



# Working Session Minutes

The working session was kicked off with welcoming introductions from our co-champions Andre Fresco and Nicole Bell. Our co-champions expressed their gratitude to the Committee and expressed the importance of this work, both in terms of advancing the state's goals, but also in terms of what it means for Committee members. Following these welcoming remarks Committee introductions were made.

Slides 4 – 23 were skipped and the Committee transitioned to content work.

The goal of the working session was to begin honing in on problem statements and potential solutions the Committee might want to undertake (2-3 solutions). Problem statements (slides 3-5) reflect survey submissions. Breakout sessions were broken into three main categories/groups: People, Systems/Process and Technology. Breakout groups were tasked with identifying barriers in relation to the problem statement, how the Committee might be suited to address the barriers outlined, developing potential solutions and outlining next steps.

The three group returned the below information (slides 7-9) for broader Committee review. It was determined that the Committee would like to hold progressive conversations around all topic areas and would like refine each topic for Committee consideration.

# Breakout Session Overview

## Pre-Session

- Contribute articles & insights to Box.com site
- Identify and submit 2-3 biggest challenges for rural health, in the form of problem statements

Level-setting context and a curated set of ongoing problem statements

## Working Session

- **DEFINE** problem statements to be explore in breakout session
- **DISCUSS** and identify proposed solutions / actions to take against problem statements (in breakout groups)
- **PRESENT** leading solution proposals to the full group (may be multiple proposals/problem)
- **DECIDE** as a group if there are any specific problem-solution pairs worth pursuing, and define next steps to begin taking action

A limited set of tangible problem-solution pairs that the group intends to make meaningful progress in exploring and initial action items to get going

## Post-Session

- Finalize next steps, team, and action plan
- Begin exploring solutions based on action plan defined

Take action to begin addressing issues that matter!

# Problem Statements: People

*Workforce recruitment and retention of providers. Opportunity: Values-based care transforming how care is provided and by whom (e.g., models of team based care)*

*Physician Shortages*

*Lack of physician and board engagement/knowledge*

*Access to primary care in order to manage patients in a lower cost setting.*

*Ready supply of licensed health care professionals to provide care and services across populations and care settings.*

*Physician, and other health care professional supply, for rural health.*

## **Group #1:**

There is a lack of providers in rural communities, nursing, primary care, specialty...  
What are actionable strategies to recruit and retain providers in rural communities?

# Problem Statements: Systems/Process

*Lack of viable delivery models that work financially*

*Lack of internal infrastructure/processes to capture quality in a fashion that measures can be tied to payment*

*There exist regulatory silos in the current system, how can we engage the community to prevent out migration?*

*Creating clinically integrated networks (relationships) with referral partners (tertiary hospital, specialist).*

*Is there a model to build strong and consistent clinic-community linkages to provide whole person care, including social services, housing, food?*

*Change management capacity and competency.*

*Managing the change to population health and wellness, from fee for service.*

*Translating urban models to rural in a way that works for all*

*Access to behavioral health services for older adults receiving LTSS in home and in community based residential care settings.*

*Defining success in the delivery of healthcare in rural areas.*

*Rural morbidity/mortality and health outcomes disparities. Opportunity: integrated care to address whole person health disparities*

## **Group #2:**

*It is vital for rural communities to connect between public health, health care providers, long term care, home health, community services, hospice, oral health, behavioral health, and larger tertiary facilities and so on. How can we network amongst rural communities to create better processes and reduce costs?*

# Problem Statements: Technology

Having solid community level data

*Lack of internal infrastructure/processes to capture quality in a fashion that measures can be tied to payment*

Limited telemedicine capabilities

*With an aging community, long term care is a persistent issue. What are some innovative strategies/technologies that can help to keep people in their community?*

## Group #3:

*There are currently huge gaps between the quality and access to care found in Rural communities when compared to their urban counterparts. What are actionable strategies to enable and deploy technologies that can improve access to care and bridge the quality gap in rural areas of the state?*

# We've preliminarily broken out the team into 3 "Focus Groups"

## Focus Group #1 *People*

- **Andre Fresco**, Yakima Health District
- **Keith Watson**, Pacific NW University
- **Marc Provence**, HCA
- **Mark Johnson**, Amazon
- **Avtar Varma**, Elevar

## Focus Group #2 *Systems*

- **Nicole Bell**, Cambia Health
- **Daryl Edmonds**, Amerigroup
- **Mark Stensager**, WA Health Benefit Exchange
- **Karina Uldall**, Virginia Mason
- **Eric Moll**, Mason General
- **Matt Holman**, Cambia Health

## Focus Group #3 *Technology*

- **Linda Gipson**, Whidbey General
- **Sue Dietz**, Critical Access Hospital
- **Ralph Derrickson**, Carena
- **Ken Roberts**, WSU College of Medicine
- **Brian Myers**, Empire Health
- **Dawn Bross**, RHCAW
- **Gary Swan**, HCA

# Breakout Group 1: People

Problem Statement / Barrier(s) to be Addressed	What are actionable strategies to restructure and rethink the model of care delivery such that patients are able to receive comparable access to care when compared to the urban setting without necessitating a large influx of providers to be relocated to the rural setting?		
Why is this a barrier this committee is uniquely positioned to address?	What is/are the proposed solution(s) that this committee can develop action strategies around?	Who will be engaged, and who will be accountable, for driving the solution forward?	When will take action – what are the immediate and long-term next steps
<p>By combining forces of state government, reimbursement, technology and education as the core pillars for this re-structuring, we can ultimately change the mentality behind changing the zeitgeist that has continued to drive this problem.</p>	<p>Re-structuring healthcare facilities at their core, implementing a new staffing structure in which the system is heavily staffed with navigators and case managers which will guide patients along their journey, with “medical intervention” being delivered via telemedicine when possible.</p> <ul style="list-style-type: none"> <li>▪ The ideal is for physicians to only be dealing with the most complex elements of care for a patient</li> </ul>	<p>Need to engage</p> <ul style="list-style-type: none"> <li>▪ The HCA</li> <li>▪ The governors office</li> <li>▪ Research / university systems that could act as test beds (incubators)</li> <li>▪ Which will act as partners</li> <li>▪ <i>Public Health system</i></li> </ul> <p><i>Accountability to be decided based on conversation with the group, but this should ultimately fall on those that have the <b>authority</b></i></p>	<p><i>To be decided based on conversation with the group</i></p>
How will we measure impact (indicators & proxies of success)?	<ul style="list-style-type: none"> <li>▪ Reduction in re-admission rates</li> <li>▪ Patient Satisfaction</li> <li>▪ Earlier interventions</li> <li>▪ Reducing costs of care</li> </ul>		

# Breakout Group 2: Systems/Process

<p><b>Problem Statement / Barrier(s) to be Addressed</b></p>	<p><b>We have an urban paradigm of care delivery that doesn't understand the needs and optimize for cost, quality, and access in rural communities . It is not flexible to adapt to specific community needs.</b></p> <p><b>We need to shift the paradigm of what the model of a hospital should be and what rural care delivery should look like in the future. Must address cost of making the transition, as well as fear of losing the physical institution that still symbolizes employment, access, and even quality in many places.</b></p>		
<p><b>Why is this a barrier this committee is uniquely positioned to address?</b></p>	<p><b>What is/are the proposed solution(s) that this committee can develop action strategies around?</b></p>	<p><b>Who will be engaged, and who will be accountable, for driving the solution forward?</b></p>	<p><b>When will take action – what are the immediate and long-term next steps</b></p>
<ul style="list-style-type: none"> <li>• Deep rural healthcare delivery experience &amp; credibility</li> <li>• Access to sources of funds</li> <li>• Understanding of generational and technology changes that can facilitate the shift</li> </ul>	<ul style="list-style-type: none"> <li>• Understanding best practices already in place that can be extended</li> <li>• Develop conceptual model for rural care delivery (Primary care, BH, urgent/ER, Lab/Rad, EMS, Dental, Pharm, Telemed)</li> <li>• Develop promotional campaign to inform the community</li> <li>• Pick a community and develop a pilot</li> <li>• Execute!</li> </ul>	<ul style="list-style-type: none"> <li>• HILN Subcommittee to define means &amp; action plan</li> <li>• WSHA (community engagement &amp; support)</li> <li>• Potential funders (HCA, grant funders, foundations, legislature)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>2016:</b> Understand best practices, develop model &amp; criteria, and pick pilot site</li> <li>• <b>2017+:</b> Build community support, implement pilot &amp; beyond</li> </ul>
<p><b>How will we measure impact (indicators &amp; proxies of success)?</b></p>	<ul style="list-style-type: none"> <li>• Community evaluation (pilot vs. control) access, cost, patient satisfaction, and quality improvement at community level (third party evaluator)</li> <li>• Quantified shift in site of care for specific service (avoidance of high-cost care downstream)</li> </ul>		



# Breakout Group 3: Technology

<p><b>Problem Statement / Barrier(s) to be Addressed</b></p>	<p><b>Prompt: What are actionable strategies to enable and deploy technologies that can improve access to care and bridge the quality gap in rural areas of the state?</b></p> <ol style="list-style-type: none"> <li>1. There are many issues surrounding the implementation and use of EMRs. For rural providers EMRs commonly are time and resource intensive, take away from provider ability to delivery care, drive systems and processes as opposed to being built around hospital operations and are difficult and expensive to administer.</li> <li>2. Provider recruitment and retention is difficult in rural areas.</li> <li>3. There is a lack of remote technology use in rural areas.</li> </ol>		
<p><b>Why is this a barrier this committee is uniquely positioned to address?</b></p>	<p><b>What is/are the proposed solution(s) that this committee can develop action strategies around?</b></p>	<p><b>Who will be engaged, and who will be accountable, for driving the solution forward?</b></p>	<p><b>When will take action – what are the immediate and long-term next steps</b></p>
<ul style="list-style-type: none"> <li>• Committee is composed of a cross sector mix of providers and entrepreneurs that understand all sides of the issue and can bring to bear skills and talents to address these issues.</li> <li>• Can help to draw linkages between design challenges and goals, implementation and rural realities.</li> <li>• There exists a continuity from provider training to placement in the Committee.</li> <li>• Access to resources and ability to promote/explore development.</li> </ul>	<p><i>EMRs:</i></p> <ol style="list-style-type: none"> <li>1. Have a 'geek squad' to support personalization/development of EMRs</li> <li>2. Support on the longer term</li> </ol> <p><i>Cost links/extraction:</i></p> <ul style="list-style-type: none"> <li>• Create a composite risk score based on quality, time and other factors to extract cost from EMR</li> </ul> <p><i>Professional Technology Networks:</i></p> <ul style="list-style-type: none"> <li>• Create professional collaboration network</li> </ul> <p><i>Remote technologies:</i></p> <ul style="list-style-type: none"> <li>• Triggers outside of the EMR system</li> <li>• Remote patient monitoring</li> </ul>	<ul style="list-style-type: none"> <li>• HILN Committee to define the solution</li> <li>• Focus is required to advance:             <ol style="list-style-type: none"> <li>1. Need to finish the discussion on EMR barriers and challenges</li> <li>2. Need to round out the conversation on how technology might help to shift the paradigm of what a rural hospital should be</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• Co-champions and HCA support to develop something to react to regarding EMR conversations</li> <li>• Follow-up with the Committee during upcoming Committee meetings</li> </ul>
<p><b>How will we measure impact (indicators &amp; proxies of success)?</b></p>	<ul style="list-style-type: none"> <li>• Contingent upon what aspect the Committee decides to address.</li> </ul>		



# Working Session Themes

## **Group 1 – People**

- Spouse can be a barrier to recruitment and retention
- Incentive structures are inadequate to draw in providers
- Need to support structures for providers
  - Mentoring
  - Communities
  - Extension support
- Need care teams that support/cover across the hospital
- *Outcome:*
  - Need to discuss how we can restructure the hospital to support/address the above elements

## **Group 2 – Systems and Processes**

- Should focus on what rural delivery looks like in the future
- Need to address the upfront investment to transform
- *Outcome:*
  - Identify best practices already in place
  - Develop a conceptual model for rural delivery
  - Promote and pilot

## **Group 3 – Technology**

- EMRs can be a barrier, there needs to be action strategy and support
- Need collaborative networks to support providers
- Data sharing and delivery is difficult and is not shared in a standard way
- Remote supports within rural communities
- *Outcome:*
  - Complete discussion EMR challenges and barriers
  - Discuss how technology can support hospital transformation



## Next Steps

- The Committee identified the following next steps:
  - It would be beneficial to hold in-person working sessions every 2 months
  - Conference calls will be used as feedback mechanisms and would focus around updates
  - This foundational work needs to be pulled together in a meaningful way for Committee review and react

# Notes from Breakout Group 1

## *Recruitment and Retention*

- Culture beats strategy every time -
  - If you're not used to living in a rural community, its difficult to adjust
  - Spouse - if the spouse is not used to rural environment, this creates another large barrier
  - Connotation of having to give something up (perception vs. reality)
- How to change the perception that there is something that you have to give up:
  - Spouse?
  - Children (education / needs)
  - Culture?
- Community that is welcoming?
- How can you create an environment in which the spouse is engaged in a meaningful way?
- It's not easy to be an outsider in a small community and find your niche?

## *Incentive Structures*

- Physician Providers are becoming burned out
- Need to create a brand new incentive structure to implement an attitude of agility at all levels
- Some sort of underwriting (quid pro quo) that will allow physicians to be pulled into these regions for education and then they have to serve there (2+2 type of model)
- Are there opportunities to create a community amongst the providers?
  - Mentoring? Communities? Etc.?
- Retention in programs like FQHC's (Federally Qualified Health Centers)?
- Targeted Outreach to those people that are going to be facing the "squeeze"?
  - Declining income (reimbursements) and increasing cost of living in these urban environments

# Notes from Breakout Group 1

## *Care Teams*

- Creating a network (care teams), where multiple specialties are able to communicate and learn best practices from each other.
  - Existing initiatives:
    - Patient Navigators
    - Case Managers
- Healthcare facilities are majorly staffed with navigators, case managers, and medical intervention is delivered via telemedicine
- Hospital Staff needs to be educated and/or moved as needed, with “care teams” being created
- Are there any situations in which Nurses/Nurse Practitioners would be able to solve some of these provider access needs?

# Notes from Breakout Group 3

## *EMR Barriers*

- Can be a barrier to patient care
  - Is expensive, resources could be better used elsewhere
  - Requires configuration and re-optimization
  - Drives operations, not optimized for workflow
- Need to up-level data to support providers and patients
  - Move data from the local level to the cloud so data can be translated into information
- Need to identify the drivers of EMR purchase
- How can we either shift the current dynamic?
- Is there an opportunity for a co-op program?
- Is there an opportunity to subsidize the cost of EMRs through a risk profile?
  - E.g. Those that benefit downstream financially support upstream based on risk

## *Collaboration Networks*

- Bring to bear expertise that might not otherwise be available in rural regions
- Need to develop support new providers in rural areas so they can manage alone
  - Help to build confidence
  - Without this, it makes it difficult to bring in new providers
- It is challenging to bring in mid-careerists

## *Data Sharing/Delivery*

- Data is shared in a non-standard way
  - It is not uncommon for onsite providers to take pictures of screen readouts and send via secured phone to colleagues
- Porting data into the EMR is difficult and resource intensive (often done manually)

# Notes from Breakout Group 3

## *Next Steps*

- Need to characterize the EMR problem
  - Cost/quality/access
- Need to uniquely characterize the difference between rural and urban in terms of technological barriers
  - Develop a problem statement that captures the issue for rural providers
- Need to refine what the role of the hospital is if it no longer is to exist in the brick and mortar form
  - An honest reflection of changing times and industry – identifying what this means for rural providers
- This needs to be identified on a 1-3 year timeframe
- What are the greatest challenges over the next 1-3 years?
  - CAHs are faced with making ‘the least bad choice’

# Accelerator Committee Action Pathway Template

## Formulation

### Identify Action Areas

- Aligned with Healthier Washington goals and investment areas
- Potential to achieve quick and meaningful wins based on partner engagement and existing efforts underway

### Seek HILN Consensus and Refinement

- Secure HILN support for Accelerator Committee scope
- Seek HILN Co-Chair recommendation on Accelerator Committee Co-Champions

### Convene Accelerator Committee

- Identify Accelerator Committee membership based on interest, with input from Co-Champions, HILN Co-Chairs and Healthier Washington Executive Governance Council
- Ensure committee includes key HILN partners, subject matter experts, and multi-stakeholder representatives

## Pathway Development

### Develop Initial Scope

- Building upon draft scope, committee drafts problem statement and goals to identify barriers drivers, of change, and indicators or proxies of success

### Review and Refine Pathway

- Incorporate learnings and feedback from committee members on initial scope

### Prioritize strategies to address barriers

- Identify three or four high-leverage drivers around which to develop action strategies

### Develop Strategies & Action Steps

#### Consider

- Who is accountable?
- Who else is needed?
- What needs to be done by when, by whom and how?

## Execution

- Broadly communicate and disseminate the pathway through committee members, HILN, and interested stakeholder groups
- Promote alignment and generate momentum through existing activities and outreach to key partners
- Foster connections and supports to drive action on the identified strategies
- Establish feedback loops with HILN and other stakeholder groups
- Elicit ongoing committee report backs about actions, progress, barriers and results
- Refine strategies and action steps as needed

## Evaluation

- Monitor committee execution and progress on goals and proxies of success
- Analyze feedback, lessons learned, and best practices to identify additional opportunities
- Document action pathway development, execution and results
- Communicate committee successes and promote continued efforts for sustainability

Months 1-3

We are here  
Months 4-7

Months 8-12