STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, Bree Collaborative
Amy Etzel, Bree Collaborative
Nick Locke, MPH, Bree Collaborative
Julie Stroud, MD, MMM, CPE, Chief Medical Officer, Optum Care Network
Rachel Madding, School Mental Health Program Manager, Highline Public Schools
Gracious Gamaio, Community Engagement Specialist, Unite Us
Kendra Roettjer, Senior Account Manager, Unite Us
Marc Rosen, Unite Us
Brissa Perez, Community and Tribal Engagement Specialist, Greater Columbia ACH

Jessica Bowen, Confluence Health
Karen Haugen, Molina
Brianna Ramos, Department of Health
Maria Courogen, WA Department of Health
Diane Halo, Greater Columbia ACH
Cindee Dewitt, Kaiser Permanente
Carol Moser, Greater Columbia ACH
April Haram, Harborview Medical Center
James Manuel, Health Benefit Exchange
Kate Wells, PacificSource Health
Holly Bates, University of Washington
Lauren Russel, VA New England Healthcare Systems
Deborah Pineda, Child and Adolescent Clinic

INTRODUCTIONS AND APPROVAL OF MINUTES

Nick Locke, MPH, Bree Collaborative, opened the meeting and those present introduced themselves.

Motion: Approval of January minutes

Outcome: Passed with unanimous support.

Mr. Locke described the decision to focus on referrals to community-based organizations during this meeting. The workgroup will revisit the role of health plans and benefits in March when more partners from health plans and benefits are available to provide member spotlights for discussion.

MEMBER SPOTLIGHT: REFERRAL PROCESS

Dr. Phyllis Cavens discussed her clinic's process to connect patients with resources; addressing social determinants of health within primary care. The clinic serves 18,000 patients with 75% on Medicaid.

- Program to screen for SDoH through a team-based approach.
- Weekly QA meeting to focus on system priorities (e.g., maternal depression, developmental screens) to develop policies and workflows with rapid-cycle change.
- Use a pre-visit questionnaire for many needs such as violence in the home that was expanded to include food, housing, transportation needs. Pediatrician discusses barriers and solutions and provides with a staff-developed resource list.
 - Questions are based off of standardized screens and have been edited.
- Also part of care coordination program with a registry of patients with a positive screen. Over about two months with 4,000 visits, more than 95% had a pre-visit summary handed to the family and 20 families had a positive SDoH screen. Coordinator follows up within a week to see if resource packet meets needs. Negotiate with the insurance companies to bill for care coordination code and z-codes for SDoH.
 - Initially wanted to use portal to do pre-screen but both times had to go back to paper due to inadequacy of the vendor.
 - Most families have about three visits a year so primary care is the best home for this work.
- Staff of 70 at clinics many of whom use the clinics and serve as the patient voice into the process.
- Cost of care coordination coded by clinician or team, billed for by minutes 30 and another 30. Embedded into EHR. HCA has not made this an allowable code.

Jon Ehrenfeld and Ashley Clayton discussed the Seattle Fire Department and Mobile Integrated Unit presented:

- Short-term case management organization
- Dispatched from fire alarm center – through 911, or a crew on a scene will call someone to a scene. Also can have people walk into station or through observation or through EHR system.
- Have been doing this process for a bit over a year, pediatrics to geriatrics. Most people are:
 - 50% unsheltered
 - Substance use disorder
 - Mental health crisis – not really acute crisis but those who are disorganized.
 - Those who are aging in place and suddenly find that a health condition or a mobility issue is a problem (e.g., lift assist) and hoarding.
- Goal is to reduce the use of 911 for social needs.
- Work for division of aging and disability services, area agency on aging for King County. Manage referrals to community services and that service org does outreach.
 - Follow-up depends on who the referral is to. Example would be high referral program at Harborview and whether they have capacity to take referral. Mostly person to person conversations site to site.
 - Goal is to be bridge between hospital space and community. Mobile and can transport people.
 - Gelata has been used since October. An internal case management and referral system that can be a closed loop referral system.
- EMR is not configured to be interoperable and share longitudinal information. Hospitals and health systems cannot see if someone has received services. This is still a goal.
- Resources to include fire EMS records and information sharing is needed to bridge barriers of EMR systems.

UNITE US OVERVIEW

Gracious Gamino and Kendra Roettjer with Unite Us discussed the program.

- Closed-loop referrals and shared client record.

- Organizations opt-in to have to use the platform.
- Assist with workflows internally.
- Provide at no cost for network partners. Funded by variety of organizations including plans and provider organizations.
- Work alongside community information exchange team at HealthierHere.
- Interface with 211 and other community organizations.
- 3 CHCs joining the Unite Us network through Healthier Here Catalyst Funds; also have an org in Yakima (Community Health of Central WA) currently using it
- Unique due to it's intended close loop/bidirectional referral functionality
- Multi care is a new funding partner, currently in implementation stage, go live April.
- Not insurance specific; meant to be able to send referrals regardless of insurance status
- For an anchor institution to sponsor in a new region, reach out to them to start that conversations re specific needs and patient population and regional current state
- Feel free to reach out to either for more questions

GENERAL DISCUSSION

- Nick asked the group what concerns there are about close loop referrals and screening in general
 - Zandy from KP brought up concerns about how stretched the current safety net is, and need to think about this when we make a recs. Need to make sure we include the safety net orgs in these convos to make sure we are not creating more stress that would lead to a poor experience for the patient when needs not met
 - Amy mentioned provider concerns about screening and asking potentially uncomfortable questions of patients when there are not sufficient community resources to then refer them to
 - How to quantify the capacity needed vs what is available
- Utilizing care coordinators: is there capacity for this in medical settings?
 - Confluence health Jessica Bowen said capacity is low for this, slightly better in acute settings but only one SW in ambulatory sites.
- Financial models to drive some of this work, similar to Health Homes program.
 - Jessica Bowen mentioned they have received some small scale grants – so having a dedicated grant person can be beneficial to find those funding sources
 - Dr Cavens mentioned re VBC, having data to show high-cost patients decreased ED utilization due to some of this work can help; also in COVID we have seen increased BH needs among children. There is a path for VBC contracting around the connection to care coordination and social needs.
 - No funding for this in FFS environments, needing a value-based mechanism.
 - Community-based organizations want to hear the vision. Very under resourced and will not buy in if we focus on the operational needs not transformational ones.
- Unite us doesn't differentiate based on the person's insurance coverage. All patients benefit.
- Multipayer initiatives as a way to meet this need for services unfunded in the FFS environment.

CLOSING COMMENTS

Mr. Locke thanked all for attending. Next month's meeting will focus on health plans and benefits, as well as continue the conversation on financial models. The meeting adjourned.