Community Health Transformation:

from Planning to ACTION

June 2017

Presented to the Lincoln County Board of Commissioners

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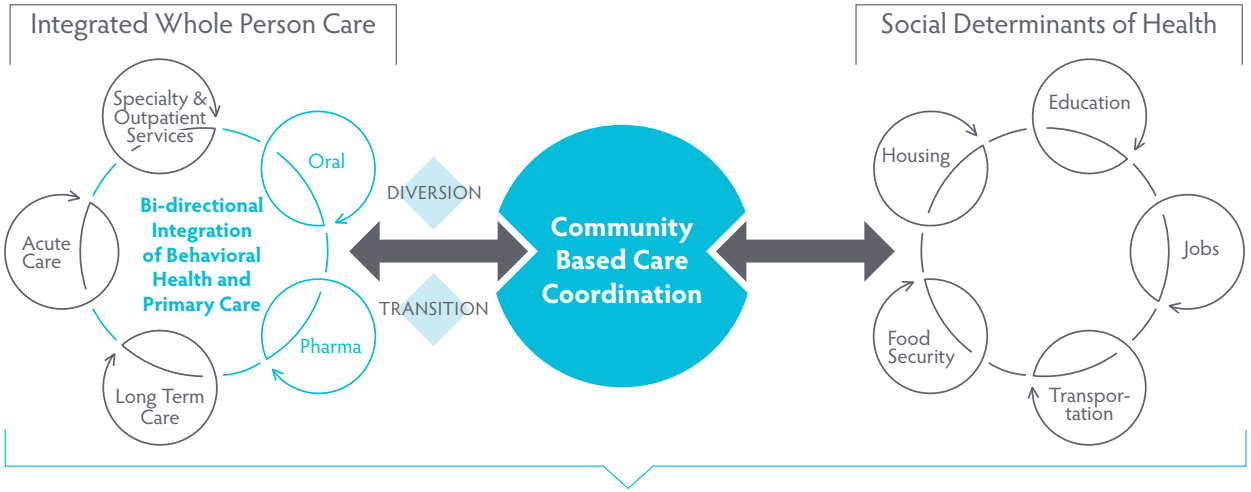
BHT's Theory of Action

TRANSFORM COMMUNITY HEALTH

Create robust linkages between health care and social determinants of health to improve population health outcomes and accelerate transition to value based payment



5 YEAR DEMONSTRATION PERIOD TARGETED POPULATIONS & OUTCOMES

- People transitioning out of jail*
- People with chronic conditions (diabetes, asthma, hypertension, & cardiovascular disease)
- Women of child bearing age & children
- Kids in foster care & aging out*
- Addressing opioid use*

*Expected to affect the number of people experiencing homelessness, dual eligibles

MEASUREMENTS

- 90% of state payment tied to value by 2021
- Implement full integration of Medicaid payments and delivery system by 2020
- Implement Fully Integrated Managed Care as a mid-Adopter by 2019
- Demonstrate multi-sector savings and creating shared savings models to invest in upstream prevention
- TBD measurement to demonstrate integrated care delivery
- TBD measurement around data sharing
- Increase primary care capacity by x%
- Increase rural health capacity by x%
- Increase Medicaid accepting Oral Health providers by x%
- Increase behavioral health capacity by x%
- Increase utilization of community-based care coordinators by x%
- 100% of eligible community members have health insurance

PAY FOR VALUE

Pay for outcomes in the health care and in social determinants of health systems

- Implement robust data management mechanisms throughout the region
- Encourage Value Based Care models

EXPAND EQUITABLE ACCESS TO CARE

Everyone has the right level of culturally appropriately care in the best setting.

- Retain 95% insurance rates
- Increase and sustain health workforce capacity

ALIGN COMMUNITY STRATEGIES

Create integrated community based plans to improve population health outcomes throughout the region.

- Population Health Strategy Maps
- Social Determinants of Health Strategy Maps

BHT Board Approved 5.12.2017

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Key Elements of Medicaid Waiver

Transform the Medicaid health care delivery system to a whole person care system that improves health across the region

Focus of BHT Region's efforts:

- Bi-directional integration of physical and behavioral health services
- Robust Community Based Care Coordination
- Linking the Health Care to Social Determinants of Health systems

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How much could we earn?

- Statewide total Project Pool funds is set by year, and will be distributed amongst ACHs primarily based on **share of Medicaid attribution**
- Receipt of total available Project Pool funding will adjusted based on performance

ACH		Estimated Potential Project Pool Funding (millions)**					
ACH Name	Est. % Medicaid Attribution*	TOTAL	Y1	Y2	Y3	Y4	Y5
Olympic Community of Health	4.5%	$38	$6	$9	$9	$8	$7
North Central	5%	$42	$7	$10	$9	$9	$8
Southwest Washington	6.5%	$55	$9	$13	$12	$11	$10
Cascade Pacific Action Alliance	10%	$85	$14	$19	$19	$18	$15
Better Health Together	10.5%	$89	$15	$20	$20	$18	$16
Pierce County	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	$21	$18
Greater Columbia	14%	$119	$19	$27	$26	$25	$21
North Sound	15%	$127	$21	$29	$28	$26	$23
King County	22.5%	$191	$31	$43	$43	$39	$34
STATEWIDE PROJECT POOL FUNDS	100%	$847	$138	$193	$189	$175	$152

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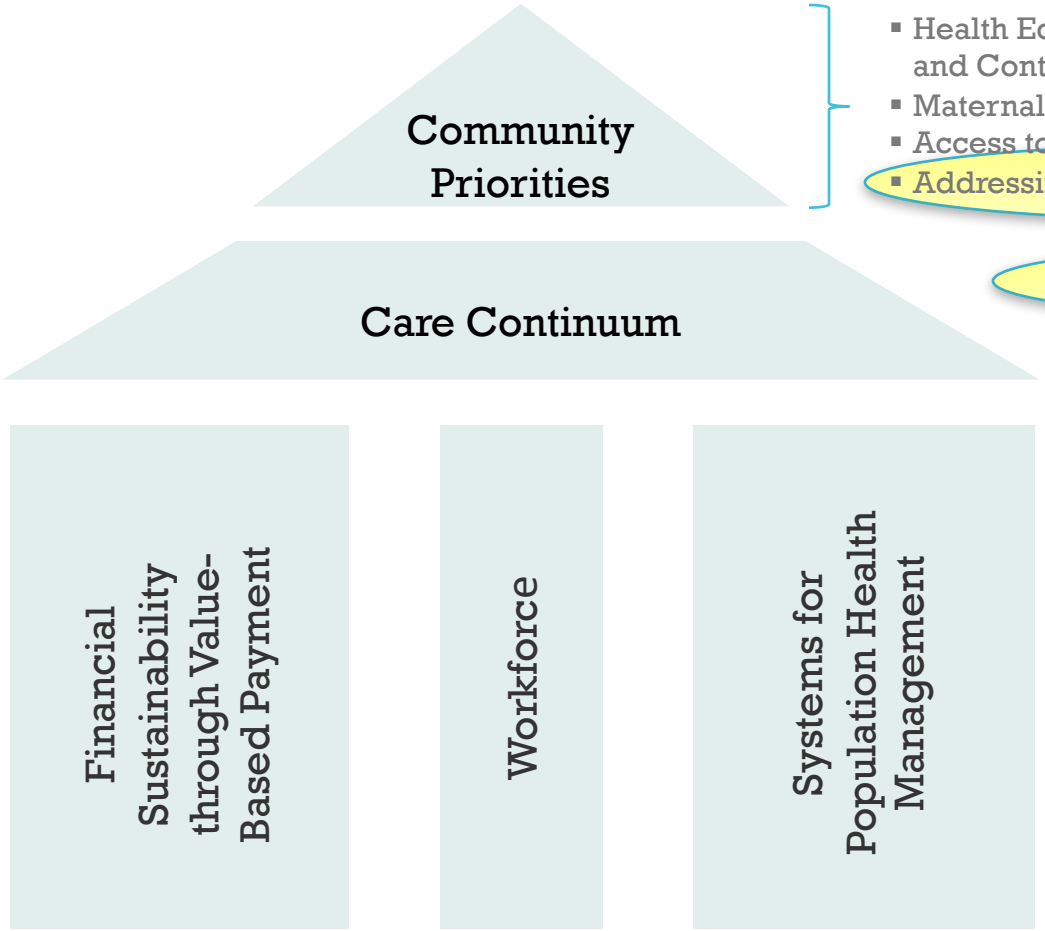
Medicaid Transformation Tool Kit

Projects are designed to be interrelated and interdependent, both under the overall toolkit and each domain. Projects within Domains 2 and 3 are reliant on workforce, systems for population health management, and financial sustainability objectives.



Domain 3

- Health Equity through Chronic Disease Prevention and Control -**$7.9M**
- Maternal and Child Health - **$4.45M**
- Access to Oral Health Services - **$3.5M**
- Addressing the Opioid Use Public Health Crisis- **$3.56M**

Domain 2

- Bi-Directional Integration of Care and Primary Care Transformation **$28M**
- Community-based Care Coordination **$19M**
- Transitional Care **$11M**
- Diversion Interventions **$11M**

Domain 1

- Financial Sustainability through Value-Based Payment
- Workforce
- Systems for Population Health Management

How do we earn Incentive Dollars?

Year 1 Earning Potential

Phase 1 Certification **COMPLETE**	Triggered **$1 million dollar** investment in June	Theory of Action, Governance, Tribal Engagement, Community Engagement, Budget and Clinical Capacity & Engagement plus Data and Transformation Project Planning
Phase 2 Certification **due August 14**	Triggers up to **$5 million dollar** investment in September	Theory of Action, Governance, Tribal Engagement, Community Engagement, Budget and Clinical Capacity & Engagement plus Data and Transformation Project Planning
Region agrees to Fully Integrated Managed Care **by September 15**	Triggers a **$8.7 million dollar** investment in January 2018 and in January 2019	Each of County agrees to transition from County managed Behavioral Health Organization to Managed Care Contracts (Molina, Coordinated Care, United, CHPW and Amerigroup) *Note the state law requires this to happen by 2020*
Regional Transformation Demonstration Project Portfolio **due November 16.**	Incentives to be earned up to **$15 million,** paid in January 2018	Design dollars based on independent assessors Project Plan scores and ability to meet project metrics

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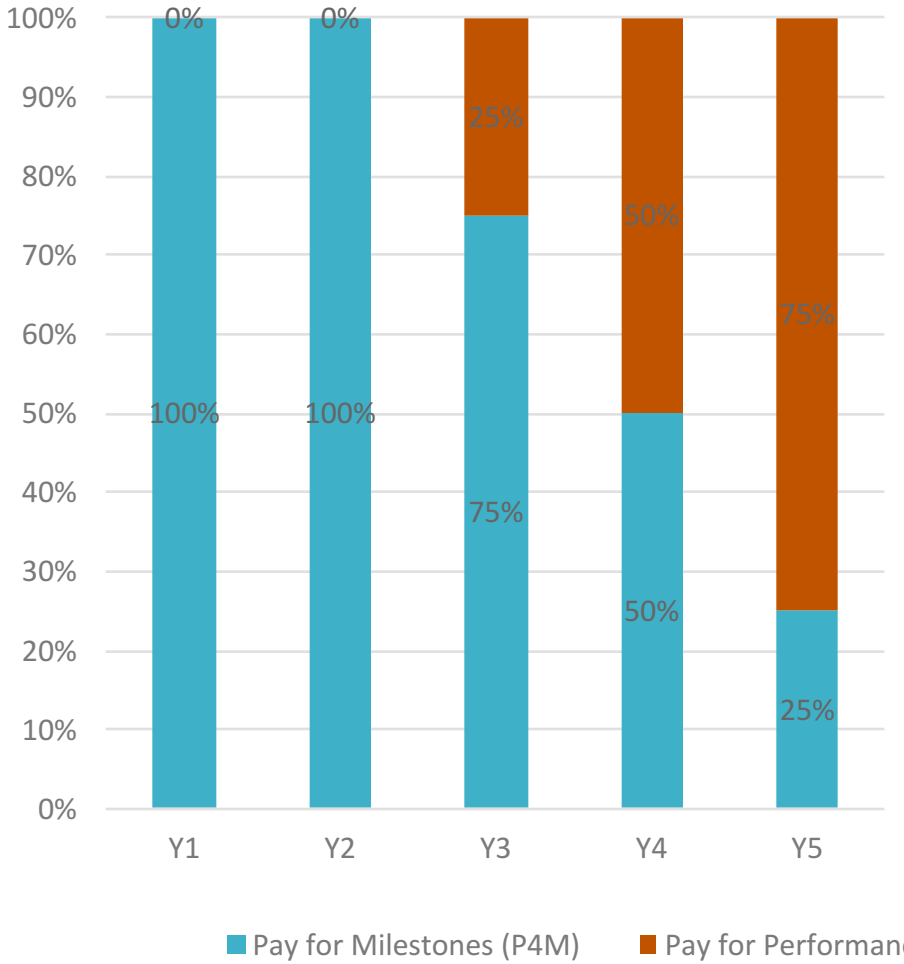
How do we earn Incentive Dollars?

Year 2 thru 5



Example of Metrics:

- *% of Value Based Contracts*
- *Outpatient ED visits*
- *% Homeless*
- *Inpatient Utilization*
- *Mental Health Treatment Penetration*
- *Substance Use Treatment Penetration*
- *Medication Management for Asthma*
- *Medication Management for Anti Depression*
- *Contraceptive Care Postpartum*
- *Well Child visits*
- *Oral Health Utilization*
- *Low Birth Rate*
- *% Arrested*

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Fully Integrated Managed Care (FIMC)

CURRENT SYSTEM

BHO Insurance

- Behavioral health prevention
- Treatment for serious mental health conditions
- Therapy/treatment for substance use disorder conditions
- Withdrawal management (e.g. detoxification) in a substance use disorder facility
- Psychiatric hospitalizations
- Emergency services for mental health conditions (e.g. crisis services)
- Recovery support services

MCO Insurance

- Primary care
- Counselling for mild mental health conditions
- Medication assisted treatment (e.g. opiate substitute therapy)
- Medical detoxification in an inpatient hospital setting
- Hospitalization/In-patient admission (non-psychiatric)
- Emergency services for physical health
- Pharmacy benefits

INTEGRATED SYSTEM

Integrated Insurance

- Primary care treatment and preventative services
- Mental health outpatient treatment (mild and serious conditions)
- Substance use disorder outpatient treatment
- Medication assisted treatment
- Pharmacy benefits
- Inpatient treatment for physical health and behavioral health conditions
- Emergency services and behavioral health crisis services
- Recovery support services

BHT can earn an additional $8,795,000 if our region moves to adopt by 2019

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What is Fully Integrated Managed Care?

- Ability to access care for physical and behavioral health in one location or through a coordinated system approach
- Ability to pay for physical and behavioral health seamlessly
- Remove burden from the patient / family / community to find care because the payment system is disjointed
- Supports providers in delivering necessary services

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What can we spend EARNED Incentive $s on?

- Investment in partners to develop Regional Medicaid Health Transformation Plans
- Investment in building interconnected, robust data, IT Health, and Population systems
- Support alignment and development of Tribal Medicaid Transformation Plans
- Capacity building for direct care or workforce development models
- Capacity building for ACH

BHT Board, in consultation with ACH Leadership Council and community, will develop governing policies for Earned Incentive Funding

We can NOT spend $s on:

- Alcohol
- Bad Debt
- Fundraising
- Entertainment

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How will we get there?

Key elements:

- Redesign our clinical health care practices to integrate Physical and Behavioral services as well as connect to community based services
- Develop a robust community care coordination system that will allow community members to access the right set of services at the right time
- Prepare our health care providers to contract with Managed Care Organizations (like Molina and Community Health Plans of WA) for Value Based Care focusing on improved health not just services

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Considerations for Fully Integrated Managed Care (FIMC)

- Clinical integration efforts will begin in 2018 with Medicaid Transformation Demonstration dollars being released in the BHT region
- FIMC will accelerate whole person care when linking clinical transformation with financial integration
- Leverage dollars across the demonstration to improve outcomes and support targeted services
- Financial Integration is required in 2020
- If the region moves to financial integration by 2019, our region could earn an additional **$8.7 million dollars** to support needed infrastructure in our primary care clinics. (Ideas for Lincoln County could include: Psychiatric Nurse Practitioner or working with telemedicine for psychiatric care, etc.)

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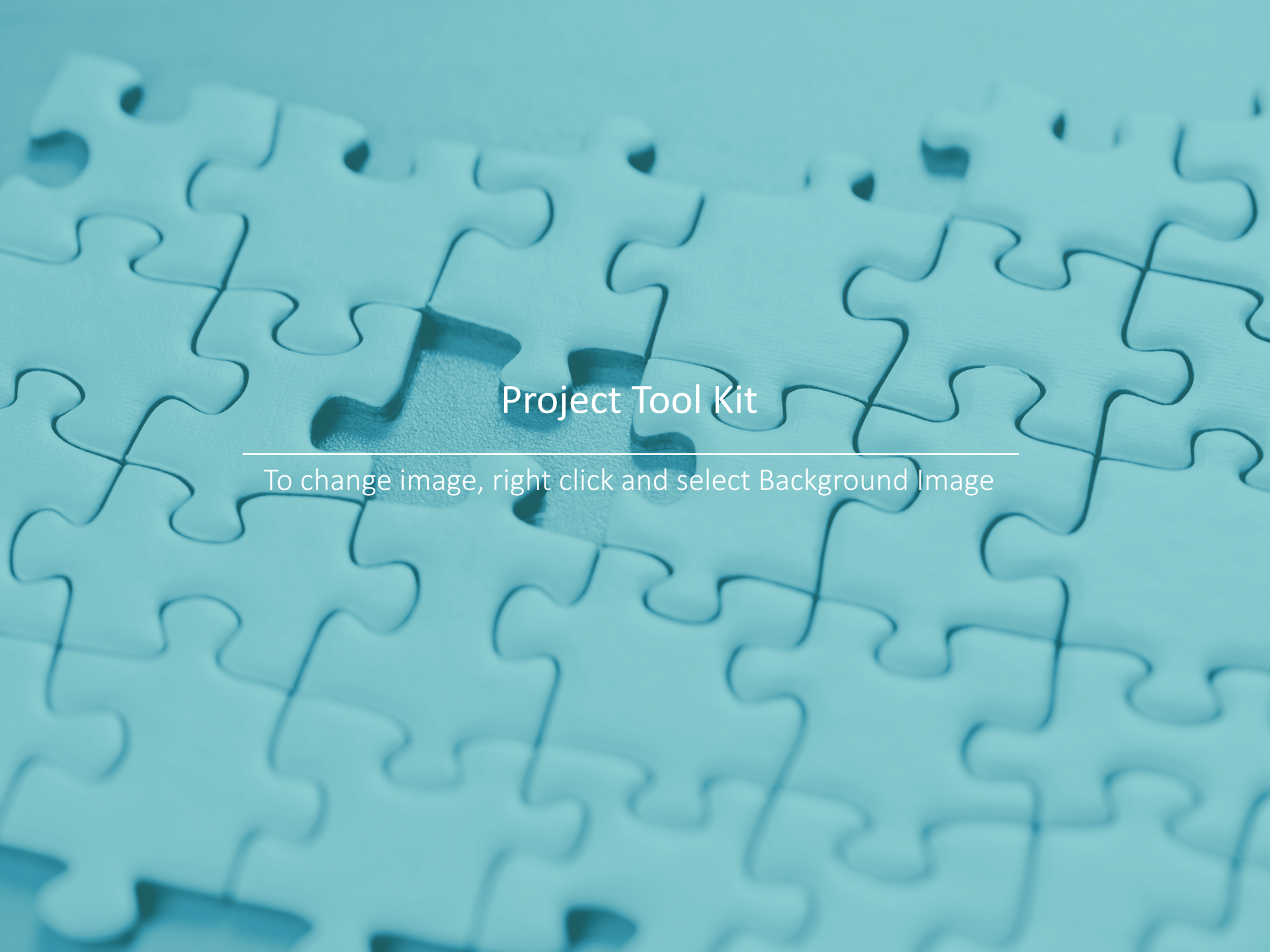

Project Tool Kit

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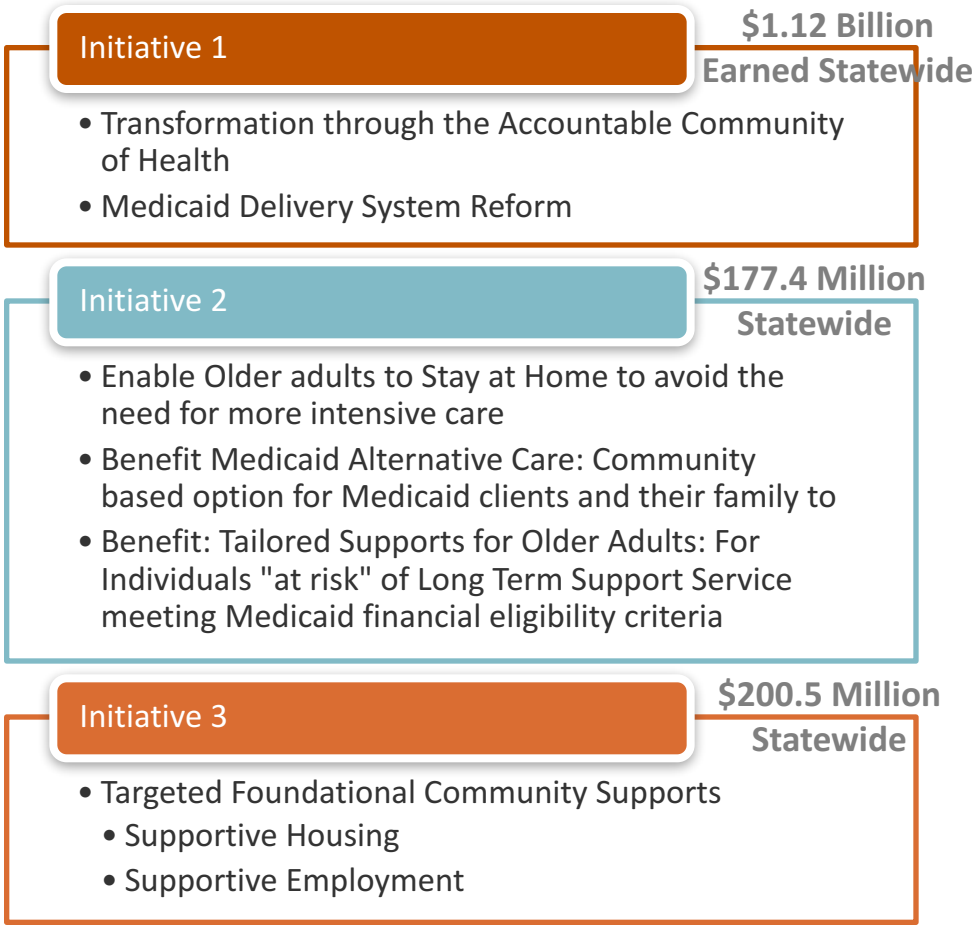
5 Year Medicaid Transformation Overview

GOALS

- Reduce ***avoidable use of intensive services*** and settings—such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional long-term services and supports, and jails.
- Improve ***population health—prevention and management*** of diabetes, cardiovascular disease, mental illness, substance use disorders, and oral health.
- Accelerate the ***transition to value-based payment***—using payment methods that take the quality of services and other measures of value into account.
- Ensure that ***Medicaid cost growth is below national trends***—through services that improve health outcomes and reduce the rate of growth in the overall cost of care.



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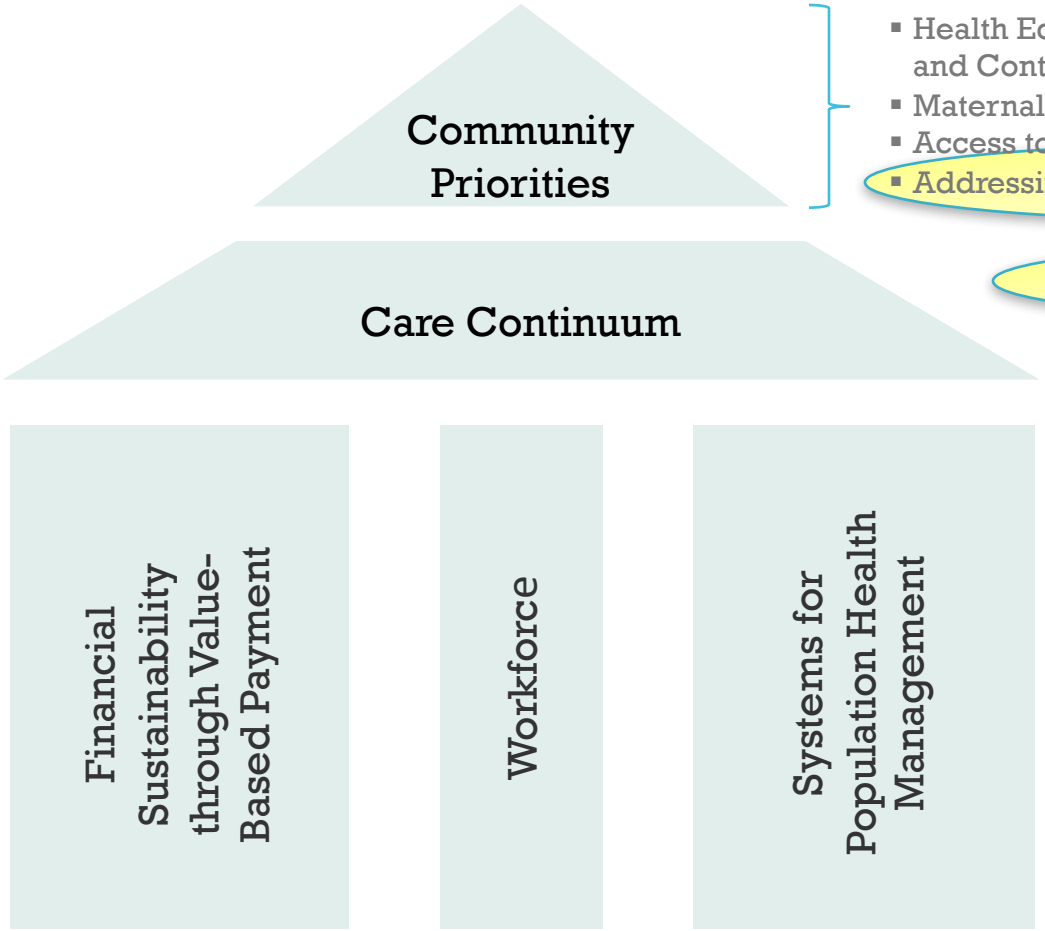

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Domain 1

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- Workforce
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DOMAIN 1-Financial Sustainability through Value-Based Payments

Paying for value across the continuum of care is necessary to ensure the sustainability of the transformation projects undertaken through the Medicaid Transformation demonstration.

HCA will facilitate a statewide Medicaid Value-based Payment (MVP) Action Team to serve as a learning collaborative.

Goal: Achieve the Healthier Washington goal of having 90% of state payments tied to value by 2021.

Key Planning & Activities:

- Support Medicaid Value-Based Payment and disseminate learnings
- Develop a VBP transition plan for region
- Implement strategies for region

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DOMAIN 1-Workforce

The health services workforce will need to evolve to meet the demands of the redesigned system of care. Workforce transformation will be supported through the provision of training and education services, hiring and deployment processes, and integration of new positions and titles to support transition to team-based, patient-centered care and ensure the equity of care delivery across populations

Goal: Improve and sustain alignment between health services workforce capacity and community health needs.

Key Planning & Activities:

- Provide representation and in put into statewide Workforce Action Plan
- Implement statewide Workforce Action Plan
- Training of existing workforce
- Recruitment and retention incentives and efforts to address workforce shortages

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DOMAIN 1-System for Population Health Management

The expansion, evolution and integration of health information systems and technology will need to be supported to improve the speed, quality, safety, and cost of care. This includes linkages to community-based care models. For purposes of this demonstration, population health management is defined as: Data aggregation, Data analysis, Data-informed care delivery, Data-enabled financial models

Goal: Leverage and expand interoperable health information technology (HIT) and health information exchange (HIE) infrastructure and tools to capture, analyze, and share relevant data including combining clinical and claims data to advance VBP models.

Key Planning & Activities:

ACHs will create Population Health Management Transformation Plans that:

- Defines a path toward information exchange for community-based, integrated care
- Responds to needs and gaps identified in the current infrastructure.
- Develops or enhances patient registries

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DOMAIN 2- Bi-Directional Integration of Care and Primary Care Transformation

REQUIRED

Rationale: Through a whole-person approach to care, physical and behavioral health needs will be addressed in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through managed care organizations, for people enrolled in Medicaid.

Approaches:

1. Evidence-based Approaches for Integrating Behavioral Health into Primary Care Setting:
   - Collaborative Care Model
   - Bree Collaborative' s Behavioral Health Integration Report and Recommendations
2. Emerging Evidence for Integrating Primary Care into Behavioral Health Setting applying the core principles of the Collaborative Care Model
   - •Off-site, Enhanced Collaboration
   - •Co-located, Enhanced Collaboration

System wide Metrics: Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Utilization per 1,000 Member Months • Plan All-Cause Readmission Rate (30 Days) • Psychiatric Hospital Readmission Rate • Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) • Controlling High Blood Pressure • Adult Mental Health Status • Substance Use Disorder Treatment Penetration

Project-level Metrics: Antidepressant Medication Management • Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 to 64 Years) • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version)

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DOMAIN 2- Community Based Care Coordination

OPTIONAL

Rationale: Care coordination is essential for ensuring that children and adults with complex health service needs are connected to the evidence-based interventions and services that will improve their outcomes. Appropriately coordinated care is especially important for high-risk populations, such as those living with chronic conditions, those impacted by the social determinants of health such as unstable housing and/or food insecurity, the aging community, and those dependent on institutionalized settings.

System wide Metrics: • Inpatient Utilization per 1,000 Medicaid Member Months Outpatient Emergency Department • Visits per 1000 Member Months • Plan All-Cause Readmission Rate (30 Days) • Percent Homeless (Narrow Definition) • Percent Employed (Medicaid) • Home and Community-Based Long Term Services and Supports Use • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration

Project-Level Metrics: To be determined based on approval of region-specific target populations and selected interventions.

Approaches:

- Utilize Pathways Model or other evidenced based community care coordination
- Assess current community capacity based on workforce, technology, partners and financial sustainability aligned with Domain 1 plans
- Develop HUB Implementation Plan

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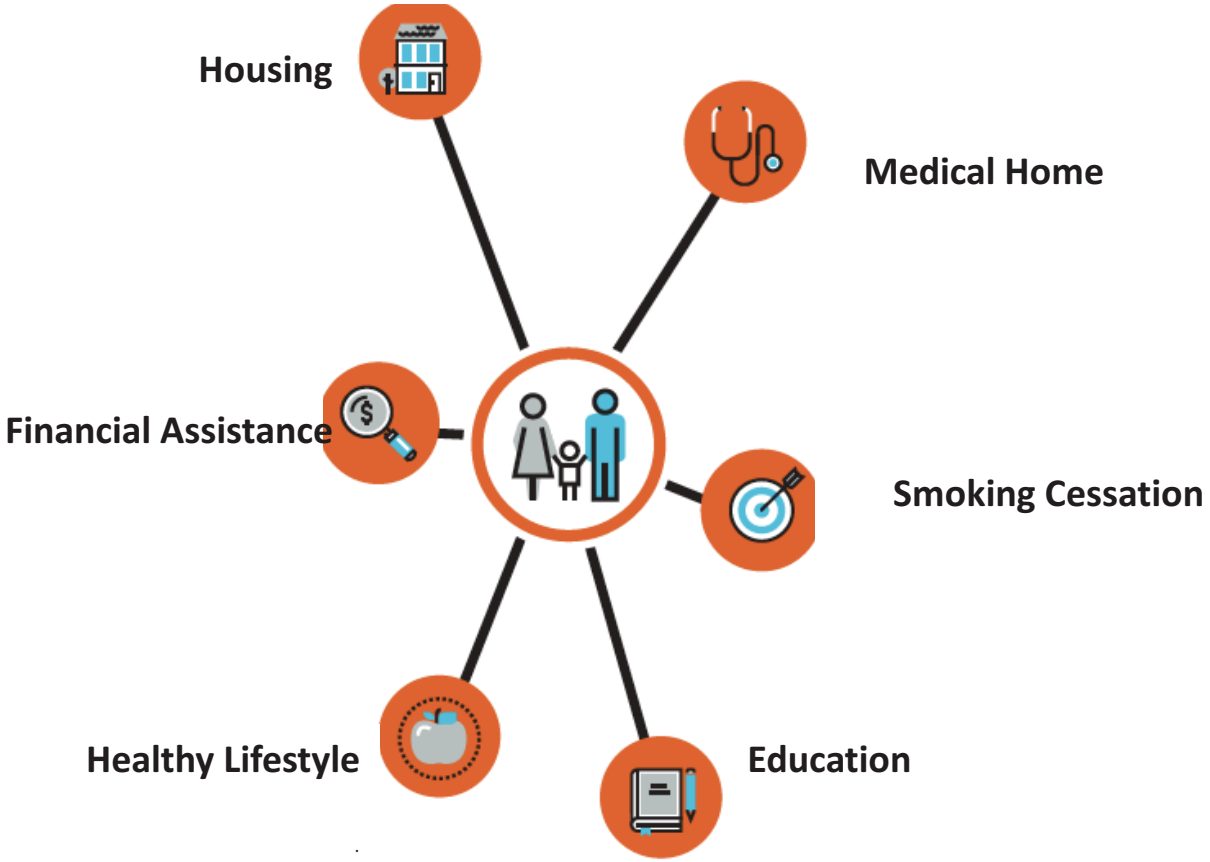
ACH Projects: Pathfinder Community Hub



Meet Joe, A Pathways Client
Meet Kathy, A Pathway Care Coordinator
Pathfinder Hub

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Ferry County Pilot

Long Term Outcomes by December 2018:

(Ferry County Pilot)

Recidivism

- Reduction in recidivism in Ferry County Jail by 20% by December 2018 Ferry County recidivism rate is 62% (Ferry County data 2015) National statistics show that 43% of all inmates return to prison within three years of their release (Pew, 2011) Ferry County is 274% higher incarcerated than Washington State average (Vera.org, 2013)

Cost

- Reduction in cost of providing jail health services in Ferry County by 20% by December 2018 Annual County Budget $2million / Annual Jail Budget $800,000 / Annual Jail Health Services $45,000 (Ferry County data 2015)

ED Diversion

- Reduction of emergency department utilization for ambulatory sensitive conditions in target population in Ferry County from 20% to 16% of all ED visits by December 2018 (both inmates and their families) National emergency department overuse is $38 billion in wasteful health care spending; 56% or roughly 67 million visits, are potentially avoidable. Significant Savings, average cost of an ED visit is $580 more than the cost of an office health care visit (National Quality Forum, 2016)

Pathways:

- *Adult Education*
- *Behavioral Health*
- *Developmental Screening Pathway*
- *Education Pathway*
- *Employment Pathway*
- *Family Planning Pathway*
- *Health Insurance Pathway*
- *Housing Pathway*
- *Immunization Referral Pathway*
- *Medical Home Pathway*
- *Medical Referral Pathway*
- *Medication Management Pathway*
- *Smoking Cessation Pathway*
- *Social Service Referral Pathway*

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DOMAIN 2- Transitional Care

OPTIONAL

Rationale: Transitional care services provide opportunities to eliminate avoidable admissions and readmissions. Points of transition out of intensive services/settings and into the community are critical intervention points in the care continuum.

Approaches:

Evidence-based Approaches for *Care Management and Transitional Care*

Interventions to Reduce Acute Care Transfers, INTERACT™4.0, a quality improvement program that focuses on the management of acute change in resident condition

Transitional Care Model (TCM), - a nurse led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up

The Care Transitions Intervention® (CTI®)- a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives.

Care Transitions Interventions in Mental Health - provides a set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness (SMI)

Transitional Care for people with health and behavioral health needs leaving incarceration utilizing:

1. Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison
2. A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model,
3. American Association of Community Psychiatrists' Principles for Managing Transitions in Behavioral Health Services

System wide Metrics: Percent Homeless (Narrow Definition) • Inpatient Utilization per 1,000 • Medicaid Member Months Psychiatric Hospital Readmission Rate • Plan All-Cause Readmission Rate (30 Days) • Ambulatory Care - Emergency Department Visits per 1,000 Member Months • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness **Project-Level Metrics:** To be determined based on approval of region-specific target populations and selected interventions.

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DOMAIN 2- Diversion Interventions

OPTIONAL

Rationale: Diversion strategies provide opportunities to re-direct individuals away from high-cost medical and legal avenues and into community based health care and social services that can offer comprehensive assessment, care/case planning and management to lead to more positive outcomes.

Approaches:

Emergency Department (ED) Diversion - a systematic approach to re-directing and managing persons who present at the ED for non-emergency conditions, which may be oral health, general physical health, and/or behavioral health conditions.

Community Paramedicine Model - an evolving model of community-based health care in which paramedics function outside customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations.

Law Enforcement Assisted Diversion, LEAD® - a community-based diversion approach with the goals of improving public safety and public order, and reducing the criminal behavior of people who participate in the program

System wide Metrics: Percent Homeless (Narrow Definition) • Percent Arrested • Outpatient Emergency Department Visits per 1000 Member Months • Adult Access to Preventive/Ambulatory Care •

Project-Level Metrics: To be determined based on approval of region-specific target populations and selected interventions.

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DOMAIN 3- Health Equity through Chronic Disease Prevention and Control

OPTIONAL

Rationale: Chronic health conditions are prevalent among Washington's Medicaid beneficiaries, and the number of individuals with or at risk for chronic disease is increasing. Disease prevention and effective management is critical to quality of life and longevity. Many individuals face cultural, linguistic and structural barriers to accessing quality care, navigating the health care system, and understanding how to take steps to improve their health.

Approaches:

- Develop a disease/population specific implementation plan using the Chronic Care Model Examples of specific strategies to consider within the model include:
    1. The Community Guide
    2. Million Hearts Campaign
    3. Stanford Chronic Disease Self-Management Program
    4. CDC-recognized National Diabetes Prevention Programs (NDPP)
    5. Community Paramedicine model
- Regions are encouraged to focus on more than one chronic condition

System wide Metrics: Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Utilization per 1000 Medicaid Member Months • **Project Level Metrics:** *To be determined based on approval of region-specific target populations and selected interventions. May Include:* Child and Adolescents' Access to Primary Care Practitioners • Adult Access to Preventive/Ambulatory Care • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Medical attention for nephropathy • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life • Well-Child Visits in the First 15 Months of Life • Medication Management for People with Asthma (5 – 64 Years) • Comprehensive Diabetes Care: Blood Pressure Control • Influenza Immunizations 6 months of age and older • Statin Therapy for Patients with Cardiovascular Disease (Prescribed) • Adult Body Mass Index Assessment

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DOMAIN 3- Maternal and Child Health

OPTIONAL

Rationale: Maternal and child health is a primary focus for the Medicaid program as Medicaid funds more than half of the births in the state and provides coverage to more than half of Washington's children.

Approaches:

Evidence-based family planning strategies, and if applicable, leverage the Reproductive Health Pathway.

- Evidence-based models for home visiting:

  Nurse Family Partnership (NFP) or other federally recognized evidence-based home visiting model currently operating in Washington State- provides first-time, low-income mothers and their children with nurse-led home-based support and care.

  Early Head Start Home-Based Model (EHS), which works with parents to improve child health; prevent child abuse and neglect; encourage positive parenting; and promote child development and school readiness.

  Parents as Teachers (PAT) promotes optimal early development, learning and health of children by supporting and engaging their parents and caregivers.

  Family Spirit, offers culturally tailored home-visiting to promote the optimal health and wellbeing of American Indian parents and their children

- Evidence-Based models to improve regional well child visit and immunization rates:

  Bright Futures, Improve regional well-child visit rates (for ages 3-6) and childhood immunization rates.

  Stony Brook Children's Hospital Enriched Medical Home Intervention (EMHI).

System wide Metrics: Rate of Teen Pregnancy (15–19) • Unintended Pregnancies - Low Birth Weight Rate
Project Level Metrics: Prenatal care in the first trimester of pregnancy • Mental Health Treatment Penetration (Broad Version) (women and children) • Substance Use Disorder Treatment Penetration (women and children) • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life Well-Child Visits in the First 15 Months of Life • Chlamydia Screening in Women Ages 16 to 24 • Contraceptive Care Most & Moderately Effective Methods Contraceptive Care – Access to LARC • Contraceptive Care – Postpartum • Childhood Immunization Status

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DOMAIN 3- Oral Health Access

OPTIONAL

Rationale: Oral health impacts overall health and quality life, and most oral disease is preventable. Oral disease has been referred to as a "silent epidemic" and has been associated with increased risk for serious adverse health outcomes. Increasing access to oral health services for adults provides an opportunity to prevent or control the progression of oral disease, and to reduce reliance on emergency departments for oral pain and related conditions.

Approaches:

- Utilize one or more Evidenced-based approach to Oral Health Access model:
  - Oral Health in Primary Care - integrating oral health screening, assessment, intervention, and referral, into the primary care setting
  - Mobile/Portable Dental Care – the national maternal and child health resource center provides a manual to guide planning and implementation of mobile dental units and portable dental care equipment for school-age children, which could be adapted for adults
- Ensure participating provider has secured necessary training and resources
- Implement robust, bi-directional communications strategy
- Establish mechanisms for coordinating care management that includes performance tracking

System wide Metrics: Oral health services utilization among Medicaid beneficiaries • Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers • Outpatient Emergency Department Visits per 1000 Member Months • **Project Level Metrics:** 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

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DOMAIN 3- Opioid Use Public Health Crisis

REQUIRED

Rationale: The opioid epidemic affects communities, families, and overwhelms law enforcement, health care and social service providers. Opioid use disorder is a devastating and life-threatening chronic medical condition and access to treatments that support recovery and access to lifesaving medications to reverse overdose needs to be improved.

Goals:

- Prevent opioid use and misuse
- Link individuals with opioid use disorder to treatment support service
- Intervene in opioid overdoses to prevent death
- Promote long-term stabilization and whole person care
- Use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions

Approaches:

Develop a Regional Opioid Working Plan utilizing:

Clinical Guidelines

- AMDG's Interagency Guideline on Prescribing Opioids for Pain
- Substance Use during Pregnancy: Guidelines for Screening and Management,
- CDC Guideline for Prescribing Opioids for Chronic Pain

Statewide Plans:

- 2016 Washington State Interagency Opioid Working Plan
- Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan,

System wide Metrics: Opioid Related Deaths (Medicaid Enrollees and Total Population) per 100,000 • Non-fatal overdose involving prescription opioids (Draft specification as of 02/2017) • Substance Use Disorder Treatment Penetration (Opioid) • **Project Level Metrics:** New opioid users that become chronic users (in development) • Patients on high-dose chronic opioid therapy by varying thresholds (in development) • Patients with concurrent sedatives prescriptions (in development) • Non-fatal overdose involving prescription opioids (in development) • Medication Assisted Therapy (MAT) With Buprenorphine (Count and %) • Medication Assisted Therapy (MAT) With Methadone (Count and %)

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