Regional Health Summit
Summary Report

June 1-2, 2017

Prepared by:
Collective Impact, LLC

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Executive Summary

The 2017 Regional Health Summit was held on June 1 & 2, 2017 at the St. Mary's Education Center located at 2849 Fifth Avenue in Huntington, West Virginia. Sponsored by Cabell Huntington Hospital, Inc., a recent community needs assessment served as the catalyst for bringing together nearly 150 stakeholders to identify ways to improve health, wellness, and prevention efforts across a 21-county region in the Tri-State area of eastern Kentucky, southern Ohio, and West Virginia.

Summit participants included individuals representing hospitals, health systems, health departments, health care providers, health care insurance providers, and elected officials from 44 organizations and 21 counties in the Tri-State area. A detailed list of the participating organizations is provided in *Appendix 1*.

The purpose and importance of improving health, wellness, and prevention efforts across the region were the overarching themes of the Summit. On the first day of the Summit, national content experts conducted a variety of presentations on the first day of the Summit that focused on changing the way stakeholders think about health; aligning, leveraging, and mobilizing assets, and using public health intervention tools to better achieve accountability. Day two sessions focused on the importance of using various strategies to improve population health outcomes, including health information technology and data analytics, building upon promising and innovative models; expanding collaborative partnerships; and transitioning to value and population health management from the provider, public health, and payer perspectives.

Afternoon breakout sessions on Day two focused on identifying ways to strengthen strategic efforts across health care, public health and community organizations in four priority areas: *Chronic Disease, Access to Care, Behavioral Health & Substance Abuse, and Data & Technology*. Summit participants were provided with a summary of regional data related to these topic areas and through facilitated discussion, identified key issues and challenges, successful initiatives to build upon, and outlined initial action steps to undertake following the Summit. Highlights and common themes were recorded from the breakout sessions and shared with all Summit participants in the closing session. Verbatim responses from small group discussions and participants for each breakout session can be found in *Appendix 2*.

Participants indicated interest in continuing the collaborative work launched at the Summit and finding ways to address regional health improvement issues and challenges. Work groups will be formed around the four priority areas and will receive support in moving their respective work forward. It is anticipated that a follow-up meeting will be held in the fall of 2017 to assess progress and activities. Information from the Summit will be available on the website: www.regionalhealthsummit.org.

Day 1

Welcome & Opening Remarks - Kevin Fowler, President & CEO, Cabell Huntington Hospital

Mr. Fowler welcomed participants, thanked and recognized members of the Summit Planning Committee, and discussed the purpose and importance of delivering effective patient care to improve health outcomes across the region. As part of opening remarks, US Senator Joe Manchin, addressed participants and discussed the impact of the opioid addiction crisis, concerns with the American Healthcare Act of 2017, and plans to improve the legislation. US Congressman Evan Jenkins also provided remarks and noted the impact of the opioid crisis in terms of the Federal budget, and changes that are being proposed to assure funding is in place to support research and treatment. Mr. Fowler also recognized other members of the WV State legislature in the audience, including Senator Bob Plymale and Delegate Shawn Hornbuckle.

Mr. Fowler noted that Cabell Huntington Hospital is a community hospital that now serves 26 counties, 21 of which were represented at the Summit. Mr. Fowler made the following additional comments in his opening remarks:

- √ The recently completed 2016 Cabell Huntington Hospital Community Health Needs Assessment process and data, with findings and priority issues similar to many other assessments, served as a catalyst for launching the Regional Health Summit.
- √ It is important to listen to our community health partners and providers in the outlying areas to better understand the emerging health needs of our region and the impact we can collectively have on the health of the citizens of our region.
- √ Healthcare providers have an uncertain future and are facing unprecedented change while trying to meet their individual missions. They are dealing with fundamental change in how they do business and will need to work together. This Summit is about identifying working ideas to make change and creating opportunities for collaboration.
- √ We need to consider "access to care" in the sense of not only do people have access to the services they need but also do patients and doctors in our region trust us with their care. Access requires trust at a personal level from the community.
- √ An opportunity exists to expand the reach of care through regional collaboration and "honing in" on each organization's mission.

"A New Way of Thinking About Health: Changing How We Change" - Bruce Behringer, MPH, Deputy Commissioner for Continuous Improvement and Training Tennessee Department of Health (retired)

Mr. Behringer discussed (1) partnerships – bringing people together; (2) population health improvements; and (3) regionality. He noted that the challenge is that there are advantages and disadvantages to addressing issues at the regional level. Behringer commented on the importance of clarifying language, specifically the difference between health problems and solutions. "If you use the wrong language, you can set an expectation that can't be met."

Behringer noted that the four "priorities" that the region is dealing with (chronic disease, access to care, behavioral health & substance abuse, and data & technology) are really big issues and there is an expectation from the public that providers are taking care of this (or should be) – "that is what they're getting paid for." He noted that providers are "swimming upstream" with efforts to address these complex issues. He also stated, "It is hard to change the behaviors of the general public, as it encroaches on their perceived freedoms."

Behringer provided the audience with five tools for consideration in developing a public health intervention model, including: 1) documenting units of practice that help you think about units of solutions to define who is contributing to the health of the community (Huntington's Kitchen is an example of this); 2) using "working together" strategies including networking, coordination, cooperating, and collaborating; 3) discovering contributions and expected benefits of partnership building through the 'Give-Get Model/Grid'; 4) defining a model of health care access; and 5) using a strategic map of actions and efforts. Behringer also stressed the importance of making participation in the regional effort meaningful work and celebrating the good work and accomplishments of these collaborations to sustain the engagement of regional partners.

"Aligning, Leveraging, and Mobilizing Assets: Becoming Deeply Accountable for What is Possible" - Gary Gunderson, MDiv, DMin, DTh (Hon), Stakeholder Health Advisory Group | Wake Forest Baptist Medical Center

Dr. Gunderson's presentation focused upon the importance of identifying and bringing together assets and connecting hospitals to their communities. He provided an overview of the health and faith collaboration referred to as the "Memphis Model," which has also been implemented in North Carolina at Wake Forest Baptist Medical Center. The Memphis Model includes various components, including a signed covenant among churches and hospitals, clergy, patient navigators, and trained volunteer connectors. The importance of building patient trust was noted. Dr. Gunderson emphasized that when social structures are connected, health access improves.

Additional comments made and questions asked by Dr. Gunderson include the following:

- √ "We can only move at the speed of trust." – Emergence of webs of trust is what moved things forward in Memphis and North Carolina.
- √ Assets and stakeholder health – How do we become accountable for what we have (not what we don't have)?
- √ Social structures are critical to bringing together the population to improve health – they are naturally there.
- √ How do you link the generative nodes/assets in the community? Approach them with curiosity and possibility.
- √ Hope the possibilities of this region match the actuality of this region.
- √ Economic and policy drivers are encouraging us to reach out to the communities, but need to do it with humility.
- √ Religious Assets Health Mapping – Community Assets Health Mapping – asset mapping builds trust and identifies untapped potential partners in improvement efforts.
- √ Building robust health system and community partnerships:
    - Asset focus and mapping

- Develop shared metrics
- Push resources as far into community as possible
- Person-centric, not hospital-centric

√ YOUR Assets
- Faith-based or community partnerships
- Relationships with volunteers
- Your own health system employees – help engage their passions
- Better self-management – pay it forward

√ "Dying from Despair" – need to focus on what gives/creates life vs. death

√ Hospital and health care systems have always been considered to be anchor institutions. "We must not tie our anchors in the heavy seas we are in now."

Gunderson stated that "no one knows the suffering of the community better than the people in the community." He stressed the importance of getting to know the community and becoming humble before leaping in to serve the community.

Day 2

Welcome & Opening Remarks - Kevin Fowler, President & CEO Cabell Huntington Hospital and Secretary Bill Crouch, West Virginia Department of Health and Human Resources (WVDHHR) Secretary

Mr. Fowler welcomed participants and reiterated the purpose of the Summit. Fowler briefly discussed access in a broad sense – how comfortable is a person reaching out to you as a provider of care? It all goes back to a baseline of trust.

West Virginia Department and Health & Human Resources (DHHR) Secretary Bill Crouch addressed participants and provided a synopsis of an epidemiological study completed on the recent overdose incident in Huntington. Secretary Crouch stressed the importance of building a "data warehouse" as part of the answer to addressing the opioid crisis and solving health problems in the state. The warehouse would include data from a variety of stakeholders (medical providers, local health departments, PEIA, Medicaid, social service providers, etc.). All that contribute to the data warehouse would have access to the data free of charge. The warehouse will help people make more informed decisions. It will include information like hospital discharges, etc. in one place and providers will be able to link to utilization data.

There are plans to eventually add additional data, including behavioral health, prescription drug use, poison control, emergency medical services (EMS), etc. WVDHHR is currently working with Marshall University and West Virginia University for data mining, forecasting, modeling, best practices, etc. Secretary Crouch ended with the following comment "The Federal approach to "repeal and replace" will hit you all hard at the community level as you fill the gaps being created. This will create a serious problem from the top of the healthcare system to the bottom."

"Panel Discussion – Transition to Value and Population Health Management – Provider and Public Health Perspective"

Panel Members:

- Dr. Michael Canady, Holzer Health System
- Dr. Brian Gallagher, Marshall University School of Pharmacy
- Dr. Michael Kilkenny, Cabell-Huntington Health Department
- Dean Joseph Shapiro, MD, Marshall University Joan C. Edwards School of Medicine
- Dr. Daniel Snavely, Huntington Internal Medicine Group
- Bob Whitler, Charleston Area Medical Center Health System/Partners in Health

Moderator: Dr. Hoyt Burdick, Chief Medical Officer, Cabell Huntington Hospital

Members of this panel addressed key issues in transitioning to value and population health management from a provider and public health perspective as summarized:

√ Challenges of remaining in a private practice (quality service, productivity, efficiencies, etc.).
√ Population heath measures and the impact of economic development on public health need to be recognized.
√ A regional patient information exchange system would help inform decision-making.
√ Pharmacists should be part of the health care team if we want to address the triple aim model of access, quality and cost.
√ Utilize unique patient identifiers, access each other's information and look at high utilizers to make sure they have a primary care provider.
√ The need to increase access and quality and decrease costs.
√ Engage different members of the community to solve a problem.
√ Get involved in data and provide care to the small percentage of clients demanding the most care and resources.
√ Avoid duplication.
√ Encourage managed care organizations to form partnerships.
√ Most doctors aren't experts in public/community health. The focus is on a specific patient. They need to re-focus on the health of the population as part of health care delivery.
√ Insurance does not equal access - because someone has insurance, does not mean they have access to health care.
√ Regional healthcare information exchange would help save money and deliver care better. We won't get answers from Washington but from the people here.
√ Economic development is a huge driver of public health – hospitals, health systems, and related health industries offer good paying jobs, benefits, and excellent health coverage.
√ Policy makers want to increase access and quality and decrease cost – which seem to be mutually exclusive. Pharmacists can help with this (medication therapy management, patient education, etc.).
√ The region is dealing with population health issues related to poverty, drug use, high rates of mental health issues, unemployment, etc. For example, the WV rate of the child welfare system removing kids from the home is four times higher than the rest of the

country. WVDHHR is looking at this as a quality of life issue and not just a health issue or money issue (e.g., there may be food insecurity).

- √ We have a reason to change because we are struggling. We can't wait for the Federal government to solve the problem. There is opportunity in WV to build upon. We have a pioneer spirit, a culture of helping our neighbors, good work ethic, etc.
- √ WV received an AHC/CMS grant of $2.5 million for enhanced navigation services for some Medicaid recipients in 48 clinical delivery sites. They will screen for social determinants of health if there are more than two emergency department visits, beginning in January 2018. These patients will be connected to services such as food banks, etc.
- √ Question for panel: *"How can we leverage community partners to improve population health?"*
  - Unified electronic medical record (EMR) would help improve outcomes and prevent duplication of effort.
  - Communication between providers is key.
  - The West Virginia Health Information Network (WVHIN) is a state health exchange. It has established a new partnership with Maryland and Washington. DC exchanges. WV will start with notifications – for example, when someone is discharged from the hospital, the primary care provider (PCP) will be notified. They hope to add clinical data eventually but there is a challenge because there is a lot a data.
  - Prescription monitoring program is being started.
  - Unique patient identifier would help to share patient data.
  - Patients, especially higher users, don't have a PCP. Waste could be avoided if these patients had a PCP coordinating their care.
  - Important to engage different members to the community to solve problems (e.g., opioid crisis).
  - To solve the big problems affecting population health, it is important to avoid duplication of services and for providers to share information.
  - The lack of a unique patient identifier is challenging. "Cloud" technologies may offer some solutions.
  - Regional collaboration can be an approach to consider.
- √ Government payers in WV are covering 70-75% of the health care costs. What can the government do to help providers? Encourage managed care organizations (MCOs) to partner with others and pay for services across state lines.

A brief overview of the Veteran's Administration (VA) Medical Center in Huntington was also shared. Over 30,000 veterans are served in the region. Outreach teams and community partners help to coordinate primary and behavioral health care, including suicide prevention. The VA Medical Center is also a leader in tele-health medicine.

"Panel Discussion – Transition to Value and Population Health Management – Payer Perspective"

Panel Members:

- Dr. James Becker, West Virginia Medicaid and Marshall Health
- James Fawcett, Highmark West Virginia

- Deputy Secretary Jeremiah Samples, WVDHHR
- Todd White, Aetna, Inc.

Moderator: Gene Preston, Cabell Huntington Hospital

Members of this panel addressed key issues in transitioning to value and population health management from a payer perspective as summarized:

- √ Health homes under the Affordable Care Act – pay a fee to a practice (PCP) that agrees to coordinate care for those with chronic conditions. Care coordination can improve patient outcomes (and satisfaction) and decrease cost – hitting the Triple Aim of "Better Health, Better Care and Better Value." Marshall Health did this for two years with those with bipolar disorder and is now doing it with those with diabetes.
- √ Elimination of Medicaid expansion would greatly impact charity care. There are many population health challenges to address, including high rates of opioid use, mental illness, low workforce participation rates, and the impact on other systems such as the child welfare system. Actionable change is needed.
- √ Four (4) key things to consider in transitioning: flexibility in the system matters, prompt data is important, team care is essential, and the patient has to be engaged.
- √ There has to be agreement on the data, data quality and validity of the data.
- √ You can compete and cooperate at the same time.
- √ Value based purchasing.
    - Flexibility is needed. Need to be responsive and innovative to the diverse needs of the population, even within a specific area.
    - Partnership with others is important – so much is done in silos. For example, Aetna saw an issue of food insecurity, so partnered with a mobile food pantry to work with the health education department to disseminate health information to food recipients. Best advice is "don't get yourself in a box," and "never say never." You can compete and cooperate at the same time. Urgency and crisis will drive us toward opportunity and solutions.
    - "Can't let perfection get in the way of good progress."
    - Population alignment across payers is complex.
    - Data, data quality, and data validity
    - Challenges of attribution to providers
    - Engage patients so they understand what they need to do – what we are trying to achieve. Co-pays don't do it – need the patient to "put skin in the game."
    - 50% of Medicaid population does not select their PCP – it is assigned for them. This shows that they are not invested in their care.
    - Patient engagement and personal responsibility are huge.
    - Level of distrust among everyone! (provider to payer, payer to government, etc.) – need to trust each other's intentions.
    - Social determinants of health – truly integrating approach to look at people holistically (medical, social, etc.) – broadening scope of what we consider "health."
    - Medicaid 1115 waiver for substance abuse – can cover supportive housing, etc.
    - Building team approaches/models to care

- Costs reductions will occur due to increased efficiencies.
- Flexible funding can help address social determinants and public health in a holistic manner.

A few takeaways from the panel discussion include:

- √ The barriers we have to overcome include educating the patient, invalid data, transient patients, and patient engagement in selecting a doctor and healthcare plan.
- √ We have to engage patients and help them to understand their goals.
- √ More can be done if we partner with other stakeholders.
- √ Cooperation and urgency drives partnerships.

"Aligning, Leveraging, and Mobilizing Assets: Becoming Deeply Accountable for What is Possible" - Gary Gunderson, MDiv, DMin, DTh (Hon), Stakeholder Health Advisory Group | Wake Forest Baptist Medical Center (continued)
and
"Measuring What Matters: Driving Trends & Regional Health Outcomes" Teresa Cutts, PH.D., Wake Forest School of Medicine

As part of this presentation, Dr. Gunderson provided additional information about the key elements and framework of the "Memphis Model." Dr. Cutts reviewed health outcomes data collected at Wake Forest Baptist Medical Center, which showed the average patient going 306 days between hospital visits, compared to patients engaged in the Memphis Model who stayed away for 426 days. The data also showed network patients with a 50 percent reduction in mortality and a 20 percent reduction in hospital readmissions compared to non-network patients, helping the hospital system save about $4 million per year. The data demonstrated improved outcomes and cost savings.

Dr. Cutts discussed the importance of regional assets and being person centric, versus hospital centric. The following are additional points made by Cutts:

- √ 3 As: Assets, Abundance, and Adaptation - Aligning, leveraging, and mobilizing what you have (assets), lead to abundance. "You get what you need." Adaptation – you learn as you go and change when you need to.
- √ In the "Memphis Model," they asked patients in the emergency department (ED) whether they were part of a congregation or social network. They were also connected to staff (navigators) to coordinate social care – inclusion of the social network in health care in a highly structured way. Connectors are also used. These are social specialists, residents within the community who are deeply immersed with the population. Connectors are critical – need to be based in the community.
- √ Need to build webs of trust and community capacity.
- √ It is disconcerting that de-centralizing of care will happen and it's not always comfortable.
- √ "Don't allow perfect to be the enemy of good." – Measure something. Can't always get perfect data, perfect measures, etc.
- √ Look at your own data, but with fresh eyes. Be creative with your metrics – use what is already being collected.
- √ Metrics need to be something the community cares about.

√ When you increase access, you will increase utilization (and costs initially).

A question is "how to set structure (sail) to capture the spirit of community to impact change?"

Cutts identified the following assets in the Tri-State Regional Summit service area, that includes 21 counties and 2,403 congregations, of which 29% of the population are churched:

√ Faith-based community partnerships
√ Relationships with volunteers
√ Passions and interests of hospital employees
√ Better self-management of health and accountability
√ Love for community

Breakout Sessions: Highlights and Common Themes

Summit participants were engaged in breakout sessions to begin discussions around the priority topic areas of *Chronic Disease, Access to Care, Behavioral Health & Substance Abuse, and Data & Technology*, which were common to most community health needs assessments conducted across the region. Participants self-selected to participate in a breakout session, choosing from the four topics based upon areas of expertise and/or interest.

In each of the four breakout sessions, participants were engaged in strategic conversations in small groups. Members in each of the small groups recorded comments and reported out to the larger group. Highlights and common themes were recorded from the large group report outs and then shared with all Summit participants in the closing session.

The following are highlights and common themes that emerged throughout the strategic discussions. Verbatim responses from all small group discussions and participants for each breakout session can be found in *Appendix 2*.

Chronic Disease

Facilitator: Becky King, Collective Impact, LLC
Reporter: Lisa Zappia, Prestera Center

1. *Reflecting upon the data points, what are the top issues or challenges?*

- Culture is an underlying cross-cutting issue impacting chronic disease rates.
- Unhealthy lifestyles – such as poor eating habits, lack of exercise and smoking are contributing factors.
- Lack of social supports and lack of access are challenges.

2. What is working now?

- Projects such as the Pediatric Obesity Project, Health Home
- Peer group sessions

- Diabetes education
- School-based programs
- Community Engagement Specialists
- Integrated health programs
- Increase in the tobacco tax
- The growing social movement around reducing obesity such as the expansion of local farmers markets, community gardens, and healthy eating messages and environments

3. What is not working?

- How prevention education is being delivered – there is more of a focus on information versus education and what is being given is in a manner that patients do not always understand
- There are not enough physical infrastructures in place to encourage healthy lifestyles such as walking and biking trails, parks etc.
- Lack of reimbursement for preventive services
- Lack of tobacco cessation programs as well timeliness around providing assistance through the statewide Quitline

4. *Reflecting upon what is working and what is not, what is most needed?*

- Greater emphasis on prevention and early intervention
- Patient follow-up and addressing social determinants of health
- Data sharing and analysis across systems
- Enhanced, holistic patient support and education systems (focus on families versus individuals and using individualized approaches)
- Educating funders that population health changes/cost benefit of prevention take time

5. *What are our next 3 action steps that we can collectively undertake?*

- Continue to have opportunities such as the Summit to share best practices.
- Identify one or two social determinants of health as priorities to work on as a region.
- Identify clear roles within the system for clarity.
- Advance policy changes such as the soda tax, tobacco tax.
- Commit to providing education to the community, patient, and family support systems to dispel magical thinking.
- Commit to sharing data and using data to create programs.

Access to Care

Facilitator: Denina Bautti-Cascio, Collective Impact, LLC
Reporter: Joshua Austin, WVU School of Public Health

1. ***Reflecting upon the data points, what are the top issues or challenges?***

    - Transportation to care
    - Consistent primary care and behavioral health care source
    - Preventable hospital visits – nearly 2 times the national average – related to lack of primary care and behavioral health care and asymmetry of providers (in terms of location in the region)

2. ***What is working now?***

    - Community outreach for preventive and primary care – but need to bring it more directly to the people (e.g., WV Health Right – Marshall Mobile Dental Unit)
    - Telehealth for behavioral/community health
    - Case management/community health workers/paramedicine/navigation

3. ***What is not working?***

    - Education on appropriate access to care – e.g.- what the ED is for
    - Cannot reach people due to geography/state borders
    - Poor distribution of labor and resources - need the payment model to allow a shift
    - Asymmetry of providers – availability is working, especially in urban centers

4. ***Reflecting upon what is working and what is not, what is most needed?***

    - Patient engagement and accountability – and a focus on prevention/wellness/youth
    - Access to transportation, especially in rural areas
    - Case management - expansion

5. ***What are our next 3 action steps that we can collectively undertake?***

    - Information sharing and regional resource mapping – connecting community resources – be smarter and thrifty in using what you have ("Memphis Model")
    - Networking/collaboration among providers (e.g., best practices, sharing of electronic health records through a health information exchange (HIE)
    - Health education and community outreach - prevention focus at a younger age

Behavior Health & Substance Abuse

Facilitator: Bruce Decker, Collective Impact, LLC
Reporter: Craig Richards, Mildred Mitchell-Bateman Hospital

1. ***Reflecting upon the data points, what are the top issues or challenges?***

- Stigma
- Lack of jobs, economic depression
- Funding for services
- Follow-up services

2. ***What is working now?***

- Harm reduction programs
- Public awareness – anti-stigma availability
- Community engagement specialists
- Care coordination
- Discharge planning including referrals to community services

3. ***What is not working?***

- Economic issues impacting self-worth and productivity
- Jail incarceration
- Warm handoff referrals
- Data and EHR sharing (West Virginia Health Information Network (WVHIN)
- Current payment model – paying for services, not outcomes of performance

4. ***Reflecting upon what is working and what is not, what is most needed?***

- Workforce development of specialized career tracks in the behavioral health/substance abuse field
- Update active directory of resources
- Stabilized funding
- Re-development of special trainings for individuals in treatment and recovery

5. ***What are our next 3 action steps that we can collectively undertake?***

- Economic/workforce development. Hire Medication-Assisted Treatment (MAT) and those in recovery
- Strategies to better serve those needing frequent services
- Active engagement of community organizations (i.e., North Carolina Model)

Data & Technology

Facilitator: Kevin Jones, Collective Impact, LLC
Reporter: Sonia Chambers, WVHIN

1. ***Develop an inventory of what exists today pertaining to Data and Technology related to population health?***

    - Inpatient data and outpatient data from all three states
    - Data warehouse
    - Analytics
    - Electronic Health Records (EHR)
    - Regional community inventories of community services
    - WVHIN
    - Telemedicine

2. ***Where are the gaps that exist pertaining to Data and Technology related to population health?***

    - Access to common format/standards data
    - No sharing policy
    - Lack of people and tools to do analytics
    - Lack of trust among organizations

3. ***Where are some opportunities that may be leveraged through collaboration pertaining to Data and Technology related to population health?***

    - Better prioritization of issues
    - Local expertise
    - Environmental factors - better alerting
    - Better coordination of care and management of complex care

4. ***What are some ways to best align Electronic Health Records (EHRs) and data platforms to exchange health information (WHIN tools, Emergency Department Information Exchange (EDIE) tools from WV Hospital Association, Direct Messaging, etc.)?***

    - Standardized open source to pull data
    - WVHIN
    - EHR and vendor offerings
    - Common patient identifier

5. ***How do we use Heath Information Technology (HIT) to engage community health partners to support patient self-management?***

- Proactive automated flags
- Using everyday technology (Fitbit, smartphone)
- Understanding the cost of care – self manage
- Friendlier and easier to use patient portal options. Simple and easy to use for all age ranges.

Closing Remarks & Adjourn - Kevin Fowler, President & CEO, Cabell Huntington Hospital

Mr. Fowler closed the Summit by thanking participants and summarizing follow-up steps, which will include establishing workgroups in the four priority areas: *Chronic Disease*, *Access to Care*, *Behavioral Health & Substance Abuse, and Data & Technology*. All information from the Summit will be posted on the website. It is anticipated that a follow-up meeting will be held in the fall of 2017 to assess progress and activities. Mr. Fowler noted that input, collaboration, and guidance would be needed moving forward and encouraged participants to stay involved. Fowler stated that there is a need for hospitals and large healthcare systems to take the lead on this regional initiative due to their greater resource capacity and ability to put "boots on the ground."

Appendix 1: Regional Summit Participants

- Aetna, Inc.
- Boone County Health Department
- Boone Memorial Hospital
- Bowles Rice, LLP
- Cabell-Huntington Health Department
- Charleston Area Medical Center Health System
- Cabell Huntington Hospital, Inc.
- Cornerstone Hospital Huntington
- Eastern Kentucky Health Center
- Greenbrier Valley Medical Center
- HealthSouth Rehabilitation Hospital of Huntington
- Highlands Health System Regional Medical Center
- Highland Hospital
- HIMG
- Holzer Health System
- Hoops Family Children's Hospital at Cabell Huntington Hospital
- Hospice of Huntington
- Huntington Chamber of Commerce
- Huntington VA Medical Center
- Jackson County Health Department
- Jackson General Hospital
- Marshall University Joan C. Edwards School of Medicine
- Kanawha-Charleston County Health Department
- King's Daughters Health System
- Marshall Health
- Marshall University College of Health Professions
- Marshall University School of Pharmacy
- Mildred Mitchell-Bateman Hospital
- Mingo County Health Department
- Our Lady of Bellefonte Hospital
- Partners in Health
- Pleasant Valley Hospital
- Prestera Center
- Putnam County Health Department
- River Park Hospital
- St. Mary's Medical Center
- Southern West Virginia Health System
- Thomas Health System
- Tug Valley Regional Medical Center
- Valley Health Systems
- West Virginia Department of Health and Human Resources
- West Virginia Health Information Network
- West Virginia Public Employee Insurance Agency
- West Virginia University School of Public Health
- Williamson Memorial Hospital

Appendix 2: Breakout Sessions: Verbatim Responses and Participants

Chronic Disease

Facilitator: Becky King, Collective Impact, LLC
Reporter: Lisa Zappia, Prestera Center

1. *Reflecting upon the data points, what are the top issues or challenges?*

- Overweight – poor eating habits, lack of exercise
- Need to focus on themselves and each other
- Data sharing does help to highlight areas of need
- Heart Disease (BP and cholesterol)
- Diabetes
- Obesity (physical activity, fruit and vegetables, soda consumption)
- Culture
- Resources – transportation, etc.
- Economy
- High cholesterol
- High blood pressure
- Overweight
- Culture challenges for healthy lifestyle
- Tobacco
- Diabetes
- Obesity

2. What is working now?

- Health Home concepts
- Strong faith-based network
- Farm-to-table
- Education and outreach
- Preschool age children nurturing learning playgrounds and gardens
- Family support
- Support/group reinforcement
- Home visits post-discharge
- Veterans – take primary care to client
- Take more to client home, group visits (medical)
- Partnerships
- Health Homes

- Home care education
- Resources
- Tobacco: tobacco tax, grants for tobacco cessation, clear indoor/public regulations
- Limited success: health and wellness programs incentives
- Diabetes: Success of Diabetes Education Programs
- Diabetes education/negates fatalistic attitudes
- Access to diabetes medications and testing supplies
- Obesity: social movement, more opportunity for eating healthy (restaurants and farmer's markets) more physical activity opportunities (walking paths)

3. What is not working?

- Lack of understanding of disease process – patients and family, (not doing a good job of educating families leads to poor compliance)
- Data sharing
- Lack of infrastructure
- Lack of reimbursement for preventive services
- Access to fresh foods
- Collaboration
- Chronic diseases self-management
- Expecting clients to come to us
- Lack of specialty providers
- Data sharing
- Education is difficult (either too much or not enough)
- Patients can't grasp – takes too much time
- Tobacco: lack of cessation programs, funding cuts, patient buy-in/motivation to quit
- Ads – don't get anticipated results
- Quit line – lapse of time to care
- Diabetes – cultural, attitudes, personal decisions, cost of healthy eating
- Lack of physical education in school
- Safety/environmental conditions
- Screening time increases
- Cost of healthy eating

4. *Reflecting upon what is working and what is not, what is most needed?*

- Caregiving arrangement of some kind
- Transportation
- Data sharing and then using data to make informed decisions and rewarding people with it
- Enhanced family/support system education
- Collaboration and reimbursement (patient-focused)
- Community para medicine
- Enhanced managed care after discharge

- Social determents/patient navigators
- Health literacy
- Infrastructure
- Connection of data systems (sharing)
- Transportation
- Using data to make informed decisions
- Funding
- Covenant – agreements with churches and volunteers
- So much funding/effort on substance abuse, other issues are suffering
- Timely care - to quit smoking, you wait weeks – drug addiction treatment - little to no waiting
- Key is prevention/early intervention to keep problems from escalating (i.e. heart disease)
- Sustainable funding – programs work then "go away"
- Funders understanding the time it takes to change population health – they want immediate results

5. ***What are our next 3 action steps that we can collectively undertake?***

- Commit to the WVHIN to share data
- Commit to providing education to community, family, support to dispel magical thinking they would be ok, it will pass, isn't the meds
- Sweetened beverage tax to pay for public health
- Social determinants - address one to two as a group
- Share what is working or not forums
- Health education campaign
- Data to share
- Health campaigns in our community - take care of self & at least 1 person - Adopt a Neighbor
- Leadership collaboration A. Education systems leadership (physical education in schools) B. Legislators supporting prevention policies – taxes, school mandates
- Regional systematic approach to affordable healthy foods
- Collaboration among physical activities, facilities, parks, etc.

Chronic Disease Breakout Participants

Name	Organization
Elizabeth Adkins	Cabell-Huntington Health Department
Laura Bradley	Huntington VA Medical Center
Judy Crabtree	Kanawha Coalition for Community Health Improvement (KCCHI)
Brandon Gagnon	Cornerstone of Huntington
Evelyn Davis Garcia	Marshall Cardiology
Gary Gunderson	Wake Forest
Melanie Hall	Hospice of Huntington

Dan Lauffer	Thomas Health System
Julie Miller	Boone County Health Department
Laura Patrick	KDMC
Brandy Preston	OLBH
Tina Ramirez	Kanawha-Charleston Health Department
Hannah Rehm	Cabell-Huntington Health Department
Andy Rice	Valley Health Systems
Christena Ross	CAMC
Todd White	Aetna, Inc
Bob Whitler	CAMC/PIHN
Kristy Wolfe	Health South
Mike Zuliani	Health South
Lisa Zappia	Prestera Center

Access to Care

Facilitator: Denina Bautti-Cascio, Collective Impact, LLC
Reporter: Joshua Austin, WVU School of Public Health

1. *Reflecting upon the data points, what are the top issues or challenges?*

- Demographic challenge – we have an older, disabled, impoverished population
- Transportation for access to primary care – linked to asymmetry of providers
- Primary care and mental health access
- Consistent primary care source
- Preventable hospital events
- Depression
- Transportation to care
- Education around appropriate access points
- Willingness of primary care access providers to accept patients

2. What is working now?

- Partnering around projects, like telehealth
- Access Center via telephone for nurses, doctors, etc. (commercial payers)
- High coverage rate
- Coalition of community workers
- Community engagement (case management, transition of care)
- Primary care medical homes (PCMH) and health homes (transportation)
- Access to primary care
- Effective interdisciplinary relationships between healthcare agencies/facilities
- Culture of community
- Increased screening to identify depression and other mental health risk factors
- Awareness/resources of the problem
- Community outreach (health fairs, low cost testing and education)

- Enhance case management
- Community paramedicine

3. What is not working?

- Ownership of the provider of overall patient care
- Distribution of providers in rural areas
- Timely access/urgent access to PCP for management of acute issues
- Complex comorbidities of our population
- Access to mental health services
- Limited support systems
- Not consistent in all counties (all providers and services in one area)
- Proper education from primary care physician
- Primary care physicians do not utilize community workers
- Lack of payment for oral healthcare
- Poor distribution of labor and resources
- Transportation
- Care coordination across the continuum
- Data sharing and service duplication
- Appropriate care resources based on acuity
- Misaligned compensation models

4. *Reflecting upon what is working and what is not, what is most needed?*

- Early and consistent "health education" throughout school years
- Ongoing, intensive, individualized care management
- Reliable transportation source in rural areas
- Gainful employment
- Getting and identifying primary care needs (i.e., barriers to solutions)
- Patient engagement – take charge of health
- Provider/patient linked to/utilizing entire community resources
- Integration of behavioral and physical primary care
- Patient education/patient accountability
- Navigation/case management
- Alignment of the compensation models

5. *What are our next 3 action steps that we can collectively undertake?*

- Healthcare agencies/facilities to increase provision of health education in school settings – get in the communities (more outreach)
- Ongoing inter-agency networking like this Summit
- Getting community resources connecting to one another (resource mapping)
- Record sharing for quality of care and less duplication (regional HIE)
- Increase focus on integration of behavioral and physical primary care
- Community education around appropriate access points

- Continued collaboration/info sharing around access – best practices in the community
- Work to open access for high utilizers' access to primary care

Access to Care Breakout Participants

Name	Organization
Joshua Austin	WVU School of Public Health
Lisa Caldwell	Health South
Carrie Hensley	Huntington VA Medical Center
Angela Jewell	Tug Valley ARH Regional Medical Center
Diva Justice	Our Lady of Bellefonte Hospital
Zach Kerns	Pleasant Valley Hospital
Kate Luikart	Prestera Center
Brian Lilly	Thomas Health System
Amy Marcum	Health South
Tim Martin	Cabell Huntington Hospital
Barbara McKee	Partners in Health Network
Kayla Murphy	King's Daughters Medical Center
Casey Napier	Cabell-Huntington Health Department
Brian Nimmo	Huntington VA Medical Center
Loretta Simon	Williamson Memorial Hospital
Crystal Thelley	Pleasant Valley Hospital
Miranda Tussey	Health South

Behavior Health & Substance Abuse

Facilitator: Bruce Decker, Collective Impact, LLC
Reporter: Craig Richards, Mildred Mitchell-Bateman Hospital

1. ***Reflecting upon the data points, what are the top issues or challenges?***

- Social connections and support
- Safety-net/follow-up care post discharge
- Follow-up care post overdose
- Availability of services – prevention
- Stigma of the issue and trauma (emotional, verbal, physical, sexual, neglect, abuse)
- Funding
- Funding for follow-up care
- Lack of pediatric/adolescent follow-up programs
- Under recognition of opioid use disorder
- Other psychoactive substance abuse
- Lack of resources to manage the issues

2. What is working now?

- Governor's Advisory Council for Substance Abuse
- Harm Reduction Programs
- Local coalitions
- Care coordination
- Needle exchange programs
- Increased public awareness
- Narcan availability
- Help line for referral (West Virginia)
- NTU/Lilly's Place
- Treatment – drug courts (VLARC) and voluntary
- Adoption of CDC guidelines for safe prescribing of opioids
- Monitoring of controlled substance prescriptions
- Anti-Stigma campaigns
- Awareness and information on prevalence
- Evidence-based practices – motivational interviewing
- Reduced stigma with admitting to drug addiction
- Provider education – requirements for training
- Data systems available for reporting - KASPER

3. What is not working?

- Jail instead of treatment
- Mental Hygiene process
- Availability of drugs
- Workforce education
- Rules and regulations regarding treatment (MAT)
- Warm handoffs/referrals
- Funding sources and uses
- Economic development and redevelopment
- Linking to improved levels of function – stabilization > therapy/intervention > job re-education > job pursuit > employment
- Silo funding and duplication of services
- Access is not working optimally
- Teacher education
- Community education
- Need more facilities
- Not testing for Neurontin
- Narcan to same people repeatedly
- Treatment centers not accepting particular insurances
- Treatment centers not in proximity to homes
- Stigmatizing this population
- Insurance not covering pain management

- Patient education regarding their pain expectations – some will never be completely pain free

4. ***Reflecting upon what is working and what is not, what is most needed?***

- Updated active directory of resources
- Engagement of community and churches to build support systems in a coordinated effort
- Portable standardized record – interoperable
- Access – acute, behavioral health, detox
- Workforce development
- Economic development
- Workforce education for meaningful employment
- Stable funding for behavioral health from prevention to intervention to treatment
- Follow-up through overdose response teams – engaging the community in the process
- Follow-up care for overdose patients
- Call center for treatment facilities
- Data repository
- Treatment for behavioral health/substance abuse is too protected from being shared with other providers
- More treatment for pregnant users
- Education needs to be started in elementary school
- Peer-to-peer education
- Get people back into the workforce
- Education to help encourage people to foster/adopt children with addiction backgrounds
- Culture change

5. ***What are our next 3 action steps that we can collectively undertake?***

- Lobbying of politicians for education at the elementary school level
- Industry – people/places that are willing to hire people with stable addiction issues, to get them back into the workforce
- Build trust with the population. Peer-to-peer experiences and education
- Formal coalitions for substance abuse
- More public health information and funding
- Economic development
- Develop specific strategies for those who are high users of services (health, law enforcement, social engagements, legal, etc.)
- Sharing provider information collectively for optimal patient benefit
- Continue these health Summits for continuing regional system improvement
- Follow through with the work started at the Summit
- Refine Help4WV process and directory

- Workforce development and training – peer recovery
- Active engagement of our community organizations (i.e., congregation health network [CHN], sports, schools, etc.,)

Behavioral Health and Substance Abuse Breakout Participants

Name	Organization
Debbie Armstrong	Thomas Health System
Shane Arnett	VAMC Huntington
Keith Blankenship	Mingo County Health Department
Jeffery Breaux	VAMC Huntington
Mike Brown	VAMC Huntington
Tom Hastie	Cabell Huntington Hospital
Amy Haskins	Jackson County Health Department
Amy Hoyer	Kanawha Charleston Health Department
Beth Jennings	River Park Hospital
Stephen Kuhn	River Park Hospital
Namdini Manne	Marshall University
Rachel Merino	Valley Health
Craig Richards	Mildred Mitchell Bateman Hospital
David Sheils	SMMC
Brianna Sheppard-Willis	WVU Institute for Community Rural Health
Sandy Smith	King's Daughters Medical Center
Nancy Sullivan	WVDHHR
Karen Villanueva-Matkovich	Valley Health
Karen Yost	Prestera Center
Debbie Zuberbuehler	Valley Health
Terry Stephens	River Park Hospital

Data & Technology

Facilitator: Kevin Jones, Collective Impact, LLC
Reporter: Sonia Chambers, WVHIN

1. ***Develop an inventory of what exists today pertaining to Data and Technology related to population health?***

    - Patient data inpatient 3 states
    - Patient data outpatient 3 states
    - Med Par 2016 IP & OP
    - CDC/Health Dept.
    - Internal CERNER – all other platforms
    - Data warehouse – CHH/MU data, ECCC data,
    - Census population
    - Trauma Registry-Cancer Registry

- CERNER
- CHA & CHNA
- WV HIN
- Pharmacy database
- Disease demand
- Health Status
- Kaiser
- DW (financial, clinical, med trust), define populations: outside data
- Visualization
- Data
- Analytics
- MLM
- E Source: GPS, Census, Medicaid
- Telemedicine
- External tools: survey tools/EHR
- Organizational EHRs and data warehouses
- Government collection of data
- Commercial & government payer data
- Vendor tools available
- WVHIN availability
- Regional & national registries & comparison data
- Regional inventories of community resources & services (bank, homeless)

2. ***Where are the gaps that exist pertaining to Data and Technology related to population health?***

- Data warehouse statewide
- Access to data warehouse
- Claims data – OP data
- Enterprise Master Index
- Unique patient identifier MR number in affinity
- Share data
- Define populations with in regions
- Know functional capability
- Communicate effectively between organizations
- Finance efficiently
- No flowchart
- E institutions: EHR no standards
- Who does analysis security policy?
- Lack of expertise
- No documented work plan
- Lack of socio-economic data sources
- Connectivity & sharing between organizations
- Lack of common resources (people & tools) to turn data into information

- Access to near real-time data from multiple sources
- Lack of trust to share date between organizations
- Requires multi-discipline approach to get, validate & interpret data (clinical, etc.)
- Variability in operations/patient care process between organizations
- Security & privacy

3. ***Where are some opportunities that may be leveraged through collaboration pertaining to Data and Technology related to population health?***

- Ohio Hospital Association (OHA) membership program
- Access to data warehouse
- Data format – common
- Methodology – common
- Data attribution
- Better prioritization of issues for population health – organizations can then collaborate
- Predictive analytics opportunity
- Predictive analytics prevention, ex payers – smokers – tobacco cessation- info payers
- Test population hypothesis
- Establish valid baseline
- Set a goal
- Measure - do gap analysis
- Ability to evaluate community / vaccination
- Improve environmental factors for alerting
- Communicate integrated systems: crowd sourcing during challenging events
- Unify system response (environment, mental health)
- Telemedicine: service funding limited
- Develop local experts
- Simplified interaction to data: pre-provider information artificial intelligence-based (AI) altering
- Assess/respond threats quicker
- Better coordinated care for patients
- Furthering integration beyond hospitals & personal health care telemedicine services (PHTS) to urgent care, rehab, psych, facilities, etc.
- Identifying high cost populations that should be managed to reduce cost
- Enable shared decision making throughout multiple entities
- Manage care process adherence to evidence-based medicine (EBM), best practice, etc.
- Manage patient adherence to care plans
- Improvement to overall patient safety/quality

4. ***What are some ways to best align Electronic Health Records (EHRs) and data platforms to exchange health information (WHIN tools, EDIE tools from WV Hospital Association, Direct Messaging, etc.)?***

- WVHIN saturation
- EDIE – frequent ER users
- Homeless shelter, hospice, social agencies, Prestera - alerting providers
- Best way to align – highly functional logical categorizations
- Cognitive, intuitive, adaptable
- Single source to pull in the data
- Standardized open source with formatting
- XML based standardize access, consistent date format
- System – non-proprietary/open sources
- Statewide (WV-wide) system and using proxy API – for security
- Single EHR platform
- Electronic health records interoperability
- Common patient identifier (lifetime)
- WVHIN & EHR vendor HIE offerings

5. ***How do we use Heath Information Technology (HIT) to engage community health partners to support patient self-management?***

- Once developed explain What's In It For Me (WIIFM) benefit proposition
- Bus, Food Bank, Child Protective Services/Adult Protective Services
- Provide to community health data partners population health data and analytics
- Alerting patients – proactive automated alerts, flags
- Application (APP)
- Align with technology – Apple/Fitbit
- Bidirectional
- Accountability
- Crowd sourcing
- AI Based: mealtime learning: E device (Fitbit), open source
- HIT Team – support/technology
- Cannot communicate: lack of interoperability intro normal life to offer information
- Patient portal: elderly, not tech savvy, simplify
- Better patient portal options – today it's complicated and fragmented experience
- Connecting all health department on a patient's health needs at a point with time

Data and Technology Breakout Participants

Name	Organization
Trish Sacconi	Marshall Health
Courtney Adkins	Boone Memorial Hospital
Girmay Berhie	Marshall Health
Rebecca Bookwalter	Cabell Huntington Hospital
Ed Bowdish	Thomas Health
Lisa Bragg	Health South Rehab - Huntington

Hoyt J. Burdick, MD	Cabell Huntington Hospital
Alfred Cecchetti	Marshall Health
Lisa Chamberlin	Cabell Huntington Hospital
Sonia Chambers	WVHIN
Teresa Cutts	Wake Forest SOM
Chris Edwards	Cabell-Huntington Health Department
Marty Emmett	CAMC Health System
Ken Fitzwater	Prestera Center
Tim A. Hatfield	Tug Valley Regional Medical Center
Cyndi Isaacs	Cornerstone
Grace Kalmias	Cabell Huntington Hospital
W. Michael Skeens	VAMC
Gouthami Kothakapu	Marshall Health- Informatics
Dennis Lee	Cabell Huntington Hospital
Michael McCarthy	Marshall Health
George Ryan	Marshall Health - Informatics
Anthony Yeager	HIMG