Greater Columbia Accountable Community of Health

Medicaid Demonstration Project Team Presentations

Leadership Council Meeting

June 22, 2017

Project Team 2A:
Bi-Directional Integration of Care and Primary Care Transformation
Project Team Report

Bidirectional Integration of Physical & Behavioral Health

- Overarching goals:
  - Increase access to BH services
  - Improve coordination of physical health, MH, SUD, and community resources (schools, jail, peer resources)
  - Enhance reporting capability
  - Measure progress related to VBP goals

- Method:
  - Optimize systems, organizations, and clinics to successfully integrate physical, mental, and SUD
  - Gap analysis and partnership formation
  - Use of Toolkit methods for bidirectional approach (Bree, Collaborative Care, Coordination)
  - Use of appropriate resources/consultants
  - Meet identified milestones

- Scope and Target Population
  - All 9 counties
  - All individuals (Medicaid focus)

Bidirectional Integration of Physical & Behavioral Health

- Health Equity
  - BH and SUD disproportionally linked to low income, ethnic minorities, gender-based minorities, etc. (e.g. women, LGBTQ, etc.)
  - Also, SPMI diagnosis relates to disproportionate rates of morbidity/mortality, chronic disease, ED use
- Workforce
  - Hire, promote, train, or contract for providers to meet the clinical and community/system gaps across GCACH

Bidirectional Integration of Physical & Behavioral Health

- Implementation
  - Phase 1: Practice Readiness (all clinics) – MeHAF, PCMH-A
  - Phase 2: Qualitative Data Gathering & Assessment
    - Gap Analysis at the county/regional level, focused on:
      - Care provision
      - Coordination of resources
      - Reporting capabilities
  - Phase 3: Road Map Finalized and Approved (milestones)
  - Phase 4: Coordinated roll-out based on identified needs
  - Phase 4a: Measure progress related to road map and VBP metrics
  - Phase 5: Engage support (i.e. Qualis) as needed based on 4a results

- Pain Points
  - Ability top monitor/collect/report data for VBP outcome with various EHRs
  - Aggregation of data
  - Coordination and communication regarding coaching needs across GCACH

Project Team 2B:
Community-Based Care Coordination

Community Pathways Hub

- Description
  - Strategy to identify and address risk factors at the level of the individual, but can also impact population health through data collected
  - Members receive comprehensive assessment of their risk factors and are assisted by local community health workers who use standard pathways to connect members to needed resources and progress is tracked via a centralized "Hub"
- Scope
  - This approach will be gradually extended to all regions of the Greater Columbia ACH, one or two high risk populations will be selected for initial implementation
    - High utilizers of ED services with high needs, (PRISM score 1.5+)
    - High utilizers of ED with moderate needs, (1.0 - 1.5)?
    - High utilizers of ED with identified needs in Behavioral Health and C.D.
    - Maternal a Child Populations with specific risks
    - Populations impacted by Chronic Disease with high incidence in the region
  - Decision to be made whether to focus on one population for all sub-regions in the first phase, or select different at-risk populations

Community Pathways Hub

- Health Equity
  - The project connects clinical care coordination agencies and community based organizations providing social services in a collaborative, direct, and “standardized” way
  - This interaction provides members with direct access to services that are currently hard to reach, for those not engaged with health systems
  - Individuals who are high utilizers of care are often underserved and lack access to social services and community resources

- Workforce
  - Community Health Workers are a key human resource for the pathways hub, they will provide culturally competent coordination of services; reaching the members in their own environment and “holding their hand” through navigating clinical and social interventions

Community Pathways Hub

- Implementation Plan
  - Planning: Determine Hub Entity, agree to payment model for contracted CCAs, determine initial priority populations, connect with project teams utilizing care coordination services, develop project plan
  - Implementation: Launch the Hub, enable pathways, create mechanics for outcome measures tracking
  - Scale & Sustain: Determine long term payment mechanisms, monitor and continuously improve quality of care metrics, extend pathways for other populations at risk

- (Potential) Pain Points
  - Approach to selecting an agency as the hub
  - Approach to selecting priority populations at risk, (by sub-region or for entire service area)
  - 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

Project 2C:
Transitional Care
aka
Interdisciplinary/Interagency Life Support at Transitions (IDIALST)

Project 2C: IDIALIST

- Description
  - Transitions are high risk events
  - There are several initiatives in the region which have built local strengths which can be leveraged to serve those communities. This is the greatest opportunity we see.
  - Additionally, INTERACT offers evidence-based tools to support care without transport to ED
- Scope and Target Population
  - 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.

Project 2C: IDIALIST

- Health Equity
  - We know that those at highest risk for readmission are those impacted by social determinants of health. Those disadvantaged by such disparities will appropriately receive greater service and support, and ideally long-term reduction of disparities.
- Workforce
  - 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:
  - Depending on area, augmenting or implementing use of field-based RN care coordinators, community paramedics, and CHW.
  - Augmentation of existing staffing regardless to support a broader population, e.g.- expanding Health Homes eligibility or increased use of collaborative community paramedicine to extend reach and penetration.
  - WSU nursing and social work students, CWU community paramedicine students, and other trainees across the ACH may be used to augment existing work force.

Project 2C: IDIALIST

- Implementation
  - Resources vary across GCACH.
    - Rural implementation will build on existing networks and resources including collaborative and simple community paramedicine and Health Homes if possible.
    - Consistent Care has laid a solid foundation in more populous areas which will facilitate implementation in those 4 counties
    - Institutional settings will implement INTERACT, presumably on a county-by-county basis
- Pain Points
  - The people who choose to live miles from their nearest neighbor have different sensibilities and attitudes than those in larger population centers. 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.
  - 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. We should expect growth pains.
  - 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.
  - 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.
  - Coordination of discharge processes between community workers and hospital discharge planners may be a learning curve.
  - The broadened role we are considering for Health Homes may be beyond their legislated charter, and that may have to be addressed.

Project 2D:
Diversions
Interventions

Project 2D: Diversion Intervention

Initiative 1

- CCS ED Diversion Regional Referral Center
  - Super-User Program
    - Community Paramedicine
    - Hot Spotters
  - Low-Moderate User Program
    - Community Paramedicine
  - Medically Intensive Case Management Program

Initiative 2

- Health System Education & Public Education
  - PSA (ER is for Emergencies)
  - Partner with GCACH for wide spread distribution of message

Initiative 3

- Ride to Care
  - If non emergent patient is taken in a van to urgent care instead of an ambulance to the ED

Project Description

- **CCS ED Diversion Regional Referral Center**
  - Assigns patients to Super User Group, Low-Moderate User Group, or Medically Intensive Case Management Group
  - All three groups use a team of RN Case Managers and CHWs to provide medical care coordination and outreach for social determinants
  - Community Paramedicine used as another resource to provide care at the patients home (tele-medicine)
- **Ride to Care**
- **Health System and Patient Education** (ER is for Emergencies)

Scope & Target Population

- **Population:**
  - *Super-users:* more than 10 ED visits
  - *Low-Moderate Users*: less than 10 ED visits
  - *Medically Intensive:* complex medical and social needs, at risk for hospitalizations
- **Scope:** Start in Benton, Franklin, Yakima, Kittitas, and Walla Walla where CCS services already exist. Expand in those areas and then move into rural areas.

Health Equity

- Outreach done by CHWs will address health inequalities and barriers to an effective outcome.

Workforce

- Additional RN Case Managers and CHWs
- Infrastructure for Community Paramedicine needed everywhere except at Prosser Memorial Hospital
- Implementation of Ride to Care across the GCACH

Pain Points

- Differences in resource availability and ability across GCACH
- Requires engagement and active participation of hospitals
  - Established in Benton, Franklin, Kittitas, Yakima, and Walla Walla Counties

General Implementation

- CCS is established but would need expansion in current locations.
- Initiate services in additional locations.
- Build Community Paramedicine across GCACH
- Implement Ride to Care

Project 3A:
Addressing the Opioid Use Public Health Crisis

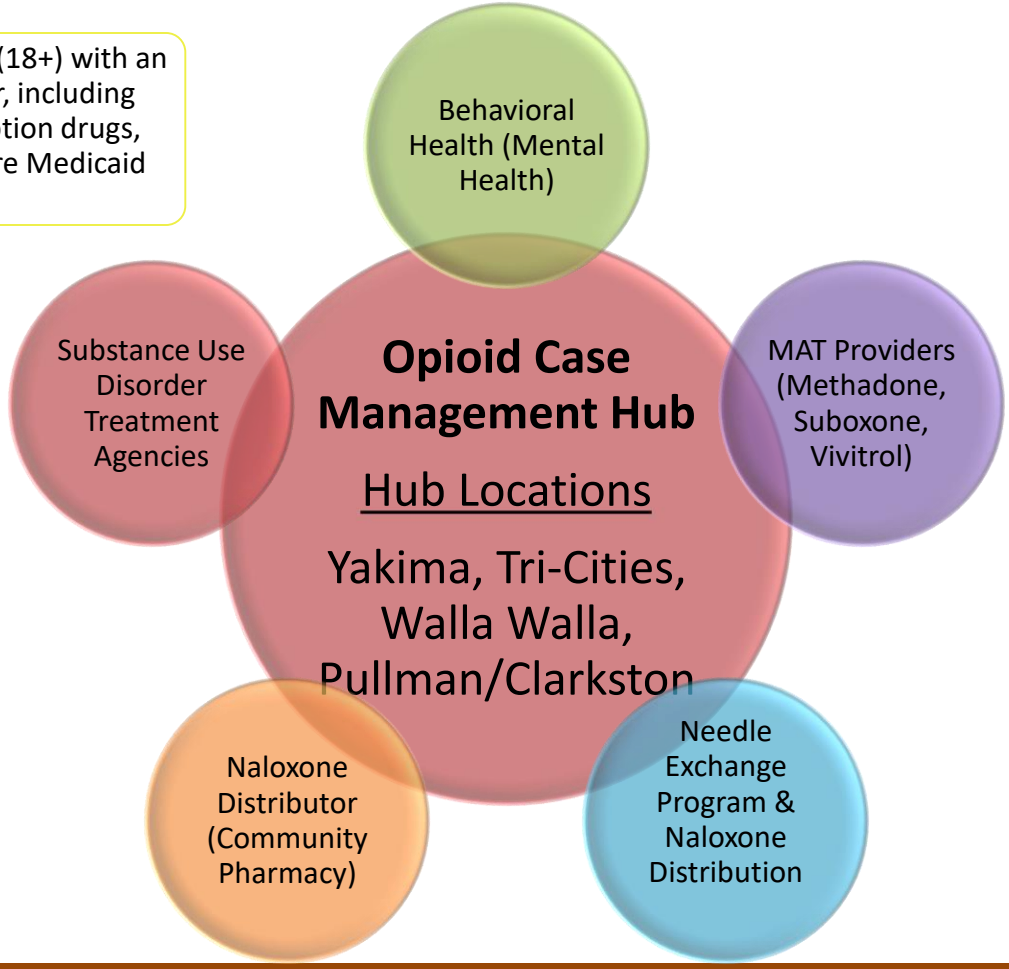
OCRC: Opioid Crisis Response Collaborative

Description

- **Harm Reduction Model**, patients are managed regardless of their readiness to obtain treatment
- Focus on **bridge to recovery,** barriers to effective MAT are addressed
- **Components include**: case management, outreach with CHWs, needle exchange implementation and promotion, MAT, & access to Naloxone
- **Overdose management**

Scope & Target Population

- **Population:** Patients (18+) with an opioid use disorder, including heroin and prescription drugs, estimate 75-80% are Medicaid patients
- **Scope:** Case management hub in strategic locations across GCACH, developed by sending out LOI's to agencies in each area. Develop requirements for each hub.



OCRC: Opioid Crisis Response Collaborative

Health Equity

- **Outreach** done by **CHWs** will address any health inequalities, identified by case managers, or barriers to an effective outcome.

Workforce

- Recruit & train additional **CHWs**
- Use **existing work force** within current substance abuse agencies

OCRC: Opioid Crisis Response Collaborative

Implementation

- Develop case **management hubs**
- Rural areas may have people from a case management hub **traveling to areas on a rotating basis**.
- Use **tele-health** where appropriate.
- **Build infrastructure** where it does not exist (needle exchange, MAT providers)

Pain Points

- **Defining deliverables** across multiple agencies
- Communication collaboration **(HIPAA)**
- **Political opposition** to harm reduction approach
- Long term **sustainability**
- **Workforce** development
- **Geographical distance** that needs to be bridged to facilitate collaboration
- LOIs will be sent out to gage each communities **level of interest** from different agencies

Project 3B:
Reproductive and Maternal/Child Health

Maternal Child Health Home Visiting

- Description
  - Two home visiting models
  - Nurse Family Partnership
  - Parents as Teachers
- Scope and Target Population
  - Mothers and children through age 3
  - At risk
  - Disparities
  - Serve Greater Columbia region

Maternal Child Health Home Visiting

- Health Equity
  - Serves low income, urban and rural, racial/ethnic minorities, non-English speaking, teenage mothers, risk of poor health outcomes, others at risk for health disparity.
- Workforce
  - NFP implemented with Registered Nurses
  - PAT trains Parent Educators (minimum AA in early learning or education)

Maternal Child Health Home Visiting

- Implementation
  - NFP active in Benton-Franklin and Yakima Counties
  - PAT active in Walla Walla and Yakima Counties
  - Serve both urban and rural families
  - Scalable to urban and rural
- Pain Points
  - Difficulty recruiting culturally competent nurses and parent educators
  - Geographic and seasonal challenges

Project Team 3C:
Access to Oral health Services project Team Report

Breaking Down the Walls of the Dental Clinic

- Description
  - Expand Hygienists providing oral health services to adults in community settings and medical offices
  - Embed dental hygienists in the medical primary care team, and expand dental school sealant programs
  - Train Community Health Workers in oral health issues and develop case management for oral health services
- Scope and Target Population
  - Reduce caries rates for low-income children across GCACH
  - Increase access to oral health services for adults across GCACH
  - Greatest access needs in Southeastern WA

Breaking Down the Walls of the Dental Clinic

- Health Equity
  - Reduce transportation barriers
  - Reduce language and cultural barriers
  - Make access easier by integrating care
- Workforce
  - Expand the # of hygienists out in the community
  - Train community health workers in oral health issues

Breaking Down the Walls of the Dental Clinic

- Implementation
  - Building the workforce will take time but this project kick starts the process
  - Metrics to confirm model
- Pain Points
  - Changing the dental paradigm
  - Low reimbursement rates for adult dental
  - Developing a data collection process across GCACH
  - Lack of medical/ dental integration

Project 3D:
Chronic Disease Prevention and Control

Regional Chronic Disease and Wellness Project

Project Description:

Through multi-county collaboration and partnerships, this project will target treatment and prevention for chronic disease (as it relates to diabetes.)

- 5210 Media campaign (primary prevention)
- Diabetes Prevention Program (secondary prevention)
- Chronic Disease Self-Management Program (tertiary prevention)

Scope and Target Population

- Targets all counties in the GCACH
- Medicaid children and adult population
- High risk population
- Rural population: low income people & families across the region
- High Hispanic and Native American populations

Regional Chronic Disease and Wellness Project

Health Equity

- Language barrier - Evidence Based Programs (EBP) offered in English and Spanish
- Rural/Urban communities
- Target children and all age adult population
- Gender Disparities
- Provide EBP at local community centers, faith-based, housing sites, schools, worksites, hospitals and health care locations

Workforce

- Lead project manger/Lead agency
- Program facilitators
- Project coordinator
- Outreach coordinator
- Data specialist
- Community Health Workers
- Marketing/Media specialist

Regional Chronic Disease and Wellness Project

Implementation

- Lead agency guiding planning and implementation
- Depending on region, implementation of different aspects of the project will differ
- Rural communities with high Spanish speaking populations will need greater focus in Spanish
- Rural areas with limited participants will collaborate with other counties and utilize remote learning
- Each region will work with local partners for outreach activities and program implementation

Pain Points

- Shortage of community health workers/facilitators
- Train the Trainer – facilitation of trainings for lay educators that will teach the classes
- Build trust and relationships with different populations (e.g., Native American, physician community, etc.)
- Imbedding the EBP into primary care
- Data collection pre/post intervention and outcome analytics

Thank you!