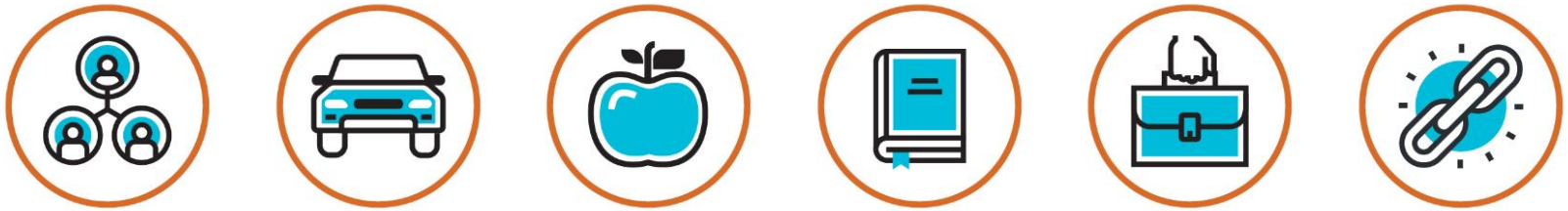
Community Health Transformation: *from Planning to Action*

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.

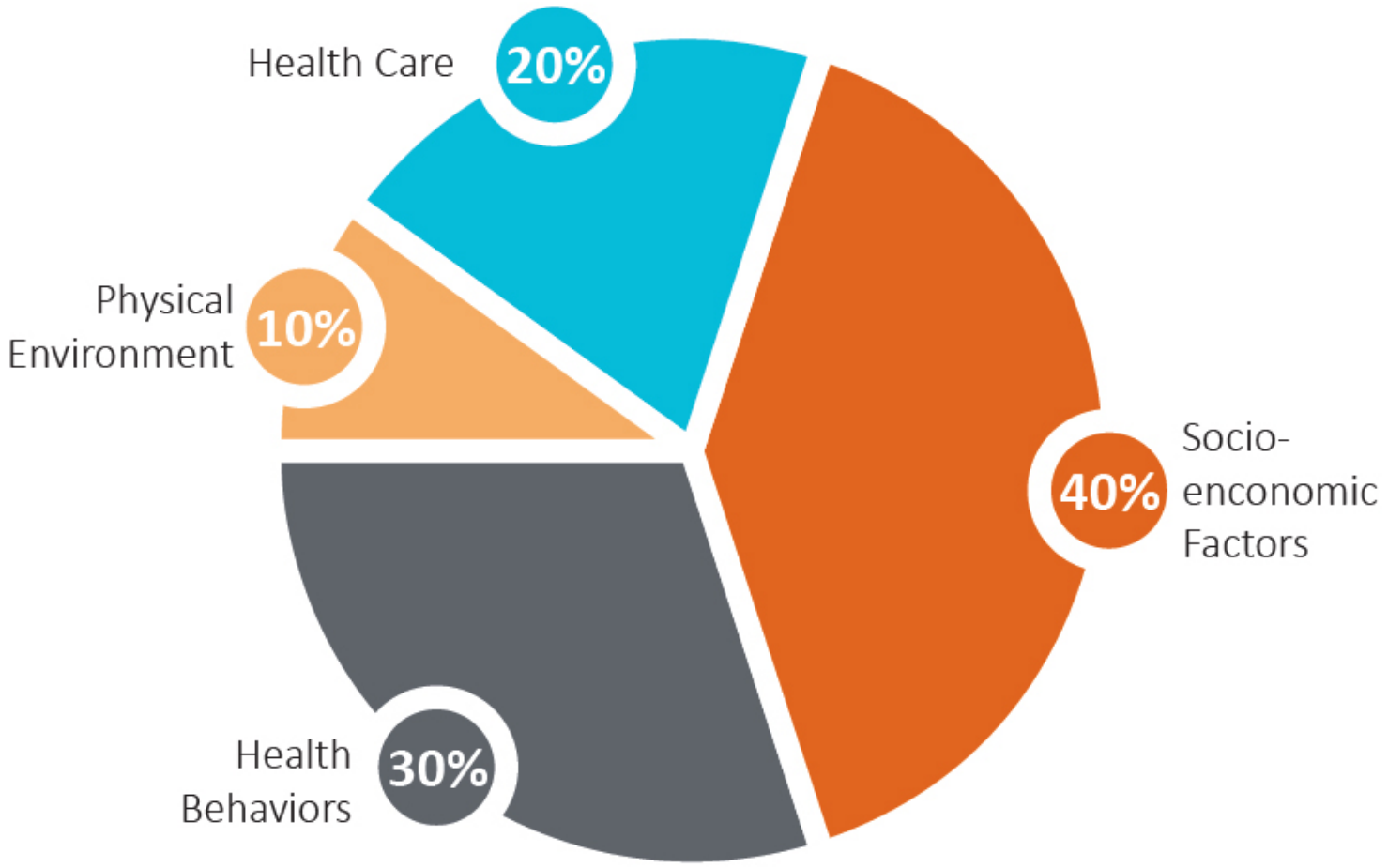
Stable **housing**, nutritious **food**, and **transportation**.

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.

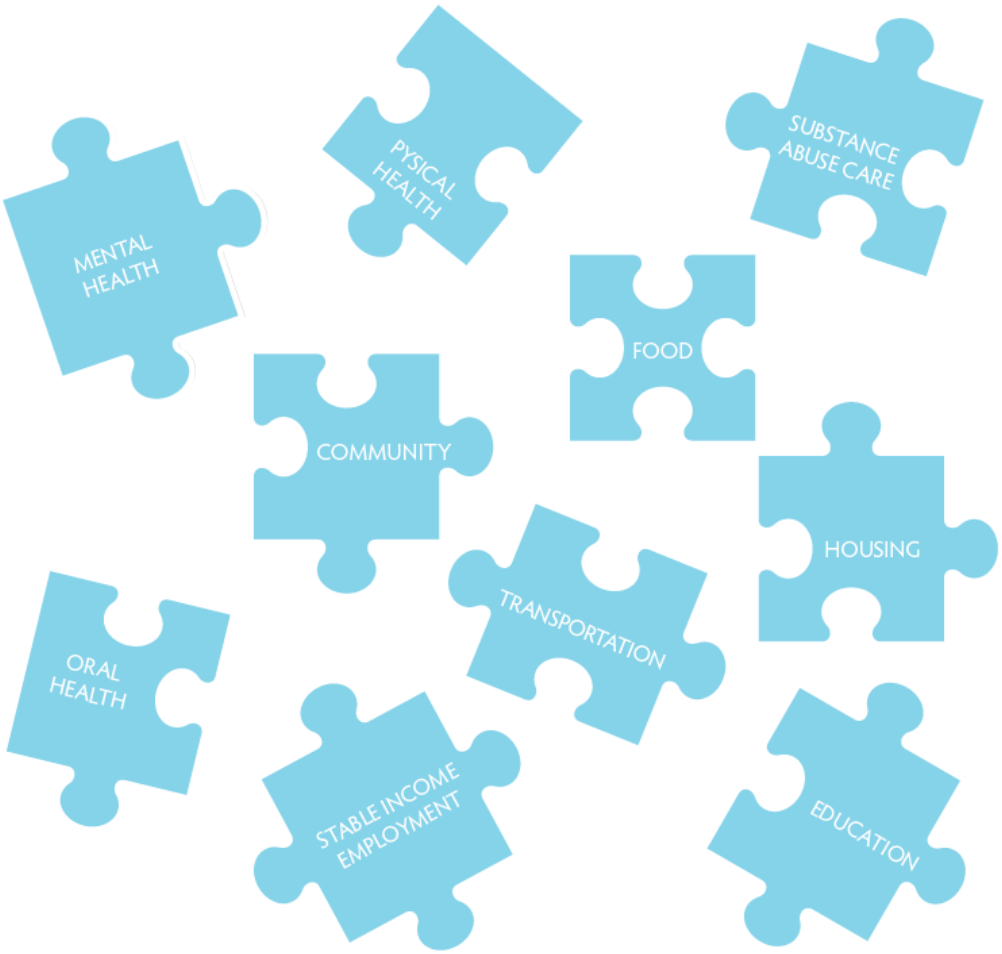
better health together

What determines Health?



Adapted from: Magnan et al. (2010). ***Achieving Accountability for Health and HealthCare: A white Paper***, State Quality Improvement Institue. Minnesota.

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:

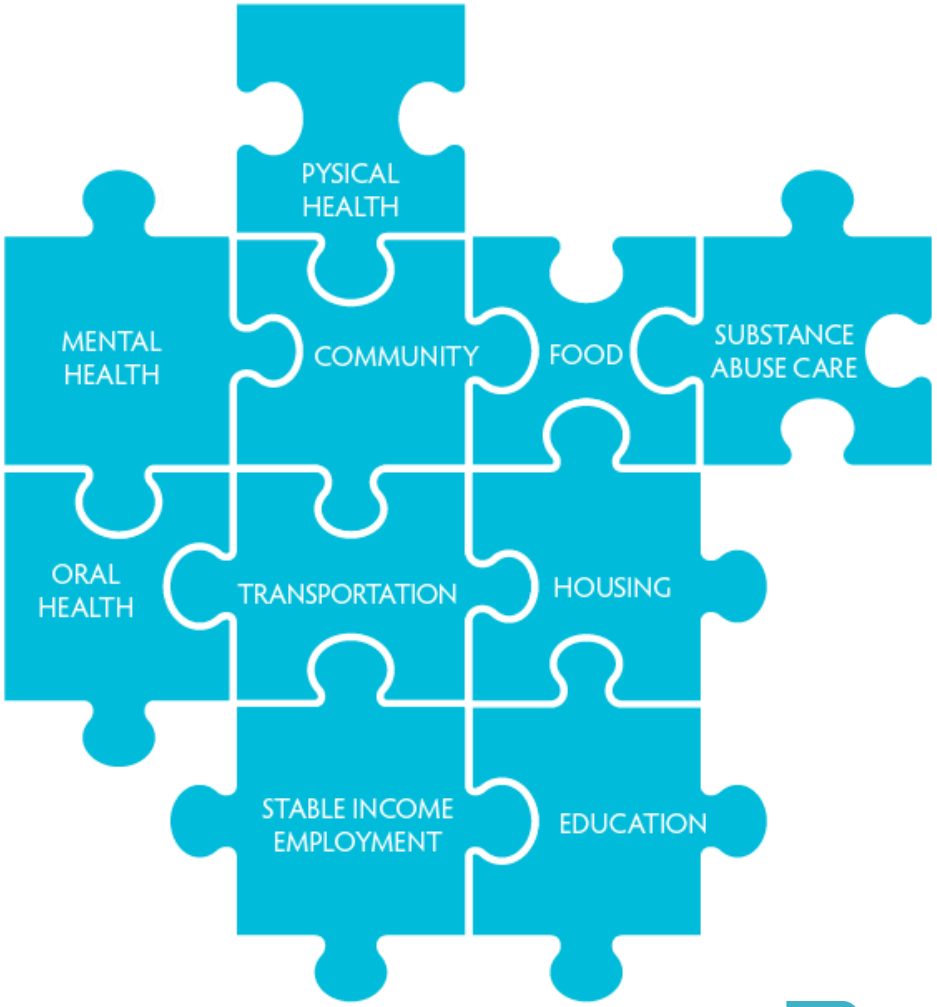
- Good intentions to partner
- Creative Pilots never taken to scale
- Inconsistent funding
- Lack of investment in data and evaluation capacity

better health together

2021 **VISION**

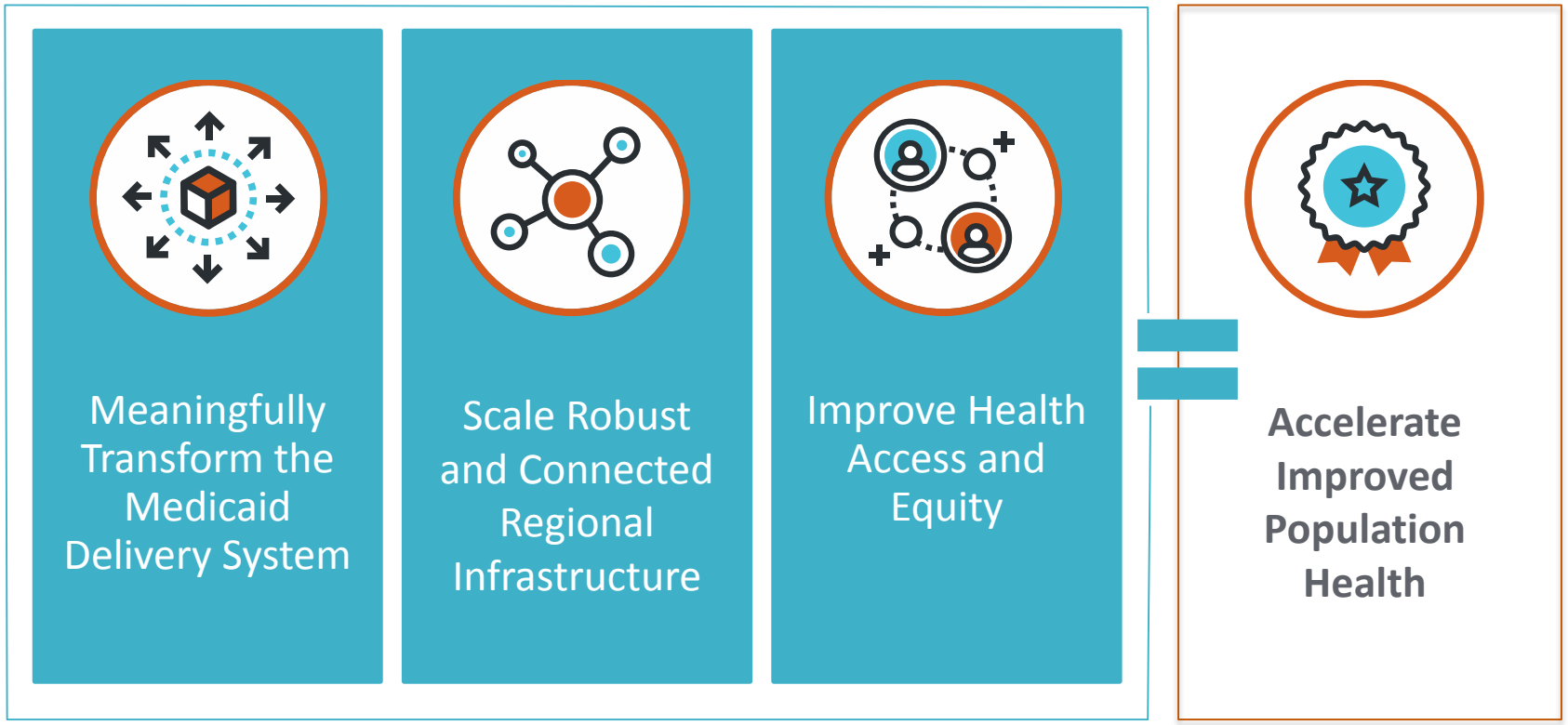
Healthier Communities!

- 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



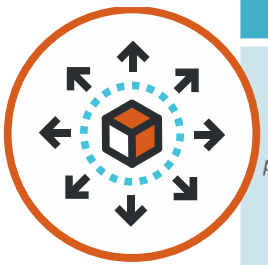
better health together

Medicaid Transformation **Framework**



better health together

Medicaid Transformation **Framework**



Transformation Happens Across These SETTINGS:

PC/BH Clinical *Including Oral prevention and maternal and child health activities at PC/BH*	ED Acute & Post Acute Care	Pharmacy	Emergency Medical Response	Law Enforcement & Criminal Justice	Social Determinants of Health & Community Based Organizations	Key Partners Public Health, Oral Health, Chronic Disease, Special Services, County

Build a REGIONAL INFRASTRUCTURE to Sustain Whole Person Care

Workforce Development	Payment Reform	Population Health Management (HIT/HIE, Data Analytics, Evaluation)	Community Health Equity Partnerships	Community Resiliency Investments	Policy & Advocacy

Focus on Medicaid Beneficiaries within these TARGET POPULATION(s)

People with Opioid Dependence	People with Behavioral Health Problems	People with Chronic Conditions	Women of Child-Bearing Age	People Transitioning out of Jail

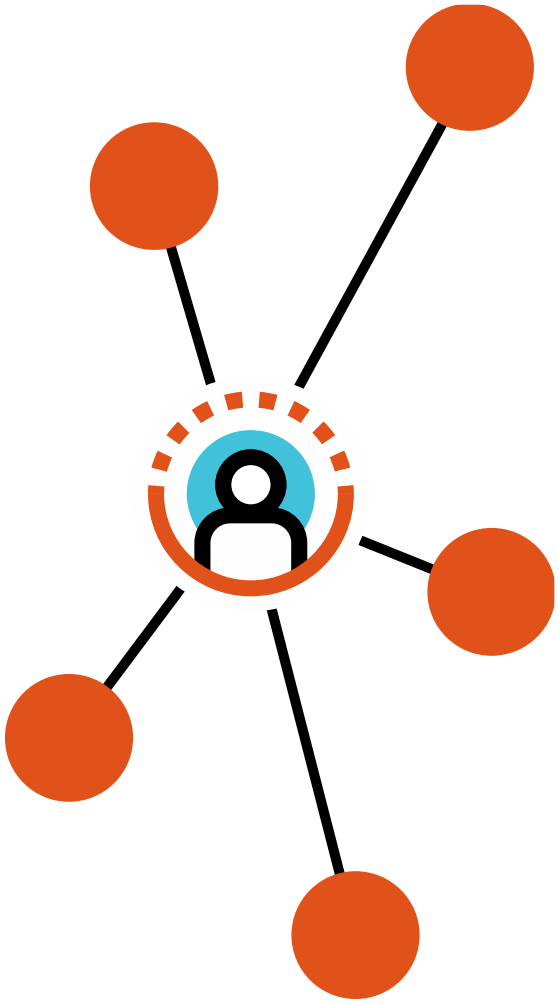
What is **Success**? *(or how will we measure it?)*

Medicaid Transformation Project **Examples of State Measures**	BHT ACH **Local Measures**	**Collaborative Health Outcomes**
✓ 90% of Medicaid contracts are Value Based in 2021 ✓ Reduce Medicaid ED utilization ✓ Reduce readmission rates ✓ Increase substance use disorder (SUD) treatment penetration rate ✓ Increase mental health treatment penetration rate ✓ Increase well child visits for 3-,4-, and 6-year-olds ✓ Improve Anti-depressants Medication Management ✓ Improve Medication Management for Asthma	✓ Decrease jail recidivism ✓ Reduce unintended pregnancies ✓ Increase oral health ✓ Increase behavioral health access	✓ To be determined by local Collaborative

better health together

Community Based Care Coordination & Pathways Hub

better health together



Why we need Community Based Care Coordination?

Community Care Coordination?

MORE THAN 1/2 of patients	can't state their diagnosis when leaving the hospital
MORE THAN 1/3 of patients	can't explain their medications
LESS THAN 1/2 of patients	saw a primary care physician within 2 weeks of leaving the hospital
1 IN 5 patients	has an adverse event transitioning from hospital to home

better health together

Pathways Community Hub

20 Pathways and Outcomes

Pathway	Outcome
Adult Education	Confirm that client successfully completes stated education goal: • course/class completed • quarter/semester completed • training program completed
Behavioral Health	Client has kept 3 scheduled appointments f behavioral health issue(s).
Developmental Referral	Document the date and results of the completed developmental evaluation.
Developmental Screening	Child successfully screened using the age-appropriate ASQ or ASQ-SE.
Education	Client reports that he/she understands the educational information presented. (docum educational content and format)
Employment	Client has found consistent source(s) of ste income and is employed over a period of 3 months.
Family Planning	Confirm that client has kept appointment a document family planning method: 1. Completed with permanent sterilizat or LARC (long acting reversible contraceptive) 2. All other methods, completed if clien

Pathway	Outcome
Immunization Screening	Client is up to date on all age appropriate immunizations.
Lead	Confirm that appointment was kept and document results of lead blood test.
Medical Home	Confirm that client in need of ongoing primary care has kept first appointment with medical home.
Medical Referral	Verify with health care provider that client has kept appointment.
Medication Assessment	Verity with primary care provider that medication chart was received. (requires chart)
Medication Management	Verify with prima medications as pr
Postpartum	Confirm that clien
Pregnancy	Confirm that clien more than 5 pour
Smoking/Tobacco Cessation	Confirm that clien
Social Service	Verify that client

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.

better health together

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
- Gives feedback back to Referral Partners (clie
- Works closely with Pathfinder Community Hu review data, gaps in services, identify prioriti
- Quality improvement plan to identify areas c network of CCAs
- Obtains national Pathways Community HUB participates with partner HUBs

better health together

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 $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*

better health together

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.

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

Long Term Outcomes:

- Reduce Recidivism
- Increase Protective Factors
- Increase Permanent Housing

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

better health together

Questions

For more information contact

Alison Poulsen, Executive Director

Alison@BetterHealthTogether.org