better health together

Notes
Spokane Collaborative

21 November 2019 | 1:00-4:00pm
Enduris, 1610 Technology Blvd.

GOALS

Look forward into 2020 and brainstorm vision for ongoing work of the Spokane Collaborative.
Celebrate the wonderful work accomplished in 2019 by the Spokane Collaborative!

AGENDA

WELCOME, MEETING GOALS, AND COMMUNITY ANNOUNCEMENTS

- Community Announcements
  - See community announcement information here: https://mailchi.mp/e2faf5cb6b75/spokanecollaborativeannouncements1119?e=01214833ec
- Proposal awardees announcement
  - *5 proposals awarded, representing 8 organizations:*
    The Zone Project & Catholic Charities, Partners with Families & Children, Smile Spokane, SNAP 2nd Harvest & Spokane Housing Ventures, Spokane Regional Health District

LOOKING FORWARD*

- Preview of Q1 2020
- Big picture
  - What do you want from a health system for our community?
  - How does the Spokane Collaborative contribute to that vision? What is our value-add?
  - What brought you to the table up to this point? What will keep you invested?
- Workgroup gut-check
  - How does each activity chosen last month contribute to that vision?
  - How do we design to include the most partners for bigger impact?
- Share out

CELEBRATION!

- Share a compliment about a fellow Collaborative member or something you're grateful for from our work this year
- Sweet treats!

NEXT MEETING

- Thursday, January 16 @ Enduris

***Notes for LOOKING FORWARD section start on next page**

BIG PICTURE

What do you want from a health system for our community?

ACCESS WITHOUT BARRIERS

- Easily accessible for the most vulnerable
- Increased access to quality care
- Reduction in barriers to care
- Affordable access for all – no deserts of care
- Efficient, easy to use, equity of access
- Access for all
- Reduce all barriers for access to care for community members
- Simplicity of access and navigation for most vulnerable patients
- Access for all demographics
- Access to any and all services no matter the means or the ability to pay
- A system that has broad access
- Anyone can access the care they need, when they need it
- Care is provided where people can access it (in community, mobile, etc.)
- Transportation so individuals/families can get to locations that are not currently served by our current bus transit system
- The right service, at the right place, at the right time, for the right person, at the right price.
- Wholistic frame - transportation, cost should not be barriers
- No wrong door sort of system that supports patients across whatever modality they're meeting, including SDOH

A HEALTHY COMMUNITY ENVIRONMENT

- Health is not one place it's an environment for our community
- A system where everyone has access to the conditions that foster good health, and a focus on prevention

PERSON-CENTERED CARE

- Flexible to meet individual needs
- An integrated client/patient centered system that addresses the SDOH
- Patient/person centric
- Wholistic includes sense of belonging and community building
- We want to have trust in our providers as a patient, and have knowledgeable providers

REDUCTION IN HEALTH SYSTEMS SILOS

- The continued recognition and focus that it takes primary care, BH, public safety, schools, SDOH all working together to move the needle.
- Actual time together and practice around interprofessional work
- Collaborative across specialties and systems
- Data sharing
- Free flow of info. digital EHR
- Understanding existing services
- Collaboration
- Breakdown communication barriers
- Fluid communication for all health systems. Ability to connect resources for all partners involved.
- A system with no wrong door that supports people in their health journey across services both health and SDOH
- A simplified way to communicate
- Important to demonstrate collaborative strategizing - "avoid re silo'ing work"

CONSISTENCY IN CARE/EQUITABLE CARE

- Optimized care for all community members seeking services

- Consistency within the area Identify specific pockets of need i.e. zip codes addressing areas of need
- The right service, at the right place, right time, for the right person, at the right price
- Equality and non-exclusive equal services
- Everyone to get the same info/resources/care regardless of who they reach out to
- Three e's to success: Efficient, Easy to use, Equitable to access

CARE COORDINATION

- Clear path to link outside the med office and inside
- Small teams of tight knit care navigation - connection wakens? for every high-risk individual
- Turn healthcare upside down instead of individuals going to large facilities and having a diagnosis forcing the individual to go to them for their care – instead have a broad screening process, with small care coordinating teams
- Connection to community resources

How does the Spokane Collaborative contribute to that vision? What is our value-add?

The SC creates a forum for discussion & creative ideas

- Giving an outlet to everybody who wants to engage in their creative ideas that they have given up on
- Giving us a forum for discussion and to share information/resources
- ID points to improve delivery
- New perspectives
- Can I.D. overlooked opportunities
- We appreciate BHT for the innovation - BHT has allowed the opportunity for us to think outside the box, think about no wrong doors, going to have to be innovative

The SC aids in building meaningful connections and partnerships

- Incentivizing coming together physically to discuss ways of coming together
- This group provides one of the only opportunities to regularly network with partners that we might not ever see and to consider connecting points that we may never have dreamed.
- Formerly unlikely partners are now in the same room with a shared language working toward common goals
- Facilitates relationships across and between organizations
- Creating connections within the care community
- Puts formerly unlikely partners together in one room
- Work processes together
- The collaboration contributes by connecting silos of care to increase equity for the underserved in our community
- Identify and introduce various existing healthcare services to assist with appropriate and optimized referrals/optimize care
- BHT value add: Introduction and collaboration with various healthcare providers
- Breakdown barriers between partners to make communication
- Bring housing, mental, physical, multi-generational work together
- We help create relationships that enable new pathways for patients and improved integration
- Creates relationships with many caregivers in different specialty areas. Networking opportunities
- How can we create a health market – maybe a place where several entities can come together to offer what is needed to meet needs of community Emotional health etc possibly working with the reducing impacts of family violence and neglect.
- Getting all providers at the same table and disrupting the pattern of an us vs. them mentality. Keeping information flowing and conversations going.
- De-silo care
- Can eliminate barriers
- Can provide broad outreach

The SC promotes a shared language and encourages information sharing

- Helps discussions on how to best share info.
- Shared language
- Shared understanding through joint training
- Sharing best practices, strategizing, and actioning those strategies as a collaborative community and involving patients who will be affected in the process
- Formerly unlikely partners are now in the same room with a shared language working toward common goals
- To expose us to resources in the area and bind us together with relationships, funding, encouragement, and challenge.
- Collection of data to be openly shared within the collaborative

The SC promotes a community-minded approach

- Community minded approach versus singular approach
- A central advocate for the agencies to continue equity work
- By adding a whole community team approach we will be able to share resources, funds
- Spokane collaborative creates/presents common framework for entities (public, private) to build out the ??? so when implemented by nature of common construct naturally align well together
- Getting all health providers on the same page
- The collaborative brings a community minded approach
- Coordinate funds and focused change/intervention
- Shift the paradigm

The SC should take the opportunity to show the success of a Collaborative approach

- Network analysis – show that we're breaking silos
- Speak to the power of collective and collaborative work - has increased the potential of collaborating
- Get some client voices to talk about how partnerships across orgs. positively impacted their experience
- Executive titles in the room & push to the front-line staff - the people doing the work need to buy into the process
- Share equity project work and work of funding awardees broadly

What brought you to the table up to this point? What will keep you invested?

Learning from others

- Learning from others about gaps in care or access to care helps us to think about ways we can do our work better without every org. having to figure out how to survey the folks who aren't seeking us out.
- Ability to present/learn results of initiatives
- Continuing to find potential ways for community agencies to help the clients we serve
- The ability to connect to resources that we did not know were available and make partnerships to help our agency and offer our services to others
- Wanted to hear about gaps and silos; problem solving some of the issues

Proven success/predicting positive outcomes

- Proven success/improvement will keep me invested (i.e. show me it works and that it's worth my time and effort)
- Positive outcomes for my community
- Momentum! Being able to continue to see progress and not just another meeting
- Seeing that the collaborative work continues to make an impact in breaking down barriers to accessing services needed
- We want to be part of the solution. We want to be an effective health provider for our community members. Progress will keep us invested.
- Seeing the progress of the collaborative
- Hearing the positive impact in the community
- Guessing my director's motivation to send somebody and engage was money for meeting the requirements of the original transformation plan. Seeing connectivity meet the holistic needs of our clients would keep me invested. Being able to help our clients easily build a holistic recovery and improve all areas of their wellbeing such as physical health, spiritual health, life skills etc. would reduce significant frustration.
- I was volun-told, but I will keep coming back as there are proven successes

- $ incentive plus a sense of responsibility to support our patients in improving healthcare
- Aiding in decreasing barriers to care
- Streamlining the referral process
- Eliminate stigma
- A focus on oral health

SDOH continues to be a priority
- Ensuring that an integrated health system has a focus on SDOH
- The excitement that SDOH are recognized as contributing to health
- The needs address SDOH needs and meet the community where they are
- My role is about thriving families and safe and nurtured children. Participation in this workgroup helps me develop strategies for this.
- Keep coming to leverage the investment among members to there is benefit whether or not you are a direct recipient of fund or not

Continued networking/maintaining partnerships
- I wanted our organization to break out of its own silo and be more connected to community work – just keep doing what you're doing
- It will be important to still come together often enough and for long enough to ensure that connections aren't broken or that in our busy-ness that they don't atrophy.
- In for the long haul! Can't leave now!
- Continued networking, sharing, and collaboration will keep partners engaged
- Brought me? Chris Wherity. New partners. $ for integration.
- Potential funding and increased networking.
- Openness and decisions of change via meeting other community providers
    - Helps ensure accurate referrals and optimized care
- Impactful collaboration
- Continued collaboration
- Health is a very large issue to look at from an individual standpoint. Working as a collaborative seems to make things work better
- I was invited, and it's required by the Tribal Carve Out. It's not a wasted afternoon - seeing the positive linkages made in the city of Spokane. Continuing that work is very important.
- When I think of health - it is a ginormous topic, incredibly important to continue the partnerships
- Relationships and tangible support to continue creating and enhancing collaboration
- Brought to table: City of Spokane should be a proponent and contribution to group
- Collaboration and exploring new partnerships as we reshape our organization
- Making new connections to strengthen organizations ability to meet mission and provide care
- Meeting individuals here that I've had the opportunity to sit down with just from this meeting – would like to see even more people from the community here

Other
- Appreciation and involvement with front line staff and people in services
- Medicaid transformation uncertainty
- I was originally told to show with not much information provided
- Continued focus on the community we serve - breaking down barriers

WORKGROUP GUT-CHECK

Family Violence & Trauma Workgroup

Strategy 1: Increased childcare and parent support plan:

How does each activity chosen last month contribute to that vision?

- Decreases stress
- Increases concrete supports for parents
- Age 0 is very upstream

How do we design to include the most partners for bigger impact?

Create data, share out

- For both activities, data we create is story we can tell to expand work and impact
- Advertise specific activities so that others will join/see

Engage any and all relevant orgs

- Think outside your "normal" process and identify who "could" help
- Support Plan includes how to connect these
- Continue BHT convenings
- Connecting with community centers
- After school programs
- Day television programs
- Crisis respite
- YMCA
- Breaking Intergen – city align to one support, make connection
- DCYF
- Vanessa Behan
- Childcare Aware

Parenting prep work

- Kids sick? – what can help?
- Including i- parenting prep work
- Brain health
- Circle of security instead of lamaz

Other provider to include childcare providers

- Opportunity to collocate health i- childcare
- Childcare in health system; place to connect
- Hospital connection – referral to home visiting parent supports

Strategy 2: Community-facing ACEs training program:

How does each activity chosen last month contribute to that vision?

- Zero focus on negatives, bring hope
- Resiliency piece
- Practical tools to parent in a supportive way
- Parents as part of health system

How do we design to include the most partners for bigger impact?
Internal collaborative work/planning

- Commitment from orgs to also incorporate in practice
- Need to rotate workgroups
- Include healthcare and insurance systems in our group (may be in another workgroup)
- Commitment to take back to org, be champion
- Do we need to design a program? What trainings/curriculum might already be available?
    - Identify several as part of next step?
- I think it should be built in stages/phases Start with a case build from there 1) How 2) Impact 3) What to do (emotional support)
- Calendar of trainings/resources created for parents distributed from identified spaces
- Look up clinical decision support rules ACE screen --> EBP Knowledge

Train the trainer

- Train the trainer
- Multigen training and trainers
- Train the trainer for ACEs all employees should be trained
- Develop a train the trainer approach within agencies
- Identify trusted spaces within target zip codes to host community faces ACEs
- Portability of training is vital to ensure equitable access (train the trainer)
- Those serving clients also need to know own trauma
- Staff do not have one skill level to know how to work with children who come from trauma-based environments

Variety in trainings/target audiences

- Health curriculum in schools (HS)
- Build on training – not a one off
- Target training for diff. and…
- Examine health curriculum within schools and see if ACEs is included
- Variety of individuals involved in the training so that it can be presented to the various systems – parents – kids – professional staff etc.
- Handouts in peds clinics and hospital locations
- Educate providers in hospitals and ?
- Targeted curriculums for different audiences e.g. teachers, law enforcement, clients, etc.
- Combination of formal and informal trainings
- Health curriculum in public schools for students Include trauma trainings/awareness
- Roles for community organizations who support but don't directly provide this work
- Circle of security to all new parents Brilliant (at the hospitals)
- Easily accessible information to share with local food bank network, which serves population that would benefit
- Post birth intervention
- A lot of the community does not know what ACEs is – let alone have identified their own before they can reach out to another in greater need
- BJ Snyder commercial

Affordable Housing Workgroup

Strategy 1: Expand Responsible Renters curriculum in partnership with Behavioral Health providers:

How does each activity chosen last month contribute to that vision?

- Can measure success/data and stories that show impact (are folks who complete housed earlier?)
- Transferable skills of navigating other systems
- Empowering individuals – folks who go through the curriculum are way more successful

How do we design to include the most partners for bigger impact?

- Identify and educate on ROI of program (landlords #1)
- Ask landlords what they need/want
- All partners so there's more spread/impact (audience)
- Networking all sectors for broader reach and understanding
- Query group – what skills are needed to be successful in responsible partners/housing/life skills coaching
- Include medical too
- How to maintain housing – cleaning, cooking

Strategy 2: Develop and implement an education & outreach agenda to reach landlords & policymakers:

How does each activity chosen last month contribute to that vision?

- Framing ROI to particular audience – figure out later?
- Unusual partners are a new voice and message
- Equity gives us a new lens to frame discussion/message
- Cross sector breaks down silos
- We each bring our unique experience that can help share vision
- Share CDC Data and info on housing models
- Social justice

How do we design to include the most partners for bigger impact?

- Be intentional that our workgroups are varied and we play to strengths
- Make agenda for the whole group, broad spectrum, and all work on it
- Bring the best practices that we all have to the table (collective data/stories)
- Folks in services who may be impacted advocating for housing/services
- Neighborhood Association – using collaborative to share
- Use entire collab to contribute and include folks who use services

Strategy 3: Pilot a subsidized transportation program for target population:

How does each activity chosen last month contribute to that vision?

- Transportation inventory – what do we have?
- Spokane transit collab and using info to this collab.
- Reducing barriers to access and make connections (medical)
- Targeting zip codes that are transportation islands increase housing access by increasing access to transporation
- Increase access to episodic need and instances – on demand
- Equitable access to all services, increase health and housing
- Collab identifies transportation barriers/gaps
- Develop education around transportation and gaps
- Expense of transportation

How do we design to include the most partners for bigger impact?

- Make connection between transit authority and BHT
- Make connection between different workgroups (trauma violence/BH)
- Education around barriers and including community
- Collab helps identify actual target pop (link and something together)
- Making sure all orgs sectors understand links/importance of transportation and impact on folks

Access to Behavioral Health Workgroup

Strategy 1: Expand community health worker/peer model to connect socially isolated individuals to community centers/hubs

How does each activity chosen last month contribute to that vision?

- Inclusive and increase access to community voice and input
- SDoH meet people where they're at
- Identify barriers in advocacy
- Helps community members receive integrated care – no wrong door
- Creates relationships you need to understand services and access them
- Loneliness and social isolation are now a publicly recognized health issue – help connect people beyond traditional healthcare – the intervention is identifying a health need
- Recognizes the critical value of the front-line and the peer mentor
- Peers are not biased by an allegiance to a certain system – peer supports are there for the patient/client

How do we design to include the most partners for bigger impact?

Find barriers to having peer supports/Incentivize

- What is the barrier to support the # of interested peer supports?
- To have CHWs who work in very different context share with this group – for people here to think about how this could work if we were to engage CHWs/peer supports
- If an org. can't afford their own peer – community sponsorship fund – to sponsor peers at every org.
- Bring in agencies who have peer supports to BH agencies to educate our staff on what they do – and for **clients to hear** what's available in a peer support
- Provide training for organizations to have peer supports
- Not a matter of them paying for a CHW – they need to see the value add of having a peer support
- How to incentivize orgs to have peer supports – what will it take for you to take on this training?

Other

- Tap into existing CHW and peer networks across the state, including training – leading EWA CHW Network
- Train and educate non-traditional peers (all marginalized communities open and welcoming reducing stigma)
- CHWs and peer supports could get together as front line staff –
- Develop systems that will facilitate a referral process that will close the loop – ask: What's the standard process of participating orgs. to get their referrals closed?
- Bring in community centers, senior centers etc.

Strategy 2: Education campaign to address stigma and educate on available resources

How does each activity chosen last month contribute to that vision?

- EMPOWERMENT – not just what resources are available but highlight accuracy of info.
- Can't prevent problems unless you acknowledge them
- This will promote a shared language across all of our orgs – will promote a warm handoff – the whole community can stay engaged in that effort – not just an external facing campaign – but a resource for orgs to train their staff on stigma reduction messages
- Will create a sense of compassion and hope – which is the fuel of recovery
- Hire more non-traditional peers, that will open the door to allow others in
- Campaign can be: how to identify what stress looks like, not just: "see a therapist"
- Reduce barriers increase access

How do we design to include the most partners for bigger impact?

- Making our partnerships attractive by having a pamphlet that every participating org is named in – make it attractive for others to want to join

Content related

- Need to include the medical community – have you had your annual health check up?
- Content and delivery that cross audiences – diff. languages etc.
- Campaign needs to include internalized stigma!!!!!!!
- Culturally – language – speak to people "in the trenches"
- Marketing toward people who aren't seeking treatment – use a known face in the community to normalize bh
- Reduce stigma messaging – social media toolkit
- Formally commit. Need shared language and talking points
- Identify existing trainers and trainings

Community voice

- Having trusted messengers within each community – neighbor over doctor
- Need peers
- Peer driven speakers' bureau
- Different orgs. who can identify youth that have gone through support services – that would have impact in schools
- Ask people what were barriers before you sought services?
- Do the work with the communities that have high needs that aren't being met (folks not showing up for BH services)