WELCOME & INTRODUCTIONS

Care Coordination Meeting Agenda
Technical Team – Pathways Hub Model

- Welcome & Introductions – *Michael O'Neill & Doctor Haughton*
- Review Community Care Coordination Medicaid Transformation Demonstration (MTD) Objectives and Measures – *Robbi Kay Norman*
- Explore Initial Data Set & Care Coordination Inventory– *Michael O'Neill*
- Learn from an Existing Maternal Child Health - Pathway Hub Experience – *Doctor Sarah Redding, Founder of the Pathways Hub Model*
- Identify Steps for Developing a Project Proposal for a CPAA Pathways HUB - *Michael O'Neill*

Community-Based Care Coordination

Objective	Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
Strategies / Approaches	Pathways Community HUB • Coordinate care beyond the walls of health care • Pay for outcomes • Reduce duplication of care coordination services

Community-Based Care Coordination: Project Ideas

Planning	• Assess current capacity and existing care coordination activities • Determine HUB leadership and governance • Recruit and secure formal commitments from implementation partners • Develop HUB Implementation Plan
Implementation	• Complete HUB Operations Manual and HUB Quality Improvement Plan • Develop polices and procedures • Create tools and resources for care coordinators • Hire and train staff • Conduct community awareness campaign
Scale & Sustain	• Recruit additional community organizations and partners to participate in HUB • Implement additional focus areas or pathways • Continuous quality improvement • Provide training, technical assistance, learning collaboratives to support HUB • Develop payment models to support care coordination model • Implement VBP strategies to support HUB care coordination model

Community-Based Care Coordination: Progress Measures

Planning	• Binding letter of intent from HUB / lead entity • Formal commitment from implementation partners • Complete Implementation Plan
Implementation	• Complete HUB Operations Manual • Complete HUB Quality Improvement Plan • Policies and procedures in place • Number of partners participating and the number implementing each selected Pathway • Number of partners trained
Scale & Sustain	• Number of partners participating in the HUB and the number implementing each selected Pathway • Number of partners trained by focus area or Pathway • Number of partners to achieve performance targets for outcomes metrics

Community-Based Care Coordination: Incentive Measures

System-Wide	• Emergency Department visits per 1,000 member months ($) • Plan All-Cause Readmission Rate (30 days) ($) • Inpatient Utilization ($) • Percent Homeless (Narrow Definition) ($) • Mental Health Treatment Penetration (Broad Version) ($) • Substance Use Disorder Treatment Penetration ($)
	• Percent Employed (Medicaid) • Home and Community-based Long Term Services and Supports Use
Project-Level	To be determined based on approval of region-specific target populations and selected interventions. Will likely be related to pathways chosen for implementation. May include measures such as: • Well child visits • Low birth weight

Community-Based Care Coordination: Project Ideas

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Focusing on populations

DATA AND PROCESS FOR DECISION MAKING

5/17/17

Four groups to review

Project 2B: Community-Based Care Coordination

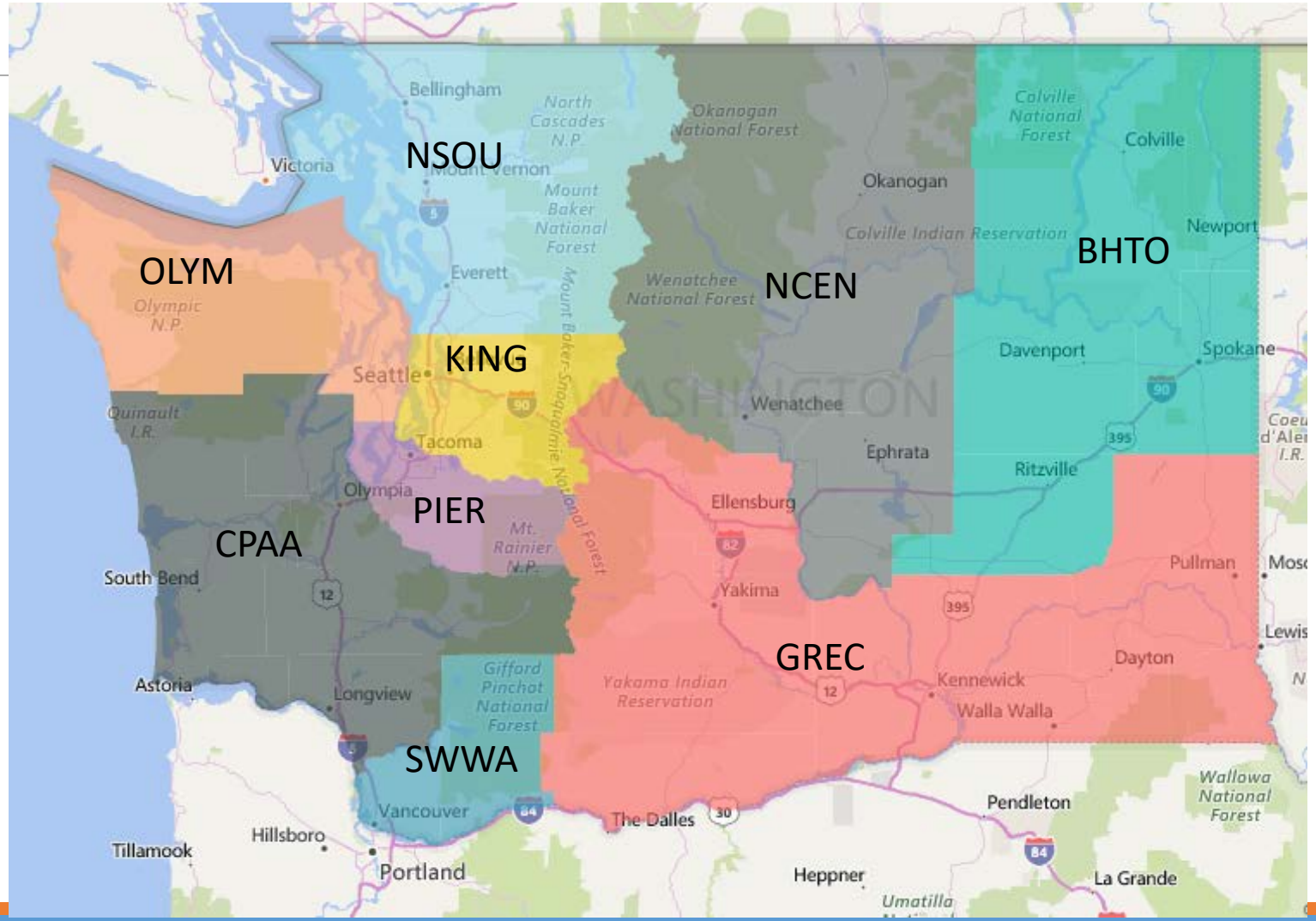
"**Target Population:** Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as, arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke), or mental illness/depressive disorders, or moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization)."

CPAA Specific Populations

- Chronic Disease
- Behavioral Health (Opioid focus)
- Frequent EMS utilizers
- Maternal/Child

ACH_ID

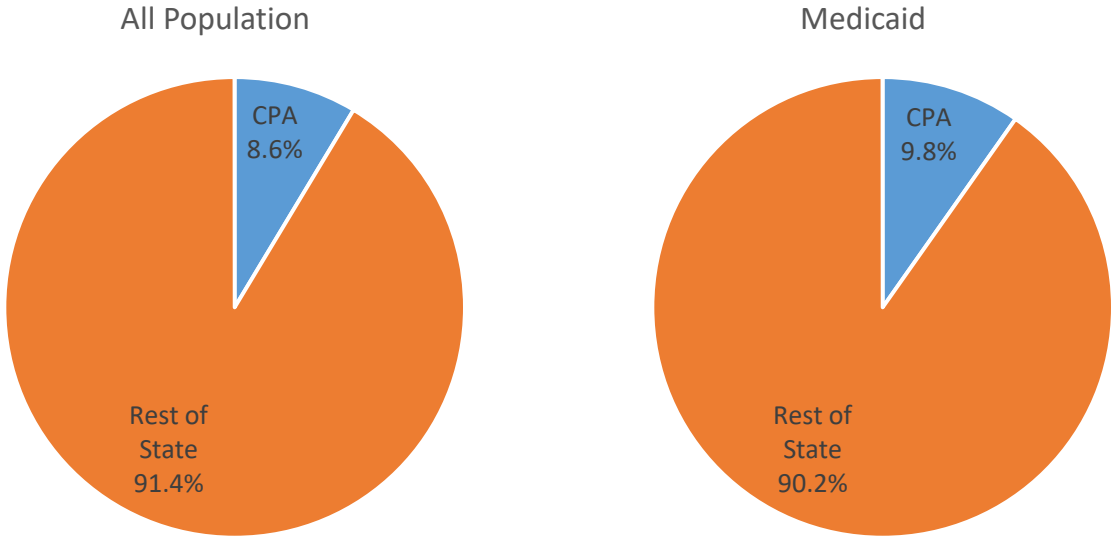
ACH organization	ACH_ID
Washington State	WASH
Better Health Together	BHTO
Cascade Pacific Action Alliance	CPAA
Greater Columbia	GREC
King	KING
North Central	NCEN
North Sound	NSOU
Olympic	OLYM
Pierce	PIER
Southwest Washington	SWWA

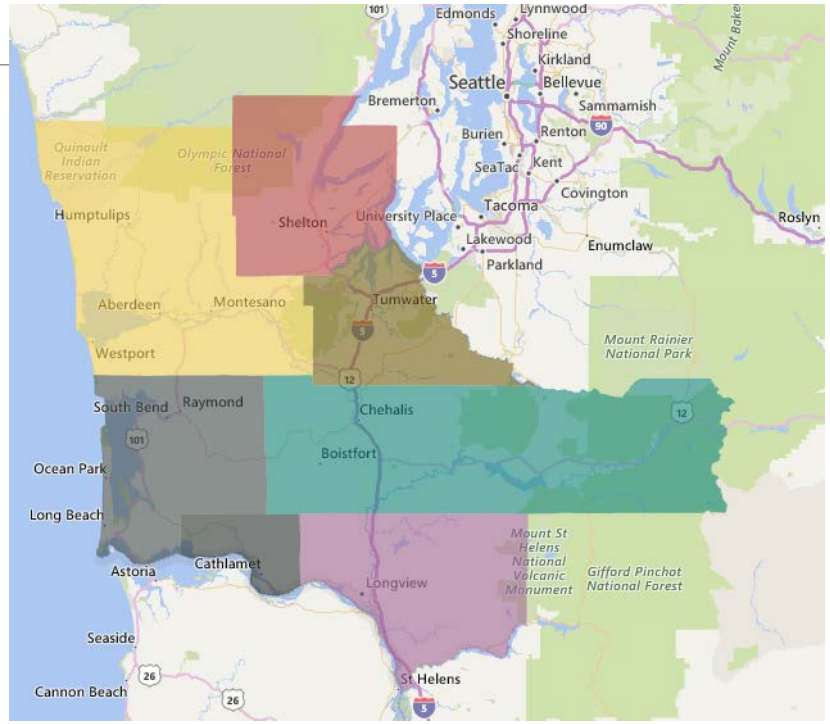


Demographics Overall / Medicaid

2015

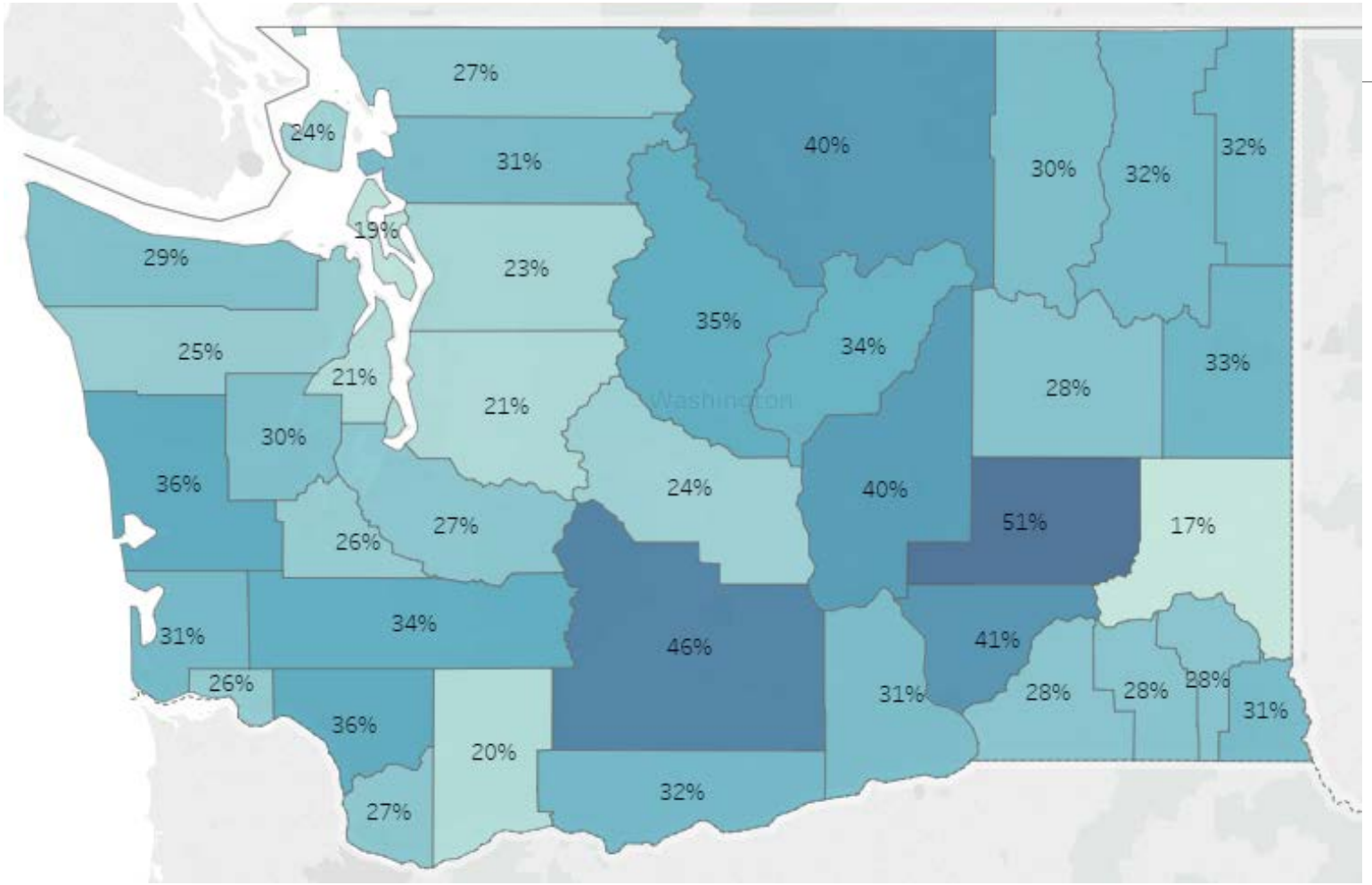
	All Population	Medicaid[1]	Percent Row
CPAA	608,850	185,194	30%
State	7,061,410	1,892,696	27%





[1] Medicaid members with any coverage in 2015. Members with both Medicaid and Medicare coverage (duals) are excluded

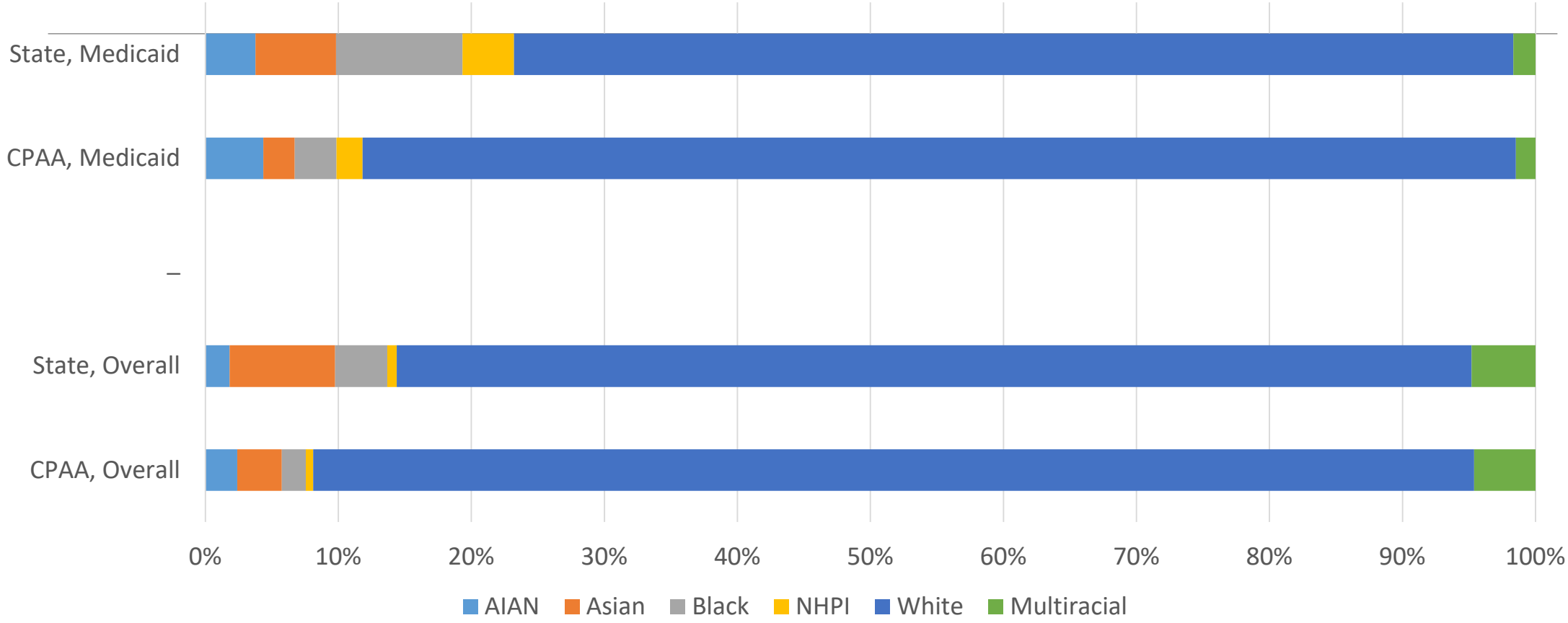
Population on Medicaid



County	Medicaid #	Population	Medicaid %
Cowlitz	37,038	104,280	35.5%
Grays Harbor	26,301	73,110	36.0%
Lewis	26,446	76,660	34.5%
Mason	18,626	62,200	29.9%
Pacific	6,679	21,210	31.5%
Thurston	69,057	267,410	25.8%
Wahkiakum	1,047	3,980	26.3%
Total	**185,194**	**608,850**	**30.4%**

Demographics Overall / Medicaid by Race

2015



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Top Ten Causes of Acute Hospitalizations Among Medicaid Recipient

Hospitalization Cause	BHTO	CPAA	GREC	KING	NCEN	NSOU	OLYM	PIER	SWWA	WASH
Mental and Behavioral Disorders	1,338	1,094	530	2,928	171	1,426	445	3,330	1,636	12,902
Injury and Poisoning	739	704	767	1,559	266	926	284	908	466	6,626
Septicemia	631	553	485	1,318	105	723	239	932	346	5,340
Diseases of Heart	420	516	390	930	135	552	156	639	279	4,024
Diseases of the Musculoskeletal System and Connective Tissue	366	394	378	678	115	509	175	388		3,178
Substance Use Disorder	434	396		856	105	484	156	441		3,232
Diseases of Liver, Biliary Tract, and Pancreas	299	306	355	559	84	363	139	306	170	2,583
Cancer/Malignancies		270	262	613	102	432	116	316	178	2,519
Respiratory Infections	335	227	428	506	132				168	2,514
Skin and Subcutaneous Tissue Infections	249	244	238	586		422	116	357	181	2,459
Diabetes	240				94			313		
Lower Gastrointestinal Disorders			238						149	
Respiratory Failure/Pulmonary Collapse						368				
Diseases of the genitourinary system							119		144	
All Other Causes	2,826	2,569	2,786	5,946	888	5,069	1,145	3,993	1,732	25,445
Total	7,637	7,273	6,857	16,479	2,197	9,848	3,090	11,923	5,449	70,822

Source: RHNI Data files – Produced by AIM Team. Determined by primary diagnosis field in HCA ProviderOne Medicaid Data System. Jan 2015 – Oct 2015

Top 10 Causes of Death Among Medicaid Recipient

Cause of Death	BHTO	CPAA	GREC	KING	NCEN	NSOU	OLYM	PIER	SWWA
Malignant Neoplasms	1	1	1	1	1	1	1	1	1
Unintentional Injury (Accident)	2	3	3	2	2	2	3	3	2
Major Cardio Vascular Disease	3	2	2	3	3	3	2	2	3
Chronic Liver Disease & Cirrhosis	4	4	5	4	5	4	4	4	5
Intentional Self-Harm (Suicide)	4	4	4	5		5	5	5	4
Chronic Lower Respiratory Diseases	6	6	7	7	4	7		7	
Diabetes	7	7	6	8		6	6	6	6
HIV				11					
Homicide	8		8	6		8		8	
Viral Hepatitis		8		9				9	
Septicemia				10					
Congenital Anomalies				12		9			

*Source: **Medicaid Mortality** Table: Leading Causes of Death for Medicaid Enrollees with Residency in Washington State, 2015. Analysis, Interoperability and Measurement, Washington Health Care Authority, 02/2017. (Medicaid deaths are identified by linking Medicaid enrollees with the Death Registry)*

Hospitalization / Death, Medicaid Recipients

Cause of Death	BHTO	CPAA	GREC	KING	NCEN	NSOU	OLYM	PIER	SWWA
Malignant Neoplasms	1	1	1	1	1	1	1	1	1
Unintentional Injury (Accident)	2	3	3	2	2	2	3	3	2
Major Cardio Vascular Disease	3	2	2	3	3	3	2	2	3
Chronic Liver Disease & Cirrhosis	4	4	5	4	5	4	4	4	5
Intentional Self-Harm (Suicide)	4	4	4	5		5	5	5	4
Chronic Lower Respiratory Diseases	6	6	7	7	4	7		7	
Diabetes	7	7	6	8		6	6	6	6
HIV				11					
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Chronic Diseases

Prevalence Estimates, Total Population

Measurement	Overall	Female	Male
Adult Mental Health	12.8	14.5	10.9
Asthma	9.2	11.1	7.2
Diabetes	8.5	7.6	9.5
Obesity	31.2	29.3	32.9
Smoking	19.4	18.8	20.2

Measurement	18-24	25-34	35-44	45-54	55-64	65+
Adult Mental Health	15.3	14.1	14.1	15.6	10.5	7.6
Asthma	8.8	8.0	7.7	10.7	10.9	9.9
Diabetes			5.3	8.6	13.7	21.1
Obesity	17.5	28.6	32.4	34.4	38.9	32.8
Smoking	19.9	22.5	22.2	25.3	15.6	11.3

Measurement	High School or Less	Some College	College Grad or More
Adult Mental Health	15	13	7.2
Asthma	9.4	10.2	7.6
Diabetes	9.5	10.7	8.2
Obesity	36.7	33.9	26.1
Smoking	25.8	20.5	6.8

Measurement	AIAN*	Black*	Hispanic	White*	Asian*
Adult Mental Health				13.8	
Asthma				9.8	
Diabetes				8.1	
Obesity	44.8		36.2	31.5	
Smoking	20.2	30.3	13.6	20.9	

Measurement	Less Than $25,000	$25,000 to $49.999	$50,000 to $74,999	$75,000 or More
Adult Mental Health	23.2	10.7		5.9
Asthma	13.6	10.2	3.3	6.9
Diabetes	13	8.4	8.1	6.1
Obesity	38.6	33.1	30.6	25.3
Smoking	32.1	21.1	14.8	9.7

Source: The Behavioral Risk Factor Surveillance System (BRFSS)
Year: Three years combined data [2013-2015]

Chronic diseases priorities

CPAA Chronic Diseases & Risk Factors higher than the State Average

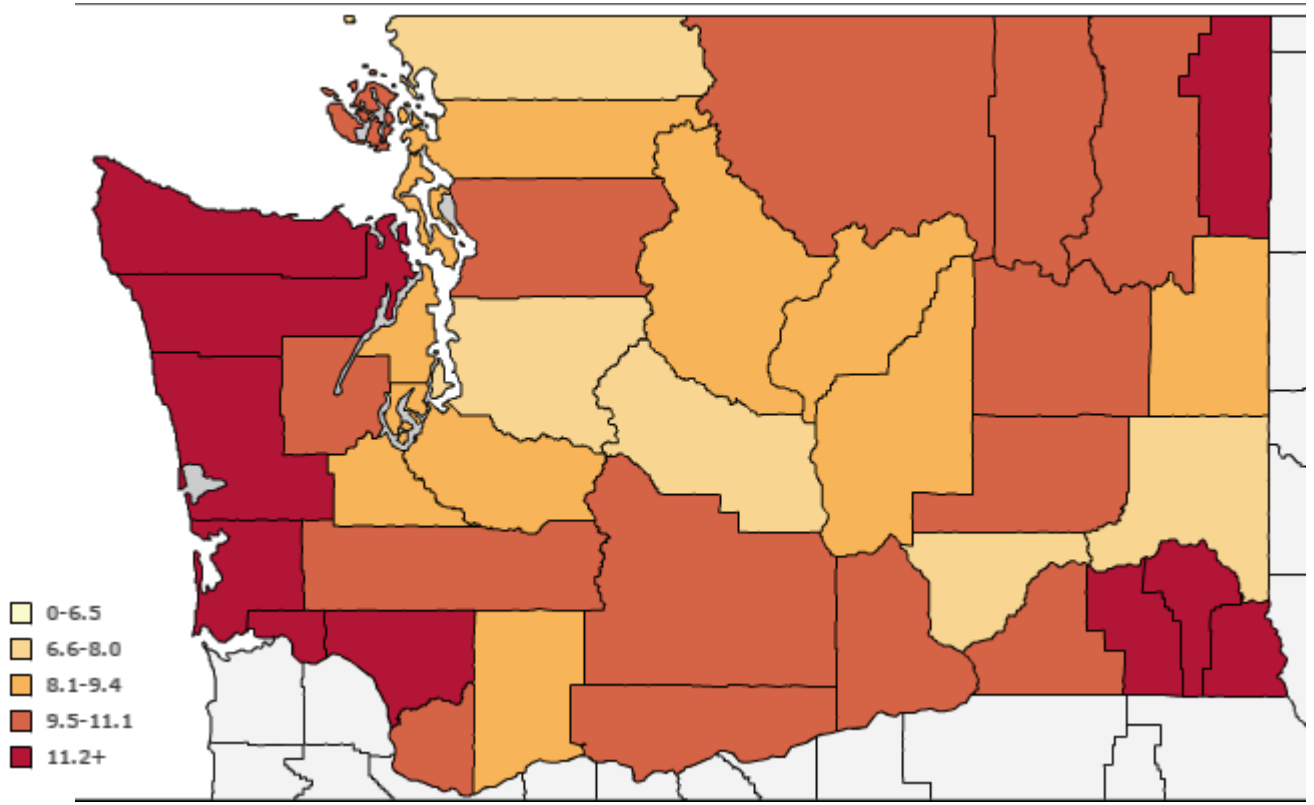
	Cowlitz	Grays Harbor	Lewis	Mason	Pacific	Thurston	Wahkiakum	**Total**
Arthritis	x	x	x	x			x	***5***
High BP	x	*		x	*			***4***
Obese	x	x	x	x				***4***
Cancer	x		x	x	x			***4***
Heart disease	*		x	x	*			***4***
Diabetes	x			x				2
Smoking		x			x			2
Asthma								0
x = statistical significance worse								
*= maybe statistical significance (hard to tell from chart)								

Chronic disease populations

	High BP	Obesity	Arthritis	Cancer	Heart Dis.
Cowlitz	30,641	27,416	27,416	13,708	6,451
Grays Harbor	22,062	22,062	19,159	7,547	4,064
Lewis	20,991	23,990	22,791	11,395	5,398
Mason	24,058	17,542	19,547	8,521	5,012
Pacific	7,042	5,105	6,337	3,169	1,584
Thurston	68,873	56,350	54,263	22,958	12,522
Wahkiakum	764	897	1,097	465	266
CPAA Total	**174,430**	**153,362**	**150,609**	**67,763**	**35,297**

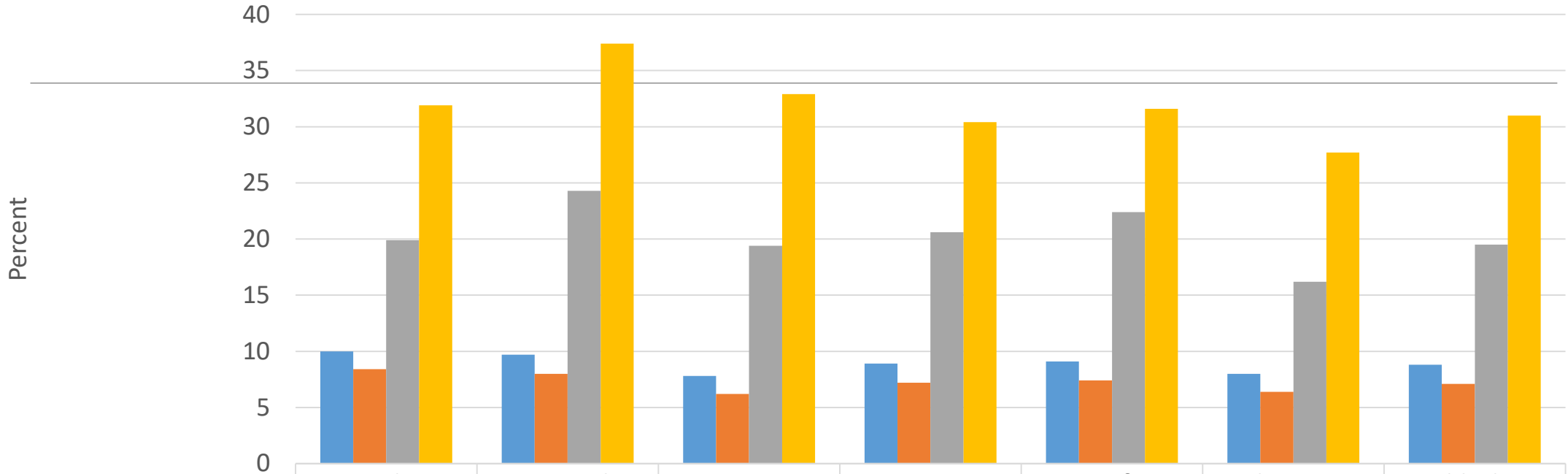
Diagnoses Diabetes, Percent. 2013*

County	Number	Percent
Cowlitz County	8,978	11.8
Grays Harbor County	6,333	11.6
Lewis County	5,401	9.5
Mason County	5,254	11.1
Pacific County	2,077	12.6
Thurston County	17,475	8.8
Wahkiakum County	417	12.8



Source: Behavioral Risk Factor Surveillance System (BRFSS) , 2013

Diabetes, Inactivity and Obesity



	Cowlitz	Grays Harbor	Lewis	Mason	Pacific	Thurston	Wahkiakum
Diabetes Prevalence %	10	9.7	7.8	8.9	9.1	8	8.8
Diabetes Incidence %	8.4	8	6.2	7.2	7.4	6.4	7.1
physical inactivity %	19.9	24.3	19.4	20.6	22.4	16.2	19.5
Obesity %	31.9	37.4	32.9	30.4	31.6	27.7	31

Source: Behavioral Risk Factor Surveillance System (BRFSS) , 2013
Diabetes Prevalence: Has a doctor ever told you that you have diabetes?
Diabetes Incidence: diagnosed with diabetes in the last year
Physical Inactivity: Responded No to: During the past month, other than your regular job, did you participate in any physical activities or exercises
Obesity: body mass index was 30 or greater. Serived from self-report of height and weight

Behavioral health priorities

	Opiate-Related Deaths per 100,000		Crime lab cases involving any opiate	
	2002-04	2011-13	2002-04	2011-13
State	6.6	8.6	19.8	36.7
CPAA	6.92	11.6	35.7	91.3

2015 Hospitalizations w/Mental Illness Dx		
	Count	Age-Adjusted Rate
State Total	32365	453.62
Cowlitz	614	614.62
Grays Harbor	479	661.04
Lewis	356	475.05
Mason	241	415.22
Pacific	105	585.38
Thurston	1291	486.71
Wahkiakum	22	693.73

Behavioral health populations

	All Medicaid Opioid Users	Heavy Opioid Users	Diagnosis of Opioid Abuse/Dependence	Medication Assisted Treatment (MAT)		% of All MCD Opioid Users			
				Buprenorphine	Methadone	heavy use	Dx	Bup.	Methadone
CPAA	28,371	5,310	6,471	486	1,075	18.7%	22.8%	1.7%	3.8%

	CPAA %	CPAA #	State %
adults poor MH status	12.8	61,238	11.3

Frequent ems utilizer priorities

Cowlitz 2 Fire & Rescue

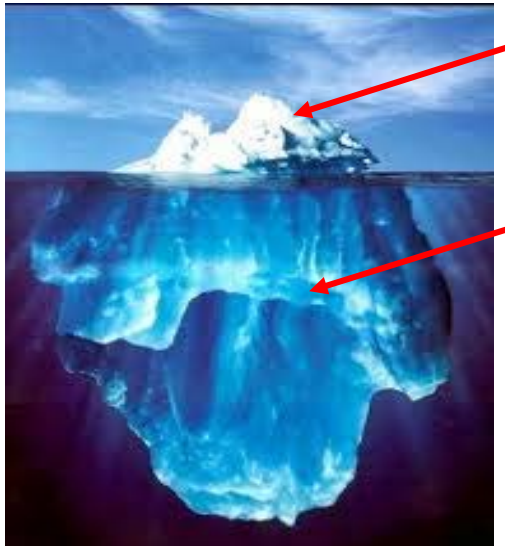
- Falls Risk
- Poorly managed chronic disease
- Behavioral Health

Maternal/Child priorities/populations

Families with children under 18 living in poverty, 2015		
	Count	% of Families
State	818,468	14.4%
Cowlitz	11,494	21.3%
Grays Harbor	7,053	21.4%
Lewis	8,133	16.8%
Mason	5,745	22.2%
Pacific	1,925	21.7%
Thurston	31,284	14.3%
Wahkiakum	357	23.2%
CPAA Total	65,991	20.1%

Low Birth Weight Births, 2015		
	Count	Percent
State Total	5734	6.45%
Cowlitz	70	5.7%
Grays Harbor	61	7.83%
Lewis	63	7.07%
Mason	37	5.9%
Pacific	19	9.84%
Thurston	196	6.39%
Wahkiakum	2	8%

Populations, 2015	
	CPAA Total
MCD Eligible Women age 15-44	29,210
MCD Children age <19	77,973
Teen Pregnancy (33.1, higher than state rate/1,000)	578



Social Determinants of Health

Step 1: Find

Step 2: Treat

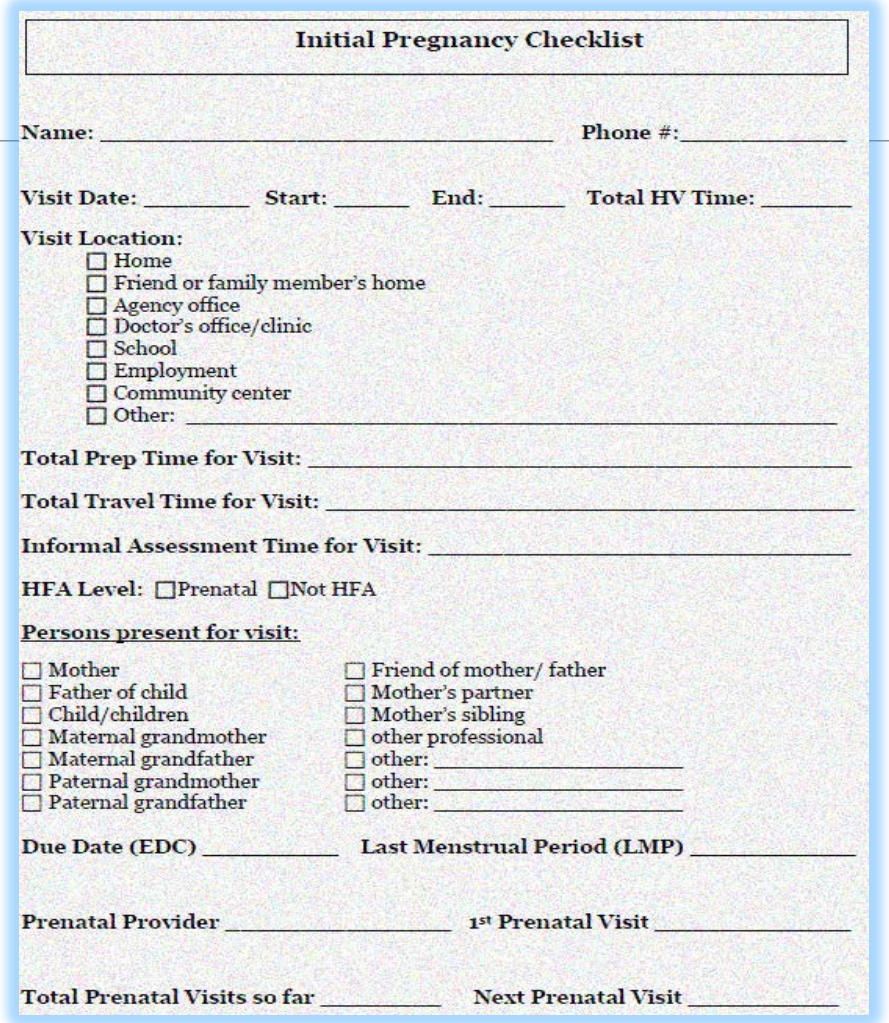
Step 3: Measure

Comprehensive Risk Assessment → **Assign Pathways (translate risk)** → **Measure Connections to Care**

Comprehensive Risk Assessment

Standard Data Collection:

- Client Profile
- Initial Checklist (enrollment)
- Ongoing Checklist at each face-to-face visit



Initial Pregnancy Checklist

Name: _____ **Phone #:**_____

Visit Date: _____ **Start:** _____ **End:** _____ **Total HV Time:** _____

Visit Location:

- ☐ Home
- ☐ Friend or family member's home
- ☐ Agency office
- ☐ Doctor's office/clinic
- ☐ School
- ☐ Employment
- ☐ Community center
- ☐ Other: _____

Total Prep Time for Visit: _____

Total Travel Time for Visit: _____

Informal Assessment Time for Visit: _____

HFA Level: ☐Prenatal ☐Not HFA

Persons present for visit:

- ☐ Mother
- ☐ Father of child
- ☐ Child/children
- ☐ Maternal grandmother
- ☐ Maternal grandfather
- ☐ Paternal grandmother
- ☐ Paternal grandfather
- ☐ Friend of mother/ father
- ☐ Mother's partner
- ☐ Mother's sibling
- ☐ other professional
- ☐ other: _____
- ☐ other: _____
- ☐ other: _____

Due Date (EDC) _____ **Last Menstrual Period (LMP)** _____

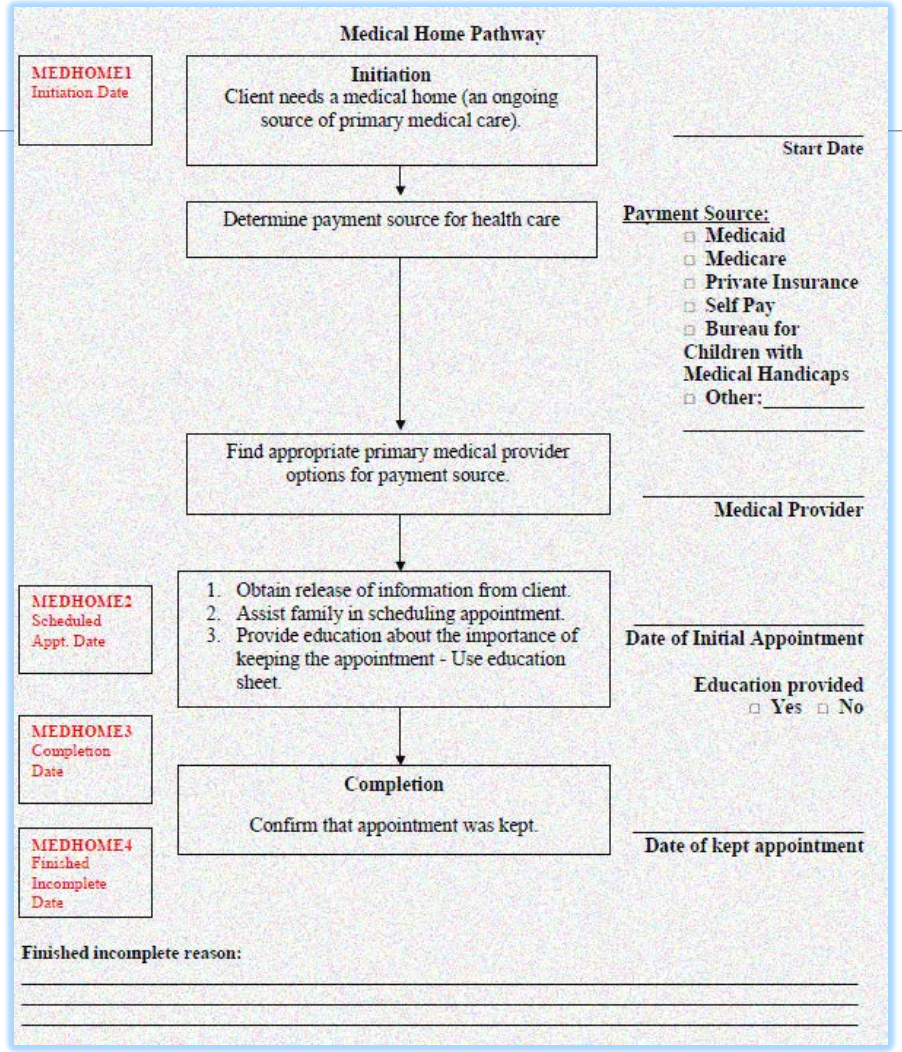
Prenatal Provider _____ **1st Prenatal Visit** _____

Total Prenatal Visits so far _____ **Next Prenatal Visit** _____

Risk = Pathways (PW)

20 Standard Pathways:

- One risk factor at a time
- Outcome achieved = finished PW & Payment!
- Outcome not achieved = finished incomplete PW



Medical Home Pathway

MEDHOME1 Initiation Date

Initiation
Client needs a medical home (an ongoing source of primary medical care).

Start Date

Determine payment source for health care

Payment Source:
- ☐ Medicaid
- ☐ Medicare
- ☐ Private Insurance
- ☐ Self Pay
- ☐ Bureau for Children with Medical Handicaps
- ☐ Other:_____

Find appropriate primary medical provider options for payment source.

Medical Provider

MEDHOME2 Scheduled Appt. Date

1. Obtain release of information from client.
2. Assist family in scheduling appointment.
3. Provide education about the importance of keeping the appointment - Use education sheet.

Date of Initial Appointment

Education provided ☐ Yes ☐ No

MEDHOME3 Completion Date

Completion

Confirm that appointment was kept.

Date of kept appointment

MEDHOME4 Finished Incomplete Date

Finished incomplete reason:

20 Standard Pathways

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

Initial Steps . . .

- Determine target population within MCH
- Who provides care coordination for this population now?
- What are the gaps in services? Strategize to fill the gaps.
- Training:
  - Care Coordinators
  - Pathways
  - Systems
- How are you connecting with providers and other referral partners?
- Standardize screening for referral into HUB & sharing of care team dashboard

Care coordination organizations

CAPACITY INVENTORY

Considerations

- Population(s) need to be selected before inventory can be completed
- Implementation scope – 7 counties vs. subset of counties
- Capacity of care coordinator agencies
- Referral patterns

Capacity of care coordinator agencies

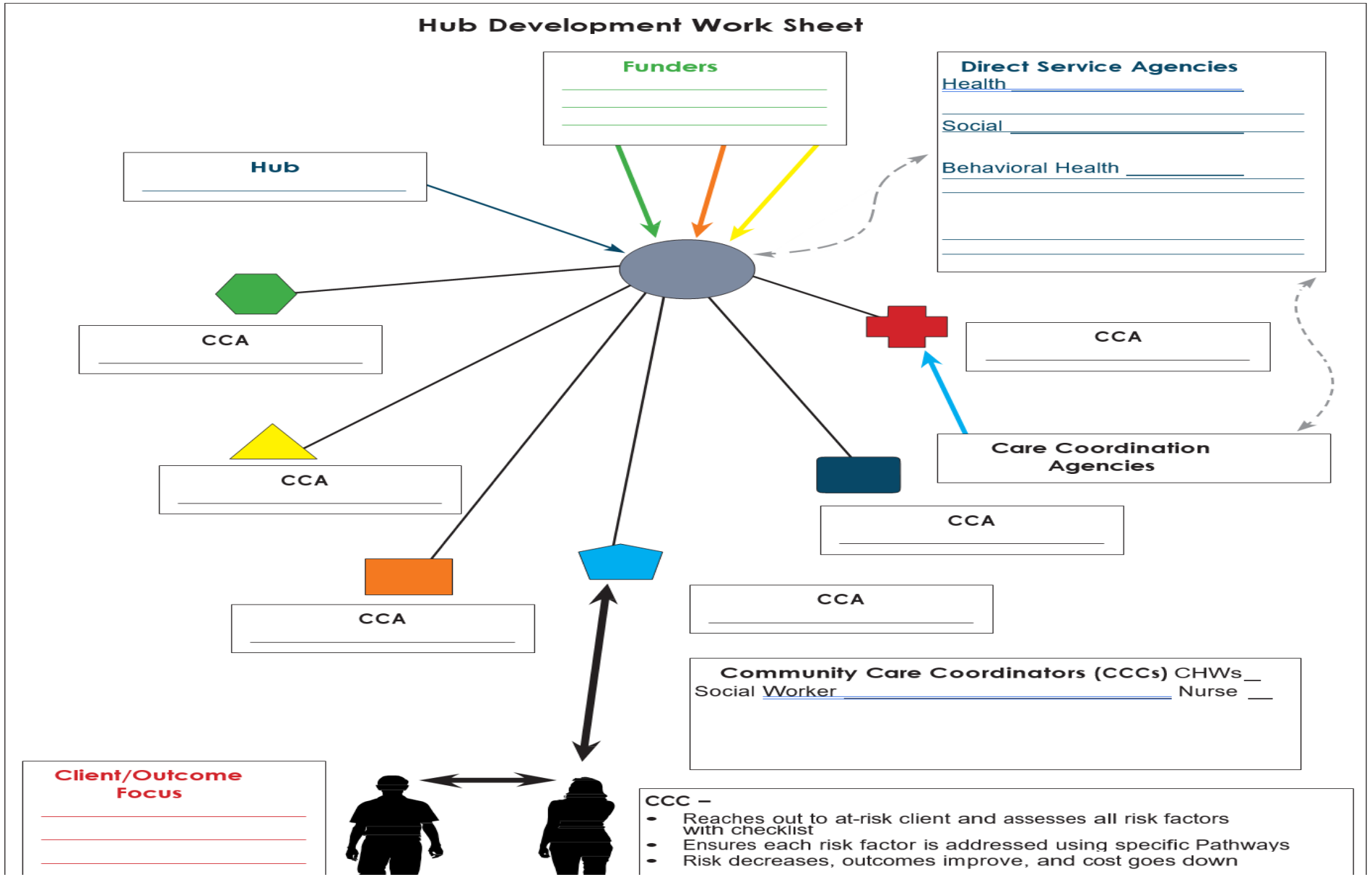
- Number of care coordinators
- Level of training (CHW, RN, etc.)
- Supervision structure
- Current capacity vs. need

Referral patterns

- Existing patterns for current care coordinating organizations
- Potential referral sources

Community-Based Care Coordination: Project Ideas

Planning	• Assess current capacity and existing care coordination activities • Determine HUB leadership and governance • Recruit and secure formal commitments from implementation partners • Develop HUB Implementation Plan	
Implementation	• Complete HUB Operations Manual and HUB Quality Improvement Plan • Develop polices and procedures • Create tools and resources for care coordinators • Hire and train staff • Conduct community awareness campaign	
Scale & Sustain	• Recruit additional community organizations and partners to participate in HUB • Implement additional focus areas or pathways • Continuous quality improvement • Provide training, technical assistance, learning collaboratives to support HUB • Develop payment models to support care coordination model • Implement VBP strategies to support HUB care coordination model	


Hub Development Work Sheet
Funders
Direct Service Agencies
Health
Social
Behavioral Health
Hub
CCA
CCA
CCA
Care Coordination Agencies
CCA
CCA
CCA
Community Care Coordinators (CCCs) CHWs
Social Worker
Nurse
Client/Outcome Focus
CCC –
Reaches out to at-risk client and assesses all risk factors with checklist
Ensures each risk factor is addressed using specific Pathways
Risk decreases, outcomes improve, and cost goes down