TRANSITIONAL CARE WORK GROUP MEETING

MARCH 27TH, 2018

Welcome and Introductions

Introduce yourself: Name, organization, and county

WELCOME

Review Proposed Agenda Items

- ✓ Next steps and closing
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Washington Medicaid Transformation

Transformation through Accountable Communities of Health*, 2017-2021

For more information visit the Healthier Washington website

Key Medicaid Transformation Activities

2017 Year 1

Washington contracts with the Centers for Medicare & Medicaid Services (CMS) to find new ways to make communities healthier by partnering with Accountable Communities of Health (ACHs) on Medicaid Transformation projects.

The nine ACHs pass two levels of certification and each receive $6 million for planning regional health projects.

ACHs submit Project Plans for the projects they will support in Years 2 through 5.

How to Get Involved

Provide input to ACHs at meetings, workgroups, councils, and through surveys.

Stay in touch by signing up for news, or emailing medicaidtransformation@hca.wa.gov to join the Feedback Network (include your name and email address).

2018 Year 2

ACHs earn money for reporting information related to their projects (called Pay-for-Reporting, or P4R).

FEBRUARY

ACH Project Plan scores finalized and approval status determined.

HCA releases the Measurement Guide for public review. It shows how the state will measure improvements in making communities healthier, and how ACHs and partners can earn funds for performance.

JULY

ACHs submit first semi-annual report, in which they describe project progress to date. This includes defining the communities they will focus on, and specific steps they will take to make them healthier.

OCTOBER

ACHs submit Implementation Plans describing how they will carry out their projects.

If you are a health or social service provider, ask your ACH about becoming a partnering provider.

Sign up for your ACH's email list to stay in touch with their progress and ways to be involved.

Help your ACH with their Project and Implementation Plans.

2019 Year 3

In addition to reporting on project milestones, ACHs begin earning money based on how well their projects are helping communities (P4P).

JULY

ACHs will participate in a mid-point assessment to identify areas of improvement to ensure successful implementation of projects.

Work with your ACH to support, improve, and strengthen projects.

2020 Year 4

JANUARY

Washington moves to Integrated Managed Care, a model that coordinates physical health, mental health, and drug and alcohol treatment to provide whole-person care under one health plan.

Help your ACH by working on projects, attending meetings, and contributing to reports.

2021 Year 5

DECEMBER

Although Washington's contract with CMS ends, Medicaid Transformation continues. ACHs have the programs and partnerships in place, and communities are reporting measurable progress. Washington's Medicaid program is proving the value of rewarding high-quality, whole-person care.

Continue to help make your communities healthier by working with your ACH to improve health care for all Washingtonians.

ACHs will submit reports twice per year (in January and July) about how they are doing on the their projects.

* Transformation through Accountable Communities of Health is one of the three initiatives of the Medicaid Transformation Demonstration. The Demonstration is an agreement with the federal government, allowing Washington to test innovative ways of improving health care.

Healthier WASHINGTON

Medicaid Transportation

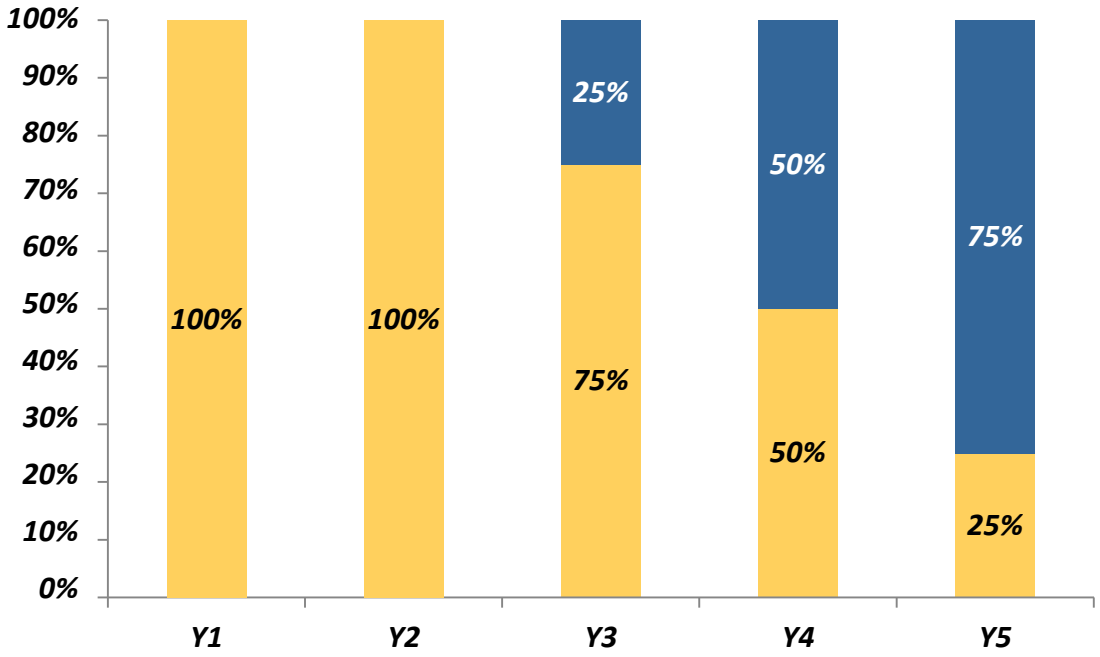
- Your ProviderOne services card
- Your complete pick-up address
- The name and phone number of your medical provider
- Exact appointment date and time
- The type of health care appointment (i.e. dialysis, OB, dental, etc.)
- Your return time, if known
- Recommend contact 7-14 days prior appointment
- If request less than 2 days, may ask patient to reschedule medical appointment
- https://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/transportation-services-non-emergency

Domain 1 Investments

- Educational Campaigns
- Training
- Workforce
- HIT/HIE
  - Registries
  - CMT Pre-Manage/EDIE

Insert logic here

Project Payment Accountability by Year



- **ACHs will report semi-annually** on progress and, starting in Y3, on their outcomes to date for selected projects
- Accountability emphasis shifts from **process** metrics to **outcome** metrics and from **reporting** to **performance** thresholds over the course of the 5-year program

P4R Update by HCA (draft)

Recommended P4R Metric List (Pending Approval) Providers Traditionally Reimbursed by Medicaid All Projects

- Practice/clinic site is actively sharing information (via HIE) to coordinate care
- Providers are trained on project selected evidence-based approach(es)
- Trained provider implementation of project selected evidence-based approach(es)

Medicaid Providers are defined as clinic/practice sites who provide physical and behavioral health services paid by Medicaid.

Community Based and Social Organizations All Projects

- Organization site is actively sharing information (via HIE) to coordinate care
- Organization staff trained on project selected evidence-based approach(es)
- Organization staff implementation of project selected evidence-based approach(es)

Feedback for refined Target Population

PAY FOR PERFORMANCE METRICS

1. Follow up after Discharge
   - -ED Mental Health FUM 7 (age 18-64/duals excluded)
   - - ED Mental Health FUM 7 (age 18-64/duals excluded)
   - -ED Mental Health FUM 30 (age 18-64/duals excluded)
   - -ED CD FUM 7 (age 18-64/duals excluded)
   - -ED CD FUM 30 (age 18-64/duals excluded)
   - - Mental illness hospitalization 7 days
2. Inpatient hospital utilization (18-64)
3. Mental Health Penetration (broad)(18+)(exclude duals)
4. Outpatient ED visits per 1000 member months
5. Percent Homelessness (Narrow Definition)(18-64) (exclude duals)
6. Plan All-cause readmission data (30 days)(18-64)

PROPOSED TARGET POPULATIONS

- Medicaid beneficiaries who are admitted into EM who are homeless or unstably house
- Medicaid beneficiaries who have used the ED in the last 12 months who do not have reliable transportation as indicated by
- Medicaid beneficiaries exiting in-patient psychiatric services**
- Medicaid beneficiaries who have used the ED in the last 12 months who have not seen the PCP in the last 12 months or do not have one assigned
- Medicaid beneficiaries who have had two instances of an “avoidable visits” in the last 6 months
- Medicaid beneficiaries who have one or more chronic illnesses and two or more ED visits in the last 6 months
- Medicaid beneficiaries who are discharged from a short stay, acute care or critical access hospital who have; 2 or more chronic illnesses, one or more chronic illnesses with SUD /MH or cognitive impairments or have 6 or more medications prescribed.

Feedback for Core Elements of Implementation

1. **Increase access Care: Primary Care**
    a) Participating ED will establish linkages to PCP who have open access scheduling. This will include a process for connectivity (Needs to be identified and ideally uniform)
    b) Participating ED will utilize a patient navigator to assist patients presenting with avoidable ED utilization to make immediate appointments with a PCP with whom they can establish a care relationship. They may also assist patient in accessing community resources.
    c) In a collaborative effort with PCP, NEMT and first responders, patients with requests for non emergency services could be transported to receive services
    d) Community support services will be established to provide information about how and where to access health services and the role of primary care/urgent care and ED services. This will include information about community resources available including contact information.
    e) Expand hours of PCP and of transport services to PCP
    f) Development of a collocated PC service in ED with case management protocol for triage and referral
2. **Population-based care**
    a) Track patients in registry which includes measures to track unstable housing and transportation. Use registry to follow patients treatment targets, clinical outcomes and dates of contact – define patient population criteria and means of identifying risk
    b) Develop workflow for Provider to review registry and do active follow-up – based on a set of parameters (see target population for suggestions)
3. **Measures to decrease readmission**
    a) Utilize a evidence based care transition intervention (Interact 4.0, Transitional Care Model, BRIDGE or Care Transition Interventions) with high risk populations to prevent readmissions. This should include pre-discharge patient education, care record transition to PCP and 1 on 1 transitional support for a 30 day transition period
4. **Accountable care**
    a) Examine clinical outcomes, quality of care, patient satisfaction and use of QI
    b) Be responsible for quality of care by reporting on health metrics
    c) Develop process for quality improvement-based around a transitional care tool.

Questions for the Group

- How are hospitals, Behavioral health agencies and community agencies currently doing risk screenings
  - When? What do they screen for? What activates the screening?
- Do hospital EHR communicate with BH, DOH and other community resources
  - To what extent? What activates the communication?
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Next Work Group

- March will be a in person meeting
- What do you want the goals of the work group to be as we move forward with implementation?
- Topics for next meeting?

Next Steps and Closing

- Develop LOI/RFP
  - RFQs are being reviewed
  - Format to follow
- Register for financial executor portal when the letter is received
- Complete assessment by March 26th
- Submit any requested training or work group topics to Alexandra Toney
  - toneya@crhn.org

Thank You!