

CARE COORDINATION WORK GROUP MEETING JANUARY 30, 2017

Welcome and Introductions

Introduce yourself: Name, organization, and county



Review Desired Meeting Outcomes

- Review & discuss county level data
- ✓ Learn about daily work for Pathways Care Coordinators
- ✓ Discuss workgroup needs for detailed implementation planning

Data Review

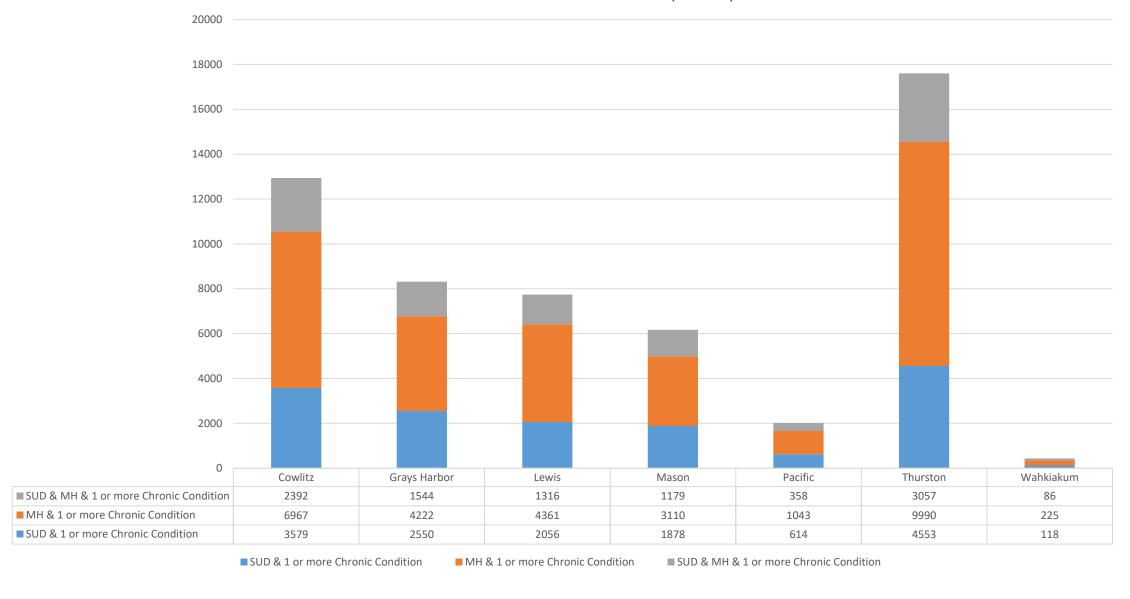
- Analyze county level data for proposed target populations
 - Co-occurring chronic physical and behavioral health
 - High risk pregnancies
 - Homeless and at risk for homelessness
 - Frequent EMS users

Considerations

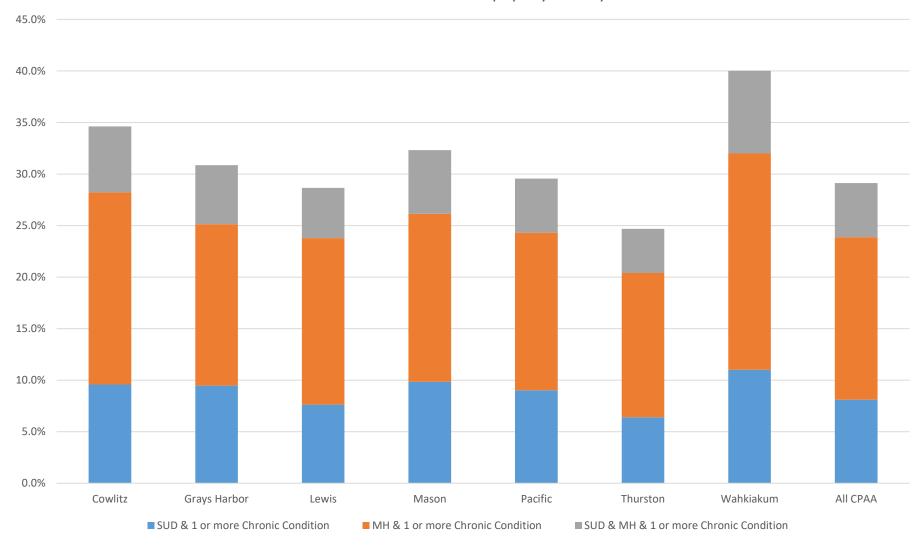
- Health Equity
- Effective Start-up
 - Rapidly fill case loads
 - Build on existing capacity
- Growth Opportunity
 - Rapidly scale and expand implementation
 - Demonstrate value to payers & MTD

Co-occurring Population

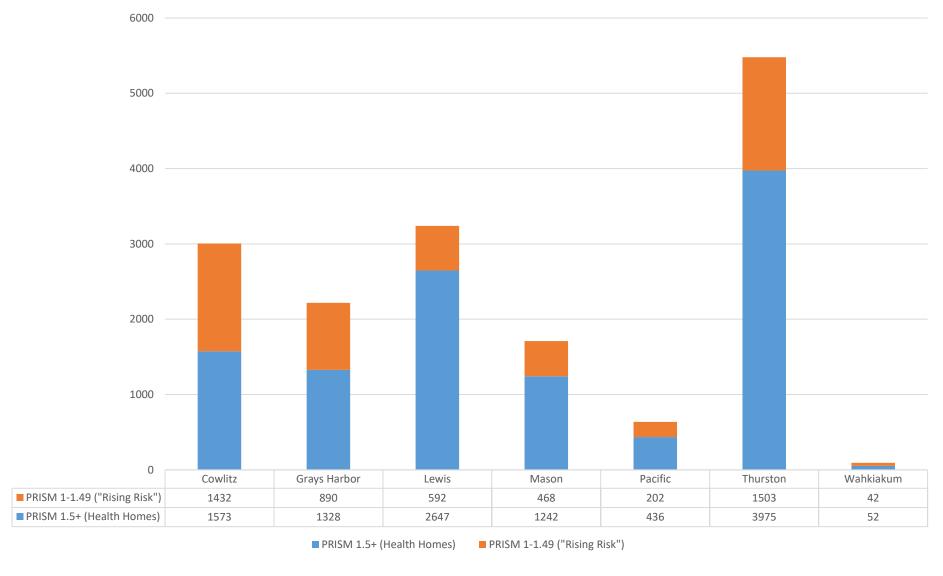
Behavioral Health & Chronic Disease by County



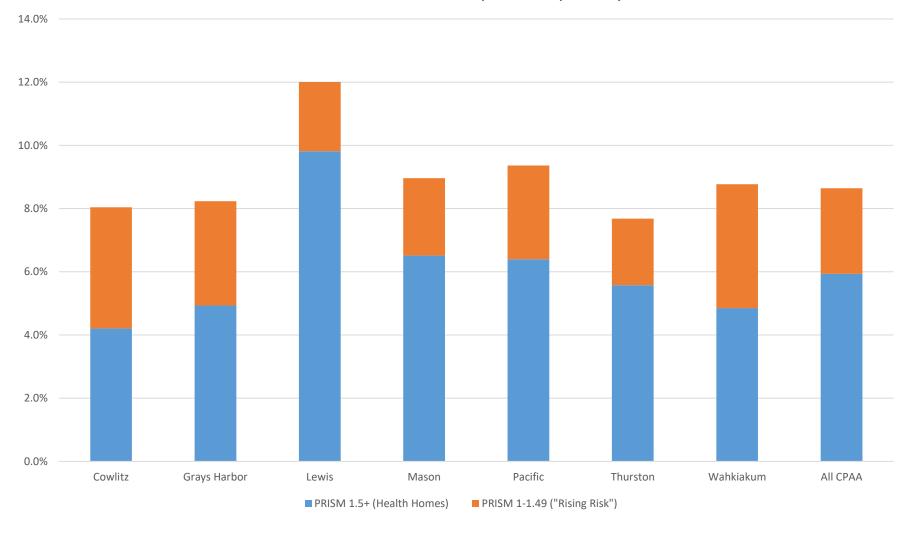
BH & CD as % of MCD pop. by County



Population with Health Homes and Rising Risk PRISM Scores by County

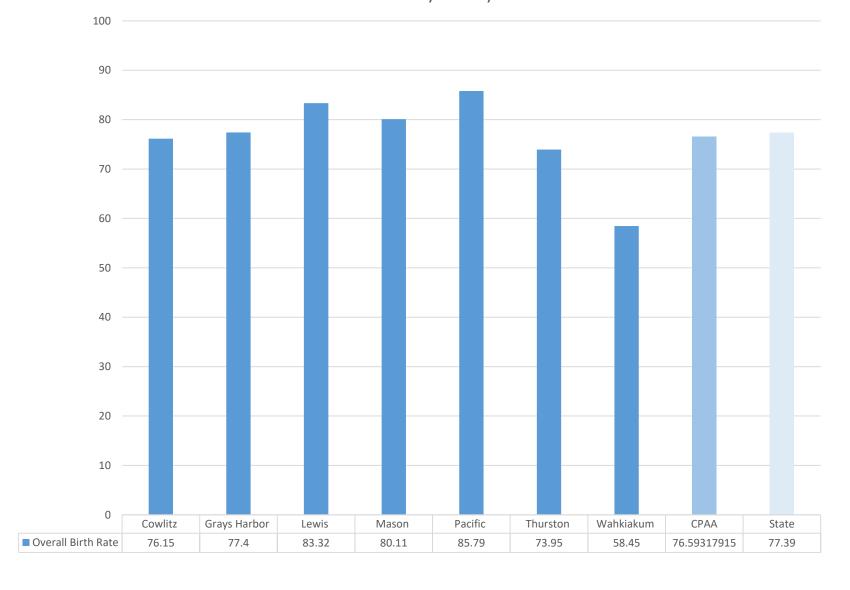


HH & RR as % of MCD Population by County

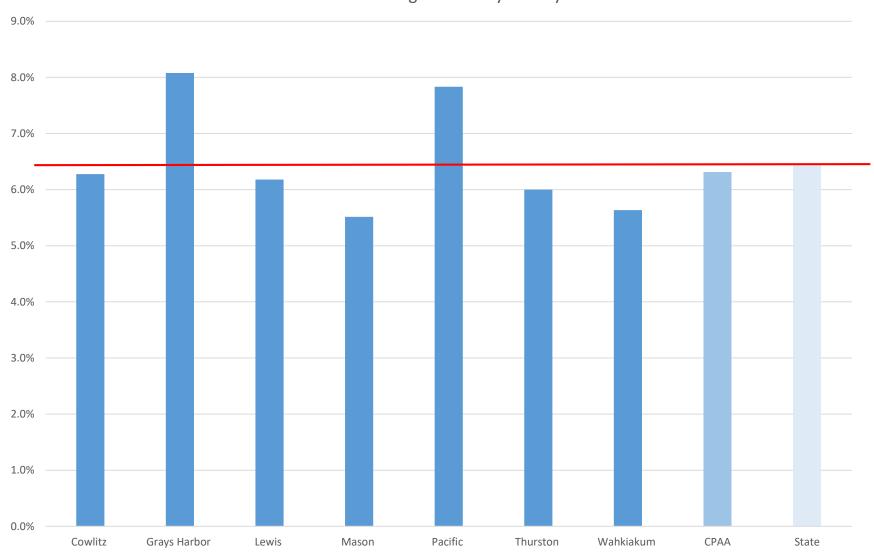


At Risk Pregnancies

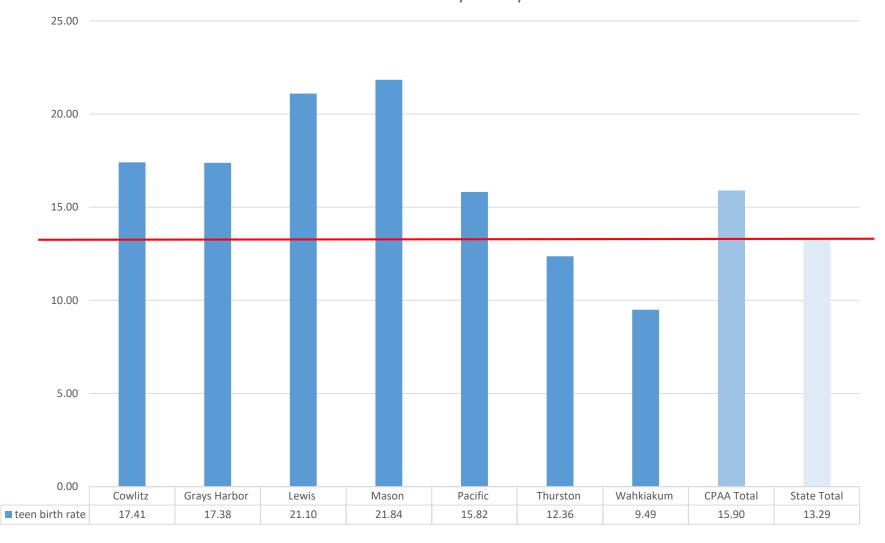
Birth Rate by County



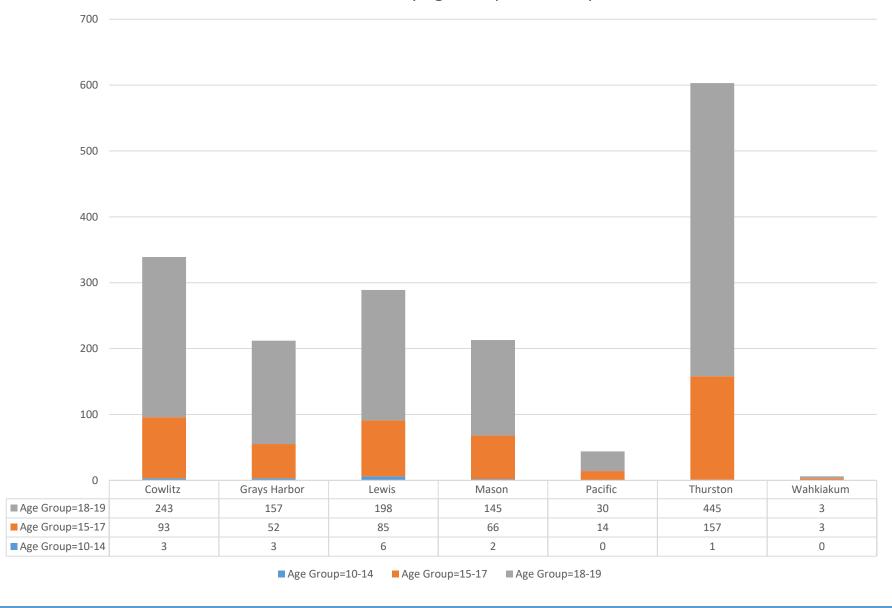
% of Low Weight Births by County



Teen Birth Rate by County



of Teen Births by Age Group and County



Births, 2015

3000

2500

2000

1168

1000

770

622

500

114

22

Mason

Pacific

Thurston

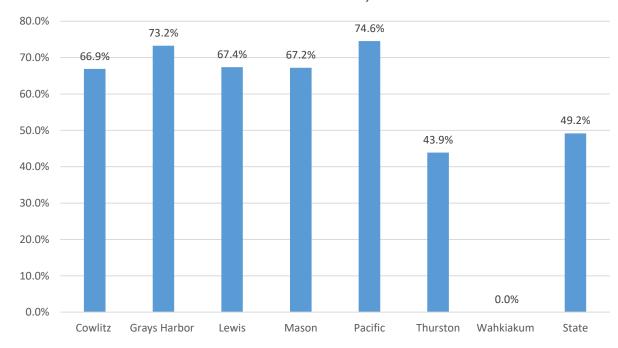
Wahkiakum

Cowlitz

Grays Harbor

Lewis

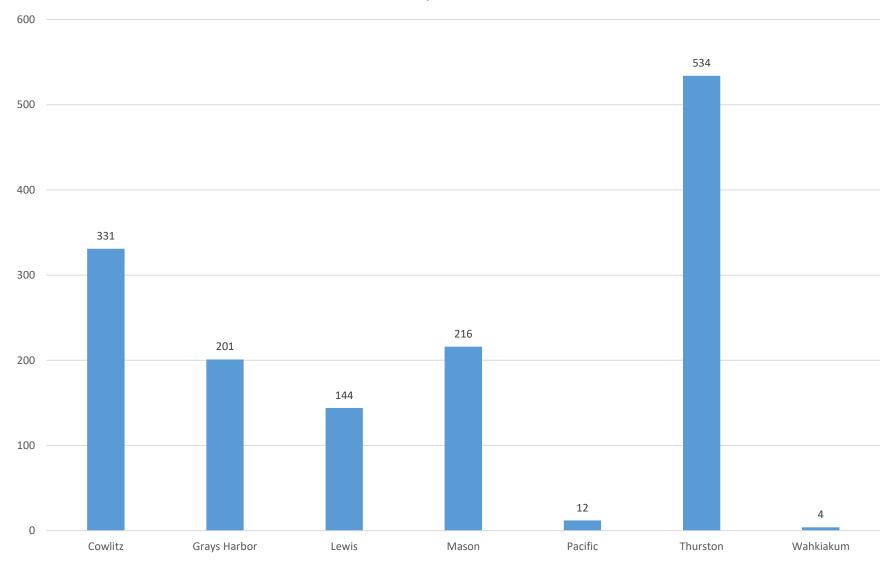
% of Births to MCD, 2015



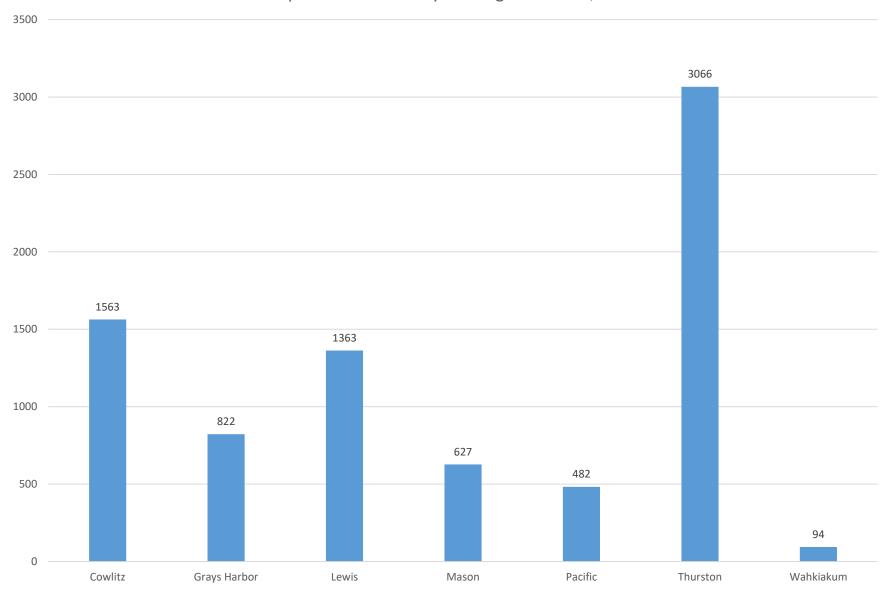
Homeless

AND AT-RISK FOR HOMELESSNESS

Homeless, 2017 PIT Count



People entered into any housing from HMIS, 2016



Frequent EMS Utilizers

Limited information available

- Not all EMS providers participate in the state-wide WEMSIS platform
- Transport data to hospitals does not capture all of the use by frequent utilizers

 Individual EMS providers use varying data systems, but can ID most frequent call locations and call types

Preview: Care Coordination Capacity Assessment

Current Responses: 15/32, additional providers identified

So far:

- Most providers rely on referrals from other agencies
- 100% report providing case management as a part of services
- All counties have some services.
- Majority of workforce are nurses and social workers
- Many existing case loads are higher than recommended for Pathways
- Most providers already have extensive reporting requirements
- Strong interest in becoming a Care Coordination Agency under Pathways model

Discussion

 How is the information reviewed impacting your thinking on target populations?

• Does it work for us to have a broader target population with some regional variation in sub-populations (e.g. co-occurring as the broad population, while allowing for a CCA to serve pregnant mothers with a co-occurring condition)?

 Are there any critical gaps in data that need to be filled before we can select a target population to recommend?

A day in the life of...

PATHWAYS CARE COORDINATORS

Q&A WITH DR. SARAH REDDING

Workgroup Needs

IMPLEMENTATION PLANNING

Forming a Core Planning Team

- Provide more rigorous feedback for program development
- Serve as program ambassadors in local communities to build support and engagement
- Work more frequently with CPAA staff and technical assistance providers
- Assist with review of program RFPs

Brainstorm criteria to ID and select core team members

Summary and Next Steps

- Next Steps:
 - Continue work on Care Coordination Capacity Assessment
 - Review additional data and make target population recommendation to CPAA Council
 - Form core planning team and schedule deep dive with technical assistance providers

Next Meeting:

Tuesday March 27th, 2018 3:15-4:45pm