Community Health Transformation: *from Planning to Action*
BHT Vision

In our region every person, regardless of environment, background, or life experiences, will live a productive, high quality life by ensuring access to:

- An integrated whole person health care system.
- Stable housing, nutritious food, and transportation.
- Opportunity for education and training that allows for meaningful employment that pays the bills with some left over for savings.
- Social support networks that allow for emotional, social and psychological wellbeing.
What determines Health?

- Health Care: 20%
- Physical Environment: 10%
- Health Behaviors: 30%
- Socio-economic Factors: 40%

Current State TODAY

Current System:
- Fragmented Care Delivery
- Disjointed partnerships between health care and community services
- Inconsistently engaged clients
- Inconsistent measurement of community health
- Fee for Service Payment Models

Held together with:
- Good intentions to partner
- Creative Pilots never taken to scale
- Inconsistent funding
- Lack of investment in data and evaluation capacity
Healthier Communities!

- Integrated, whole person care
- Coordinated community and clinic based care
- Activated clients
- Real-time data and standardized measurements
- Value Based Payments
- Braided funding for sustainability
Medicaid Transformation Framework

- Meaningfully Transform the Medicaid Delivery System
- Scale Robust and Connected Regional Infrastructure
- Improve Health Access and Equity

Accelerate Improved Population Health
## Medicaid Transformation Framework

### Transformation Happens Across These SETTINGS:

<table>
<thead>
<tr>
<th><strong>PC/BH Clinical</strong></th>
<th><strong>ED Acute &amp; Post Acute Care</strong></th>
<th><strong>Pharmacy</strong></th>
<th><strong>Emergency Medical Response</strong></th>
<th><strong>Law Enforcement &amp; Criminal Justice</strong></th>
<th><strong>Social Determinants of Health &amp; Community Based Organizations</strong></th>
<th><strong>Key Partners</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Including Oral prevention and maternal and child health activities at PC/BH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Public Health, Oral Health, Chronic Disease, Special Services, County</td>
</tr>
</tbody>
</table>

### Build a REGIONAL INFRASTRUCTURE to Sustain Whole Person Care

<table>
<thead>
<tr>
<th>Workforce Development</th>
<th>Payment Reform</th>
<th>Population Health Management (HIT/HIE, Data Analytics, Evaluation)</th>
<th>Community Health Equity Partnerships</th>
<th>Community Resiliency Investments</th>
<th>Policy &amp; Advocacy</th>
</tr>
</thead>
</table>

### Focus on Medicaid Beneficiaries within these TARGET POPULATION(s)

<table>
<thead>
<tr>
<th>People with Opioid Dependence</th>
<th>People with Behavioral Health Problems</th>
<th>People with Chronic Conditions</th>
<th>Women of Child-Bearing Age</th>
<th>People Transitioning out of Jail</th>
</tr>
</thead>
</table>
What is **Success?** *(or how will we measure it?)*

<table>
<thead>
<tr>
<th>Medicaid Transformation Project</th>
<th>BHT ACH Local Measures</th>
<th>Collaborative Health Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ 90% of Medicaid contracts are Value Based in 2021</td>
<td>✓ Decrease jail recidivism</td>
<td>✓ To be determined by local Collaborative</td>
</tr>
<tr>
<td>✓ Reduce Medicaid ED utilization</td>
<td>✓ Reduce unintended pregnancies</td>
<td></td>
</tr>
<tr>
<td>✓ Reduce readmission rates</td>
<td>✓ Increase oral health</td>
<td></td>
</tr>
<tr>
<td>✓ Increase substance use disorder (SUD) treatment penetration rate</td>
<td>✓ Increase behavioral health access</td>
<td></td>
</tr>
<tr>
<td>✓ Increase mental health treatment penetration rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Increase well child visits for 3-, 4-, and 6-year-olds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Improve Anti-depressants Medication Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Improve Medication Management for Asthma</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Community Based Care Coordination & Pathways Hub
### Why we need Community Based Care Coordination?

Community Care Coordination?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORE THAN $\frac{1}{2}$ of patients</td>
<td>can’t state their diagnosis when leaving the hospital</td>
</tr>
<tr>
<td>MORE THAN $\frac{1}{3}$ of patients</td>
<td>can’t explain their medications</td>
</tr>
<tr>
<td>LESS THAN $\frac{1}{2}$ of patients</td>
<td>saw a primary care physician within 2 weeks of leaving the hospital</td>
</tr>
<tr>
<td>1 IN 5 patients</td>
<td>has an adverse event transitioning from hospital to home</td>
</tr>
</tbody>
</table>
Pathways Community Hub
# 20 Pathways and Outcomes

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Education</td>
<td>Confirm that client successfully completes stated education goal:</td>
</tr>
<tr>
<td></td>
<td>• course/class completed</td>
</tr>
<tr>
<td></td>
<td>• quarter/semester completed</td>
</tr>
<tr>
<td></td>
<td>• training program completed</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Client has kept 3 scheduled appointments for behavioral health issue(s).</td>
</tr>
<tr>
<td>Developmental Referral</td>
<td>Document the date and results of the completed developmental evaluation.</td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>Child successfully screened using the age-appropriate ASQ or ASQ-SE.</td>
</tr>
<tr>
<td>Education</td>
<td>Client reports that he/she understands the educational information presented. (document educational content and format)</td>
</tr>
<tr>
<td>Employment</td>
<td>Client has found consistent source(s) of steady income and is employed over a period of 3 months.</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Confirm that client has kept appointment and document family planning method:</td>
</tr>
<tr>
<td></td>
<td>1. Completed with permanent sterilization or LARC (long acting reversible contraceptive)</td>
</tr>
<tr>
<td></td>
<td>2. All other methods, completed if client is still successfully using the method after</td>
</tr>
<tr>
<td>Immunization Screening</td>
<td>Client is up to date on all age appropriate immunizations.</td>
</tr>
<tr>
<td>Lead</td>
<td>Confirm that appointment was kept and document results of lead blood test.</td>
</tr>
<tr>
<td>Medical Home</td>
<td>Confirm that client in need of ongoing primary care has kept first appointment with medical home.</td>
</tr>
<tr>
<td>Medical Referral</td>
<td>Verify with health care provider that client has kept appointment.</td>
</tr>
<tr>
<td>Medication Assessment</td>
<td>Verity with primary care provider that medication chart was received. (requires chart)</td>
</tr>
<tr>
<td>Medication Management</td>
<td>Verify with primary care provider that client is taking medications as prescribed.</td>
</tr>
<tr>
<td>Postpartum</td>
<td>Confirm that client has kept postpartum appointment.</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Confirm that client has delivered a healthy baby weighing more than 5 pounds 8 ounces (2500 grams).</td>
</tr>
<tr>
<td>Smoking/Tobacco Cessation</td>
<td>Confirm that client has stopped using tobacco products.</td>
</tr>
<tr>
<td>Social Service</td>
<td>Verify that client has kept scheduled appointment with social service provider.</td>
</tr>
</tbody>
</table>
Care Coordination Organization Role

Contracts with the BHT HUB to provide community based care coordination services

Commits to having a full-time equivalent community care coordinator (CCC)

Commits to having a supervisor for CCC

Understands all requirements of participating in HUB network:
• Attends all required trainings; 230 hours which includes 5 days of Community Care Coordination and 5 days of Pathways and CCS Platform training, along with 2-4 weeks of practicum.
• Attends all required meetings.
• Uses data platform to collect all data within timeline established by HUB.
• Participates in quality improvement.
Community Hub Role

- “Air traffic control” for community based care coordination agencies (CCAs)
- Streamlines referrals
- Eliminates duplication
- Uses common data collection across all contracted CCAs (Client Intake, Checklists, Pathways, Tools)
- Develops contracts with payers – payment for Pathways
- Develops contracts with CCAs to pay for care coordination services
- Gives feedback back to Referral Partners (client found, enrolled, etc.)
- Works closely with Pathfinder Community Hub Advisory Council to review data, gaps in services, identify priorities
- Quality improvement plan to identify areas of need within the network of CCAs
- Obtains national Pathways Community Hub certification and participates with partner HUBs
Ferry County Pilot

Long Term Outcomes by December 2018:

**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 $2 million / 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
Spokane County Project

In 2017, the Spokane County was awarded a nearly $1 million grant from the Department of Justice to utilize the Pathways Community Hub as the anchor strategy to reform the criminal justice system.

Funding of $1.75 million grant from the MacArthur Foundation in 2016 to help reduce the jail population by 21% by 2019.

Long Term Outcomes:
• Reduce Recidivism
• Increase Protective Factors
• Increase Permanent Housing

86% of inmates identified an unmet need for reentry services, such as housing, behavioral health, medical/medication treatment, financial support, transportation, employment, and education.

Spokane County will refer potential clients who:
• Are on probation from non-violent misdemeanor charges
• Between the ages 18-34 years old
• Behavioral health need as identified by Spokane County Jail Mental Health Staff
• Voluntarily agrees to participate in care coordination
• Preference will be given to individuals from communities of color
Care Coordination Payer Role

- Payers are Managed Care Organizations, Foundations, City Governments and/or County Governments who contracts with the Hub

- Establishes contracts based on population covered and Pathways and Tools that are compensated

- Uses Outcome Based Units (OBUs) to develop payment strategy
Questions

For more information contact
Alison Poulsen, Executive Director
Alison@BetterHealthTogether.org