Greater Columbia Accountable Community of Health

Medicaid Demonstration Project

Project Team Reports Presentation

Leadership Council Meeting

August 11, 2017

TABLE OF CONTENTS

PROJECT 2A: BI-DIRECTIONAL INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH THROUGH CARE TRANSFORMATION

Please complete the template sections below. You may expand a box as needed to accommodate your text. If you are unable to answer a particular section, please move to the next section and continue.

PROJECT DESCRIPTION:

PROJECT TITLE

Bidirectional Integration of Physical and Behavioral Health through Care Transformation

PROJECT CO-FACILITATORS

Rhonda Hauff (rhonda.hauff@ynhs.org), Angelina Thomas (AngelinaT@yvfwc.org) and Brian Sandoval

PROJECT TEAM

Amy Person, Ashley Leir, Ben Miksch, Sarah Bollig Dorn, Caitlin Safford, Cindy Mackay-Neorr, Debbie Dumont, Dell Anderson, Ed Thornbrugh, Edward Miles, Jac Davies, Jeff Juyett, Jim Jackson, Joel Chavez, Kat Latet, Kayla Down, Linda Mayovsky, Mike Berney, Nichole Smith, Samantha Zimmerman, Sue Jetter

CONTRIBUTING ORGANIZATIONS AND TRIBES *Please list all the organizations in the nine-county GCACH region that will participate in developing the eventual project application and implementing the project.* If there is a lead organization, please identify that organization.

Yakima Valley Farm Workers Clinic, Yakima Neighborhood Health, Comprehensive Healthcare, CHPW, Molina, and others.

COUNTIES SERVED BY THIS PROJECT ☒ Asotin ☒ Benton ☒ Columbia ☒ Franklin ☒ Garfield ☒ Kittitas ☒ Walla Walla ☒ Whitman ☒ Yakima ☒ Yakama Nation ☐ Other _____

TRIBES SERVED BY THIS PROJECT (if applicable)

Yakama Nation

THIS PROJECT IS (check one): ☐ **New** ☒ **Enhancing an existing project or set of projects**

THIS PROJECT SERVES MEDICAID CLIENTS ONLY (check one): ☐ **Yes** ☒ **No**

If you checked "No", what percentage of clients served are Medicaid?

Data is still being gathered regarding Medicaid percentages.

THIS PROJECT DOES NOT CURRENTLY RECEIVE OTHER MEDICAID FUNDING FOR THE SAME SERVICES (check one):

☐ **Yes** ☐ **No**

If you checked "No", please describe what other Medicaid funding this project approach is currently receiving and what other Medicaid contracts might be involved.

This question is difficult to answer. Our current assessment process will help us understand the gaps clinically and also from a payment perspective. Our project will be focused on closing gaps in communication, infrastructure, and intervention that do not currently receive funding. Our project will also evaluate services which are underfunded and require additional funding for development, sustainability, and achievement of VBP contact measures.

PROJECT CATEGORY Please indicate which optional category area from the toolkit your project will meet. If more than one area applies, please check the primary area:

- ☒ Bi-directional Integration of Care
- ☐ Community-Based Care Coordination
- ☐ Transitional Care
- ☐ Diversion Intervention
- ☐ Addressing the Opioid Use
- ☐ Maternal and Child Health
- ☐ Access to Oral Health
- ☐ Chronic Disease Prevention and Control

PROJECT GOAL STATEMENT	*What do you hope to achieve with this project? What issue are you addressing? What problem are you trying to resolve?* Our project aims to address the issue of addressing untreated mental health issues by meeting people where they already are to access care in a way that fits their individual needs and circumstances. This project hopes to fully integrate physical, mental, and substance abuse health services in order to provide right care in the right place at the right time. It also hopes to increase access to integrated primary care and behavioral health services by maximizing tenants of the Bree Collaborative, Collaborative Care Model, and internal and external co-location. This will result in increased interoperability between providers and systems to increase efficiencies, improve communications, and reduce redundancies, as well as identifying a regional approach to data collection and registries to improve population health.
BRIEF PROJECT DESCRIPTION	*Provide a description of the project. What are the strengths and weaknesses of this particular project approach?* The project aims to integrate primary care integration in a behavioral health setting and vice versa. Through the integration of community care, primary care, and specialty care information and resources service providers will be better able to access and share specific patient information. This will assist in developing proactive and patient-focused support systems that allow for better chronic care, treatment of co-occurring disorders, and systematic follow-up that reduces future negative symptoms. The project also seeks to provide standardized metrics and measurement-based treatment that makes it easier for healthcare providers to accurately measure the effectiveness of various programs. Through the utilization of the strengths of both the Bree Collaborative and the Collaborative Care model, the project seeks to provide better treatment for "All Comers", a high volume of patients, an improved registry and tracking for key conditions, systematic follow-up of all patients, condition-focused outcome goals, and improved focus on specific population outcomes. The project will consist of three phases: Planning, Practicing Readiness, and Implementation. Phase 1 will require conducting several assessments and analysis of different clinics,
PROJECT SCOPE AND TARGET POPULATIONS	*Please describe what part of the regional GCACH community the project will serve, including which counties, target populations, health systems, providers, service organizations and other. Will it pilot in a geographic or demographic population first with intent to scale?* Integrated Behavioral Health programs are designed to work with all populations across settings (primary and specialty) and the coordination of care among these entities. Our workgroup (with assistance from practice coaches from Qualis is building a roadmap for transformation determined by formal written survey tools (i.e. MeHAF and PCMH-A) as well as a qualitative community level engagement process. These community engagement meetings will occur in-person across the Greater Columbia ACH regions to engage all 9 counties, identify gaps in care/payment, and understand next steps to improve local partnerships for behavioral integration across the care continuum, educational system, and community as a whole
EVIDENCE AND OUTCOMES	*What evidence is there to show the effectiveness of the proposed project? How does the project align with one or more approaches proposed in the toolkit? Which ones? Are there any real-world outcomes for this project locally?* Evidence indicates that registry-driven processes are essential to providing effective population health. Evidence also indicates increased morbidity and mortality when patients have comorbid mental and physical health concerns. Thus, Greater Columbia ACH has chosen to utilize Bidirectional approaches to integration including the Bree Collaborative, Collaborative Care, and Behavioral Health Home approach. This strategy will allow GCACH to provide a "no wrong door approach" and allow for access to appropriate care wherever the patient seeks help. Also, local providers are utilizing integration models going

HEALTH EQUITY	*How might this project approach address health disparities, where they exist due to ethnicity, gender, race, language, sexual orientation, etc.?* Behavioral health and substance use disorders are disproportionally linked to individuals with low income or who identify as an ethnic minority group, or who are gender-based minorities (e.g. women, LGBTQ, etc). The project is aimed at providing access to behavioral health care in all settings where social and ethnic minorities receive care. These settings include primary care, specialty mental health care, substance use treatment centers, and jails/legal system. Given that ethnic, class, and gender minorities are at greater risk for health risks, it helps to address these concerns via an upstream and downstream approach (across all health care and community settings). What will be highly important in our process is to identify gaps among partners so that each entity is working towards the same end (i.e. reducing disparities) and coordinating care approaches to optimize success.
WORKFORCE REQUIREMENTS	*Will your project approach require any special workforce requirements not already in place, such as the addition of Community Health Workers? What might these requirements be?* Hire, promote, train, or contract for providers to meet the clinical gaps in your clinic(s) for behavioral health. Examples could include: psychologists, clinical care manager (LISW, RN, master's level mental health counselor), and psychiatric specialist (psychiatric ARNP or psychiatrist), and/or behavioral health providers.
GENERAL IMPLEMENT-ATION	*Without going into specific detail, how do you perceive that this project might be implemented differently depending upon the service area? How would a rural implementation differ from an urban one?* Care coordination will look different in rural areas based on limited resources and differences in EHR functionality, which will be further identified by the assessment our workgroup will perform with Qualis.
SCALABILITY	*How is the project scalable to other communities in the GCACH region?* This will determine the assessment we are doing and will be unique to the sub-communities in GCACH, as well as identifying opportunities to leverage existing funding and identify funding gaps which will allow for building a sustainable infrastructure that can be generalized across GCACH.
PAIN POINTS	*A pain point is a problem, real or perceived. Broadly, what pain points do you foresee with the implementation of this project? What are some ways to resolve these pain points?* The ability to successfully monitor and collect data required to show VBP outcomes since the organizations operate on different EHR systems.
ALTERNATIVE PROJECT APPROACHES	*Please list the <u>major</u> alternative project approaches you considered in your work but rejected. BRIEFLY, why were the alternate projects considered but rejected?* We decided on all four models listed in the MDT, so this was not an issue for us.

DATA ANALYSIS AND ROOT CAUSES:
DATA ANALYSIS *Please briefly summarize the team's analysis of data relating to this Project Category. This may include your analysis of population health data (e.g. obesity), social well-being data (e.g. poverty), and healthcare utilization data (e.g. ED Visits) provided by the GCACH and other data sources. What did the data identify as being areas of concern?* Our group is in the process of creating a roadmap that will informed by the MeHAF and qualitative interviews at the county level, ED utilization data, and mental health/substance abuse services access data to determine health disparities and opportunities for intervention across the GCACH.
ROOT CAUSE ANALYSIS *Based upon the data analysis above, what might be some of the underlying root causes to these findings? For example, local obesity might be attributed to cultural issues, living in a "food desert", a lack of exercise opportunities, etc.* This is pending based on data collection and evaluation.

ADDRESSING ROOT CAUSES *How does your proposed project approach attempt to address the identified underlying root causes from above?*
Pending

LINKAGES AND ALIGNMENT:

ALIGNMENT *How is the project aligned with the GCACH Regional Survey results, Regional Health Improvement Plan, Community Asset Inventory, and the goals of the Medicaid Demonstration Project?*

The surveys identified gaps in care as well as opportunities for behavioral health need in primary and specialty clinics, and our project supports the overarching goal of cost savings and system integration as defined by the MDT.

LINKAGES *How does your project offer the opportunity for collaborating with other Demonstration Waiver project areas? With which other project areas? How might this look like?*

We link with Chronic Disease Prevention, Opioid Use, Care Coordination and Diversion.

CLINICAL-COMMUNITY LINKAGES *The goals of clinical-community linkages include: Coordinating health care delivery, public health, and community-based activities to promote healthy behavior, forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services. How does this project approach foster clinical-community linkages?*

Through our qualitative interviews, areas for community linkages will be organically derived and used in the roadmap to prioritize next steps.

PATHWAYS COMMUNITY HUB (OPTIONAL) *The GCACH may adopt the Pathways Community HUB model as part of its work toward creating community care coordination. How might this project align with the HUB model? Which Pathways in the HUB might you work be affected by?*

For more information on the Pathways Community HUB, please see:
https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf

OUTCOMES AND IMPACT:

TOOLKIT METRICS *Which Toolkit metrics in your project area will this project approach positively impact (e.g. ED visits)? How will this likely take place? What measures will you be monitoring to assess outcomes?*

Considering all the measures listed in the toolkit that we will be reporting on, our workgroup chose to specifically focus on: Follow-up after discharge from ED for mental health; Follow-up after hospitalization for mental illness; Mental health treatment penetration (broad); Mental health treatment penetration (children); and Substance Use disorder treatment penetration (adults).

IMPACT *Of all the potential project approaches you reviewed, why would this approach achieve the greatest positive impact for the potential financial investment made?*

The impact of this project is measured by the extensive framework that it will establish between community agencies and achievement of the FIMC metrics as defined by the VBP contracts. Our healthcare system requires a wider net to reach individuals where they seek treatment, and this project aims to provide that net. The integration of information among healthcare providers and the ability to proactively assist and guide patients through the system reduces and eliminates a number of inefficiencies and mistakes that add to the growing cost of health care.

SUSTAINABILITY & ROI *Please describe how this project will be sustainable after DSRIP funding ends and what is a likely positive return-on-investment (and to whom) within three to five years. This can be stated in terms of a potential downward effect on healthcare utilization for Medicaid clients.*

Recent legislation efforts, such as SB5779, reduce administrative barriers for this type of work as well as develops a billing matrix that develops a billing guide, which will help provide financial stability and ensure the project is sustainable. As VBP payments become more actualized, sustainability will move away from FFS and more towards value based methodology.

SOCIAL DETERMINANTS OF HEALTH *How might this project approach have a long-term positive impact on the social determinants of health (e.g. housing, employment, incarceration, etc.)?*

We plan to use the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) as well as optimize data already collected at the clinic and regional level to identify and address social determinants of health.

COMMENTS:

What additional comments would you like to state regarding your project?

PROJECT 2B: COMMUNITY-BASED CARE COORDINATION

Please complete the template sections below. You may expand a box as needed to accommodate your text. If you are unable to answer a particular section, please move to the next section and continue.

PROJECT DESCRIPTION:

PROJECT TITLE
Community Based Care Coordination – Pathways Community Hub

PROJECT FACILITATOR
Jorge Rivera – Molina Healthcare of Washington (JorgeArturo.Rivera@MolinaHealthCare.Com)

PROJECT TEAM

Jac Davies, Jannette Weber, Nicole Austin, Susan Campbell, Kirk Williamson, Deb Gauck, Bill Hinkle, Kevin Martin, John Raymund, Julie Petersen, Tim Cooper, Amanda Hinrichs, Elizabeth Garrett, Susann Bassham, Scott Adams, Shawnie Haas, Sandra Aguilar, Diane Liebe, Tracie Hoppis, Cindy Carroll, Michelle Sullivan, Corrie Blythe, Victoria Keetay, Sarah Dorn, Siobhan Brown, Kayla Down, Caitlin Safford

CONTRIBUTING ORGANIZATIONS AND TRIBES *Please list all the organizations in the nine-county GCACH region that will participate in developing the eventual project application and implementing the project.*

Molina Healthcare, NW Rural Health Network, Tri Cities Chaplaincy, Benton Franklin Medical Society, Columbia Basin College, Benton Franklin Health Alliance, Hope Source, Kittitas Valley Healthcare, Prosser Memorial Hospital, Virginia Mason Memorial Hospital, The Children's Village, Pullman Regional Hospital, Signal Health, Catholic Charities of Yakima, Walla Walla Department of Community Health, South Eastern Washington Agency for Aging and Long Term Care, Yakima Neighborhood Health Centers, Pacific Northwest University, Community Health Plan, United Healthcare, Amerigroup, Coordinated Care

COUNTIES SERVED BY THIS PROJECT ☒ Asotin ☒ Benton ☒ Columbia ☒ Franklin ☒ Garfield ☒ Kittitas ☒ Walla Walla ☒ Whitman ☒ Yakima ☒ Yakama Nation ☐ Other _____

TRIBES SERVED BY THIS PROJECT (if applicable)

Yakama Nation

THIS PROJECT IS (check one): ☒ **New** ☐ **Enhancing an existing project or set of projects**

THIS PROJECT SERVES MEDICAID CLIENTS ONLY (check one): ☒ **Yes** ☐ **No**
If you checked "No", what percentage of clients served are Medicaid?

This project will primarily serve Medicaid members

THIS PROJECT DOES NOT CURRENTLY RECEIVE OTHER MEDICAID FUNDING FOR THE SAME SERVICES (check one):
☒ **Yes** ☐ **No**
If you checked "No", please describe what other Medicaid funding this project approach is currently receiving and what other Medicaid contracts might be involved.

PROJECT CATEGORY Please indicate which optional category area from the toolkit your project will meet. If more than one area applies, please check the primary area:

- ☐ Bi-directional Integration of Care
- ☒ Community-Based Care Coordination
- ☐ Transitional Care

☐ Diversion Intervention ☐ Addressing the Opioid Use ☐ Maternal and Child Health ☐ Access to Oral Health ☐ Chronic Disease Prevention and Control	
PROJECT GOAL STATEMENT	*What do you hope to achieve with this project? What issue are you addressing? What problem are you trying to resolve?* Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs, or at risk of becoming complex needs members, are connected to the interventions and services needed to improve and manage their health Project aims to reduce duplication of care coordination efforts, increase effectiveness of referrals and ultimately improve health outcomes
BRIEF PROJECT DESCRIPTION	*Provide a description of the project. What are the strengths and weaknesses of this particular project approach?* The Pathways Community HUB model is a strategy to identify and address risk factors at the level of the individual, but can also impact population health through data collected. As individuals are identified, they receive a comprehensive risk assessment and each risk factor is translated into a Pathway. Pathways are tracked to completion, and this comprehensive approach and heightened level of accountability leads to improved outcomes and reduced costs
PROJECT SCOPE AND TARGET POPULATIONS	*Please describe what part of the regional GCACH community the project will serve, including which counties, target populations, health systems, providers, service organizations and other. Will it pilot in a geographic or demographic population first with intent to scale?* The team will select final target populations after a complete analysis of the following: - Prevalence of poor outcomes across the region - Lack of current alternative approaches addressing a particular target population - Ability to connect the services with Payors willing to engage with the hub services - Priority of a few target populations as a focus of a Phase I implementation; other populations could be added in following phases Candidate populations at risk, at this point, are - High utilizers of ED services with high needs, with a PRISM score of 1.5 or higher - High utilizers of ED services with moderate needs, and at risk of become high needs; PRISM score of 1.0 to 1.5 - High utilizers of ED services with identified needs in Behavioral Health and Chemical Dependency - Maternal a Child Populations with specific risks - Populations impacted by Chronic Disease with high incidence in the region
EVIDENCE AND OUTCOMES	*What evidence is there to show the effectiveness of the proposed project? How does the project align with one or more approaches proposed in the toolkit? Which ones? Are there any real-world outcomes for this project locally?* Extensive evidence across the country on the effectiveness of the model, particularly with populations at risk of low birth weight; Pathways Hub approach to standardization of intake processes, communication and coding of care coordination of services, and direct integration of social services, provides the platform for more effective coordination of care provided to different segments of Medicaid population
HEALTH EQUITY	*How might this project approach address health disparities, where they exist due to ethnicity, gender, race, language, sexual orientation, etc.?* Pathways Community Hub focuses on populations at risk by directly connecting clinical and social services through coordinated and standardized pathways; this allows for a coordinated interaction of social services providers, who are very connected to populations suffering health disparities, with clinical providers who have the expertise to provide medical interventions

	This approach, effectively implemented through the engagement of community organizations specifically serving communities experiencing health disparities, and by breaking the rather siloed approach in existence between clinical and social services, has the potential to effectively eliminate many of these disparities, as experts in providing health interventions will be connected to members, by the work of community organizations that are trusted by members, and regularly engage with them
WORKFORCE REQUIREMENTS	*Will your project approach require any special workforce requirements not already in place, such as the addition of Community Health Workers? What might these requirements be?* Project is likely to use extensive workforce of Community Health Workers, which are in existence in most sub regions of the ACH, but currently lacking a coordinated approach to training, certification and deployment to priority target populations; this will allow for geographically focused and culturally competent outreach of members requiring coordination of their health and also of social services provided for them, and it will also allow for coordination of services to whole families and not only to specific individuals within a family, reducing duplication of resources and overall cost The Pathways Hub will also require participation of the traditional clinical workforce, and of community navigators and specialists that will provide connection to social services
GENERAL IMPLEMENT-ATION	*Without going into specific detail, how do you perceive that this project might be implemented differently depending upon the service area? How would a rural implementation differ from an urban one?* The Pathways Hub will be implemented through a main coordination entity, the Hub, and several Community Care Coordination and Clinical Care Coordination Agencies that are local to specific sub-regions, and have detailed knowledge and understanding of specifics about different population needs in those regions GCACH plans to implement a single hub for the ten county region, and to contract with care coordination agencies in all communities; this way specific pathways will be implemented in different regions with focus in each region's particular needs The project team will study the possibility to implement different pathways first in different regions, depending on the specific priority needs of each region
SCALABILITY	*How is the project scalable to other communities in the GCACH region?* The pathways hub will be implemented first for a small set, one or two, target populations, and pathways to care coordination will be enabled as contracting with care coordination agencies happens; as the model becomes successful and stable, more target populations are going to be added; the team will study the possibility to phase in implementation of specific pathways as capacity allows for it
PAIN POINTS	*A pain point is a problem, real or perceived. Broadly, what pain points do you foresee with the implementation of this project? What are some ways to resolve these pain points?* - Agreeing on the approach to selecting an agency as the hub - Agreeing on the approach to select priority populations at risk, if this should be done by sub-region or for the entire service area of the ACH - Determining long term funding mechanisms for "less traditional", non-clinical pathways - Interoperability, ability to capture and process the right information without creating additional labor for providers of the services A process that is inclusive to team's input, but that also leads to clearly defined decision making points, should be created to address these pain points For interoperability, there needs to be a clear analysis of interfaces and technology aids available to integrate the hub's intake systems with provider's EHR and other operational systems

ALTERNATIVE PROJECT APPROACHES	*Please list the major alternative project approaches you considered in your work but rejected. BRIEFLY, why were the alternate projects considered but rejected?* Pathways Hub was the only approach preselected for the MDP Toolkit in Community Based Care Coordination

DATA ANALYSIS AND ROOT CAUSES:

DATA ANALYSIS *Please briefly summarize the team's analysis of data relating to this Project Category. This may include your analysis of population health data (e.g. obesity), social well-being data (e.g. poverty), and healthcare utilization data (e.g. ED Visits) provided by the GCACH and other data sources. What did the data identify as being areas of concern?*

The team has reviewed GCACH's Community Assets Inventory and all available aggregated metrics from the Regional Health Needs Inventory, County Ranking from RHJ Foundation, Health Needs Inventory and Healthier Washington Dashboard

The team is yet to complete a detailed analysis of these data for specific populations candidates to be addressed first in the implementation of the hub; this is the next expected step

ROOT CAUSE ANALYSIS *Based upon the data analysis above, what might be some of the underlying root causes to these findings? For example, local obesity might be attributed to cultural issues, living in a "food desert", a lack of exercise opportunities, etc.*

The team has not yet completed a root cause analysis of data; this should happen in the upcoming weeks, and will be focused in preselected populations at risk

ADDRESSING ROOT CAUSES *How does your proposed project approach attempt to address the identified underlying root causes from above?*

N/A at this point

LINKAGES AND ALIGNMENT:

ALIGNMENT *How is the project aligned with the GCACH Regional Survey results, Regional Health Improvement Plan, Community Asset Inventory, and the goals of the Medicaid Demonstration Project?*

All of the prior work listed above identified care coordination efforts happening across the region, and provided details on partner organizations, their challenges and their opportunities; in alignment with this work, the implementation team will reach out to all agencies currently providing these services, both, in the clinical and in the social services side, and will invite them to become CCAs, Care Coordination Agencies, contracted with the Pathways Hub, to achieve a better coordinated delivery of services

LINKAGES *How does your project offer the opportunity for collaborating with other Demonstration Waiver project areas? With which other project areas? How might this look like?*

Most health improvement initiatives being explored as Demonstration Waiver projects, do incorporate some level of care coordination, and in consequence have a level of possible synergy with the implementation of the Pathways Hub

The goal is to connect with all of these initiatives to:

- Identify specific services planned to be delivered in each project, that would require a level of care coordination
- Map them, when applicable, to one of the pathways to be implemented under the hub
- Discuss touch points and specifics for referrals, data sharing, payment

In the end, the idea is to integrate naturally connecting initiatives in a single portfolio, where care coordination for members can be managed by the hub, when and where it makes sense, to improve the actual outcome and reduce the overall cost

CLINICAL-COMMUNITY LINKAGES *The goals of clinical-community linkages include: Coordinating health care delivery, public health, and community-based activities to promote healthy behavior, forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services. How does this project approach foster clinical-community linkages?*

All clinical providers would be part of the Pathways Hub as partners organizations, allowing for data sharing of information as members are seeing by different entities, allowing also for warm handoff of members from and to more social pathways, and for the provision of services to entire families through the connections facilitated by Community Health Workers

PATHWAYS COMMUNITY HUB (OPTIONAL) *The GCACH may adopt the Pathways Community HUB model as part of its work toward creating community care coordination. How might this project align with the HUB model? Which Pathways in the HUB might you work be affected by?*

This project will look to implement 20 pathways in all regions at some point; the path to implementing this pathways, though, will follow an analysis on priority populations at risk in each region, and priority based on opportunity for improvement in specific outcomes, based on care coordination work

For more information on the Pathways Community HUB, please see: https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf

OUTCOMES AND IMPACT:

TOOLKIT METRICS *Which Toolkit metrics in your project area will this project approach positively impact (e.g. ED visits)? How will this likely take place? What measures will you be monitoring to assess outcomes?*

This project aims to impact all metrics considered in the Waiver Toolkit as described in the June 2017 draft, which include state reported and ACH reported metrics, P4P and P4R

IMPACT *Of all the potential project approaches you reviewed, why would this approach achieve the greatest positive impact for the potential financial investment made?*

This team only reviewed the Pathways Hub approach, and agrees that, evidence provided of its success, and the fact that it addresses some of the issues with existing systems for care coordination, make this approach a potentially transformational health improvement demonstration project

SUSTAINABILITY & ROI *Please describe how this project will be sustainable after DSRIP funding ends and what is a likely positive return-on-investment (and to whom) within three to five years. This can be stated in terms of a potential downward effect on healthcare utilization for Medicaid clients.*

After initial funding ends, this project would have three main potential funding streams:

- Medicaid Benefits covered by MCOs in their regular practice of contracting for care coordination; MCOs should cover some (not all of) services provided through Pathways Hub from initial stages

- Services, mainly social and training services, that turned into covered services as they proved their benefit in contributing to achieving expected outcomes; HCA could turn some social services to covered services in a similar way as it is being done under Healthier Washington Initiative 3
- Alternative funding stream through community service grants and others facilitated by community organizations that have become part of the pathways hub service network

On the clinical side these payments will be justified by the ROI driven by actual outcomes reducing the cost of unnecessary ED visit, readmissions, and other improvements to the system

SOCIAL DETERMINANTS OF HEALTH *How might this project approach have a long-term positive impact on the social determinants of health (e.g. housing, employment, incarceration, etc.)?*

A successful implementation of the Pathways Hub will directly connect social services to clinic services in a way that makes both more effective and that engages their shared population in continuum of health and other live conditions improvement; the direct connection between traditionally disconnected agencies will have a major impact in the overall benefit of the members

COMMENTS:

What additional comments would you like to state regarding your project?

This is a work in progress with many decisions still to be made and significant data analysis pending to determine initial target populations; work needs to happen with other project teams, to align vision to pathways and populations, before a final project implementation plan can be finished

PROJECT 2C: TRANSITIONAL CARE

Please complete the template sections below. You may expand a box as needed to accommodate your text. If you are unable to answer a particular section, please move to the next section and continue.

PROJECT DESCRIPTION:

PROJECT TITLE

InterDiscipline/InterAgency Life Support at Transitions (IDIALIST)

PROJECT FACILITATOR

Kevin Martin (kbmartin@kvhealthcare.org), Mandy McCollum (Mandy@consistentcare.org)

PROJECT TEAM

Barbara Edwards, Ben Shearer, Brisa Guajardo, Caitlin Safford, Corrie Blythe, Elissa Southward, Grant Baynes, Hollie Kaiser, Jac Davies, Jay Henry, Jordan Byers, Kat Latet, Kayla Down, Kim Keltch, Madelyn Carlson, Mandee Olsen, Martin Valadez, Matt Davy, Mike Bonetto, Sandra Suarez, Sarah Bollig Dorn, Shawnie Haas, Sierra Knutson, Suzy Diaz, Virginia Janin, Kevin Walsh

CONTRIBUTING ORGANIZATIONS AND TRIBES *Please list all the organizations in the nine-county GCACH region that will participate in developing the eventual project application and implementing the project. If there is a lead organization, please identify that organization.*

Implementation and spread will of necessity involve all hospitals in the region, region SNFs/LTCs/ALFs, select first responders that have community paramedicine (including KVFR Districts 1 & 2 Prosser, and Whitman), ALTC-SE WA, Community Health of Central Washington, Consistent Care, DSHS (Health Homes), home health agencies, Hopesource. There will also need to be integration with primary care, such as Community Health of Central Washington, KVH, Yakama Indian Health, Yakima Valley Farm Workers, and so on, many of which already contribute to such networks. Many these will participate through existing networks in their communities.

COUNTIES SERVED BY THIS PROJECT ☒ Asotin ☒ Benton ☒ Columbia ☒ Franklin ☒ Garfield ☒ Kittitas ☒ Walla Walla ☒ Whitman ☒ Yakima ☒ Yakama Nation ☐ Other _____

TRIBES SERVED BY THIS PROJECT (if applicable)

Yakama Nation

THIS PROJECT IS (check one): ☐ **New** ☒ **Enhancing an existing project or set of projects**

THIS PROJECT SERVES MEDICAID CLIENTS ONLY (check one): ☐ **Yes** ☒ **No**

If you checked "No", what percentage of clients served are Medicaid?

Greater than 95% estimated

THIS PROJECT DOES NOT CURRENTLY RECEIVE OTHER MEDICAID FUNDING FOR THE SAME SERVICES (check one):

☐ **Yes** ☒ **No**

If you checked "No", please describe what other Medicaid funding this project approach is currently receiving and what other Medicaid contracts might be involved.

Health Homes operate under DSHS, but do not receive funds for serving the population we suggest. ALTC is HCA funded but this Project calls for work outside their current scope.

PROJECT CATEGORY Please indicate which optional category area from the toolkit your project will meet. If more than one area applies, please check the primary area:

- ☐ Bi-directional Integration of Care
- ☐ Community-Based Care Coordination
- ☒ Transitional Care
- ☐ Diversion Intervention

☐ Addressing the Opioid Use ☐ Maternal and Child Health ☐ Access to Oral Health ☐ Chronic Disease Prevention and Control	
PROJECT GOAL STATEMENT	*What do you hope to achieve with this project? What issue are you addressing? What problem are you trying to resolve?* **Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.**
BRIEF PROJECT DESCRIPTION	*Provide a description of the project. What are the strengths and weaknesses of this particular project approach?* **Transitions are high-risk events because care crosses a boundary which can silo information and be a barrier to communication. We understand that different communities have different needs and resources and therefore will need to implement different but aligned evidence-based approaches. The project will improve support for at-risk enrollees at care transitions by strengthening and broadening existing person/family-centered interdisciplinary/interagency (ID/IA) collaborative initiatives across the region and implementing proven tools to support management of acute changes in condition without transport to hospital. These include person/family-centered assessment and service (eg-ConsistentCare), collaborative community paramedicine efforts, and the INTERACT tool sets. Further, there may be benefit to expanding the scope of Health Homes by extending eligibility to enrollees at high risk for readmission as identified by tools such as BOOST. This has the advantage of building on existing relationships and networks. These efforts do not have uniform penetration across the ACH and would have to be spread, which will require time, resources, and in some areas institution of novel systems or networks. We further note the nascent state-wide efforts by WSMA and WSHA to increase advance care plans (ACP) through Honoring Choices PNW (www.honoringchoicespnw.org) and note the possibility for synergy without needing to be explicitly included in this project.**
PROJECT SCOPE AND TARGET POPULATIONS	*Please describe what part of the regional GCACH community the project will serve, including which counties, target populations, health systems, providers, service organizations and other. Will it pilot in a geographic or demographic population first with intent to scale?* **Our target population is Medicaid enrollees discharging from hospital to home, a home health agency, a skilled nursing facility or other domiciliary and those transitioning from those settings to a less intensive level of care. The assets we identified in the CAI exist to some extent across the region except within the Yakama Nation. The project will include exploring broader inclusion criteria for Health Homes, strengthening collaborative community paramedicine initiatives, and programs with in-home care management. Additionally, we will support region-wide implementation of the INTERACT tool sets. This latter is under way in the Tri-Cities area, and would probably be best implemented on a county-by-county basis using a learning collaborative model (eg-http://www.qualishealth.org/sites/default/files/Pierce-Co-Medicaid-NH-Collab-0415.pdf).**
EVIDENCE AND OUTCOMES	*What evidence is there to show the effectiveness of the proposed project? How does the project align with one or more approaches proposed in the toolkit? Which ones? Are there any real-world outcomes for this project locally?* **1) Nurse-based care management showed a reduction in ED visits and readmissions in a study of Consistent Care's RAP program.** **2) Health Homes have been successful statewide in addressing appropriate utilization.** **3) Community paramedicine is called out in Project 2D as an evidence-based strategy to reduce inappropriate ED utilization. The same rationale applies to inappropriate readmission, a process that runs through ED. There is every reason to believe this is stronger when combined with strong ID/IA networks. Similarly, the use of CHW has been successful, and would strengthen this effort.**

	4) The INTERACT tool sets have been widely studied as a practice to maximize the care received in settings such as SNF, LTC, ALF, and home health; reduce transport to ED; and improve communications when transport is necessary. **5) Appropriate advance care plans (ACP) have been shown to reduce readmission and are included in the INTERACT tool sets, called out in the toolkit as an evidence-based intervention. Honoring Choices PNW is an evidence-based approach to increasing population with ACP in place across communities.**
HEALTH EQUITY	*How might this project approach address health disparities, where they exist due to ethnicity, gender, race, language, sexual orientation, etc.?* **We know that those at highest risk for readmission are those impacted by social determinants of health. Therefore, those disadvantaged by such disparities will appropriately receive greater service and support. Because this project is limited to transitions, a short-term event or process, we are unlikely to impact larger social determinants of health in the near-term, but may see reduction of disparities in outcomes over time.**
WORKFORCE REQUIREMENTS	*Will your project approach require any special workforce requirements not already in place, such as the addition of Community Health Workers? What might these requirements be?* **The existing set of projects we plan to support have differing staffing and funding models. The potential for mutual learning is impressive. The workforce implications include:** **1) Depending on area, augmenting or implementing use of field-based RN care coordinators, community paramedics, and CHW.** **2) Augmentation of existing staffing regardless to support a broader population, eg- expanding Health Homes eligibility or increased use of collaborative community paramedicine to extend reach and penetration.** **3) WSU nursing and social work students, CWU community paramedicine students, and other trainees across the ACH may be used to augment existing work force.**
GENERAL IMPLEMENT-ATION	*Without going into specific detail, how do you perceive that this project might be implemented differently depending upon the service area? How would a rural implementation differ from an urban one?* **As noted, resources vary across GCACH. Rural implementation is challenged by access, distance, work force, and attitudes. In particular, the rural population may be skeptical of what is perceived as outside intervention, even when care is based in the county-seat. Health Homes and collaborative community paramedicine currently have a greater footprint in the smallest counties, and have developed local knowledge and trust there. Consistent Care has laid a solid foundation in the more populous areas of the ACH and that will facilitate implementation in those 4 counties.**
SCALABILITY	*How is the project scalable to other communities in the GCACH region?* **The basic players for a robust ID/IA approach exist in every county across the region. These include hospital systems, EMS, primary care, CAP, SNF, ALF, and so on. The opportunity is to develop ways to organize those existing resources, whether enhancing existing networks or helping implement new networks, into networks to reduce risk at transitions in both populous and rural communities. The programs we want to support can model, support, or even supply leadership to those efforts in areas where they are not as robust or are nonexistent.**
PAIN POINTS	*A pain point is a problem, real or perceived. Broadly, what pain points do you foresee with the implementation of this project? What are some ways to resolve* these *pain points?* **1) The people who choose to live miles from their nearest neighbor have different sensibilities and attitudes than those in larger population centers. They are more distrustful of outside interventions. It is important that they perceive GCACH as part of their community, not something imposed from outside. Close partnerships among local agencies and primary care are critical here.**

	2) In larger centers, sheer numbers at risk can overwhelm an inadequately staffed and supported model. Staffing and training in advance of need may ameliorate this to some extent, but we should expect growth pains. **3) It is crucial that we maintain a focus on the patient and the family. We must acknowledge that that is not a given for every agency that comes in contact with them. We need to insure that the project maintains this focus.** **4) We should acknowledge that this work is an outgrowth of the ACA, and may be perceived as a holdover from the previous administration and face resistance from some clients on that basis alone.** **5) Coordination of discharge processes between community workers and hospital discharge planners may be a learning curve.** **6) The broaden role we are considering for Health Homes may be beyond their legistlated charter, and that may have to be addressed.**
ALTERNATIVE PROJECT APPROACHES	*Please list the major alternative project approaches you considered in your work but rejected. BRIEFLY, why were the alternate projects considered but rejected?* **We considered other transition models, specifically those called out in the toolkit such as the Transitions Care Model. The other programs called for training providers in specific protocols. This is an expense, especially across our large region. The sense of the group was that there are innovative approaches with solid rationale in place, and that it made sense to build on those strengths and successes, especially where local efforts have resulted in success and community trust.**

DATA ANALYSIS AND ROOT CAUSES:

DATA ANALYSIS *Please briefly summarize the team's analysis of data relating to this Project Category. This may include your analysis of population health data (e.g. obesity), social well-being data (e.g. poverty), and healthcare utilization data (e.g. ED Visits) provided by the GCACH and other data sources. What did the data identify as being areas of concern?*

We discussed readmission rates across the matrix (fig. 1) of transitions (discharging from hospital, SNF, ALF, home health to SNF, ALF, home health, home) all of which are at-risk events, and interventions that had been shown to impact readmissions. Data we had was largely based on experience and knowledge of team members rather than GCACH/HCA data. We need better data across this matrix.

Transitions (fig. 1)		Discharge from			
		Hospital	SNF	ALF	HH
Discharge/readmit to	Hospital				
	SNF				
	ALF				
	HH				
	Home				

ROOT CAUSE ANALYSIS *Based upon the data analysis above, what might be some of the underlying root causes to these findings? For example, local obesity might be attributed to cultural issues, living in a "food desert", a lack of exercise opportunities, etc.*

1) **Lack of effective communication across transitions.**
2) **Lack of understanding of resources/challenges present in the home environment by the discharge team.**
3) **Lack of support and coordination in the post-discharge environment.**
4) **Inability or unwillingness to care for the patient in place in the face of a change of condition. This may be a result of fear of citation or liability, lack of resources, or long-standing practices which underutilize nursing assessments and treatments, especially in the skilled nursing and long term care settings.**

ADDRESSING ROOT CAUSES *How does your proposed project approach attempt to address the identified underlying root causes from above?*

1) **ID/IA collaboration breaks down silos and improves communication.**
2) **In-home assessment and coordination increases understanding of those challenges and creates the opportunity for problem solving.**
3) **Tools such as INTERACT for SNF/LTC, ALF, and HH support clinical decision making and care-in-place, and facilitate communication if transfer is appropriate.**

LINKAGES AND ALIGNMENT:

ALIGNMENT *How is the project aligned with the GCACH Regional Survey results, Regional Health Improvement Plan, Community Asset Inventory, and the goals of the Medicaid Demonstration Project?*

Our project is based on assets listed in the CAI as called out in the GCACH Regional Survey. Our goals are specifically those of the Medicaid Demonstration Project. We feel that our communities have shown early successes in impacting care at transitions, and believe that what would functionally be a huge collaborative approach would result in better care across GCACH.

LINKAGES *How does your project offer the opportunity for collaborating with other Demonstration Waiver project areas? With which other project areas? How might this look like?*

The Pathways Community HUB model offers some tools for our work, as well as a potential funding mechanism. This is called out as an evidence-based intervention for Project 2B. As noted, readmissions usually start in the Emergency Department, and the approaches we have considered would, if generalized to broader populations, also increase the impact of Project 2D. Conversely, our work will impact Project 2D metrics as well.

CLINICAL-COMMUNITY LINKAGES *The goals of clinical-community linkages include: Coordinating health care delivery, public health, and community-based activities to promote healthy behavior, forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services. How does this project approach foster clinical-community linkages?*

The backbone of the work we are calling for is rooted in community networks providing improved communication. The collaborative community paramedicine work in Kittitas crosses every sector in the county. Consistent Care is based on a model with in home care and collaboration across the community. Health Homes are also person/family centric models focused on aligning resources. The INTERACT program cannot function absent cooperative relations between hospitals and lower-acuity settings. It is important that this work be integrated with the client's primary care providers. We anticipate existing and novel community networks will take the lead in implementing approaches in their communities.

PATHWAYS COMMUNITY HUB (OPTIONAL) *The GCACH may adopt the Pathways Community HUB model as part of its work toward creating community care coordination. How might this project align with the HUB model? Which Pathways in the HUB might you work be affected by?*

We see the PCH as a useful way of aligning our work across the Domain 2 projects. Of particular relevance to our project may be

1) **Adult Education Pathway**
2) **Behavioral Health Pathway**
3) **Housing Pathway**
4) **Medical Home Pathway**
5) **Medical Referral Pathway**
6) **Medication Assessment Chart**
7) **Medication Assessment Pathway**
8) **Medication Management Pathway**
9) **Social Service Pathway**

For more information on the Pathways Community HUB, please see:
https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf

OUTCOMES AND IMPACT:
TOOLKIT METRICS *Which Toolkit metrics in your project area will this project approach positively impact (e.g. ED visits)? How will this likely take place? What measures will you be monitoring to assess outcomes?* **The crucial metrics are Potentially Avoidable ED Visits for the target population and Plan All-Cause Readmission Rate.**
IMPACT *Of all the potential project approaches you reviewed, why would this approach achieve the greatest positive impact for the potential financial investment made?* **We have identified extant resources on which to build, reducing up-front cost. By supporting a set of existing efforts, we are flattening the start-up expenses. We are reducing the need for individuals to be trained across the area in branded programs. We are leveraging local strengths for regional benefit.**
SUSTAINABILITY & ROI *Please describe how this project will be sustainable after DSRIP funding ends and what is a likely positive return-on-investment (and to whom) within three to five years. This can be stated in terms of a potential downward effect on healthcare utilization for Medicaid clients.* **ID/IA is low-hanging fruit. Conversely, its absence is one of the huge hidden expenses of modern health care. Before there is a readmission, there may be one or more EMS runs. These may or may not result in transport. There may be multiple ED visits. There may even be multiple readmissions.** **To the extent that one payor or system bears the burden of those costs, successful efforts to anticipate and prevent these events will result in significant ROI. To the extent that payors are willing to fund those efforts and realize the ROI, it will be sustainable.**
SOCIAL DETERMINANTS OF HEALTH *How might this project approach have a long-term positive impact on the social determinants of health (e.g. housing, employment, incarceration, etc.)?* **The interventions proposed are short-term. Much of the work done by the programs we want to support directly addresses housing and housing safety. We identified PCH pathways which impact risk at transitions as supportive of our goals.**

COMMENTS:
What additional comments would you like to state regarding your project? **The project we envision is an effort to collaboratively and cooperatively build and strengthen a number of programs within the ACH which have demonstrated success and garnered some amount of community and partner support. They are based in precisely the relationships needed to support care in place and increase the safety in care at transitions.**

Project 2D: Diversion Interventions

Please complete the template sections below. You may expand a box as needed to accommodate your text. If you are unable to answer a particular section, please move to the next section and continue.

PROJECT DESCRIPTION:

PROJECT TITLE:
ED Diversion Regional Referral Center

PROJECT FACILITATORS:
Karla Greene and Stein Karspeck

CONTRIBUTING ORGANIZATIONS AND TRIBES *Please list all the organizations in the nine-county GCACH region that will participate in developing the eventual project application and implementing the project.*

Consistent Cares, Fire/EMS, Hospitals, Urgent Care, PCP's, Behavioral Health, MCO's, Social Services

COUNTIES SERVED BY THIS PROJECT ☒ Asotin ☒ Benton ☐ Columbia ☒ Franklin ☒ Garfield ☒ Kittitas ☒ Walla Walla ☒ Whitman ☒ Yakima ☐ Yakama Nation ☐ Other _____

TRIBES SERVED BY THIS PROJECT (if applicable)

THIS PROJECT IS (check one): ☐ **New** ☒ **Enhancing an existing project or set of projects**

THIS PROJECT SERVES MEDICAID CLIENTS ONLY (check one): ☐ **Yes** ☒ **No**
If you checked "No", what percentage of clients served are Medicaid?

75-85%

THIS PROJECT DOES NOT CURRENTLY RECEIVE OTHER MEDICAID FUNDING FOR THE SAME SERVICES (check one):
☒ **Yes** ☐ **No**
If you checked "No", please describe what other Medicaid funding this project approach is currently receiving and what other Medicaid contracts might be involved.

PROJECT CATEGORY Please indicate which optional category area from the toolkit your project will meet. If more than one area applies, please check the primary area:

- ☐ Bi-directional Integration of Care
- ☐ Community-Based Care Coordination
- ☐ Transitional Care
- ☒ Diversion Intervention
- ☐ Addressing the Opioid Use
- ☐ Maternal and Child Health
- ☐ Access to Oral Health
- ☐ Chronic Disease Prevention and Control

BRIEF PROJECT DESCRIPTION	*Provide a description of the project. What are the strengths and weaknesses of this particular project approach?* Using CCS as a centralized referral center, this program would allow for the intake of referrals from ED's, EMS, Urgent Care, Behavioral Health, Substance Abuse, PCP's, as well as other community agencies. The referral center would assign the patient to the ED Super-user group or to the ED Low-Moderate User group. From there the patient could be referred to the medically intensive case management group if the patient had complex medical needs. The ED user groups usually have larger social determinant

	barriers to be addressed. All three groups use a team of RN Case Managers and community health workers (CHW) to provide medical care coordination and outreach that connects them with the appropriate services resulting in decreased ED visits. CHSs meet with patients in their homes, in shelters, in the ED, and on the streets to assist them in accessing the right care and addressing basic needs. For the Super-user group a care plan is placed in a statewide database called the Emergency Department Information Exchange (EDIE). Each time the patient presents to the Ed the EDIE system transmits the Ed care plan to the ED provider by fax or into the electronic medical record. Regular community meetings are held that engage all the hospitals and social services agencies to address the patient's needs. For the Low-Moderate User group patients will be contacted by the RN Case Manager and CHW to discover the causes for using the ED and then those causes will be addressed. Many of these users will benefit from education on local resources and linking them to the appropriate social services agencies. The Medically Intensive Case Management group will use a RN Case Manager and CHW to address the complex medical and social needs of these patients. Once their medical needs have been stabilized they will be referred back to one of the ED user groups for further management if necessary. Community Paramedicine would be used as another resource for providing care in the patient's home. They may go to a home with a CHW and/or RN Case Manager. This program offers the opportunity to integrate tele-medicine and other monitoring services that will enhance the services provided by CCS. The Hotspotters program will also be used to address difficult cases where the courts may be helpful. Another aspect of this program is the implementation of the Ride to Care program. This program is currently in use in Spokane County, and offers an alternative to an ambulance ride to the ED. The patient is triaged by EMS and if deemed appropriate they offer the patient the opportunity to take a van ride to an urgent care. Strengths: CCS already has a wide footprint in our ACH. By providing a full range of community resources that are managed under a single entity, efficiency, communication, and care coordination would be greatly enhanced. Weaknesses: Differences in resource availability and ability across the ACH. Would require engagement and active participation from the hospitals which would adversely affect their profits unless they are otherwise incentivized.
PROJECT GOAL STATEMENT	*What do you hope to achieve with this project? What issue are you addressing?* Reduce ED visits by connecting the patients with appropriate medical and social resources. Reduce preventable high cost emergency department use.

PROJECT SCOPE AND TARGET POPULATIONS	*Please describe what part of the regional GCACH community the project will serve, including which counties, target populations, health systems, providers, service organizations and other. Will it pilot in a geographic or demographic population first with intent to scale?* Initially the project would serve populations where CSS is already in place which includes Benton, Franklin, Yakima, Kittitas, and Walla Walla counties. The target population for the Low-Moderate user group would be clients with less than 10 ED visits within the last year. The target population for the Super-user group would be patients with 10 or more ED visits in the last year. The target population for the Medically Intensive Case Management are patients with complex medical and social needs that are at risk for hospitalization in addition to ED use. The project would pilot in rural areas utilizing an "a la carte" approach based on available resources, demographics, and geographically specific needs.
EVIDENCE AND OUTCOMES	*What evidence is there to show the effectiveness of the proposed project? How does the project align with one or more approaches proposed in the toolkit? Which ones? Are there any real-world outcomes for this project locally?* Evidence Supporting our project: This paper describes the reduction in ED visits and controlled substance prescribing from the Consistent Care Program based on a randomized controlled trial in the Tri-Cities. Neven, D., Paulozzi, L., Howell, D., McPherson, S., Murphy, S., Grohs, R., Marsh, L., Lederhos, C., & Roll, J. (2016). A randomized controlled trial of a citywide emergency department care coordination program to reduce prescription opioid related ED visits. *The Journal of Emergency Medicine, 51(5),* 498-50. DOI: http://dx.doi.org/10.1016/j.jemermed.2016.06.057 This paper describes the cost savings from implementing the Consistent Care Program based on a randomized controlled trial in the Tri-Cities. Sean M. Murphy, Donelle Howell, PhD, Sterling McPherson, PhD, Rebecca Grohs, RN, BSN, CCM, John Roll, PhD, Darin Neven, MS, MD (2017) "A Randomized Controlled Trial of a Citywide Emergency Department Care-Coordination Program to Reduce Prescription Opioid-Related Visits: An Economic Evaluation." Journal of Emergency Medicine, DOI: http://dx.doi.org/10.1016/j.jemermed.2017.02.014 This paper describes the cost savings to the hospital from the Consistent Care Program based on financial data from Sacred Heart Medical Center. Murphy, S. M. & Neven, D. (2014). Cost-effective: Emergency department care coordination with a regional hospital information system. *The Journal of Emergency Medicine, 47*(2), 223-231. DOI: http://dx.doi.org/10.1016/j.jemermed.2013.11.073 This paper describes the research supporting the effectiveness of case management for frequent ED users.

	Kumar, G.S. & Klein, R. (2013). Effectiveness of Case Management Strategies in Reducing Emergency Department Visits in Frequent User Patient Populations: A Systemic Review. *The Journal of Emergency Medicine, 44(3),* 717-729. <u>These two paper support the Ride to Care program.</u> Schaefer RA1, Rea TD, Plorde M, Peiguss K, Goldberg P, Murray JA. (2002). An Emergency Medical Services Program of Alternate Destination of Patient Care. *Prehosp Emerg Care*. Jul-Sept;6(3):309-14. Langabeer JR 2nd1, Gonzalez M2, Alqusairi D3, Champagne-Langabeer T4, Jackson A5, Mikhail J6, Persse D3. (2016). Telehealth-Enabled Emergency Medical Services Program Reduces Ambulance Transport to Urban Emergency Departments. *West J Emerg Med*. 2016 Nov;17(6):713-720. Epub 2016 Sep 6. This project also aligns with the "Non–Emergency Department (ED) Interventions to Reduce ED Utilization: A Systematic Review" from the toolkit by using patient education, care coordination, and partnering with managed care organizations.
HEALTH EQUITY	*How might this project approach address health disparities, where they exist due to ethnicity, gender, race, language, sexual orientation, etc.?* Outreach done by CHW's will address any health inequalities and barriers to an effective outcome.
WORKFORCE REQUIREMENTS	*Will your project approach require any special workforce requirements not already in place, such as the addition of Community Health Workers? What might these requirements be?* CCS would need to be scaled up to handle the added workload. Administrative staff would need to be supplemented. Ideally, one RN and one CHW would need to be added to CCS in each county with large populations. Community Paramedicine infrastructure is not currently in place with the exception of Prosser Memorial Hospital. Staffing and equipment would need to be added in all other places where community paramedicine would be an adjunct.
GENERAL IMPLEMENT-ATION	*Without going into specific detail, do you perceive that this project might be implemented differently depending upon the service area (e.g. rural versus urban)? Generally, what might be the differences?* In Tri-Cities, Yakima, and Walla Walla CCS already exists and in doing this work now. There are components that would need to be added but the infrastructure is in place. These areas would allow for the most effective initial implementation. The other areas of the GCACH would then be scaled to in accordance with hospital cooperation.

SCALABILITY	*Is the project scalable to other communities in the GCACH region?* This project can scale to all communities in the GCACH.
PAIN POINTS	*A pain point is a problem, real or perceived. Broadly, what pain points do you foresee with the implementation of this project?* Pain points are the same as our weaknesses: Differences in resource availability and ability across the ACH. Would require engagement and active participation from the hospitals which would adversely affect their profits unless they are otherwise incentivized.
ALTERNATIVE PROJECT APPROACHES	*Please list the major alternative project approaches you considered in your work but rejected. BRIEFLY, what are the major advantages and disadvantages of each? Why did you reject these over your preferred approach?* Stand-alone community paramedicine program: Does not address all aspects of the ED problem.

DATA ANALYSIS AND ROOT CAUSES:

DATA ANALYSIS *Please briefly summarize the team's analysis of data relating to this Project Category. This may include your analysis of population health data (e.g. obesity), social well-being data (e.g. poverty), and healthcare utilization data (e.g. ED Visits) provided by the GCACH and other data sources. What did the data identify as being areas of concern?*

Healthier Washington Dashboard, DSHS RDA (Medicaid Data)										
	Counties									
	Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Walla Walla	Whitman	Yakima	WA State
ED Visits per 1000 MM	124%	67%	51%	55%	72%	41%	65%	43%	72%	67%
ED Visits per MM, age 1-17	79%	53%	34%	48%	58%	31%	48%	31%	56%	52%
ED Visits per MM, age 18+	162%	84%	64%	69%	84%	50%	85%	52%	95%	86%
Potentially Avoidable ED Visits %	21%	18%	11%	21%	21%	16%	16%	16%	19%	19%
Potentially Avoidable ED Visits, age 1-17	31%	24%	n/a	25%	30%	22%	20%	24%	24%	24%
Potentially Avoidable ED Visits, age 18+	17%	15%	12%	16%	15%	13%	13%	13%	15%	15%

ROOT CAUSE ANALYSIS *Based upon the data analysis above, what might be some of the underlying root causes to these findings? For example, local obesity might be attributed to cultural issues, living in a "food desert", a lack of exercise opportunities, etc.*

Root causes are social determinants of health, lack of connection with community resources, substance use disorders, mental health disorders, etc.

ADDRESSING ROOT CAUSES *How does your proposed project approach attempt to address the identified underlying root causes from above?*

This project addresses these root causes by addressing social determinants of health in a focused manner, connecting patients with community resources, substance use disorder treatment, and mental health services.

LINKAGES AND ALIGNMENT:

ALIGNMENT *Is the project approach aligned with the GCACH Regional Survey results, Regional Health Improvement Plan, Community Asset Inventory, and the goals of the Medicaid Demonstration Project?*

This project is aligned with all four above documents.

LINKAGES *Does the project approach offer the opportunity for collaborating with other Toolkit project areas? With which other project areas? How might this look like?*

This project offers the opportunity to collaborate with opioid, transitions, and pathways hub.

CLINICAL-COMMUNITY LINKAGES *The goals of clinical-community linkages include: Coordinating health care delivery, public health, and community-based activities to promote healthy behavior. Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services. Does this project approach foster clinical-community linkages?*

This project fosters clinical-community linkages with coordinated health care delivery and public health. CCS already has strong partnerships and relationships in their current locations among clinical, community and public health organizations.

PATHWAYS COMMUNITY HUB *The GCACH may adopt the Pathways Community HUB model as part of its work toward creating community care coordination. How might this project align with the HUB model? Which Pathways in the HUB might you work be affected by?*

This project could be a spoke in the hub but it will also affect these areas of the pathways hub.
Adult education, employment, housing, medical home, medical referral, medication assessment, medication management, smoking cessation, social services referral, behavioral referral, developmental screening, developmental referral, education, family planning, immunization referral, immunization screening, pregnancy, postpartum.

For more information on the Pathways Community HUB, please see: https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf

OUTCOMES AND IMPACT:

TOOLKIT METRICS *Which Toolkit metrics in your project area will this project approach positively impact (e.g. ED visits)? How will this likely take place?*

Systemwide Metrics
Outpatient Emergency Department Visits per 1000 MM
Adult Access to Preventative/Ambulatory Care

Project-Level Metrics
To be determined

Other Metrics
Mental Health Treatment Penetration
Substance Use Disorder Treatment Penetration
Substance Use Disorder Treatment Penetration (opioid)
Follow up After Discharge from ED for Mental Health, Alcohol, or Other Drug Dependence
Non-fatal Overdose Involving Prescription Opioids

IMPACT *Of all the potential project approaches you reviewed, would this approach achieve the greatest positive impact for the potential financial investment made?*

Yes, this project achieves the greatest positive impact for the investment made.

ROI *Please describe how this project approach is likely to affect a positive return-on-investment within three to five years. This can be stated in terms of a potential downward effect on healthcare utilization for Medicaid clients.*

The super-user program in the tri-cities and Yakima has already shown a return on investment and a decrease in utilization from 40-60% across the board. Expanding this program across the GCACH and enhancing it by adding the additional services will have a positive ROI and decrease utilization.

SOCIAL DETERMINANTS OF HEALTH *How might this project approach have a long-term positive impact on the social determinants of health (e.g. housing, employment, incarceration, etc.)?*

This project addresses all social determinants of health by outreach in the home done by RN Case Managers and CHWs.

COMMENTS:

What additional comments would you like to state regarding your project?

PROJECT 3A: ADDRESSING THE OPIOID USE PUBLIC HEALTH CRISIS

Please complete the template sections below. You may expand a box as needed to accommodate your text. If you are unable to answer a particular section, please move to the next section and continue.

PROJECT DESCRIPTION:

PROJECT TITLE

Opioid Crisis Response Collaborative (OCRC)

PROJECT FACILITATOR

Becky Grohs, RN, BSN, CCM (becky@allianceconsistentcare.org)
Consistent Care Services

CONTRIBUTING ORGANIZATIONS AND TRIBES *Please list all the organizations in the nine-county GCACH region that will participate in developing the eventual project application and implementing the project.*

Comprehensive Healthcare, Walla Walla Health District, Benton-Franklin Health District, Blue Mountain Heart to Heart, Consistent Care Services, Kittitas Health District, Ideal Option, Yakima Neighborhood Health, Virginia Mason Memorial, Substance Abuse Coalition, Coordinated Care, United Healthcare, and Pacific Northwest University.

COUNTIES SERVED BY THIS PROJECT ☒ Asotin ☒ Benton ☒ Columbia ☒ Franklin ☒ Garfield ☒ Kittitas ☒ Walla Walla ☒ Whitman ☒ Yakima ☒ Yakama Nation ☐ Other _____

TRIBES SERVED BY THIS PROJECT (if applicable)

Yakama Nation, Confederate Tribes of Umatilla, Nez Perce Tribe

THIS PROJECT IS (check one): ☒ **New** ☐ **Enhancing an existing project or set of projects**

THIS PROJECT SERVES MEDICAID CLIENTS ONLY (check one): ☐ **Yes** ☒ **No**
If you checked "No", what percentage of clients served are Medicaid?

Estimated that 75-80% of the project population served are Medicaid clients.

THIS PROJECT DOES NOT CURRENTLY RECEIVE OTHER MEDICAID FUNDING FOR THE SAME SERVICES (check one):
☒ **Yes** ☐ **No**
If you checked "No", please describe what other Medicaid funding this project approach is currently receiving and what other Medicaid contracts might be involved.

PROJECT CATEGORY Please indicate which optional category area from the toolkit your project will meet. If more than one area applies, please check the primary area:

- ☐ Bi-directional Integration of Care
- ☐ Community-Based Care Coordination
- ☐ Transitional Care
- ☐ Diversion Intervention
- ☒ Addressing the Opioid Use
- ☐ Maternal and Child Health
- ☐ Access to Oral Health
- ☐ Chronic Disease Prevention and Control

BRIEF PROJECT DESCRIPTION	*Provide a description of the project. What are the strengths and weaknesses of this particular project approach?* This project seeks to use a harm reduction model to comprehensively assist patients with an opioid use disorder. The focus is on a bridge to recovery where barriers to effective medication assisted therapy (MAT) are addressed. In the harm reduction model patients are managed regardless of their readiness to obtain treatment for their opioid use disorder. There are multiple components to this project including case management, outreach by community health workers, promoting the use of and building the availability of needle exchange programs, MAT, and access to naloxone. Strengths: Our approach is evidence based on multiple levels. The following links give more information on the harm reduction model. http://harmreduction.org http://harmreduction.org/wp-content/uploads/2012/11/pdse-toolkit-with-links.pdf http://harmreduction.org/our-work/training-capacity-build/contract-trainings/ See evidence and outcomes section for more information. Weaknesses: Defining the deliverables across multiple agencies, communication collaboration (HIPAA), political opposition to harm reduction approach, long-term sustainability, workforce development, and geographical distance that needs to be bridged to facilitate collaboration.
PROJECT GOAL STATEMENT	*What do you hope to achieve with this project? What issue are you addressing?* To reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery.
PROJECT SCOPE AND TARGET POPULATIONS	*Please describe what part of the regional GCACH community the project will serve, including which counties, target populations, health systems, providers, service organizations and other. Will it pilot in a geographic or demographic population first with intent to scale?* Counties Served: Columbia, Garfield, Benton, Franklin, Kittitas, Walla Walla, Yakima, Whitman, and Asotin Populations served: Patients with an opioid use disorder, including heroin and prescription drugs. Entry Points: Schools, substance abuse agencies, behavioral health providers, hospitals/emergency departments, law enforcement, jails, syringe exchange programs, and other community agencies. This project will have cross jurisdictional sharing in an attempt to be comprehensive in the delivery of services. This project will scale by creating a Case Management Hub in each county. A subcommittee has been set up to define the roles and responsibilities of the case management hubs in each area. Some rural areas may share hubs. A letter will be sent

	out to agencies in all the communities to gage their interest and commitment in being involved with this project.
EVIDENCE AND OUTCOMES	*What evidence is there to show the effectiveness of the proposed project? How does the project align with one or more approaches proposed in the toolkit? Which ones? Are there any real-world outcomes for this project locally?* <u>Clinical Guidelines</u> AMDG's Interagency Guidelines on Prescribing Opioids for Pain: Our project aligns with their recommendation of early identification of patients at risk for opioid use disorder, use of MAT and behavioral therapies, along with supporting use of Naloxone. <u>Statewide Plans</u> 2016 Washington State Interagency Opioid Working Plan: Our project aligns with their Goals and Strategies. Specifically Goal 1: Strategy 1, Goal 2: Strategies 1, 2, 4, Goal 3: Strategies 1, 2, Goal 4: Strategies 1, 2, 3, 4. <u>Additional literature supporting our project</u> <u>http://store.samhsa.gov/shin/content/SMA15-4215/SMA15-4215.pdf</u> <u>http://www.sciencedirect.com/science/article/pii/S0955395905000782</u> <u>http://harmreduction.org</u> This is a new project therefore we do not have any real-world outcomes for this project locally. However, elements of our intervention have been implemented in certain areas and they are evidence based.
HEALTH EQUITY	*How might this project approach address health disparities, where they exist due to ethnicity, gender, race, language, sexual orientation, etc.?* Outreach done by CHW's will address any health inequalities and barriers to an effective outcome.
WORKFORCE REQUIREMENTS	*Will your project approach require any special workforce requirements not already in place, such as the addition of Community Health Workers? What might these requirements be?* We will need additional community health workers. We will leverage existing work force within current substance abuse agencies. We plan to use the DOH's training curriculum for CHW's.
GENERAL IMPLEMENT-ATION	*Without going into specific detail, do you perceive that this project might be implemented differently depending upon the service area (e.g. rural versus urban)? Generally, what might be the differences?* Yes, access points will vary according to area. Availability to MAT will also vary. We are interested in using tele-health where appropriate. One of the goals of this project is to build infrastructure where it may not exist.

SCALABILITY	*Is the project scalable to other communities in the GCACH region?* Yes, this will be scaled throughout the GCACH keeping in mind that implementation may be slightly different in each area depending on their individual needs and resources.
PAIN POINTS	*A pain point is a problem, real or perceived. Broadly, what pain points do you foresee with the implementation of this project?* Our pain points are the same as our weaknesses: Defining the deliverables across multiple agencies, communication collaboration (HIPAA), political opposition to harm reduction approach, long-term sustainability, workforce development, and geographical distance that needs to be bridged to facilitate collaboration.
ALTERNATIVE PROJECT APPROACHES	*Please list the major alternative project approaches you considered in your work but rejected. BRIEFLY, what are the major advantages and disadvantages of each? Why did you reject these over your preferred approach?* Rejected system-wide policy changes. Also, rejected pursuing work that is already being done through the State Opioid Working Plan. Our program is targeted at addressing local community needs.

DATA ANALYSIS AND ROOT CAUSES:

DATA ANALYSIS *Please briefly summarize the team's analysis of data relating to this Project Category. This may include your analysis of population health data (e.g. obesity), social well-being data (e.g. poverty), and healthcare utilization data (e.g. ED Visits) provided by the GCACH and other data sources. What did the data identify as being areas of concern?*

Washington State Department of Health 2012-1016

2015 Heroin deaths= 313, 2015 Prescription Opioid deaths= 415

County	2012-2015: Deaths per County (opioid related)	2012-2015: Rate per 100,000 population
Asotin	12	10.8
Benton	84	9.3
Columbia	2	too few to calc.
Franklin	17	4.4
Garfield	0	0
Kittitas	17	9.1
Walla Walla	25	8.5
Whitman	13	8.1
Yakima	65	5.5

http://www.doh.wa.gov/Portals/1/Documents/Pubs/346-083-SummaryOpioidOverdoseData.pdf

University of Washington ADAI
From 2002 to 2013 publicly funded treatment admissions involving an opioid, state wide, went up 196.5%. Three counties in the GCACH increased over 250%.
http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf

MDT Toolkit Measure Set: Regional Health Needs Inventory
% Users of opiates for more than 30 days: GCACH percentage is higher than the state average in every age group.

ROOT CAUSE ANALYSIS *Based upon the data analysis above, what might be some of the underlying root causes to these findings? For example, local obesity might be attributed to cultural issues, living in a "food desert", a lack of exercise opportunities, etc.*

Root causes resulting in an increased risk for opioid abuse are family history of substance abuse, personal history of substance abuse, age between 16-45 years, history of preadolescent sexual abuse, and psychological disease.

There has also been an increase in access to prescription opioids due to inappropriate prescribing leading to the increase use of heroin.

ADDRESSING ROOT CAUSES *How does your proposed project approach attempt to address the identified underlying root causes from above?*

Promoting use of prescription monitoring program through case management, addressing opioid mis-use through case management services, increasing access to behavioral health services, creating positive relationships with personal case manager (who promotes addressing underlying issues). All staff will be trained in Trauma-Informed Care.

LINKAGES AND ALIGNMENT:

ALIGNMENT *Is the project approach aligned with the GCACH Regional Survey results, Regional Health Improvement Plan, Community Asset Inventory, and the goals of the Medicaid Demonstration Project?*

Yes, this project approach aligns with the four-above mentioned documents.

LINKAGES *Does the project approach offer the opportunity for collaborating with other Toolkit project areas? With which other project areas? How might this look like?*

This project approach offers the opportunity to be a spoke in the Pathways Hub. It also links with ED Diversion and Oral Heath.

CLINICAL-COMMUNITY LINKAGES *The goals of clinical-community linkages include: Coordinating health care delivery, public health, and community-based activities to promote healthy behavior. Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services. Does this project approach foster clinical-community linkages?*

Yes, this approach fosters clinical-community linkages. We propose quarterly GCACH OCRC meetings across GCACH to discuss program and rapid cycle improvement.

PATHWAYS COMMUNITY HUB *The GCACH may adopt the Pathways Community HUB model as part of its work toward creating community care coordination. How might this project align with the HUB model? Which Pathways in the HUB might you work be affected by?*

We propose that one spoke of the hub would be opioid use disorder. Our approach allows us to work collaboratively with many of the proposed projects in line with creating community care coordination.

For more information on the Pathways Community HUB, please see: https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf

OUTCOMES AND IMPACT:

TOOLKIT METRICS *Which Toolkit metrics in your project area will this project approach positively impact (e.g. ED visits)? How will this likely take place?*

System wide Metrics:
Opioid related deaths per 100,000
Non-fatal overdose involving prescription opioids
Substance use disorder treatment penetration

Project Level Metrics:
New opioid users that become chronic users
Patients on high-dose chronic opioid therapy by varying thresholds
Patients with concurrent sedative prescriptions
Non-fatal overdose involving prescription opioids
Medication Assisted Therapy with Buprenorphine
Medication Assisted Therapy with Methadone

Other project metrics also effected:
Outpatient ED visits per 1,000
Follow up after discharge from ED for Mental Health, Alcohol, or other drug dependence

IMPACT *Of all the potential project approaches you reviewed, would this approach achieve the greatest positive impact for the potential financial investment made?*

Yes, this approach achieves the greatest positive impact for the investment.

ROI *Please describe how this project approach is likely to affect a positive return-on-investment within three to five years. This can be stated in terms of a potential downward effect on healthcare utilization for Medicaid clients.*

This project approach will decrease healthcare complications, hospitalizations, and ED visits related to opioid use disorder and IV drug use.

SOCIAL DETERMINANTS OF HEALTH *How might this project approach have a long-term positive impact on the social determinants of health (e.g. housing, employment, incarceration, etc.)?*

Case manager and community health worker will address social determinants and link patient to community resources.

COMMENTS:
What additional comments would you like to state regarding your project?

PROJECT 3B: REPRODUCTIVE AND MATERNAL/CHILD HEALTH

Please complete the template sections below. You may expand a box as needed to accommodate your text. If you are unable to answer a particular section, please move to the next section and continue.

PROJECT DESCRIPTION:

PROJECT TITLE
Improving Maternal Child Health by Increasing Awareness and Accessibility of LARC and Evidence Based Home Visiting Implementation

PROJECT FACILITATOR
Carla Prock and Stan Ledington

CONTRIBUTING ORGANIZATIONS AND TRIBES *Please list all the organizations in the nine-county GCACH region that will participate in developing the eventual project application and implementing the project.*

Lara Sim, Laruen Schoenwald, Erin Tomlinson, Lupe Mares, Paul Dillon, Amanda Hinrichs, Suzy Diaz, Debra Penningjim, Steven Solam, Marilyn Van Oostrum, Lisa Hefner, Kayla Down

COUNTIES SERVED BY THIS PROJECT ☒ Asotin ☒ Benton ☒ Columbia ☒ Franklin ☒ Garfield ☒ Kittitas ☒ Walla Walla ☒ Whitman ☒ Yakima ☒ Yakama Nation ☐ Other _____

TRIBES SERVED BY THIS PROJECT (if applicable)
Yakama Nation

THIS PROJECT IS (check one): ☐ **New** ☒ **Enhancing an existing project or set of projects**

THIS PROJECT SERVES MEDICAID CLIENTS ONLY (check one): ☒ **Yes** ☐ **No**
If you checked "No", what percentage of clients served are Medicaid?

THIS PROJECT DOES NOT CURRENTLY RECEIVE OTHER MEDICAID FUNDING FOR THE SAME SERVICES (check one):
☒ **Yes** ☐ **No**
If you checked "No", please describe what other Medicaid funding this project approach is currently receiving and what other Medicaid contracts might be involved.

PROJECT CATEGORY Please indicate which optional category area from the toolkit your project will meet. If more than one area applies, please check the primary area:

- ☐ Bi-directional Integration of Care
- ☐ Community-Based Care Coordination
- ☐ Transitional Care
- ☐ Diversion Intervention
- ☐ Addressing the Opioid Use
- ☒ Maternal and Child Health
- ☐ Access to Oral Health
- ☐ Chronic Disease Prevention and Control

BRIEF PROJECT DESCRIPTION	*Provide a description of the project. What are the strengths and weaknesses of this particular project approach?* Projects proposed are informed by the evidence based strategies outlined in the Project Toolkit for Project 3**B.** **1. Improving Maternal Child Health by Increasing Awareness and Accessibility of Long Acting Reversible Contraception (LARC)** • **Pregnancies resulting in births from women 24 and under are more likely to be unintended. Many primary care providers don't routinely discuss pregnancy intentions or**

offer follow up services; many also lack the training and resources to provide the full range of contraceptives include including the most effective long acting methods (LARC) which are considered "top tier" by the CDC and WHO. Our goal is to educate providers and consumers in our region about LARC to increase access to these highly effective contraceptive options and decrease unintended and teenage pregnancies.

2. Dual Approach Home Visiting Services

Evidence based home visiting programs outlined below are currently operating in some areas of our region and are best suited to meet the needs of our residents. The programs will both support the desired outcomes while allowing for the selection of the program of best fit for each community.

2.1. Nurse Family Partnership:

- Serves first-time, low-income mothers and their babies, from early in pregnancy to child-age 2
- Home visitors are specially-trained registered nurses who tailor program and activities to individual clients' needs.
- Found to also reduce child abuse and neglect, criminal activity, and welfare use; and improve birth outcomes and child development.
- Founded on decades of rigorous research, including three randomized controlled trials and ongoing data collection.

2.2. Parents as Teachers:

- Parents of any age with one or more children can receive services prenatal to kindergarten.
- Parent Educators' backgrounds respond to cultural and structural needs of diverse families.
- Multiple program components ensure families gain & share knowledge while practicing new skills.

Nurse-Family Partnership (NFP) changes the future of babies born into poverty by empowering their caregivers. Mothers enrolled in the evidence-based program develop a trusted relationship with a registered nurse. For families facing challenges such as intergenerational poverty, homelessness, intimate partner violence and mental health problems, an NFP Nurse is an invaluable resource who provides timely, accurate medical information to moms experiencing parenthood for the first time.

Local NFP programs target low-income first-time mothers, Hispanic and Native American adolescent mothers, and other at-risk, first-time mothers. Nurses make home visits to support healthy child development, provide specialty screenings for early intervention referral, enhance parenting skills, improve the quality of parent-child interactions, and promote school readiness activities for families at risk for child abuse, neglect and poor educational outcomes. Strengths include high quality service delivery, positive birth outcomes, high rates of breastfeeding, avoidance of child abuse/neglect and domestic violence, positive child development, and improved maternal education. Outcomes also include a reduction in avoidable use of intensive services and emergency department visits, and a decrease in hospital admission, length of stay, and readmission through linkage to primary care, developmental screening, and preventive health programs.

Parents as Teachers is an evidence-based home visiting (prevention / early intervention) model designed to ensure young children are healthy, safe and ready to learn.

	The Parents as Teachers model has four components: twice-per-month personal home visits, monthly group connections events, in-home child screenings, and resource networking. Personal visits are the cornerstone of the model and focus on parent-child interaction, development-centered parenting and family well-being. PAT training and curriculum are designed to identify and build on family strengths, capabilities and skills, and build protective factors within the family. Personal visits are an integral part of the model and directly promote vital protective factors of parental resilience, knowledge of parenting and child development, and social and emotional competence of children. Parent educators share research-based information and utilize evidence-based practices with families, using the PAT *Foundational Curriculum* in culturally responsive ways. Service duration is ideally three years and varies depending on the age of the child at the time the family enrolls. In addition to the general appeal of home visiting as a service approach, the popularity of PAT is due in part to the inherent attractiveness of its basic premises: "that babies are born learning and that parents are their first and most influential teachers." Also, the use of parent educators with a wide range of backgrounds and the provision of, for the most part, monthly services make PAT a relatively inexpensive program model to implement4 compared with interventions that rely on nurses or that have center-based, child-focused components in broader two-generation program models
PROJECT GOAL STATEMENT	*What do you hope to achieve with this project? What issue are you addressing?* **LARC** - To educate providers and consumers in our region about LARC to increase access to these highly effective contraceptive options and decrease unintended and teenage pregnancies. We aim to advance health equity by improving the experience of care for women of reproductive age by focusing on a patient centered care approach and increased access to top tier contraceptive methods. This approach will center conversation on reproductive lifespan planning within the context of the patient's personal life goals and lead to decreased health disparities. **Dual Approach Home Visiting Services** - Expanding home visiting in the Greater Columbia region will: 1) increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations through linkage to county resources for child development, education and screening, resources for counseling and parenting skills, and resources for high school graduation and employment for mothers; 2) improve health outcomes and reduce costs for Medicaid and low-income populations through linkage to primary care providers, developmental screening, and early health interventions; and 3) increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks. The result will be improved maternal and child health outcomes, better care, lower long-term costs, and healthier communities The Nurse Family Partnership program centers on three goals: • Improved pregnancy and birth outcomes • Improved child health and development • Improved economic self-sufficiency of the family . Parents as teachers has four primary goals: • Increase parent knowledge of early childhood development and improve parenting practices.

	• Provide early detection of developmental delays and health issues. • Prevent child abuse and neglect • Increase children's school readiness and school success
PROJECT SCOPE AND TARGET POPULATIONS	*Please describe what part of the regional GCACH community the project will serve, including which counties, target populations, health systems, providers, service organizations and other. Will it pilot in a geographic or demographic population first with intent to scale?* LARC –This project could serve medical providers and women of childbearing age in all areas of the GCACH. Ideally the target areas would be the counties with the largest number of unplanned and Medicaid covered births to achieve the highest cost savings. Nurse-Family Partnership serves low-income, first-time mothers beginning early in pregnancy (before the 28th week) and continuing until the child reaches age 2. Existing NFP programs in Yakima and Benton-Franklin target Hispanic and Native American mothers, teenage mothers, mothers who lack social support, non-English speaking mothers. The programs engage business, community-based, consumer, education, faith-based, food system, health care provider, hospital, housing, local government, philanthropy, public health, social services, transportation, and tribal organizations. Within the GCACH region, Nurse-Family Partnership currently has the capacity to serve 287 families in Benton, Franklin and Yakima counties. Given that an estimated 2,700 low-income women in the 9-county region become first-time moms each year, there is ample opportunity to expand services and improve the trajectory of families. Through a regional hub-and-spoke approach, in which the two established county programs expand to support Nurse Home Visitors in satellite communities, NFP can reach families even in the most rural underserved pockets of our region. PAT currently has active affiliates in Yakima with Catholic Charities and in Walla Walla with Children's Home Society. The program currently serves pregnant women, and parents or guardians of children aged 0 to 3 years old. Participants with the following characteristics are prioritized: racial / ethnic minorities; pregnant women who have not attained age 21; have low income; have a child born with a low birth weight or born prematurely; have a history of child abuse or neglect or have had interactions with child welfare services; have a history of domestic violence; have a history of substance abuse or need substance abuse treatment; are users of tobacco products in the home; parents or children who have low student achievement; have children with developmental delays or disabilities; are in families that include individuals who are serving or have formerly served in the armed forces. PAT may be a model that is more conducive to implementation in the more rural/less populace counties since there are fewer restrictions on client base.
EVIDENCE AND OUTCOMES	*What evidence is there to show the effectiveness of the proposed project? How does the project align with one or more approaches proposed in the toolkit? Which ones? Are there any real-world outcomes for this project locally?* **LARC Evidence and Outcomes:** The July 2015 WA State Report states that LARC is now recommended as a first –line birth control for all women and adolescents. NIH reports that LARC methods have a failure rate of 0.27% as compared to a 4.55% failure rate among the pill, patch, and ring users. When cost,

access and knowledge barriers were removed, 72% of women participating in a St. Louis study selected a LARC method. Enhanced training for reproductive lifespan conversations, contraception counseling and LARC insertion has been demonstrated to improve access and increase choice, allowing more women on Medicaid to choose the most effective methods of contraception. The state of Virginia proposed investion $9 million for LARC access based on the 40% reduction in teen birth rate between 2009-2013 in Colorado.

NFP Evidence and Outcomes:
The NFP model is founded on decades of rigorous research, including three randomized controlled trials. NFP Nurses collect and analyze program data on an ongoing basis to ensure they are delivering the outcomes that were shown in the original trials.
NFP's outcomes affect every realm of society:

- Health Care and Medicaid
  - 79% reduction in preterm delivery for women who smoke, and reductions in high-risk pregnancies as a result of greater intervals between first and subsequent births
  - 35% fewer cases of pregnancy-induced hypertension
  - 32% fewer subsequent pregnancies
  - 67% reduction in 12-year-old children's use of cigarettes, alcohol, or marijuana
  - 28% reduction in 12-year olds' mental health problems (depression and anxiety)
- Education
  - 50% reduction in language delays of child age 21 months
  - 67% reduction in behavioral/intellectual problems at age six
  - 9 percentile increase in math and reading achievement test scores in grades 1-3 among children born to mothers with low psychological resources
- Criminal Justice
  - 59% reduction in child arrests at age 15
  - 61% fewer arrests of the mother (by child age 15)
  - 72% fewer convictions of the mother (by child age 15)
  - 33% fewer arrests among female children at age 19; 80% fewer convictions among female children at age 19
  - **By 2031, Nurse-Family Partnership will have prevented 36,000 intimate partner violence incidents and 90,000 violent youth crimes.**
- Child Welfare
  - **48% reduction in child abuse and neglect**
  - 68% increase in father's presence in household
  - 39% fewer injuries among children
  - 56% reduction in emergency room visits for accidents and poisonings
  - Reduced childhood mortality from preventable causes at age 20
  - **By 2031, Nurse-Family Partnership will have prevented 500 infant deaths in the US and 42,000 incidents of child maltreatment.**
- Economy and Workforce
  - 82% increase in months of maternal employment
  - 20% reduction in months on welfare
  - 30-month reduction in use of AFDC-TANF among mothers who were poor and unmarried at registration
  - 1.83 month reduction in use of Food Stamps between child age 5 and 6
  - $12,300 discounted savings (2006 dollars) in Food Stamps, Medicaid, and AFDC-TANF from child age 0-12

	An analysis conducted in 2005 by the Rand Corporation found a net benefit to society of $34,148 per higher-risk family served (high risk=low socioeconomic status and unmarried). That's a return of $5.70 for each dollar spent on the program. For those higher-risk families, the analysis found that communities recovered the cost of the program by the time the child reached the age of four. And there were additional savings through the lives of both mother and child. In January, the peer-reviewed Maternal and Child Health Journal published two eagerly anticipated and important studies on Nurse-Family Partnership that showed significant results on reduction in preterm births and improvement of child health outcomes. Nurse-Family Partnership's evidence is unmatched in the field of maternal and child health and is the only early childhood intervention that meets the "Top Tier" evidence standard of the Coalition for Evidence-Based Policy. **Yakima County NFP outcomes show:** ▪ 60% reduction in experience of domestic violence from enrollment to 36 weeks ▪ 29% fewer subsequent pregnancies at 24 months ▪ 94% of mothers choose to breastfeed and 38% are still breastfeeding at 6 months ▪ 7.6% premature birth rate; 6.2% premature birth rate for Native American clients; compared to 10.4% for March of Dimes statewide data and 11.4% for the Healthy People 2020 statewide goal **PAT Evidence and Outcomes:** School readiness Child health Positive parenting practices Independent evaluation has been integral to the success of Parents as Teachers. Research has been conducted and outcome data have been collected from more than 16,000 children and parents. Researchers have used rigorous research designs, including randomized controlled trials and quasi-experimental methods. Studies published in peer-reviewed journals have shown statistically significant effects, demonstrating that Parents as Teachers achieves its goals and makes a real difference in the lives of children and families. Short-term outcomes include improved maternal health and birth outcomes, increased parental knowledge of child development, improved parent-child relationships, early detection of developmental delays and health issues, and improved family health and functioning. Intermediate outcomes include improved child health/development, prevention of abuse/neglect, increased school readiness, and increased parental involvement with children. http://www.institutefamily.org/programs_PAT.asp The Parents as Teachers, Children's Home Society affiliate in Walla Walla has a strong training component, so staff are highly trained and it reaches families who are often isolated. In Walla Walla, we are able to provide services in Prescott, Waitsburg and Touchet where there is little or no preschool opportunities and support parents as the first and best teacher of their children. We see parents learning new tools as parents, children increasing their skills and families and children reaching their goals. It also gives us the opportunity to help families who

	may be headed toward a mental health challenge because we often see them before anyone else.
Disparities	*How might this project approach address health disparities, where they exist due to ethnicity, gender, race, language, sexual orientation, etc.?* The LARC project-According to a study in the June 2016 American Journal of Obstetrics and Gynecology, significant public health disparities exist surrounding teen and unplanned pregnancy in the United States. Women of color and those with lower education and socioeconomic status are at much greater risk of unplanned pregnancy and the resulting adverse outcomes. Unplanned pregnancies reduce educational and career opportunities and may contribute to socioeconomic deprivation and widening income disparities. Long-acting reversible contraception (LARC), including intrauterine devices and implants, offer the opportunity to change the default from drifting into parenthood to planned conception. LARC methods are forgettable; once placed, they offer highly effective, long-term pregnancy prevention. Increasing evidence in the medical literature demonstrates the population benefits of use of these methods. Increasing the use of highly effective contraceptive methods may provide one solution to the persistent problem of the health disparities of unplanned and teen pregnancies in the United States and improve women's and children's health. Nurse-Family Partnership specifically targets those families who are at increased risk for health disparities. The NFP model builds on the natural strengths of families and the understanding that all families are the best experts on their own lives. Within this framework, culturally attuned nurse home visitors make emotional connections with the mother and family. Culture is linked to all aspects of the nurse home visitor's relationship and activities with the mother, baby and family. Home visits emphasize linking the mother's goals with family, culture, the community as keys to success. Local NFP programs specifically target low-income, first-time mothers, Hispanic and Native American adolescent mothers, and other families at increased risk for health disparities. Portions of our ACH region are classified as rural, geographically isolated, culturally diverse, economically disadvantaged regions. The NFP National Service Office reports indicate that of all the NFP programs in Washington State, the Yakima County program serves the highest proportion of new mothers under 15 years of age (5.3% vs. 3.5% statewide). Program data bear out that the Yakima County NFP is able to successfully reach these populations, recruit them into services, retain them in services, and demonstrate capacity and success in serving Hispanic and Native American clients and families: 75% of clients served are Hispanic, 50% of the nursing staff and the nurse supervisor are fluently bilingual in English and Spanish, 12% of clients are Native American, and Yakima County NFP is currently working to hire a full-time Native American nurse to work exclusively with the Yakama tribe. Outcome data of this detail is not yet available for the Benton and Franklin programs but decades of NFP's national data support that these outcomes are replicable if the program model is followed to fidelity. Parents as Teachers defines high need as someone who has 2 or more risk factors. PAT high needs characteristics include: teen parent, child with disabilities or chronic health condition, parent with mental illness, parent with low educational attainment, low income, recent immigrant or refugee family, substance abuse, court-appointed legal guardians/foster care, homeless or unstable housing, incarcerated parent(s), very low birth weight, death in immediate family, domestic violence, child abuse or neglect, and military family.

	a. Individualized assessments will be conducted of participant families and services will be provided in accordance with those individual assessments; b. Services will be provided on a voluntary basis; c. Priority will be given to eligible participants who: 1) Have low incomes; 2) Are pregnant women who have not attained age 21; 3) Have a history of child abuse or neglect or have had interactions with child welfare services; 4) Have a history of substance abuse or need substance abuse treatment; 5) Are users of tobacco products in the home; 6) Have children with low student achievement; 7) Have children with developmental delays or disabilities; 8) Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have had multiple deployments outside of the United States.
WORKFORCE REQUIREMENTS	*Will your project approach require any special workforce requirements not already in place, such as the addition of Community Health Workers? What might these requirements be?* The LARC project could utilize Community Health Workers for some of the client education purposes but the initial provider education would best be provided by trained professional staff. Nurse Family Partnership is implemented with Registered Nurse with a Bachelor of Science (BSN) nurses. Waivers can be requested to utilize ADN registered nurses in special circumstances. RN shortages may make recruitment challengingOnce hired, the nurses undergo comprehensive training in the NFP model, including a week-long in-person education session and online modules. For **PAT**, a Bachelor or four-year degree in early childhood education, social work, health, psychology or a related field is *recommended*. However, it is also acceptable for parent educators to have a two-year degree or 60 college hours in early childhood or a related field. Supervised experience working with young children and/or parents is also recommended. It is essential that the education and experience level for parent educators is at least a high school diploma or GED and a minimum of two years' previous supervised work experience with young children and/or parents. All PAT WA State Affiliate Parent Educators have a minimum of an AA in early learning or education, with the majority having a BA in early learning. Some rural programs are also hiring a nurse, social worker, and/or infant mental health specialist. The Supervisor must have at least a Bachelor's degree in early childhood education, social work, health, psychology or a related field, and at least 5 years' experience working with families and young children. Some WA Affiliates have requested and received permission to hire a Supervisor who has their AA and is attending classes to receive their BA.
GENERAL IMPLEMENT-ATION	*Without going into specific detail, do you perceive that this project might be implemented differently depending upon the service area (e.g. rural versus urban)? Generally, what might be the differences?* **LARC: The LARC project would initially be focused on the communities with the highest Medicaid covered birth and teen pregnancy rates to achieve the greatest financial impact. Once the campaign is produced, components could be scaled to reach an audience with fewer disparities.**

	NFP: • Serving multiparous women in Native American communities: Nurse-Family Partnership has historically focused its efforts on first-time mothers and their families. However, a formative evaluation of NFP's benefit to the American Indian and Alaska Native population was recently completed. As a result of this work, NFP may now be offered to multiparous women (women who are not first-time mothers) within the American Indian and Alaska Native population. NFP programs interested in serving multiparous women in this population will work with the NFP National Service Office to develop a plan, ensure cultural competence and relevance, and ensure quality implementation. • Due to the minimum case load of 25 clients and the requirement of a 0.5 FTE supervisor for a full team of 4 nurses, implementation of NFP in communities with a low birth rate would only be possible with a cross-county collaborative effort to allow the support of the program infrastructure required to implement the program. This hub-and-spoke model has been successful in other rural communities across the country – including in Washington State. PAT: PAT requires each affiliate to develop a Community Advisory Committee that meets at least every six months (can be part of a larger committee, community network or coalition as long as the group includes a regular focus on the PAT affiliate). The majority of PAT WA Advisory Committees meet quarterly. The advisory committee has several key functions, most notably to advise, provide support for, promote, and offer input to the PAT Affiliates. At a minimum, the advisory committee should include involvement of affiliate personnel, community service providers/community leaders, and families who have received or are receiving services. In some communities, organizations join with other PAT affiliates in their area for their advisory committee (Yakima). For **PAT**, there is a 5 day training that occurs all over the country, and yearly in Washington state. 3 days of the training are focused on the web-based Foundational curriculum, and the last two days focus on Model Implementation. All managers, supervisors, and parent educators have to complete the training in its entirety. A new organization must have an approved Affiliate Plan before being able to register for training. If a WA State training is not being held, the PAT National Center in St. Louis is the preferred site. Other required trainings include family assessments and child screening tools. After training is completed, new Educators must shadow a more experienced Educator before providing home visits on their own. If the organization is new, the PAT State Lead or PAT TA Specialist will arrange for a neighboring Affiliate to provide the shadowing and mentoring of new Supervisor. New Educators must have two documented home visit observations within the first 6 months, and 1 annual observation thereafter. A required number of professional development hours are also required on an annual basis.
SCALABILITY	*Is the project scalable to other communities in the GCACH region?* The LARC project would be modeled after successful projects in Colorado and the North Sound ACH in Washington that have both successfully served rural and urban areas.

	NFP is scalable to other communities. NFP currently serves families in Benton, Franklin and Yakima Counties. Current operating agencies have operated strong NFP programs for many years and would be key partners in expanding services to other communities in the GCACH region. For **PAT,** the Affiliate design and structure is determined by community needs. Each full-time Supervisor is assigned no more than 12 Parent Educators, regardless of whether the Parent Educator being supervised is full-time or a part-time employee. Supervisors that are less than full-time should reduce that number of Parent Educators accordingly. Some Supervisors also carry a small family/client caseload. The minimum expectation for a PAT Supervisor is 20 hrs/week. The Supervisor's responsibilities include directing, coordinating, supporting, and evaluating the on-the-job performance of parent educators. This includes providing a minimum of 2hrs. of reflective supervision each month for their Parent Educators and facilitating a minimum of one monthly 2 hour staff meeting monthly. The *PAT Quality Assurance Blueprint* guides the Supervisor through the steps and timelines for individual and group supervisory requirements. The PAT State Lead or PAT TA Specialist works closely with Supervisors to assure monitoring of service documentation, data collection and reporting to assure fidelity to the PAT Model and high quality services to families. "Parent Educators" may include nurses, social workers, and infant mental health consultants.
PAIN POINTS	*A pain point is a problem, real or perceived. Broadly, what pain points do you foresee with the implementation of this project?* **Difficulty recruiting culturally competent nurses** - In rural areas, nursing workforce shortages and relatively low salaries present a challenge in recruiting qualified nurses who are passionate about the NFP program. NFP agencies will work to identify these challenges and develop strategies to attract the right nurses to the team. These strategies may include online advertising, social media, emphasizing flexible schedules and other agency benefits, the impact of the work on families, etc. **Geographic barriers** - NFP teams serving rural areas face specific challenges to achieving and maintaining caseload. Longer drive times between home visits may mean that NFP nurses will need to reduce caseload expectations. Seasonal changes such as icy mountain passes may require some visits to take place in a telehealth format. National Service Office Nurse Consultants will discuss these specific challenges with the NFP team and develop strategies on an individual basis.
ALTERNATIVE PROJECT APPROACHES	*Please list the major alternative project approaches you considered in your work but rejected. BRIEFLY, what are the major advantages and disadvantages of each? Why did you reject these over your preferred approach?* N/A

DATA ANALYSIS AND ROOT CAUSES:
DATA ANALYSIS *Please briefly summarize the team's analysis of data relating to this Project Category. This may include your analysis of population health data (e.g. obesity), social well-being data (e.g. poverty), and healthcare utilization data (e.g. ED Visits) provided by the GCACH and other data sources. What did the data identify as being areas of concern?* Nurse Family Partnership Program Outcome Data

Birth Rate Data, Department of Health
Teen Pregnancy Rates
Unintended pregnancy rates
Well Child visits
Immunization Rates
Low Birth Weight
First Trimester Prenatal Care
STI rates (Chlamydia screening)
ED utilization (by children)
Access to Mental Health Treatment
Post Partum Depression rates
Substance Use Disorder Treatment penetration

ROOT CAUSE ANALYSIS *Based upon the data analysis above, what might be some of the underlying root causes to these findings? For example, local obesity might be attributed to cultural issues, living in a "food desert", a lack of exercise opportunities, etc.*

Poverty, Adverse Childhood Experiences, Racial & Economic disparities, Family planning, family goal/self-sufficiency training, financial planning, access to contraceptives, provider shortages, & geographic barriers.

ADDRESSING ROOT CAUSES *How does your proposed project approach attempt to address the identified underlying root causes from above?*

The LARC projects primary intent is to increase access and opportunity for reliable, effective contraception. Research bears that women with unplanned pregnancies experience reduced educational and career opportunities and may contribute to socioeconomic deprivation and widening income disparities.

Home Visiting works with the families to establish family goals, address the benefits to birth spacing, resource links to financial planning and other providers. Home visitors work directly within each family unit help guide family to choices that promote thriving

LINKAGES AND ALIGNMENT:

ALIGNMENT *Is the project approach aligned with the GCACH Regional Survey results, Regional Health Improvement Plan, Community Asset Inventory, and the goals of the Medicaid Demonstration Project?*

The LARC component would return the fastest and greatest yield as a part of reduction of unintended pregnancies in the Medicaid population. The decreases in Teen Pregnancy related to the LARC project would see tremendous savings in the long term costs attributed to adolescent births.

While more upstream in nature, both NFP and PAT realize significant return on investment, are seen as best practices in early childhood and have impacts that affect multiple generations.

LINKAGES *Does the project approach offer the opportunity for collaborating with other Toolkit project areas? With which other project areas? How might this look like?*

GCACH Medicaid Project Tool Kit Opportunities to Promote Child and Family Well-Being (MCH) Draft 6/11/2017
Please see the attached table for a variety of opportunity for linkage and support with other project areas. While there may not be direct overlap between current proposed projects, the LARC project would support the target populations for the Care Coordination (2B), Transition Care and Diversion (2C/D) and Opioid Intervention (3A).

The home visiting programs would support parents and children who are participating in the previously mentioned projects as well as Bi-Directional integration of behavioral health & primary care (2A), Access to Oral Health (3C) and Chronic Disease Prevention (3D). These evidence based home visiting programs both have components that address content in all of these areas. They have research to prove they are a cost effective way to achieve numerous clinical and social objectives.

Project	Project Team	Metrics/Targets	Workforce Capacity Needs	Key Opportunities
2A	Bi-Directional integration of behavioral health & primary care	1. Mental health and substance use (children, youth and reproductive aged adults) 2. Primary care needs (those with behavioral health concerns)	• Critical need for child/adolescent behavioral health providers • Dual generation (parent-child) behavioral health interventions • Provider training on trauma-informed practices	• Expand capacity to address **pregnant and postpartum** mental health, including early identification and intervention (OB, Peds, Family Practice) • Expand capacity to address child/adolescent mental health, including early identification and intervention (Peds, Family Practice)
2B	Community-Based Care Coordination	1. Unintended pregnancy 2. Mental health and substance use (children, youth and reproductive aged adults)	• Lack of care coordination capacity for children/families • Providers who can deal with high acuity children with special healthcare needs (physical and behavioral)	• Utilize pathways including: o Family Planning o Pregnancy o Post-partum care o Immunizations referral/screening o Developmental screening/referral o Medical Home o Housing
2C/2D	Transitional Care & Diversion	1. Unintended pregnancy	•	• Ensure access to family planning services for those leaving incarceration
3A	Address the Opioid Public Health Crisis	1. Youth and adults with substance use (rx, opiates, other) 2. Overdose 3. Neonatal abstinence syndrome	• Gaps in services and supports for parents (pregnant women) with substance use concerns	• Implement substance use in pregnancy guidelines/neonatal abstinence syndrome prevention and intervention • Incorporate Family planning options/preconception care for those with substance use concerns • Expand youth prevention efforts

3B	Reproductive and Maternal Child Health	1. Unintended pregnancy/teen pregnancy (Medicaid costs savings, family economic stability, reduced childhood adversity) 2. Mental health and substance use (children, youth and reproductive aged adults) 3. Increased STI rates 4. Low birth weight 5. Immunizations (some areas with lower rates) 6. Well-Child Visits	• Need for provider training on pregnancy intention counseling and LARC use and billing • Need capacity for Home Visiting staff in rural areas	• Pregnancy intention counseling, family planning/LARC, STI testing and treatment and preconception support (pathways hub link?) • Expand home visiting capacity in targeted areas (NFP and PAT) to address multiple metrics
3C	Access to Oral Health	1. Childhood caries 2. Adult access to dental care (pregnant and reproductive age)		• Prenatal/perinatal and pediatric dental care • Rural and Isolated families
3D	Chronic Disease Prevention and Control	1. Asthma 2. Obesity 3. Diabetes		• Asthma care for children/youth • Obesity care/intervention for children/youth

CLINICAL-COMMUNITY LINKAGES *The goals of clinical-community linkages include: Coordinating health care delivery, public health, and community-based activities to promote healthy behavior. Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services. Does this project approach foster clinical-community linkages?*

Both the LARC and Home Visiting programs require clinical-community linkages to be effective. LARC required community education and advocacy to increase the demand for services and the trained clinical professionals to as the correct questions and offer appropriate care.

The evidence based home visiting programs have requirements for tracking prenatal, post-partum, well child and immunization metrics. Oral health linkages are often a part of the curriculum as well. Monitoring and referral of perinatal depression and family planning methods are also program components. Nurse-Family Partnership Nurses coordinate with the mother and child's medical providers as necessary in order to ensure an efficient and effective continuum of care.

PATHWAYS COMMUNITY HUB *The GCACH may adopt the Pathways Community HUB model as part of its work toward creating community care coordination. How might this project align with the HUB model? Which Pathways in the HUB might you work be affected by?*

Adult Education Pathway
Behavioral Health Pathway
Developmental Referral Pathway
Developmental Screening Pathway
Education Pathway
Employment Pathway
Family Planning Pathway
Health Insurance Pathway
Housing Pathway
Immunization Referral Pathway
Immunization Screening Pathway
Lead Pathway
Medical Home Pathway
Medical Referral Pathway
Medication Assessment Chart
Medication Assessment Pathway
Medication Management Pathway
Postpartum Pathway
Pregnancy Pathway
Smoking Cessation Pathway
Social Service Referral Pathway

For more information on the Pathways Community HUB, please see: https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf

OUTCOMES AND IMPACT:

TOOLKIT METRICS *Which Toolkit metrics in your project area will this project approach positively impact (e.g. ED visits)? How will this likely take place?*

Healthier Washington Toolkit Alignment: NFP and PAT align with the toolkit approach for Prevention and Health Promotion for Maternal and Child Health. The Healthier Washington Project Toolkit specifically calls out Nurse-Family Partnership as an evidence-based home visiting model for high-risk mothers and their children that ACHs may implement. Of the measures listed in the Medicaid Demonstration Project Toolkit, LARC; Nurse-Family Partnership; and Parents as Teachers most impact:

- Well Child Visits in the First 15 Months of Life
- Prenatal Care in the First Trimester of Pregnancy
- Childhood Immunization Status
- Unintended Pregnancies
- Contraceptive Care – Most and Moderately Effective Methods, Access to LARC, Postpartum

IMPACT *Of all the potential project approaches you reviewed, would this approach achieve the greatest positive impact for the potential financial investment made?*

The LARC component would return the fastest and greatest yield as a part of reduction of unintended pregnancies in the Medicaid population. The decreases in Teen Pregnancy related to the LARC project would see tremendous savings in the long term costs attributed to adolescent births.

While more upstream in nature, both NFP and PAT realize significant return on investment, are seen as best practices in early childhood and have impacts that affect multiple generations.

ROI *Please describe how this project approach is likely to affect a positive return-on-investment within three to five years. This can be stated in terms of a potential downward effect on healthcare utilization for Medicaid clients.*

Much of the current literature on LARC studies evaluates the cost effectiveness of interventions instead of the ROI to the programs.

A study involving the Colorado Adolescent Maternity Program (CAMP) participants aimed to determine the cost effectiveness of immediate postpartum implant (IPI) of a LARC product. Repeat pregnancy rates were observed at six, 12, 24 and 36 months for the IPI and comparison groups and were significantly higher in the comparison group at each time period. Upfront costs to Medicaid are seen during the initial IPI insertion and six months after, but Medicaid cost savings is shown at 12 months and continuously increases thereafter. For every dollar spent on IPI insertion at 12, 24, and 36 months, $0.78, $3.54, and $6.50 were saved.

According to a 2011 Washington State Institute for Public Policy report: Parents as Teachers has a relatively low cost per participant of $4,138, with benefits of $7,236 and a benefit to cost ratio of $1.75 resulting in a return on investment rate of 5%.

Based on a review of evidence from over 40 NFP evaluation studies, including randomized controlled-trials, quasi-experimental studies and large-scale replication data, the most current cost-benefit analysis predicts that when NFP is brought to scale in Washington, it can produce the following outcomes – yielding a $4.90 return on every dollar invested:

- 25% reduction in smoking during pregnancy
- 33% reduction in pregnancy-induced hypertension
- 15% reduction in first preterm births (<37 weeks)
- 31.3 fewer subsequent preterm births per 1,000 families served
- 25% reduction in very closely-spaced second births (within 15 months postpartum)
- 48% reduction in infant mortality
- 34% reduction in emergency department use related to childhood injuries (ages 0-2)
- 12% increase in moms who attempt to breastfeed

- 14% increase in full immunization status (ages 0-2)
- 33% reduction in child maltreatment (through age 15)
- 41% reduction in language delay
- 25% reduction in youth crimes and arrests (ages 11-17)
- 56% reduction in alcohol, tobacco & marijuana use (ages 12-15)
- 8% reduction in person-months of Medicaid coverage (through 15 years post-partum)
- 8% reduction in costs if on Medicaid through age 18
- 7% reduction in TANF payments (through 9 years postpartum)
- 10% reduction in Food Stamp Payments (through at least 15 years postpartum)
- Subsidized child care caseload reduced by 3.7 children per 1,000 families served

SOCIAL DETERMINANTS OF HEALTH *How might this project approach have a long-term positive impact on the social determinants of health (e.g. housing, employment, incarceration, etc.)?*

Mobilizes families to engage
Connects with resources and employment opportunities
Improved parent child relationships
Improved family health and functioning
Decreased child abuse and neglect
Increased parental involvement with children
Increased school readiness
Increased child spacing, educational and career opportunities due to planned pregnancies

COMMENTS:

What additional comments would you like to state regarding your project?

PROJECT 3C: ACCESS TO ORAL HEALTH SERVICES

Please complete the template sections below. You may expand a box as needed to accommodate your text. If you are unable to answer a particular section, please move to the next section and continue.

PROJECT DESCRIPTION:

PROJECT TITLE

Breaking Down the Walls Of the Dental Clinic

PROJECT FACILITATORS

Mark Koday DDS (MarkK@yvfwc.org) and Heidi Desmarais RDH (hdesmarais@columbiabasin.edu)

PROJECT TEAM

Co-facilitators: Heidi Desmarais and Mark Koday

Team Members: Aisling G. Fernandez, Annie Goodwin, Brady Woodbury, Caitlin Safford, Carol Moser, Cheri Podruzny, Dan Ferguson, Jay Henry, Jeff Schroeder, Jodi Ferguson, Jordan Byers, Kat Latet, Katherine Saluskin, Kathy Story, Kayla Down, Kim Nelson, Larry Thompson, Lindsey Ruivivar, Mary Ann Walker, Mike Bonetto, Rachae Windham, Ruth Stalcup, Rhonda Hauff, Sandra Suarez, Shannon Jones, Susan Franck, Troy Henderson and Wes Luckey

CONTRIBUTING ORGANIZATIONS AND TRIBES *Please list all the organizations in the nine-county GCACH region that will participate in developing the eventual project application and implementing the project. If there is a lead organization, please identify that organization.*

Columbia Basin College, Yakima Valley Farm Workers Clinic, Epic Headstart, ESD 105 Headstart, Whitman County Health District, CHAS, Neighborhood Health Services, Community Health of Central Washington, Total Health Hygiene, LLC, Theresa Marks, RDH, Grinnovations, Dana Harris, RDH.

Currently there is no lead organization but as more details of the GCACH process develop that can be considered

COUNTIES SERVED BY THIS PROJECT ☒ Asotin ☒ Benton ☒ Columbia ☒ Franklin ☒ Garfield ☒ Kittitas ☒ Walla Walla ☒ Whitman ☒ Yakima ☒ Yakama Nation ☐ Other _____

TRIBES SERVED BY THIS PROJECT (if applicable)

Yakama Nation

THIS PROJECT IS (check one): ☒ **New** ☐ **Enhancing an existing project or set of projects**

THIS PROJECT SERVES MEDICAID CLIENTS ONLY (check one): ☐ **Yes** ☒ **No**

If you checked "No", what percentage of clients served are Medicaid?

Difficult to assess. The majority of children will be covered by Medicaid and we estimate 70% of the adults

THIS PROJECT DOES NOT CURRENTLY RECEIVE OTHER MEDICAID FUNDING FOR THE SAME SERVICES (check one):

☐ **Yes** ☒ **No**

If you checked "No", please describe what other Medicaid funding this project approach is currently receiving and what other Medicaid contracts might be involved.

Medicaid does pay for many of the dental procedures that will be done throughout this project but not for the case management , start-op costs, metric development etc.

PROJECT CATEGORY Please indicate which optional category area from the toolkit your project will meet. If more than one area applies, please check the primary area:

- ☐ Bi-directional Integration of Care
- ☐ Community-Based Care Coordination
- ☐ Transitional Care
- ☐ Diversion Intervention
- ☐ Addressing the Opioid Use
- ☐ Maternal and Child Health
- ☒ Access to Oral Health
- ☐ Chronic Disease Prevention and Control

PROJECT GOAL STATEMENT	*What do you hope to achieve with this project? What issue are you addressing? What problem are you trying to resolve?* ***The project has three main components:*** **1. Reducing the high caries rate in low-income children** **2. Increasing access to oral health services for adults** **3. Establish a community based oral health case management program to address chronic oral health diseases**
BRIEF PROJECT DESCRIPTION	*Provide a description of the project. What are the strengths and weaknesses of this particular project approach?* **Problem Description:** **<u>Expand Hygienists providing oral health services to adults in community settings and medical offices</u>: There are two very basic unmet oral health needs for the Medicaid populations in Washington State: Access for adults to all oral health services and lowering the caries rates for children. We have seen some increase in adult access over the years but the percent of adults accessing any oral health services remains very low- %13 to 23% in the GCACH counties. This is due to a variety of issues but low Medicaid reimbursement for private sector dentists and capacity issues at the community health centers are major factors that will likely not see significant changes in future years. To compound this problem, research now shows that periodontal disease is an aggregating factor in many chronic medical conditions. Studies show that treating periodontal disease has a positive effect on diabetes, heart disease and pregnancy and lowers annual pm/pm costs for these patients. Building more of the traditional dental infrastructure is needed but not financially viable. Dental hygienists using portable equipment or mobile vans can bring many of these needed services to adults out in the community.** **<u>Embed dental hygienists in the medical primary care team, and expand dental school sealant programs</u>: Over the past 15 years, Washington State has been very successful in increasing dental access for children. Yakima County now has the highest percent of access in the state (68%) which is also one of the highest access percentages in the country. While this access has been an incredible goal to achieve, the 2016 Smile Surveys shows that we have failed to lower caries rates in children. The 68% also means that 32% of Yakima's Medicaid children which are arguably the highest risk have not seen a dentist in the past year. Basically, the teeth are decaying faster than dentist can fill them. Our traditional model of care (drill and fill) is a failed system for low-income children. This failure has also come at a steep financial cost to the state which spends millions of dollars each year trying to address the oral health needs of our most vulnerable children. There are evidence based solutions for lowering children's caries rates but these solutions need to be delivered in out in the community and in medical clinics where children can be accessed in greater numbers.** **<u>Train Community Health Workers in oral health issues and develop case management for oral health services:</u> To improve these goals we also need the ability to provide oral health case management. While case management is essential in treating chronic diseases identified in medical, no such care coordination is available for oral health, even though caries and periodontal disease are two chronic diseases affecting large majorities of the population. Adults needing treatment for oral health issues requiring a dentist, dental hygienist, or for medical issues identified in the oral health assessments will need help to coordinate the care they require and help ensure they can be connected to those services. It will also be essential to coordinate the care of those children identified at moderate or high risk of caries to insure they return for needed preventative care and/ or get plugged into the right clinical services.**
PROJECT SCOPE AND TARGET POPULATIONS	*Please describe what part of the regional GCACH community the project will serve, including which counties, target populations, health systems, providers, service organizations and other. Will it pilot in a geographic or demographic population first with intent to scale?* **The oral health project has the potential to affect all counties in the GCACH. It will take planning and time to develop the infrastructure but we feel there is wide support and interest in expanding oral health services**

EVIDENCE AND OUTCOMES	*What evidence is there to show the effectiveness of the proposed project? How does the project align with one or more approaches proposed in the toolkit? Which ones? Are there any real-world outcomes for this project locally?* **Evidence:** **1. Topical Silver Diamine Fluoride For Dental Caries Arrest In Preschool Children: A Randomized Controlled Trial P Milgrom, JA Horst, S Ludwig, M Rothen, BW Chaffee… - bioRxiv, 2017** **2. Evidence-based clinical recommendations for the use of pit-and-fissure sealants: a report of the American Dental Association Council on Scientific Affairs J Beauchamp, PW Caufield, JJ Crall, K Donly… - … of the American Dental …, 2008 – Elsevier** **3. Alternative practice dental hygiene in California: past, present, and future E Mertz, P Glassman - Journal of the California Dental Association, 2011 - ncbi.nlm.nih.gov** **Outside of the goal for Access to Oral Health Services this project aligns well with the Medicaid Waiver tool kit:** 1. **Bi-directional Integration of Care and Primary Care Transformation: The project fully supports the integration of oral health into primary care thorough establishing dental providers as part of the primary care team t and working with and bi-direction referring of patients with comorbidities in oral health and medicine** 2. **Community-Based Care Coordination: Care coordination required for oral health improvement just as it is for medical issues. This project will better integrate oral health within the care coordination process.** 3. **Addressing the Opioid Use Public Health Crisis: This project includes an education component to help ER staff understand alternative prescription protocols to better address oral health issues.** 4. **Maternal and Child Health: Research shows that periodontal disease has negative effects on pregnancies and mothers do pass on oral bacteria to their babies which begins the careis crisis we now have. This project will outreach to pregnant women delivering needed services out in the community and referral into the dental clinics.** 5. **Chronic Disease Prevention and Control: Periodontal disease and dental caries are classic chronic diseases. They also exasperate many other chronic diseases such as diabetes asthma and heart disease. This project makes major strides to both change the model for treating oral chronic conditions and also integrates that care with the treatment of other comorbidities.**
HEALTH EQUITY	*How might this project approach address health disparities, where they exist due to ethnicity, gender, race, language, sexual orientation, etc.?* **This project is designed to help those populations that cannot readily access oral health care. While this is primarily due to the lack of substantial income it also has to do with transportation, language barriers, and overcoming cultural barriers that interfere with access. Through dental public health/community health research programs designed to identify mechanisms for breaking down these barriers in order facilitate health promotion and prevention, we will be reaching outside the walls of the dental clinics and taking care to the communities.**
WORKFORCE REQUIREMENTS	*Will your project approach require any special workforce requirements not already in place, such as the addition of Community Health Workers? What might these requirements be?* **Our workforce requirement is a licensed Dental Hygienist, who has had curriculum in cultural competence education, *one entire year* in Dental Public Health and Community Dental Health, health promotion and prevention, Special Needs/ Diversity patient management, and *two years* in the clinical dental hygiene process of care.**
GENERAL IMPLEMENT-ATION	*Without going into specific detail, how do you perceive that this project might be implemented differently depending upon the service area? How would a rural implementation differ from an urban one?* **Yes, while adult access is in crisis across CGACH, there are differences in both the oral health needs and priorities within each county of the counties. Southeastern counties report they are most concerned with the lack of access for primarily for adults but also children vs counties like Yakima that have children's access issues resolved but still facing high caries rates and needs for disease reduction.**

SCALABILITY	*How is the project scalable to other communities in the GCACH region?* **Yes, the all the components of this project can be expanded throughout the GCACH. The project is designed to break down current barriers that tend to discourage community oral health projects from expanding. Our goal is to show outcome improvement and cost savings that will drive the advance of this innovative and critically needed care.**
PAIN POINTS	*A pain point is a problem, real or perceived. Broadly, what pain points do you foresee with the implementation of this project? What are some ways to resolve these pain points?* **1. Breaking down the paradigm that oral health care must be delivered in the dental office.** **2. The current dental law prohibits our ability to deliver all the preventative services we would like to. This is a limitation but not a barrier to the project. Our hope is that good outcomes will encourage a change in the dental WACs.** **3. Data: Developing data sets that can be gathered by a disparate group of organizations scattered across a large area of the state.** **4. Low Medicaid reimbursement for adult dental services** **5. No Medicaid payment for oral health case management** **6. Lack of medical/ dental integration**
ALTERNATIVE PROJECT APPROACHES	*Please list the major alternative project approaches you considered in your work but rejected. BRIEFLY, why were the alternate projects considered but rejected?* **We would have liked to engage in a dental ER Diversion component but given the time constraints available for this project, there was no ability to develop the partnerships and commitments this would require.**

DATA ANALYSIS AND ROOT CAUSES:

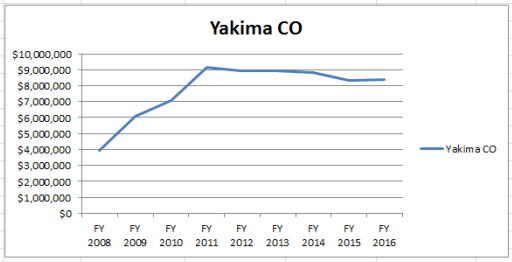
DATA ANALYSIS *Please briefly summarize the team's analysis of data relating to this Project Category. This may include your analysis of population health data (e.g. obesity), social well-being data (e.g. poverty), and healthcare utilization data (e.g. ED Visits) provided by the GCACH and other data sources. What did the data identify as being areas of concern?*

These are examples of the data that was considered. It shows that despite huge access gains and state spending for oral health for Medicaid children, caries rates have not decreased and in fact increased over the past 8 years. Adults data is more difficult to find but th evidence shows an overwhelming lack of access across GCACA.

1. **Uncontrolled caries rate in Medicaid children: Smile survey and cost data from the HCA show great access but at high costs and an increasing caries rate for 3-5 year old children.**

Age 5 and Under Medciaid Popultation- Dental Expenditures

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Yakima CO	$3,920,613	$6,093,071	$7,086,366	$9,161,124	$8,921,334	$8,912,239	$8,801,907	$8,309,876	$8,396,979



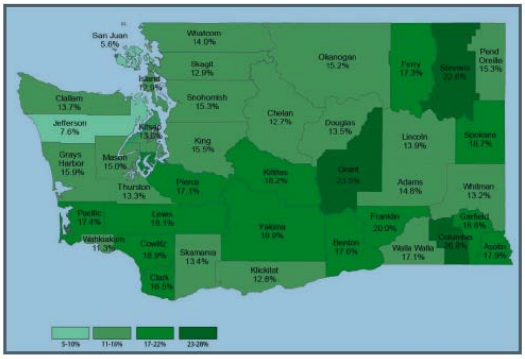
Healthy People 2020 Goals and Yakima CO Data

Preschool Goals (Age 3-5 yrs)

	HP2020	Smile Survey 2005	Smile Survey 2010	Smile Survey 2015	Meeting or Exceeding Goal?
Caries Experience	30.0%	45%	40%	49%	No
Untreated Decay	21.4%	25%	13%	8%	Yes

2. **Adult Access: The data shows the access crisis for adult oral health services throughout the GCACH.**

Adult Enrollees with at Least One Dental Service, by County, FY 2014



ROOT CAUSE ANALYSIS *Based upon the data analysis above, what might be some of the underlying root causes to these findings? For example, local obesity might be attributed to cultural issues, living in a "food desert", a lack of exercise opportunities, etc.*

1. **High caries rates in children: The state of Washington has concentrated primarily access to care as the means for resolving the oral health issues the plague our low-income children populations. The Smile Survey data has shown without any doubt that while access has increased to unprecedented levels, the caries rates have actually risen over the past 20 years.**
2. **Adult access to oral health services: High dental costs, poor reimbursement rates and an ill distribution of dentists have all contributed to an access crisis for adults**
3. **Current dental surgical model vs medical model for treating a chronic disease: caries and periodontal disease are both classic chronic diseases yet dental services are paid for and designed to treat these chronic disease surgically rather than using the approaches established in medicine for improving chronic illnesses**

ADDRESSING ROOT CAUSES *How does your proposed project approach attempt to address the identified underlying root causes from above?*

1. **High caries rates in children: This project not only brings preventive services to primary care medical clinics and schools where children are accessed at much higher numbers than dental clinics. It also uses new medicaments like silver diamine fluoride that can actually arrest caries.**
2. **Adult access to oral health services: While full access for adult oral health needs is not possible without major increases in Medicaid fees, one of the major adult issues, periodontal disease can be addressed by expanding and making it easier for dental hygienist to practice out in the community. Community Health Workers will also be able to increase risk assessment of adults, referrals to proper provider, and access for adults into dental clinics particularly those with comorbidities such as diabetes. CHW's will also provide outcomes assessment of these referrals.**
3. **Changes in the dental law, currently limiting broad access of dental hygienists to underserved populations, adult populations, and with restrictions to treatment options for patients can increase options for dental hygienists, and for accessing underserved populations.**

- **Suggestions include a dental hygiene –based community health pilot program in dental hygiene programs during the two year program term, thus eliminating the requirement for newly licensed dental hygienists to practice under the supervision of a dentists. This would allow more dental hygienists to flow into community health/alternative practice settings directly out of school. Currently new graduates are unable to accept employment in alternate practice settings, or to set up alternate practice arrangements on their own. If successful, the pilot would have a sunrise clause in two years.**
- **Another suggestion is for the state of Washington to consider a dental-hygiene based dental therapist. Dental therapists are mid-level providers of basic diagnostic and restorative services, and very cost-effective providers of oral health care for a system with a bi-furcated system of access. A dental hygiene based model could address prevention-based needs along with restorative needs of the patient population, at a fraction of the cost of a dentist.**

4. **Case management: Caries and periodontal disease are likely the only chronic diseases where case management is not currently being utilized. Adding case management will be critical in tracking children and adults during their course of the disease process to insure the appropriate preventative and treatment needs are performed.**
5. **Current dental surgical model vs medical model for treating a chronic disease: Chronic disease whether medical or dental cannot successfully be treated under a surgical model. This project begins the process of paradigm change. We believe that data gathered form this project will go a long way to influence change on the state level.**

LINKAGES AND ALIGNMENT:

ALIGNMENT *How is the project aligned with the GCACH Regional Survey results, Regional Health Improvement Plan, Community Asset Inventory, and the goals of the Medicaid Demonstration Project?*

LINKAGES *How does your project offer the opportunity for collaborating with other Demonstration Waiver project areas? With which other project areas? How might this look like?*

1. **Decrease Opioid usage by educating ER physicians on prescriptions alternative to address dental pain**
2. **Integrating oral health with medical primary care**
3. **ED diversion through case management and referral to medical, dental, dental hygiene providers and follow up on referrals.**

CLINICAL-COMMUNITY LINKAGES *The goals of clinical-community linkages include: Coordinating health care delivery, public health, and community-based activities to promote healthy behavior, forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services. How does this project approach foster clinical-community linkages?*

Yes, this project will require working with schools, community organizations, physician offices, health centers and county health districts to identify, treat and refer as needed GCACH's populations most vulnerable to the harmful effects of oral diseases and take greater strides to true health care integration.

PATHWAYS COMMUNITY HUB (OPTIONAL) *The GCACH may adopt the Pathways Community HUB model as part of its work toward creating community care coordination. How might this project align with the HUB model? Which Pathways in the HUB might you work be affected by?*

The Oral health project is a perfect example of the Pathways Community HUB model of FIND, TREAT and MEASURE. It is community based and designed to find those vulnerable patients that are currently not able to access the dental clinics or their chronic disease is not effectively being treated at those sites. The treatment will occur in the community with referrals when possible and as needed for more complicated care. Finally, we feel this is a model that needs to be measured and if successful, replicated across the state of Washington. The tracking mechanism that will need to be created is an essential part of this Project.

For more information on the Pathways Community HUB, please see: https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf

OUTCOMES AND IMPACT:

TOOLKIT METRICS *Which Toolkit metrics in your project area will this project approach positively impact (e.g. ED visits)? How will this likely take place? What measures will you be monitoring to assess outcomes?*

Tool Kit Metrics:

1. **Increase number of dental sealants: Expanding school sealant programs**
2. **Decrease untreated decay: Redesigning the model for delivering oral health prevention services and integrating with primary care medical**
3. **Increase number of adult dental exams: Expanding the dental hygiene workforce accessing adults out in the community**
4. **Increase number of adult preventive services: Expand the dental hygiene workforce out in the community**

Other Metrics: To advance this new model to a wider arena, we will need to measure health improvement. To do that new metrics capabilities will need to be developed. Some metrics we are considering are:

1. **New caries at recall**
2. **Tracking changes in risk assessments**
3. **Dental Quality Alliance periodontal care measures**

I. Expand school based sealant programs:

- # of assessments
- # of sealants placed
- # of Fluoride varnish placed
- # of children referred into dental
- # of dental emergencies referred into dental

CDT Codes, Medical Diagnostic Codes, and Diagnostic Severity Scale will be used

IIa. Embedding Dental Hygienists into the Medical Primary Care Team

- Ongoing Care in Adults with Chronic Periodontitis
- Periodontal Evaluation in Adults with Chronic Periodontitis
- Caries at Recall (Adults and Children)
- Adult Treatment Plan Completed
- Sealants - % Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk
- Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk
- Changes in risk
- Referrals into dental
- Recall rates for the dental panel in medical
- Access rates and rates of children staying in the program
- Primary and secondary prevention procedures
- Differences in rates of in-clinic procedures: i.e. SSCs and nitrous oxide etc.
- General Anesthesia rates of children accessed through this model compared to those accessed at other YVFWC clinic not using the new model
- Failure rates to understand where the process may break down
- Other

CDT Codes, Medical Diagnostic Codes, and Diagnostic Severity Scale will be used

IIb. Dental hygienists providing services for adult patients in community health settings

- Oral Health Services Utilization by Medicaid Beneficiaries
- Periodontal Evaluation in Adults with Chronic Periodontitis
- Ongoing care in Adults with Chronic Periodontitis
- Caries at Recall (Adults)
- Adult Treatment Plan Completed

- #s of adults accessed
- # pf procedures completed
- # of adults transitioned into dental offices

CDT Codes, Medical Diagnostic Codes, and Diagnostic Severity Scale will be used

III. Dental Outreach – Community Health Worker/Case Management

- # of children and adults referred into dental offices
- # of dental ED patients referred into dental offices
- # of children brought back for recall exams

CDT Codes, Medical Diagnostic Codes, and Diagnostic Severity Scale will be used

IMPACT *Of all the potential project approaches you reviewed, why would this approach achieve the greatest positive impact for the potential financial investment made?*

We haven't reviewed the other projects but can say that the current model for delivering oral health care to low-income populations is a total failure. At best, it has achieved decent access for children but at a very high financial cost and without lowering disease rates. Our adults continue to suffer from abysmal access for even oral basic needs. We could not have designed a more expensive system that delivered the least community health improvement results. This project will test out a redesign of oral health services delivery meant to improve health, access at decreased costs

SUSTAINABILITY & ROI *Please describe how this project will be sustainable after DSRIP funding ends and what is a likely positive return-on-investment (and to whom) within three to five years. This can be stated in terms of a potential downward effect on healthcare utilization for Medicaid clients.*

Sustainability:

Much of the funding required for this project involves start-up costs such as mobile equipment, portable equipment, potential teledentistry equipment and software, and support staffing. Medicaid does pay for the majority of services the project will provide making this project very sustainable. We do feel that successful results will help in attempts to make oral health case management reimbursable by Medicaid.

ROI-:

This is difficult to assess since building up the infrastructure to make a meaningful impact will take time. . With the metrics that come with the project, we hope to demonstrate cost savings and health improvement and use this data to encourage the state of Washington to revamp for oral health Medicaid services are delivered and paid for.

SOCIAL DETERMINANTS OF HEALTH *How might this project approach have a long-term positive impact on the social determinants of health (e.g. housing, employment, incarceration, etc.)?*

1. **Transportation issues: Our highest risk patients often have greatest difficulty access appointment due to transportation problems. The larger the workforce we can create with hygienist providing services in the community setting the more we can break down this barrier.**
2. **Language barriers: The dental hygiene-based Community Health Workers/case managers will have the ability for direct interpretation or indirectly through interpreter services.**
3. **Cultural beliefs: Part of the education for the dental hygiene-based Community Health Workers is in cultural competency and in motivation interviewing to try and work with various cultural beliefs to better promote oral health**

COMMENTS:

What additional comments would you like to state regarding your project?

PROJECT 3D: CHRONIC DISEASE PREVENTION AND CONTROL

Please complete the template sections below. You may expand a box as needed to accommodate your text. If you are unable to answer a particular section, please move to the next section and continue.

PROJECT DESCRIPTION:

PROJECT TITLE
Regional Chronic Disease and Wellness Project

PROJECT FACILITATOR
Bertha Lopez (berthalopez@yvmh.org), Fenice Fragoso (Fenice.Fregoso@molinahealthcare.com)

PROJECT TEAM
Chronic Disease Prevention and Control Leadership Council Workgroup

CONTRIBUTING ORGANIZATIONS AND TRIBES *Please list all the organizations in the nine-county GCACH region that will participate in developing the eventual project application and implementing the project. If there is a lead organization, please identify that organization.*
There are a number of organizations throughout the nine-county GCACH region to partner with for development and implementation. Identifying these organizations will be part of the initial development phase of the project. For example, there are entities that will have a volunteer or advocacy role and there are entities that will have costs associated with delivering a service. Once the project is chosen, each county will identify their level of participation. After this, a specific list can be supplied. Some of the smaller, rural communities/counties may need to rely on support from other areas, so it is also difficult to identify partners within a specific county at this time.

The full list will be influenced and developed by members of the Leadership Council who represent each county.

The group also agrees that considering a lead project manager may be the most efficient and organized approach to such a vast, multi-county project.

COUNTIES SERVED BY THIS PROJECT ☒ Asotin ☒ Benton ☒ Columbia ☒ Franklin ☒ Garfield ☒ Kittitas ☒ Walla Walla ☒ Whitman ☒ Yakima ☒ Yakama Nation ☐ Other _____

TRIBES SERVED BY THIS PROJECT (if applicable)
Yakama Nation

THIS PROJECT IS (check one): ☒ **New** ☒ **Enhancing an existing project or set of projects**

THIS PROJECT SERVES MEDICAID CLIENTS ONLY (check one): ☐ **Yes** ☒ **No**
If you checked "No", what percentage of clients served are Medicaid?
35% GCACH Medicaid percentage

Medicaid population by county in GCACH:

Yakima	**44.2%**
Benton	**22.3%**
Franklin	**13.7%**
Walla Walla	6.7%
Kittitas	3.9%
Whitman	3.2%
Asotin	2.7%
Klickitat	***2.6%***
Columbia	.5%
Garfield	.2%

THIS PROJECT DOES NOT CURRENTLY RECEIVE OTHER MEDICAID FUNDING FOR THE SAME SERVICES (check one):
☐ **Yes** ☒ **No**
If you checked "No", please describe what other Medicaid funding this project approach is currently receiving and what other Medicaid contracts might be involved.

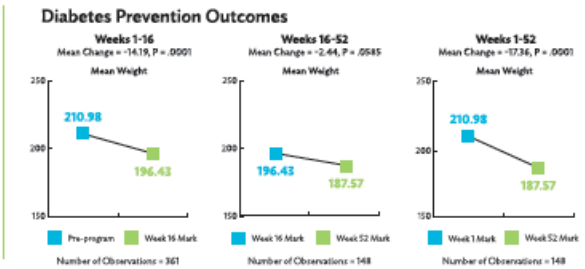
None

PROJECT CATEGORY Please indicate which optional category area from the toolkit your project will meet. If more than one area applies, please check the primary area:

- ☐ Bi-directional Integration of Care
- ☐ Community-Based Care Coordination
- ☐ Transitional Care
- ☐ Diversion Intervention
- ☐ Addressing the Opioid Use
- ☐ Maternal and Child Health
- ☐ Access to Oral Health
- ☒ Chronic Disease Prevention and Control

PROJECT GOAL STATEMENT	*What do you hope to achieve with this project? What issue are you addressing? What problem are you trying to resolve?* Obesity and Diabetes was identified as top priority issues to address in our region. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer. Obesity is the second highest leading cause of preventable death. Addressing obesity through prevention strategies will help us achieve the goal of improving chronic disease management and control. Although this project focuses on diabetes prevention and control, other areas of chronic disease will be naturally influenced. For example, heart disease, high blood pressure, and obesity. *Project Goals:* ▪ Increase awareness of Chronic Disease Prevention and Control (Chronic Disease Self-Management Program and Diabetes Prevention Program). ▪ Promote preventative visits with Primary Care Providers (PCP). ▪ Increase referrals to Diabetes Prevention Program and Chronic Disease Self-Management Programs (CDSMP) in the GCACH region. ▪ Increase awareness of 5-2-1-0 in the GCACH region.
BRIEF PROJECT DESCRIPTION	*Provide a description of the project. What are the strengths and weaknesses of this particular project approach?* **Project Description:** Through multi-county collaboration and partnerships, this project will target treatment and prevention for chronic disease (as it relates to diabetes.) Promotion of the 5210 program (primary prevention), Diabetes Prevention Program (secondary prevention), and Chronic Disease Self-Management Program (tertiary prevention) can help achieve improved health for high risk populations. By implementing these preventive measures across the GCACH region, emergency room visits, hospitalizations, readmissions, and premature deaths from diabetes should decline. **Strengths:** Utilized national, ***evidence-based approaches*** Upstream – prevention of not only obesity, but early onset of Diabetes and a reduction in cost. Promotes participation and engagement among children, which can save cost in the long-term. Although the focus is on the Medicaid population, it will reach the general population in this topic area. Involves primary, secondary and tertiary prevention Promotes self sufficiency Team based Community based Involves health care organizations Responds to the needs of each community

	Addresses high risk neighborhoods, areas, and populations Project is scalable Increases prevention and health awareness Financially sustainable **Weaknesses:** Culture shift for providers to focus on prevention. Decrease in revenues to safety net hospitals. Region is largely a medical provider shortage area—this project should increase traffic flow to Primary Care Providers (PCPs). May measure an increase in diabetes prevalence if emphasis is on better identifying pre-diabetes and diabetes in the population before a decrease is seen. Risk that focusing on Medicaid populations will exclude the general population as it pertains to diabetes/chronic disease. **Problems description:** Prevention of obesity as it relates to chronic disease. Hospitals are inundated with patients whose obesity/diabetes could be better self-managed. Critical need to integrate more upstream primary obesity/diabetes prevention to prevent this issue from spreading beyond the five-year demonstration project.
PROJECT SCOPE AND TARGET POPULATIONS	*Please describe what part of the regional GCACH community the project will serve, including which counties, target populations, health systems, providers, service organizations and other. Will it pilot in a geographic or demographic population first with intent to scale?* Targets all counties Medicaid children and adult population High risk population Rural population High Hispanic and Native American population Health Systems/ Providers/Service Organizations who represent the highest risk population Hospitals, Primary Care Providers, Managed Care Organizations (MCO's), community centers, public health organizations, schools, senior centers, Federally Qualified health Centers (FQHC's), and local parks and recreation departments.
EVIDENCE AND OUTCOMES	*What evidence is there to show the effectiveness of the proposed project? How does the project align with one or more approaches proposed in the toolkit? Which ones? Are there any real-world outcomes for this project locally?* Approaches have evidence-based data to show effectiveness. Yakima County has successfully implemented both CDSMP and DPP for several years and the outcome results for this county and population are below: **Diabetes Prevention Program Yakima outcomes (DPP):** • Average weight loss per participant = 17.36lbs • 52% of the DPP participants achieved 7% weight loss goals • 18% of participants have been able to stop taking medication after the DPP program • Intensive lifestyle intervention programs have a positive impact on weight, A1c, MAP, and other clinical measures • Increase in fruit and vegetable consumption • Increase in physical activity

	 **Chronic Disease Self-Management Program (CDSMP):** • 28% decrease in overall emergency department (ED) visits • Increase in fruit and vegetable consumption • Increase in physical activity **5210:** • Weight gain prevention • Baseline BMI • See your primary care doctors and reduce ED use • Well child visits Note: we may see an increase in Chronic Disease because of increased screening and awareness for our GCACH. In addition to the above program specific outcomes we anticipate addressing the following system and project level outcomes: ▪ Outpatient Emergency Department Visits ▪ Inpatient Utilization ▪ Adult Access to preventive/ambulatory care ▪ Comprehensive Diabetes Care: eye exams (retinal) performed) ▪ Comprehensive Diabetes Care: Medical attention for nephropathy ▪ Well-Child Visits ▪ Medication Management for people with Asthma and other Chronic Conditions ▪ Comprehensive Diabetes Care: Blood Pressure Control ▪ Adult Body Mass Index Assessment
HEALTH EQUITY	*How might this project approach address health disparities, where they exist due to ethnicity, gender, race, language, sexual orientation, etc.?* Health Disparities, as it relates to language is approached because both awareness/support material and workshops are offered in Spanish and English. We will work to identify where other disparities exist within each county and approach them with strategies that bring the services and information directly to them. Rural communities generally see a significant increase in disease and disability and suffer from geographic isolation. These health disparities will be addressed, again, by directly identifying these communities and working with partners to bring the information and services closer to them. This project is inclusive of everyone and is unique in that it goes to the need, so probability of making a true, positive impact in each county is high.
WORKFORCE REQUIREMENTS	*Will your project approach require any special workforce requirements not already in place, such as the addition of Community Health Workers? What might these requirements be?* Yes, this project approach would include training facilitators in all counties. Educating the clinical providers/Community Health Workers/outreach coordinators is a key factor. Education and awareness through a marketing campaign will also incur some cost. Recruiting and hiring an Outreach Coordinator would ensure the dedication needed to building and maintaining relationships, partnerships, and collaboration among all counties. Additional costs might include

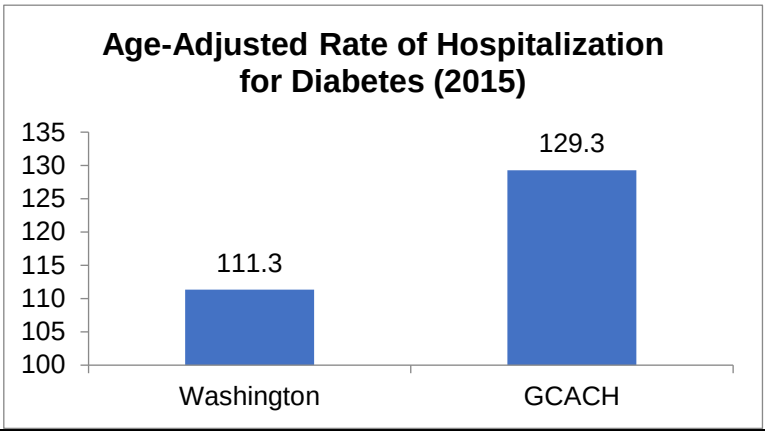
	services for public/community-wide screenings and health fairs, including transportation costs for mobile health, dental, or food distribution services.
GENERAL IMPLEMENT-ATION	*Without going into specific detail, how do you perceive that this project might be implemented differently depending upon the service area? How would a rural implementation differ from an urban one?* Implementation in our outreach activities can be done within the local provider, hospital and/or public health offices, schools and local coalitions. Implementation of different aspects of the program could differ within the urban and rural areas with hospitals, public health and schools as leaders. One option will be to host community-wide events to encourage attendance and will incorporate the project strategies and programs into the event. Some region wide sharing of services will be utilized to maximize the marketing, support, and availability of classes with minimum class attendance and minority populations. An overall project manager will be critical to define specific organizations in each area.
SCALABILITY	*How is the project scalable to other communities in the GCACH region?* Using the implementation model that Yakima has developed as a guide, we can implement this project in any of the GCACH counties. Each community will be offered help and shared services to support local community needs. A project manager will be critical to identify specific organizations in each area that will implement this project as each community will be unique in the availability of resources. If an area cannot sustain all sections of the project, alternative sharing of services and remote learning will be available as an option. The project focuses on multiple age ranges, and is available in English and Spanish to address high risk populations. We will leveraging healthy 5210 media campaign to promote the Diabetes Prevention and Chronic Disease self-management programs, through different existing organization such as community coalitions, schools, public health, and local health providers to ensure broader reach in our counties, in addition to creating a culture of health.
PAIN POINTS	*A pain point is a problem, real or perceived. Broadly, what pain points do you foresee with the implementation of this project? What are some ways to resolve these pain points?* 1) Scale to smaller counties: given population size having adequate participants in the evidenced based programs may be a challenge – we intend to address this issue by collaborating between counties and share resources (facilitators) through remote learning. 2) Shortage of community health workers in smaller communities and/or rural areas. 3) Another is the time it could take to build the trust and relationships needed in the smaller communities. One way to address/resolve these are to partner with other entities, including University programs, apprenticeships, and residency programs in health care to bring services to the smaller communities through health fairs and/or a large community-wide event. Another avenue would be to invest in an Outreach Coordinator who is committed to building relationships and trust within the communities. 4) Imbedding the evidence based program in the primary care practices as a tool to assist patients manage and prevent chronic disease 5) Train the Trainer – facilitation of trainings for lay educators that will teach the classes 6) Data collection pre/post intervention and outcome analytics

ALTERNATIVE PROJECT APPROACHES	*Please list the major alternative project approaches you considered in your work but rejected. BRIEFLY, why were the alternate projects considered but rejected?* 1) The Community Guide is primarily a list of interventions and recommendations. There was not a lot of support offered, whereas other projects had more to offer in this area. 2) Million Hearts Campaign focuses on heart health, including heart attacks and stroke. The Regional Chronic Disease and Wellness Project focuses on chronic diseases, as diabetes relates to it, so therefore will naturally include and influence heart health. 3) Stanford Chronic Disease Self-Management Program's main mission is research and also requires licensing to offer the program. Currently, Benton Franklin Health District is the only county/organization in the GCACH region who offers this program. The other programs chosen have a further reach, are more cost-effective, and are easily scaled to level of use. 4) CDC National Diabetes Prevention Program (NDPP) has limited access for in person support. It is currently offered in Walla Walla, Yakima, Colfax, and Clarkston- only four of the nine GCACH counties. 5) Community Paramedicine Models has two components: Emergency and Primary Care and Rural Health. The first is in California, so there is limited data and evidence to support the program in multiple areas. The Rural health offers good information that could be helpful in the implementation of The Regional Chronic Disease and Wellness Project, but the group did not feel it was as strong as the programs chosen.

DATA ANALYSIS AND ROOT CAUSES:

DATA ANALYSIS *Please briefly summarize the team's analysis of data relating to this Project Category. This may include your analysis of population health data (e.g. obesity), social well-being data (e.g. poverty), and healthcare utilization data (e.g. ED Visits) provided by the GCACH and other data sources. What did the data identify as being areas of concern?*

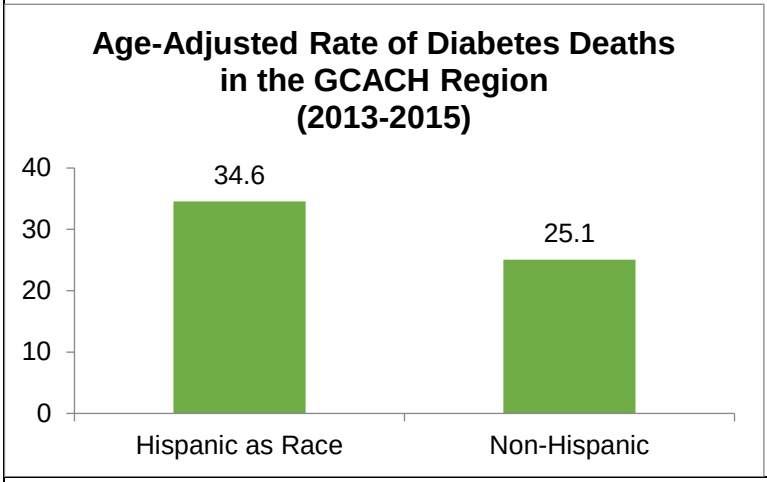
At the beginning (2014), the GCACH heard from each county in the region who had conducted a Community Health Needs Assessment. From this, diabetes and obesity was identified as a common theme across many of the counties. In the GCACH region, most of the County Community Health Needs Assessments identified obesity and/or diabetes as a top priority issue to address. Obesity is the second highest leading preventable cause of disease and death (second only to tobacco use) and addressing it is considered a winnable battle by the CDC. According to the CDC, 86 million adults in the U.S. (more than 1 out of 3) have prediabetes; 9 out of 10 people with prediabetes don't know they have it.



In 2015 the age adjusted rate of hospitalization with diabetes mellitus as the primary diagnosis was 129.3 per 100,000 in the GCACH region (significantly higher than the Washington State rate: 111.3 per 100,000) *(Source: WA Hospital Discharge Data, CHARS, DOH Center for Health Statistics, August 2016).* (See graph)

In 2015, the age-adjusted rate of mortality resulting from diabetes mellitus in the GCACH region was 26.73 per 100,000 (23.07-30.86), which was higher than the age adjusted mortality rate of 22.48 per 100,000 (21.43-23.57) in Washington.

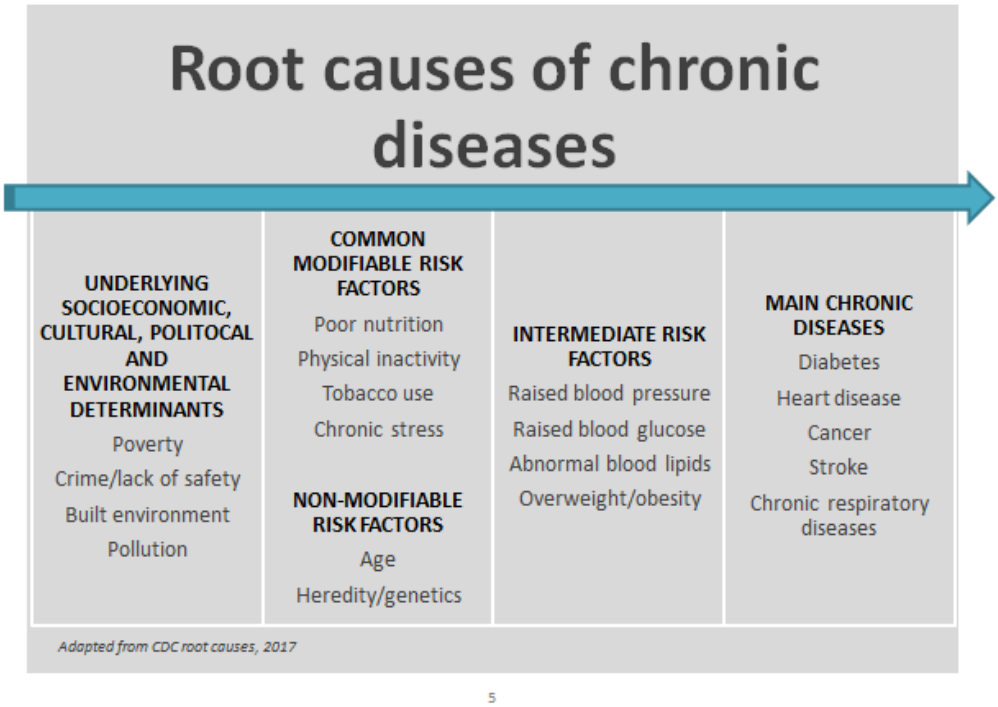
According to Medicaid claims data, an average of 7% of adults 19 years of age and older in the GCACH Region were diagnosed with diabetes (95% CI: 6,8) this was highest among the American Indian/Alaska Native population (6%, 95% CI: 5,7) *(Source: 2015-2016 HCA).*



Additionally, the graph to the left illustrates the rate of diabetes deaths in the GCACH region was higher among the Hispanic population (34.6 per 100,000) when compared to that of the Non-Hispanic population (25.1 per 100,000) (2013-2015). *(Source: WA Hospital Discharge Data, CHARS, DOH Center for Health Statistics, August 2016).*

ROOT CAUSE ANALYSIS *Based upon the data analysis above, what might be some of the underlying root causes to these findings? For example, local obesity might be attributed to cultural issues, living in a "food desert", a lack of exercise opportunities, etc.*

According to the Centers for Disease Control and Prevention, root causes of chronic diseases include underlying socioeconomic, cultural, political and environmental determinants (genetics, poverty, crime/lack of safety-perceived or actual, built environment, pollution, cultural perception/acceptance of obesity/diabetes). The common modifiable risk factors include but are not limited to: poor nutrition (foods high in fat, sugar, and sugary beverages), physical inactivity, tobacco use, and chronic stress. Intermediate risk factors of these are raised blood pressure, raised blood glucose, abnormal blood lipids, and overweight/obesity, just to name a few. All of the above factors can contribute to onset of chronic diseases including diabetes, heart disease, cancer, stroke, chronic respiratory disease, and more.



ADDRESSING ROOT CAUSES *How does your proposed project approach attempt to address the identified underlying root causes from above?*

5210 is simple and anyone, no matter their income, level of education, built environment, or culture, could follow. The campaign materials are available for use in preschools, schools, workplaces, and communities, and are available in Spanish and English.
DPP, DSMP and CDSMP are based on empowering people with pre-diabetes and diabetes to take charge and self-manage their disease whenever possible, and when implemented correctly, reduces the need for unnecessary ER/Hospital visits.

LINKAGES AND ALIGNMENT:

ALIGNMENT *How is the project aligned with the GCACH Regional Survey results, Regional Health Improvement Plan, Community Asset Inventory, and the goals of the Medicaid Demonstration Project?*
The project aligns with GCACH Regional Survey results in many areas. Chronic Disease Prevention and Control was ranked as a high priority by survey respondents. The collaborative approach for this project would incorporate many of the professionals listed as "greatest need". Being able to bring some of the professionals and services to counties that fall short in specific areas would be a great benefit to a small, under-served community. There are opportunities for crossover in areas such as diabetes screenings, immunizations, oral health screenings, blood pressure screenings, BMI tests, well child checks, and primary care preventions.

LINKAGES *How does your project offer the opportunity for collaborating with other Demonstration Waiver project areas? With which other project areas? How might this look like?*

This project aligns with several other projects by providing an outlet to identify and reach their targeted populations and patients who need integrated behavioral health in primary care, increased access to primary care, improved health for men, women and children, and screenings and services for oral health. One of our unique approaches is going to communities with mobile services or assistance. For example, hosting a free mobile food distribution or health fair to attract clients who would benefit from the projects. By offering information, free screenings, and access to actual health care through these events will not only add value and impact to the overall events, but serve more people in one place. This also provides an opportunity to reach populations who are not aware of a need they might have. Crossover and potential collaboration are with the following other projects:

- Bi-Direction Integration of Care & Primary Care Community-Based Care Coordination
- Community-Based Care Coordination
- Transitional Care and Diversion Interventions
- Reproductive and Maternal/Child Health
- Access to Oral Health Services

CLINICAL-COMMUNITY LINKAGES *The goals of clinical-community linkages include: Coordinating health care delivery, public health, and community-based activities to promote healthy behavior, forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services. How does this project approach foster clinical-community linkages?*
The evidence based programs are delivered where the community lives: community centers, housing sites, schools, churches, which are critical to the success of the program and foster clinical-community linkages. In addition, we intend to offer community health fairs where we will offer screenings, provide information and resources on food insecurity and oral health.

Our project will also link to the following project areas: care coordination and pathways hub, Maternal and Child Health, Transitional Care, diversion intervention, opioid, and Access to Oral Health.

PATHWAYS COMMUNITY HUB (OPTIONAL) *The GCACH may adopt the Pathways Community HUB model as part of its work toward creating community care coordination. How might this project align with the HUB model? Which Pathways in the HUB might you work be affected by?*
The Pathways Community HUB model can align with our project by connecting at-risk clients to community services that support care plans and produce positive health outcomes. The model focuses on prevention and early treatment. The hub receives referrals, determines eligibility, enrolls clients, conducts training for community

health workers and monitors their performance along with provider performance. The Regional Chronic Disease and Wellness Project will be led by referrals as individuals are most successful in the program if the referral is given by a medical provider. Through its hub clearinghouse and monitoring functions, it can provide quality assurance that helps reduce duplication, lower costs, improve health status and reduce health disparities by recording and reporting client service utilization and health outcomes. This will allow us to acquire data that we can use to assure that programs are being effective in each county and also bridge gaps in referrals and ensure client access to programs.

For more information on the Pathways Community HUB, please see: https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf

OUTCOMES AND IMPACT:

TOOLKIT METRICS *Which Toolkit metrics in your project area will this project approach positively impact (e.g. ED visits)? How will this likely take place? What measures will you be monitoring to assess outcomes?*

Clinical: (HCA Dashboard)
Child and Adolescents' access to primary care practitioners
Adult access to preventive/Ambulatory care
Comprehensive diabetes care (eye exam performed, and medical attention for neuropathy)

Preventive: (HCA Dashboard)
Comprehensive diabetes care: blood pressure control
Adult BMI
Well-child visits in the 3rd, 4th, 5th and 6th years of life
Well-child visits in the first 15 months of life

Other valuable project metrics:
Adolescent BMI/reduce adolescent obesity (HYS)
Increase the percentage of adults obtaining recommended physical activity
Reduce early onset preventable pre-diabetes/diabetes (may initially see an increase-better capturing prevalence)
Increase participation in DPP and DSMP (DPP, DSMP Program data)
Reduce hospitalizations for diabetes(DOH Center for Health Statistics)
Reduce preventable deaths from diabetes (DOH Center for Health Statistics)

IMPACT *Of all the potential project approaches you reviewed, why would this approach achieve the greatest positive impact for the potential financial investment made?*

*Obesity is the second highest leading **preventable** cause of disease and death and addressing it is considered a winnable battle by the CDC. According to the CDC, 86 million adults in the U.S. (more than 1 of 3) have prediabetes; 9 out of 10 people with prediabetes don't know they have it. Our focus is on upstream health (prevention) that will also address chronic disease management. These project approaches have strong evidence and have been proven and successful in Yakima county.*

SUSTAINABILITY & ROI *Please describe how this project will be sustainable after DSRIP funding ends and what is a likely positive return-on-investment (and to whom) within three to five years. This can be stated in terms of a potential downward effect on healthcare utilization for Medicaid clients.*

Promotion of 5210 across the region, combined with consistent preventive screenings for diabetes and referral to 'prescription to play,' DPP, DSMP/CDSMP, if implemented correctly, people will be empowered to prevent and self-manage their diabetes. This will reduce ER visits, hospitalizations, and preventable diabetes deaths. This will reduce costs and improve quality of life among residents.

SOCIAL DETERMINANTS OF HEALTH *How might this project approach have a long-term positive impact on the social determinants of health (e.g. housing, employment, incarceration, etc.)?*

Low-income and sub-poverty households are often faced with difficult decisions. These include forgoing needed screenings, medications, and care for routine health and chronic diseases. This may also include neglect of needs for children, such as well checks, nutritious food, child care, and housing. Choices that save them money one day often eventually threaten their own health and safety, as well as their loved ones. Addressing immediate needs may help in the short term, but access to sustainable resources and education can create lasting change.

The Regional Chronic Disease and Wellness Project address both immediate and long-term needs. Providing access to basic needs including food and other necessities can help reduce the stress and burden on struggling individuals and families. Alleviated burdens can help those struggling to be more open to learning about other needed resources (such as diabetes and health screenings). In the long term, if we can get more people on the road to chronic disease control and wellness, we can make a positive impact on social determinants of health.

Research shows that being healthier leads to decreased absenteeism and increased productivity at work, which affects employment, housing, and other social determinants of health. In addition, reduction in the prevalence of disease leads to overall economic development in developing economies.

COMMENTS:

What additional comments would you like to state regarding your project?