



## Transitional Care and Diversion Intervention Workgroup

10:00 AM – 11:30 AM Thursday April 26<sup>th</sup>

<p style="text-align: center;"><b>North Central ESD</b> 430 Olds Station Rd Wenatchee WA 98801</p>	<p style="text-align: center;">Conference Dial-in Number (669) 900-6833 or (408) 638-0968 Meeting ID: 184 522 468 Join from PC, Mac, Linux, iOS or Android: <a href="https://ncesd.zoom.us/j/184522468">https://ncesd.zoom.us/j/184522468</a></p>
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### Agenda

<u>Proposed Agenda</u>	<u>Time</u>	<u>Goals</u>
<p><b>1. Welcome &amp; Introductions</b> Eric Skansgaard</p>	10:00	<ul style="list-style-type: none"> <li>• Review of last meeting minutes</li> </ul>
<p><b>2. Small Group Updates</b> Subgroup Members</p> <ul style="list-style-type: none"> <li>a. Transitional Care Subgroup Update</li> <li>b. Paramedicine Update</li> <li>c. ED Diversion Update</li> </ul>	10:10	<ul style="list-style-type: none"> <li>• Update from Small Group meetings, recommendations, and next steps</li> </ul>
<p><b>3. Data Review and Target Population Discussion</b> Caroline Tillier</p>	10:30	<ul style="list-style-type: none"> <li>• Review data and define a target population for each approach</li> </ul>
<p><b>4. Timeline for decisions/next steps</b> John Schapman</p> <ul style="list-style-type: none"> <li>a. Engagement of implementation partners</li> </ul>	11:10	<ul style="list-style-type: none"> <li>• Update on when each approach will be implemented by partners</li> <li>• Update on funds distribution discussion from previous meeting (3/22/18)</li> </ul>
<p><b>5. Roundtable/Adjournment</b> Eric Skansgaard</p>	11:20	<ul style="list-style-type: none"> <li>• Roundtable of workgroup members in room and on phone</li> </ul>

**Next Meeting:** May 24<sup>th</sup> 10:00-11:30AM  
 Confluence Technology Center  
 285 Technology Center Way #102 Wenatchee, WA 98801  
 (regular meetings are the 4<sup>th</sup> Thursday of the month)

## Transitional Care and Diversion Intervention Workgroup

10:00 AM – 11:30 AM Thursday March 22<sup>nd</sup>, 2018

<p><b><u>Location</u></b>  <b>N Grant Integrated Services</b>        840 E Plum Street Moses Lake, WA        (Conference Room)</p>	<p><b>Conference Information:</b>  <b>Please join my meeting from your computer, tablet or smartphone.</b>  <a href="https://global.gotomeeting.com/join/604175533">https://global.gotomeeting.com/join/604175533</a></p> <p><b>You can also dial in using your phone.</b>        United States: +1 (872) 240-3412  <b>Access Code: 604-175-533</b></p>
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<b><u>Proposed Agenda</u></b>	<b><u>Goals</u></b>	<b><u>Notes</u></b>
<p><b>1. Welcome &amp; Introductions</b>            Eric Skansgaard</p>	<ul style="list-style-type: none"> <li>• Review of last meeting</li> </ul>	<p><b>Attendance:</b>  <u>On Phone:</u> Caroline Tillier, Steve Wilson, Ray Eickmeyer, Nancy Nash-Mendez, Linda Parlette, Kate Haugen, Molly Morris, Delphia Richerson,</p> <p><u>In person:</u> Kris Davis, Eric Skansgaard, Gerado Perez, Karen Lynch, Christal Eshelman, Richard Donaldson, Laurie Bergman, Juan Padilla, Matt Crawford, Deb Thompson, Jackie Weber, Misty Kunstmann, Kelly Allen, Michael Lopez, Joe Kriete, Dan Durand, Curt Lutz, Gail Goodwin</p> <p>Eric did a quick review of the prior meeting's takeaways. John mentioned that we are not presenting any further data today so we can focus on funding criteria. Next meeting, we will bring data back to the group to review target population.</p>
<p><b>2. Transitional Care Subgroup Update</b>            John Schapman</p>	<ul style="list-style-type: none"> <li>• Update from Small Group meeting,</li> </ul>	<p>John provided an overview of the March 13<sup>th</sup> subgroup meeting focused on transitional care models. Members included Laurie Bergman, Marie Richardson, Sherrill Castrodale, Richard Donaldson, Dr. Wallace, and Eric Skansgaard who have experience and expertise in this area. The group reviewed various transitional care</p>

	<p>recommendations, and next steps</p>	<p>approaches (Local Transitional Care Model adapted by Confluence Health, Care Transitions Interventions, Transitional Care Model (through UPENN), and the C-Trac Model), including benefits and concerns of models, and also what is currently happening in the region. Everyone in this subgroup agreed that adopting a consistent approach across our region would be most beneficial. They focused on the C-TRAC model and nurse case management model run by Confluence Health, ruling out the other Transitional Care models. The subgroup also discussed potential linkages to social determinants of health, and is planning on reconvening in early April to review assessment tools and finalize the approach to recommend to the broader workgroup. HCA will provide us with a definitive answer by April 23<sup>rd</sup> regarding our desire to adopt our own regional approach for transitional care (rather than the ones listed in the HCA toolkit). HCA seemed to indicate that this shouldn't be an issue. John reported that other ACHs also don't want to be confined to the approaches outlined in the toolkit.</p>
<p><b>3. Community Paramedicine Update</b> Ray Eickmeyer</p>	<ul style="list-style-type: none"> <li>• Review of EMS Meeting</li> <li>• Recommendations to the Workgroup</li> </ul>	<p>Ray provided a quick background about the regional council of EMS which has expressed commitment to community paramedicine work. Ray and NCACH staff convened a meeting with transporting EMS agencies who serve the majority of Medicaid patients in all 4 counties on April 8<sup>th</sup>. Representatives from Moses Lake Fire, Lifeline, Ballard Ambulance were present. Aero Methow was not, but they remain interested.</p> <p>Now that the rubber is starting to hit the road around this concept, the goal of this meeting was to discuss barriers, concerns and figure out ways to proceed forward. EMS entities are generally committed, but they are concerned around funding. The only way they get funded currently is if they transport, so sustainability is a problem. Ray shared his personal experience and observations around transports. He then shared a summary of concerns expressed at that meeting regarding community paramedicine model, which primarily had to do with the fact that EMS revenue would continue to drop because diversion solutions will only benefit the patient and other agencies under the current payment structure.</p> <p>EMS entities believe it's the right thing to do, but cannot do it at a deficit. Really want to know that if we start doing this work, that there is some commitment that they share in the benefits. For example, if this benefits the ER or payer, that some of those</p>

		<p>financial cost savings are routed to EMS. Proposal and recommendation to the workgroup is that we continue to find a way to use EMS to solve some of these high-cost issues in our healthcare system. EMS is well positioned to assist, but need to develop a financial incentive structure that will allow them to do that work.</p> <p>Question to MCOs: at the payer level, what has been discussed around EMS being part of the solution? Lindy from Molina provided a Spokane example where some of the payers and hospital groups are pitching in to support these kinds of services. 911 calls are triaged and if not acute, they send out alternative transportation (SUV) to urgent care and back home. This was piloted by the Spokane mayor, and much of the funding came from MCOs though this was not billed fee for service (they came up with some alternate funding structure).</p> <p>Ray explained that his EMS entity is unique in that it is hospital-based, so cost savings are direct. Most other EMS agencies are not hospital-based, and while they want to continue to care for the community, they feel they are not in a position to make diversion intervention sustainable under current payment models. <u>Finances are the real barrier.</u> But others have done this successfully, so the group feels this idea should not be dropped and that developing a pilot might be a good first step. Linda shared that data and successes from a pilot might help us push for higher reimbursements or build a case for sustainability mechanisms. Catholic Charities representative shared an example of clients who call EMS 3-4 times a day to get transported to hospital without an actual medical need. EMS providers in this case began to triage and decide whether or not to transport. Eric mentioned that Parkside, which is coming online, is working on developing protocols where some of this community paramedicine model could be discussed. Kelly Allen from Confluence Health chimed in saying that it can be done legally, but need to get buy-in from EMS, which is something we could work on with outreach and education. Ray added that regional EMS council is developing protocols to do direct transports from the field to Parkside – that is in the works. Grant Integrated is very interested in staying involved, only concern is that need to be careful as an agency about how many projects they take on.</p> <p><u>Action Item:</u> Ray will work with John to set up another meeting with EMS providers.</p>
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<p><b>4. Project Funding Approaches</b> John Schapman</p>	<ul style="list-style-type: none"> <li>• Updated Funding template</li> <li>• Discussion on Funding amounts to organizations</li> </ul>	<p>John shared a slide deck which included a review of the proposed planning timeline and a summary of the current TCDI selected approaches. While community paramedicine will not be an officially selected approach, we will continue to consider it as a supporting strategy for our region as we implement the other projects. John also shared a diagram of the current subgroup's that are in play. These smaller groups are helping evaluate specific approaches and will continue to bring recommendations back to the broader workgroup.</p> <p>John reviewed the proposed principles applied to funding distribution. Also shared the recommended funding approach, which is to fund partners within a given sector who would join a collaborative group across the region to implement process improvement changes. John reviewed number of potential implementation partners. Ray pointed out that we need to add Protection One (which operates out of Grant County) to the EMS list. We are roughly estimating that we have about \$500K in funds available to support the work of direct partners implementing the TCDI evidence-based approaches. Across 18 organizations, that comes out to about \$30K per entity on average. It is likely that we will not be able to support total costs for project and should look for ways to use this funding most efficiently (e.g. regional training and infrastructure investments that support all project partners). Funds could be available to implementation partners as soon as we have plans that are submitted to and approved by the Governing Board. John described how some of the other project workgroups are approaching this and clarified that funding could be disbursed without requiring the workgroup to have a detailed multi-year plan. Partners in the room understand that they might not know the exact funding level involved until farther down the road. For funding that is tied to performance metrics, it makes sense to think about how to align partners towards those measures (efficiency question). John shared some major funding questions for the workgroup to think about. He will also ask the subgroups to chime in and those answers will be shared at future meetings.</p> <p><u>Action Item:</u> Eric recommending that subgroups help identify the areas and measures that need to be impacted, and then can look for commonalities across subgroups as a workgroup.</p>
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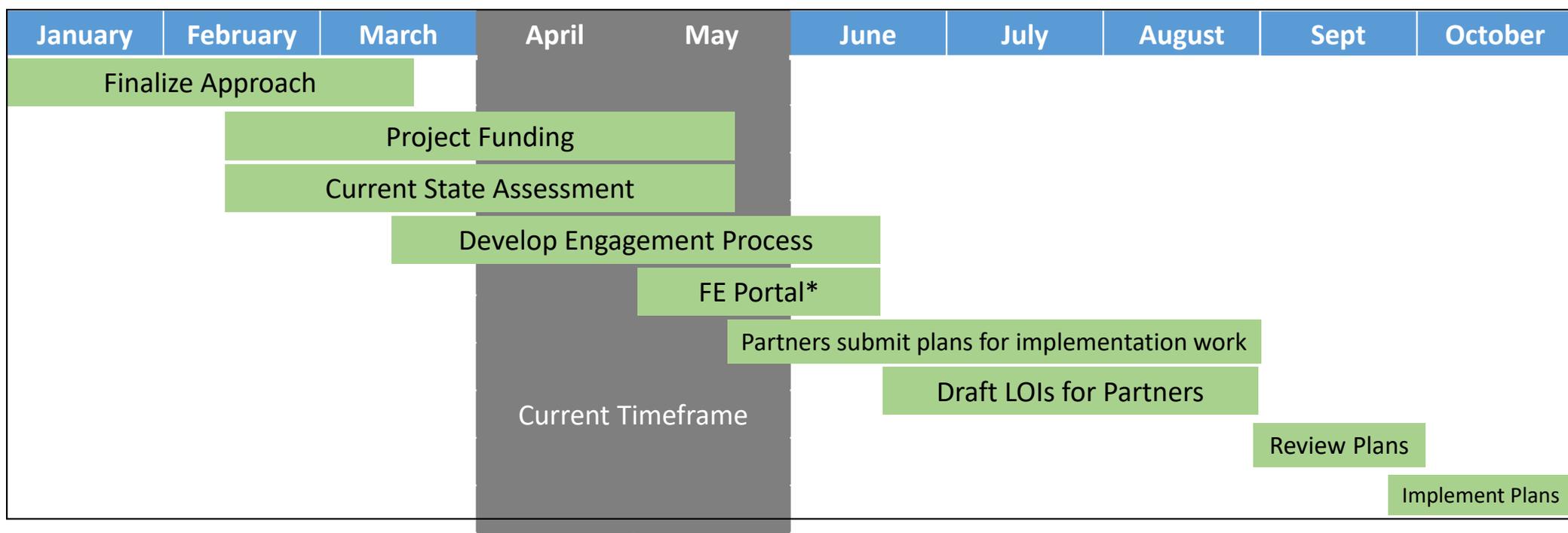
<p><b>5. Roundtable/Adjournment</b> Eric Skansgaard</p>	<ul style="list-style-type: none"> <li>• Roundtable of workgroup members in room and on phone</li> </ul>	<p>Eric encouraged group to share feedback.</p> <p>It was asked if we are still considering doing any work around jail transitions. Acknowledged that this a really common theme and we need to figure out how it fits into these projects. Initial stages will involve getting partners directly involved in selected approaches established and then determine the best way to include those partners that help influence transitions and diversion work in process.</p>
<p><b>6. Assignments</b></p>		<p><b>Next Meeting:</b> April 26<sup>th</sup> 10:00-11:30AM at CTC Wenatchee (regular meetings are the 4<sup>th</sup> Thursday of the month)</p>

# Transitional Care and Diversion Intervention Workgroup

**April 26th, 2018**

# TCDI WORKGROUP PROJECT - PROPOSED PLANNING TIMELINE

- May vary based on final approach for funding process selected by the workgroup
- Has been updated based on new understanding of LOI and current state assessment deliverables to the Health Care Authority
- \* Partners must register in the FE portal to be eligible to submit applications



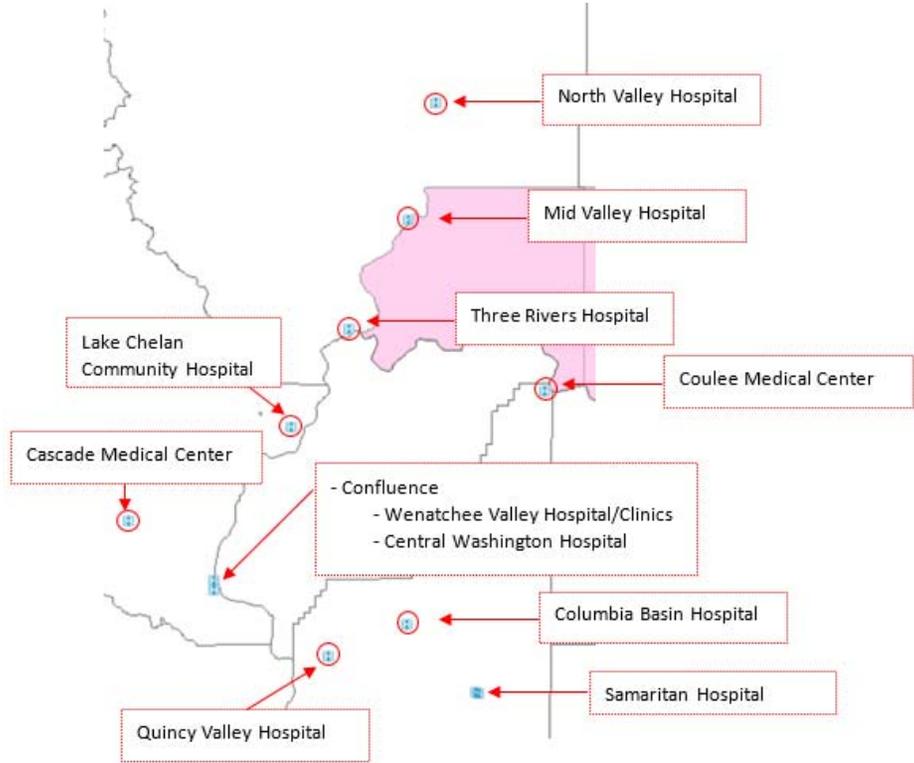
# Transitional Care Model Subgroup Update

- Reviewed CH-TCM C-TraC assessment tools
  - Concerns on focusing on SMI/SUD patients
    - Felt that more information was needed before selecting as a target population
  - Wanted to know if models were able to be scaled to smaller providers
- Recommendation to start with a pilot group of Hospitals (Mid-sized providers) and then scale to smaller providers over time
- Tasks –
  - Review potential for site visit of CH-TCM Model
  - Create a template on regional expectations of implementation partners who adopt approach

# Draft Eligibility Requirements for TCM Model participants:

- Initial Pilot Partners in 2018: Hospitals with an annual Medicaid Discharge of >200 beneficiaries a year (Approximately 4 Hospitals in Region)
- Partners who could join in 2019: All other hospital organizations with a Medicaid discharge of <200 beneficiaries a year (Approximately 6 Hospitals in Region)

# 10 Hospitals in Region



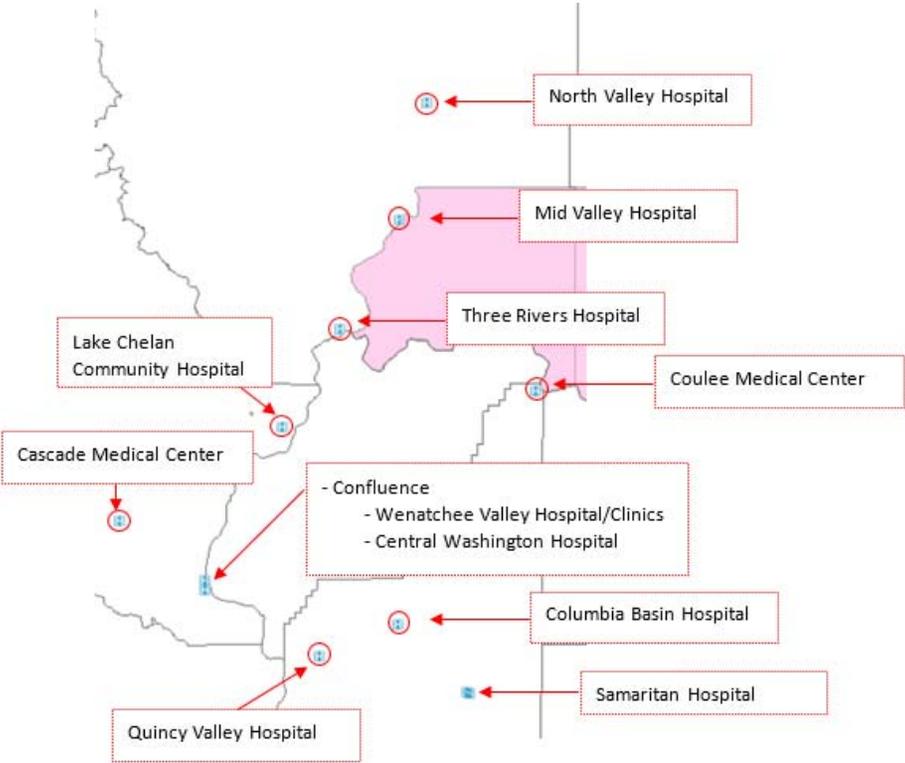
Source: Health Services and Resources (HRSA) Map Tool  
 Critical Access Hospitals circled in red

## FY2016 Hospital Census

Hospital	# of Medicaid Discharges	Mean Length of Stay (days)
Cascade Medical Center	5	3.60
Columbia Basin Hospital	25	2.16
Confluence-Central WA Hospital	3,129	3.46
Confluence – Wenatchee Valley Hospital & Clinics	42	10.07
Coulee Medical Center	228	2.24
Lake Chelan Community Hospital	156	2.12
Mid-Valley Hospital	466	1.99
North Valley Hospital	175	2.35
Quincy Valley Medical Center	4	3.00
Samaritan Healthcare	1,233	1.98
Three Rivers Hospital	193	2.09

Source: Department of Health CHARS data | Measurement Period: 1/1/16 – 12/31/16

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# Potential Funding Scenario

Approximate funding: \$40,000 - \$60,000 per organization.

Specific funding for work will be developed in Initial phase and cover cost such as:

1. Staff time to plan and develop the model including:
  - Staff time to develop a plan and integrate the work into their organization (i.e. project management expenses)
  - Staff time to train on model and implement into system(i.e. Direct service providers)
  - Travel costs associated with staff training
2. Direct Organizational investment Cost including:
  - Development of templates in electronic health records
  - Equipment needed at the organization level to implement work

# Next Steps for Subgroup:

1. Develop an implementation plan for the region (allowing for individual provider variability) to outline goals for 2018 and 2019
  1. Develop a toolkit/packet for partners to utilize for implementation purposes
  2. Develop a common assessment tool for implementation partners
  3. Develop a process for partners to develop a work plan for their organization and share with providers across the region
2. Develop a recommended funding mechanism to support implementation partners
3. Create templates for the model that could be utilized to help organizations develop a business plan to implement the model within an organization.

# EMS TCDI Update

- Currently working in collaboration with North Central Emergency Care Council (NCECC) and EMS Transport Providers
- Are tackling approaches within Diversion & Community Paramedicine, but not adopting the full model
- Developed a draft outline for 2018 – 2019 with full development of a plan by the end of July 2018.
  - Have identified 3 main objectives with additional tactics to achieve objectives

# EMS statistics that lead to Identified Objectives/Tactics

1. Average Non-Emergent- 50%
2. Total 911 Call volume for NC region- 27,000
3. 17% of Medicaid Patients for NC region (4,590)
4. Write off amount per year for Medicaid - \$5,049,000.00

# 1. EMS Agency Tactics specific to Diversion:

- **Measure- Reduce non-acute ER visits**

- Tactic- Protocol for non-acute patients referred to the HUB or other community based care coordination agency (i.e. Health Homes)
- Tactic- Fall Risk Program
- Tactic- Mental/Behavior Health transport to Parkside

## 2. EMS Agency Tactics Transitional Care Services:

- **Measure- reduce 30-day Hospital Re-admissions of chronic disease and high risk patients**
  - Tactic- Patient visitations with review of discharge instructions and medication review post discharge
  - Tactic- Patient interviews to assess pathways and social determinants of health
  - Tactic- Patient visitations at home with chronic disease measurements and assessments
  - Tactic- Reduce opioid overdoses with EMS interventions

### 3. EMS Agency Tactics to enhance Data Collection:

- **Enhance collection of EMS data and standardize how data is reported across the region:**
  - Tactic - Create a standardized process to identify the level of acuity for a 911 call
  - Tactic – Standardize the process of how/when a patient is a non-transport, non-emergent, and emergent calls across the region.
  - Tactic – Link transport data with the level of acuity to identify what kinds of calls are and/or are not being transported
  - Tactic – Evaluate current Medical Record systems for providers and evaluate how record systems can better communicate with other providers

# Process for Implementing Tactics:

NCECC & EMS will EMS transport Achieve the outlined tactics through three phrases:

- 1. Phase 1:** Evaluation and planning of how EMS agencies will achieve the above tactics outlined (working with North Central Emergency Care Council)
- 2. Phase 2:** Pre-hospital Provider Training and Process Education for all stakeholders of 2019 work plan between the Emergency Care Council and EMS agencies.
- 3. Phase 3:** Go live with implementation Jan 1<sup>st</sup> 2019.

**Recommend to Board**

# Phase 1: May 2018 – July 2018

## **NCECC will:**

1. Facilitate the process of Community Paramedicine across the Transport Agencies
2. Achieve a current Assessment of EMS agencies by June 30<sup>th</sup>, 2018
3. Develop a work plan to achieve the above strategies by July 31<sup>st</sup>, 2018.
4. The work plan for EMS agencies shall report;
  - EMS informatics and data plan
  - EMS training needs and costs
  - EMS tactics & timeline

**Recommend to Board**

## Phase 1: May 2018 – July 2018

### **EMS Transport agency (10 total) will:**

- Complete an assessment of current work
- Develop a work plan to achieve the above tactics (including a timeline when tactics will be completed)

Recommend to Board

# Funding for Phase I Planning

Agency	Dollar Amount
NCECC	\$20,000
EMS Agency (10 total)	\$50,000 (\$5,000/agency)
<b>Total</b>	<b>\$70,000</b>

# Potential Implementation Partners

## **Defined as Transport Emergency Medical Service Agencies:**

1. Ballard
2. Lifeline
3. Moses Lake Fire
4. AMR
5. LCCH EMS
6. Aero Methow EMS
7. Cascade Medical Center EMS
8. Okanogan County Fire District #15- Brewster EMS
9. Waterville Ambulance
10. Protection 1 Ambulance- Quincy

# Emergency Department Diversion

- Meeting Scheduled with Emergency Department Leads (4.30.18 at 3PM)
  - Review timeline for project implementation
  - Review Survey Results
  - Discuss next steps
- Completion of Current State Assessment as of 4.26.18
  - 8 of 10 have completed initial Emergency Department survey



North Central Accountable  
Community of Health

## Data and Target Population

*Review data and begin discussing/exploring target populations for each approach*

# TCDI and Medicaid Transformation Projects

## Transitional Care

- **Objective:** Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.
- **Target Population:** Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with SMI discharged from inpatient care, or client returning to the community from prison or jail.

## Diversion Interventions

- **Objective:** Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations
- **Target Population:** Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

# Target Population – HCA Guidance

- Provide a detailed description of population(s) that transformation strategies and approaches are intended to impact. Identify all target populations by project area, including the following:
  - Define the relevant criteria used to identify the target population(s). These criteria may include, but are not limited to: **age, gender, race, geographic/regional distribution, setting(s) of care, provider groups, diagnosis, or other characteristics**. Provide sufficient detail to clarify the scope of the target population.
- Note: ACHs may identify multiple target populations for a given project area. Indicate which transformation strategies/approaches identified under the project are expected to reach which identified target populations.

## Performance (P4P) Metrics

	2A: Integration	2B: Pathways	2C: Transitional	2D: Diversion	3A: Opioid	3D: Chronic	Total
Outpatient Emergency Department Visits per 1000 Member Months							6
Inpatient Hospital Utilization							5
Follow-up After Discharge from ED for Mental Health							3
Follow-up After Discharge from ED for Alcohol or Other Drug Dependence							3
Follow-up After Hospitalization for Mental Illness							3
Percent Homeless (Narrow Definition)							3
Plan All-Cause Readmission Rate (30 Days)							3
Substance Use Disorder Treatment Penetration							2
Mental Health Treatment Penetration (Broad Version)							2
Child and Adolescents' Access to Primary Care Practitioners							2
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed							2
Comprehensive Diabetes Care: Hemoglobin A1c Testing							2
Comprehensive Diabetes Care: Medical Attention for Nephropathy							2
Medication Management for People with Asthma (5-64 years)							2
Substance Use Disorder Treatment Penetration (Opioid)							1
Antidepressant Medication Management							1
Patients on high-dose chronic opioid therapy by varying thresholds							1
Patients with concurrent sedatives prescriptions							1
Percent Arrested							1
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)							1

# Behavioral Health Conditions

*ED outcomes*

BEHAVIORAL HEALTH	3+ Outpatient ED Visits in Year	6+ Outpatient ED Visits in Year	30 day readmission
Any Mental Health Need	2.4	2.9	1.3
SMI proxy	3	3.7	1.4
SUD Treatment Need	4.5	5.3	1.7
Co-Occurring MI/SUD	6.3	8	2
Psychiatric, high	4.7	8.2	1.2
Psychiatric, medium	5.3	8.3	1.1
Psychiatric, medium low	2.7	2.9	1.5
Substance abuse, low	5.3	6.6	1.7
Substance abuse, very low	2.9	2.7	1.7

Source: DSHS Research and Data Analysis, "Measure Decomposition Data" file released March 9, 2018.

# Physical Health Conditions

*ED outcomes*

<b>PHYSICAL HEALTH</b>	3+ Outpatient ED Visits in Year	6+ Outpatient ED Visits in Year	30 day readmission
Cardiovascular, low	3.8	4.9	1.0
Cardiovascular, extra low	1.7	1.7	1.0
Diabetes, type 1 medium	5.0	6.9	3.0
Diabetes, type 2 medium	2.8	3.6	1.8
Diabetes, type 2 low	1.6	2.4	0.7
Pulmonary, medium	5.1	6.8	1.8
Pulmonary, low	3.5	4.8	0.6

**Source:** DSHS Research and Data Analysis, “Measure Decomposition Data” file released March 9, 2018.

# PRISM Risk Score Data

## *by Region*

	<1.0		1.0-1.49		>1.5	
	<i>Count</i>	<i>Percent</i>	<i>Count</i>	<i>Percent</i>	<i>Count</i>	<i>Percent</i>
NCACH	62,773		2,035		3,522	
Chelan	16,693	27.21	606	29.78	826	23.45
Douglas	8,812	14.37	258	12.68	361	10.25
Grant	24,746	40.34	768	37.74	1,447	41.08
Okanogan	11,090	18.08	403	19.80	888	25.21

**Source:** Health Care Authority and DSHS-RDA | Measurement period CY2016, updated February 2018

**Data Notes**

- Population includes all WA Medicaid full benefit federally-qualified Title XIX and SCHIP populations.
- Members with both Medicaid and Medicare coverage (duals) are excluded.
- Those with full third payer liability (TLP) as of the December 31, 2016 are excluded.

# PRISM Risk Score Data *by Age*

	<1.0		1.0-1.49		>1.5	
	Count	Percent	Count	Percent	Count	Percent
0-10	24,017	39.15	178	8.75	771	21.89
11-19	16,244	26.48	159	7.81	317	9.00
20-29	7,702	12.56	261	12.83	430	12.21
30-39	5,201	8.48	346	17.00	433	12.29
40-49	3,459	5.64	355	17.44	467	13.26
50-59	3,379	5.51	515	25.31	750	21.29
60-69	1,327	2.16	219	10.76	349	9.91
70-79	SUPPRESSED	SUPPRESSED	SUPPRESSED	SUPPRESSED	SUPPRESSED	SUPPRESSED
80+	SUPPRESSED	SUPPRESSED	SUPPRESSED	SUPPRESSED	SUPPRESSED	SUPPRESSED

**Source:** Health Care Authority and DSHS-RDA | Measurement period CY2016, updated February 2018

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# PRISM Risk Score Data

## *by Gender and Minority Status*

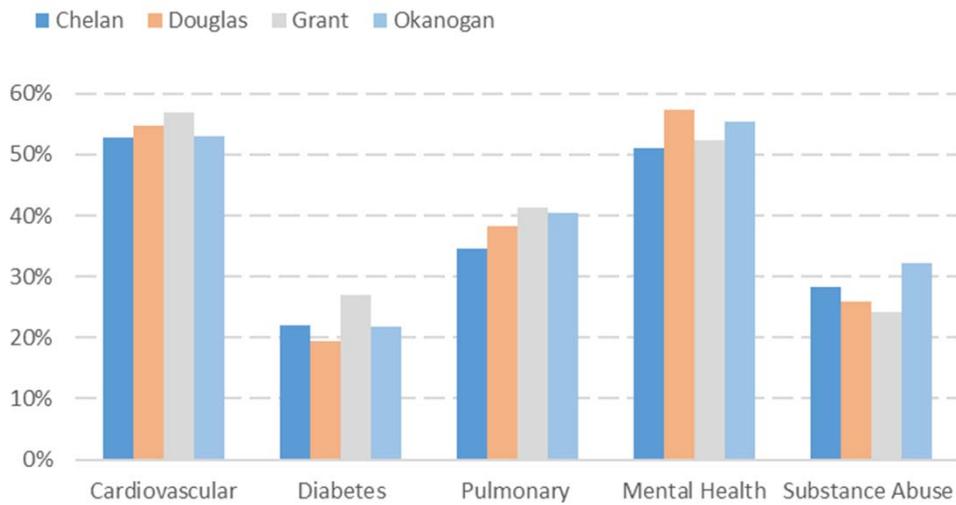
	<1.0		1.0-1.49		>1.5	
	<i>Count</i>	<i>Percent</i>	<i>Count</i>	<i>Percent</i>	<i>Count</i>	<i>Percent</i>
Female	31,816	51.87	1,247	61.28	2,056	58.38
Male	29,525	48.13	788	38.72	1,466	41.62
Any Minority	32,941	53.70	738	36.27	1,461	41.48
Non- Hispanic White	23,221	37.86	1,218	59.85	1,850	52.53
Unknown/Other	5,179	8.44	79	3.88	211	5.99

**Source:** Health Care Authority and DSHS-RDA | Measurement period CY2016, updated February 2018

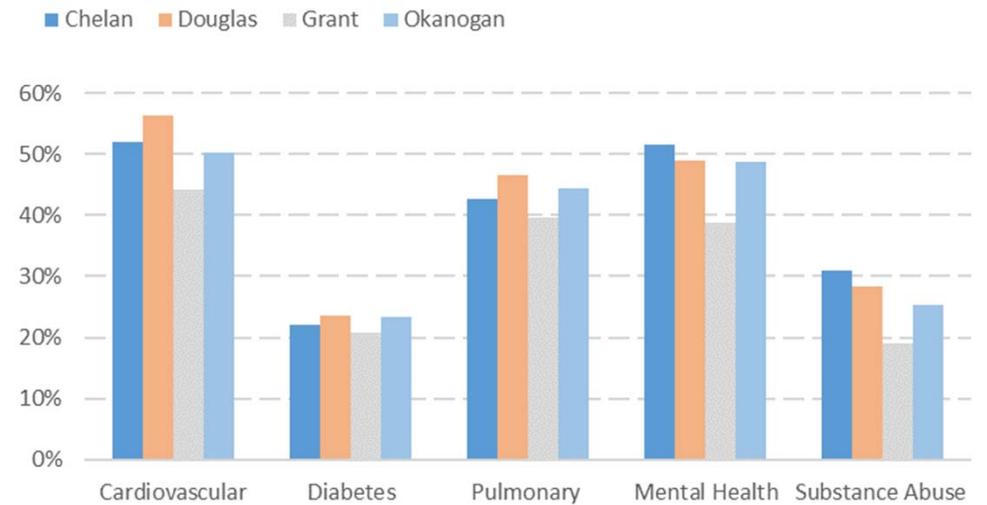
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- Members with both Medicaid and Medicare coverage (duals) are excluded.
- Those with full third payer liability (TLP) as of the December 31, 2016 are excluded.
- Race/ethnicity data based on population self-identifying by various standard race/ethnicity reporting categories

### PRISM Risk Scores 1.0-1.49

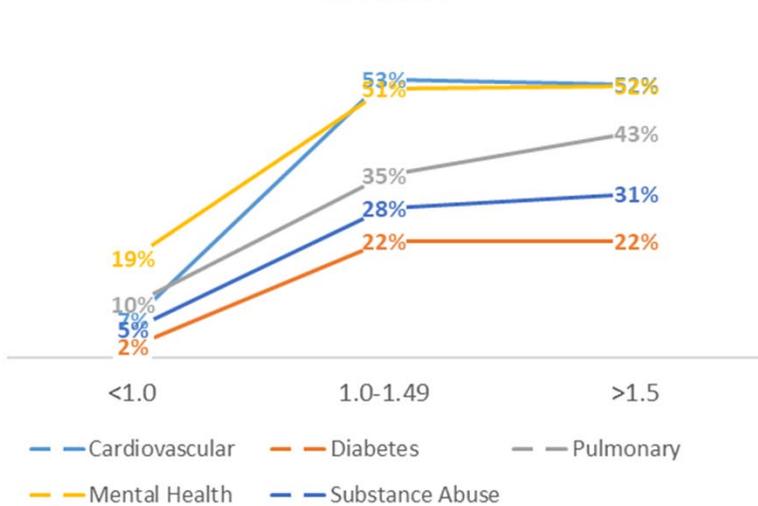


### PRISM Risk Scores >1.5

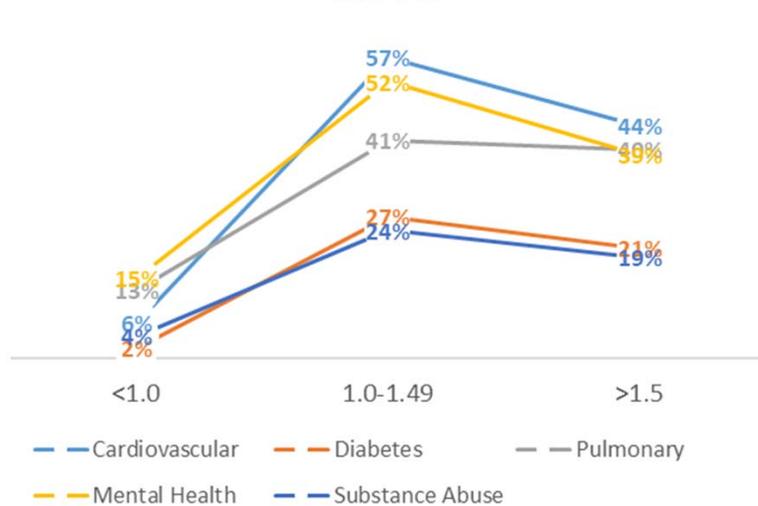


**Source:** Health Care Authority and DSHS-RDA, PRISM data set  
*Measurement period CY2016*

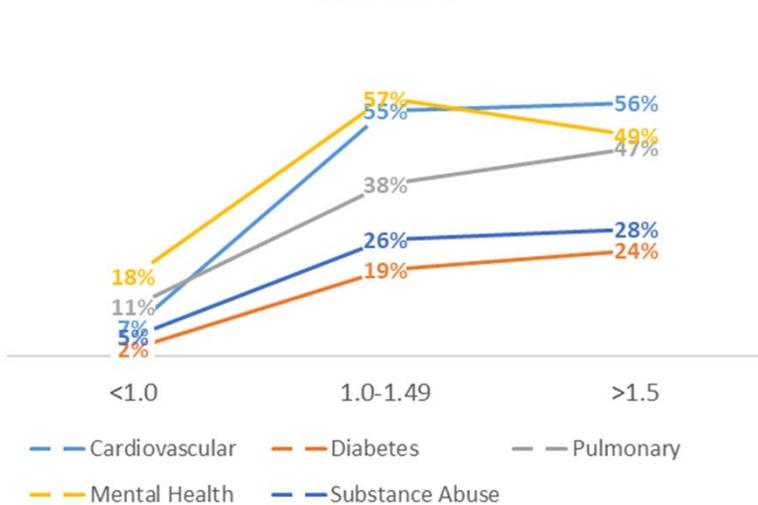
### CHELAN



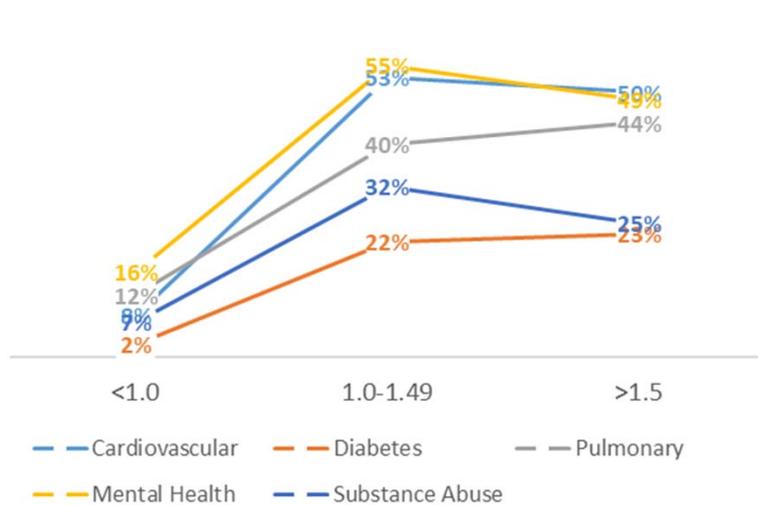
### GRANT



### DOUGLAS



### OKANOGAN

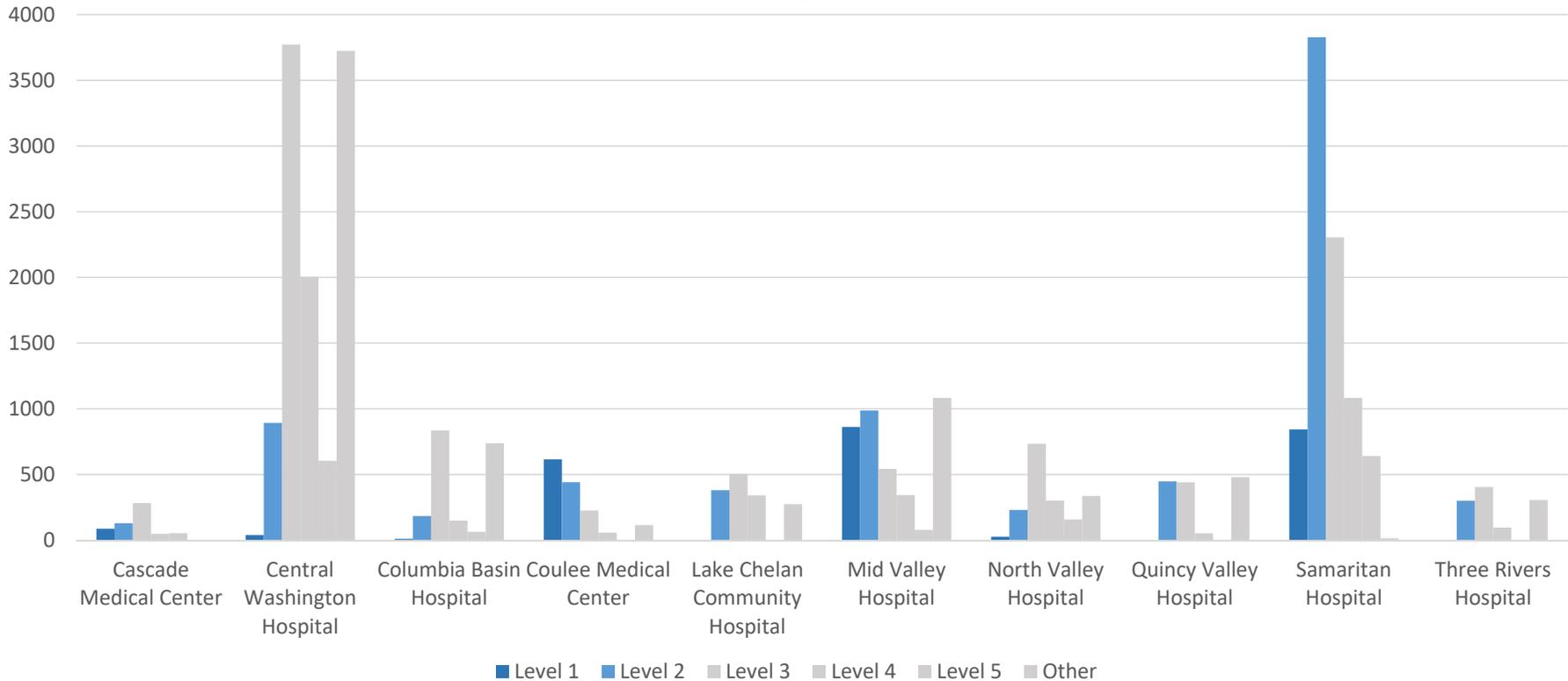


**Source:** HCA and DSHS-RDA PRISM data set

*Measurement period CY2016*

# ED Utilization

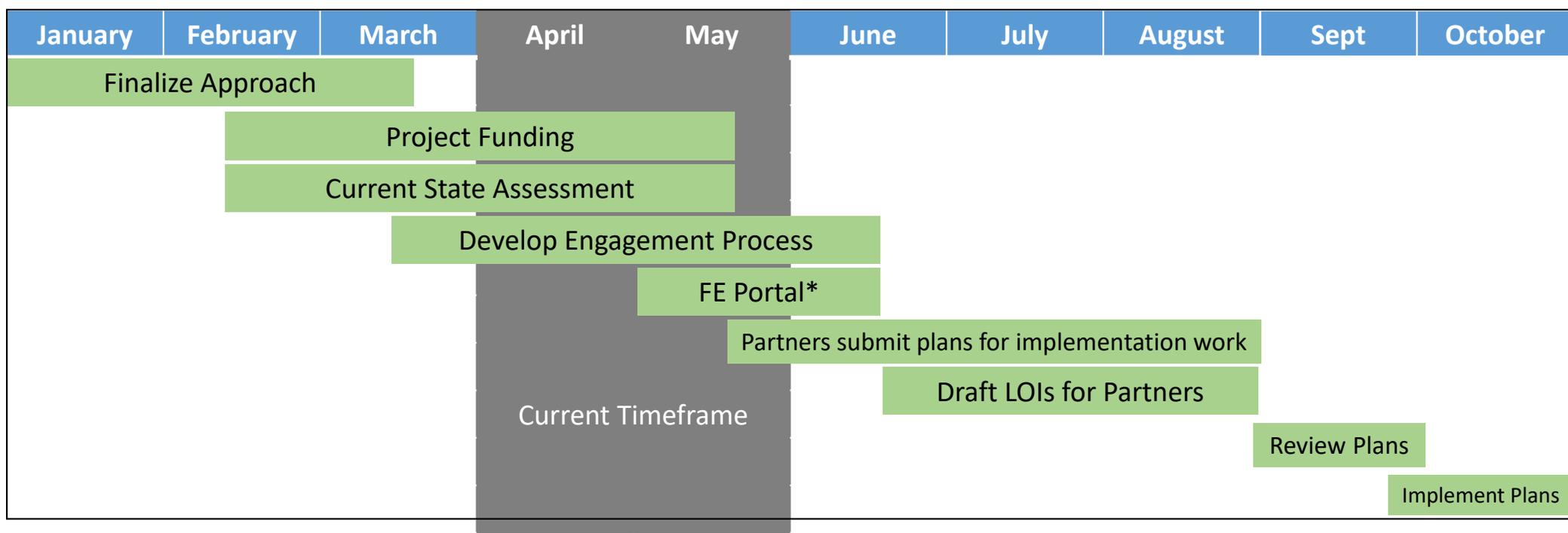
## *Counts by Hospitals and Triage Levels*



**Source:** Health Care Authority (ED utilization by Facility data set)  
 Data for North Central ACH (Measurement Period = Oct 1, 2015 - Sep 30, 2016)  
 Note: Triage Levels based on CPT code groupings

# TCDI WORKGROUP PROJECT - PROPOSED PLANNING TIMELINE

- **Main goals for next Month:**
  - Complete Current State Assessment for all participants
  - Finalize plan development
  - Define Commitment of Potential Implementation Partners



# Reporting due to Health Care Authority

Milestone	Due Date
Assess Current State Capacity to effectively deliver Interventions	June 30 <sup>th</sup> , 2018
Identify Domain I Focus areas that will support project work (Workforce, VBP, Health Information Exchange)	June 30 <sup>th</sup> , 2018
Select target population and approach informed by regional needs	June 30 <sup>th</sup> , 2018
Identify, Recruit and secure commitments for participation of implementation Partners (Registration in portal)	June 30 <sup>th</sup> , 2018
Develop Project Implementation Plan	September 30 <sup>th</sup> , 2018

# **NCECC Plan For Community Paramedicine with the NCACH**

## **Introduction:**

Medicare and Medicaid consider EMS suppliers of transportation and not as providers of emergency and lifesaving medical care. This is EMS 1.0 (back in the Civil War) and Private and Non-Profit agencies are left carrying the weight of caring for and transporting Medicaid patients at a loss.

Below are basic rates from the Medicaid Fee Schedule last updated on December 9, 2016.

Base rate:

For Basic Life Support (BLS )is \$115.34

For Advanced Life Support (ALS) is \$168.43

Mileage is \$5.08/mile

For a 20 mile ALS transport Medicaid pays: \$168.43 for base rate and \$101.60 in mileage for total of \$270.03. Note this for ALS, meaning a highly trained Paramedic delivering medications and performing lifesaving skills in an ambulance equipped to state standards ~ \$200,000 in vehicle and equipment.

## **One medication alone can cost this much.**

Patients are assured that the service is covered because they have Medicaid but don't understand the real cost. The North Central Emergency Care Council (NCECC) provider's plans to provide the NCACH with the data needed to determine the extent of non-emergent transports across the region and work with EMS providers to develop transport protocols to Emergency Departments, Behavioral Health services, or other preventative services. The NCECC has done the work of the Public Health Emergency Preparedness and Response (PHEPER) and has a staff member who administers this work and works closely with all agencies in our region, Chelan, Douglas Grant and Okanogan Counties. NCECC will work with EMS agencies to gather data, develop a work plan template, and be the liaison with the NCACH.

Each agency has agency specific training needs and a protocol must be developed. This will be identified in an agency training needs assessment based on a Community Health Needs Assessment and the agency's ability to perform the duties.

## **Core Components of the Approach:**

The region has identified several priorities that should be included within Transitional Care and Diversion services across the region. Partners who focus on transitional care and diversion work under the Transformation Project should ensure their approaches place an additional emphasis on the following regional priorities:

- Complement what is currently occurring in the region
- Identify high risk patients/utilizer for follow up care
- Coordination of care across spectrum and partners
- Includes better sharing of patient information
- Helps address the needs of those patients with SMI and SUD
- Models need to develop consistency across region and be able to be scaled for each Partner
- Include Patient and Family Engagement

**Expected Measures for Transitional Care and Diversion Models Should Target:**

Implementation partners should expect Transitional Care and Diversion programs will help improve these quality measures. If it is not feasible for organizations across the region to track specific measures, the workgroup would define proxy measures that could be used to demonstrate improvement in these quality outcomes.

Transitional Care and Diversion Project Metrics		
Year	Type	Metric
2019-2021	ACH Reported (Pay for Reporting)	<ul style="list-style-type: none"><li>Process milestones/measures will be developed during the planning stages of the timeline and partners who implement the model will be expected to report against those milestones/measures</li></ul>
2019-2021	State Reported (Pay for Performance)	<ul style="list-style-type: none"><li>Outpatient Emergency Department Visits per 1000 member months</li><li>Plan All-Cause Readmission Rate (30 Days)</li></ul>
2020-2021	State Reported (Pay for Performance)	<ul style="list-style-type: none"><li>Follow-up After Discharge from ED for Mental Health</li><li>Follow-up After Discharge from ED for Alcohol or Other Drug Dependence</li><li>Follow-up After Hospitalization for Mental Illness</li><li>Inpatient Hospital Utilization</li><li>Outpatient Emergency Department Visits per 1000 member months</li><li>Plan All-Cause Readmission Rate (30 Days)</li></ul>

**Transitional Care and Diversion Intervention Reporting Requirements:**

1. NCACH will require periodic written and verbal reports from implementation partners. During the project period, NCACH will expect implementation partners and will share reports/experiences with other organizations that are going through the process.
2. Implementation partner will be required to provide updates at a Coalition for Health Improvement meetings to update other organizations in their region about the work occurring under the Transformation Project
3. Partners will be required to submit written reports electronically through an online portal.
4. Reporting requirements will be detailed in Memorandums of Understanding between the NCACH and each partner.
5. The NCACH Annual Summit takes place in April each year. It is encouraged that partners attend this summit. This will allow community partners to share successes and challenges in implementing these projects and encourage collaboration among partners across our entire NCACH region.

**EMS Agency Tactics specific to Diversion and Transitional Care Services:**

**1. Diversion**

**a. Measure- Reduce non-acute ER visits**

- i. Tactic- Protocol for non-acute patients referred to the HUB or other community based care coordination agency (i.e. Health Homes)
- ii. Tactic- Fall Risk Program
- iii. Tactic- Mental/Behavior Health transport to Parkside

## 2. Transitional Care

(with aspects in Whole patient collaborative, HUB, Chronic Disease Management/Care Coordination, Opioid, and Referral to follow services )

- a. **Measure- reduce 30-day Hospital Re-admissions of chronic disease and high risk patients**
  - i. Tactic- Patient visitations with review of discharge instructions and medication review post discharge
  - ii. Tactic- Patient interviews to assess pathways and social determinants of health
  - iii. Tactic- Patient visitations at home with chronic disease measurements and assessments
  - iv. Tactic- Reduce opioid overdoses with EMS interventions

## 3. Enhance collection of EMS data and standardize how data is reported across the region:

- i. Tactic - Create a standardized process to identify the level of acuity for a 911 call
- ii. Tactic – Standardize the process of how/when a patient is a non-transport, non-emergent, and emergent calls across the region.
- iii. Tactic – Link transport data with the level of acuity to identify what kinds of calls are and/or are not being transported
- iv. Tactic – Evaluate current Medical Record systems for providers and evaluate how record systems can better communicate with other providers

## Process for Implementing Tactics:

Implementation process is broken into three initial phases.

1. Phase 1: Evaluation and planning of how EMS agencies will achieve the above tactics outlined (working with North Central Emergency Care Council)
2. Phase 2: Pre-hospital Provider Training and Process Education for all stakeholders of 2019 work plan between the Emergency Care Council and EMS agencies.
3. Phase 3: Go live with implementation Jan 1<sup>st</sup> 2019.

### Phase 1: May 2018 – July 2018

1. North Central Emergency Care Council will work EMS transport agencies to refine the steps to achieve the measures in #1 -#3 listed above. This will include the necessary planning need to accomplish work to implement changes.
  - a. Funding Mechanism:
    - i. \$20,000 to NCECC to help facilitate the process of Community Paramedicine across the Transport Agencies in Chelan, Douglas, Okanogan, and Grant counties. This will include achieving a current Assessment of EMS agencies and developing a work plan to achieve the above strategies by July 31<sup>st</sup>, of 2018. The work plan for EMS agencies shall report;
      1. EMS informatics and data plan
      2. EMS training needs and costs

3. EMS tactics & timeline
- ii. \$5,000 per EMS agency to complete an Assessment of current work and develop a work plan to achieve the above tactics (including a timeline when tactics will be completed)
- iii. EMS Transport Agencies: 10 total (\$50,000) + NCACC (\$20,000) = Total of \$70,000
- iv. Transport Emergency Medical Service Agencies Include:
  1. Ballard
  2. Lifeline
  3. Moses Lake Fire
  4. AMR
  5. LCCH EMS
  6. Aero Methow EMS
  7. Cascade Medical Center EMS
  8. Okanogan County Fire District #15- Brewster EMS
  9. Waterville Ambulance
  10. Protection 1 Ambulance- Quincy
- b. This phase will include developing a budget that outlines the training cost, staff cost, and time away from direct service to complete this work for Q4 of 2018 – to the end of Q4 of 2019
- c. Work plans will be evaluated on a yearly basis with funding needs identified moving forward

#### Phase 2: August 2018 – December 2019

- 1) North Central Emergency Care Council will work with EMS agencies to implement the second stage of the process. Funding will be based on 3 main principles
  - a. Time needed to offset cost of staff to train in the approaches outlined Including training costs to cross-walk work with healthcare stakeholders in the patient care coordination.
  - b. Training Cost to region/agency (i.e. Community Health Worker Training Cost/subject matter experts to help EMS agencies work on process improvement)
  - c. Support in helping organizations across the region improve collection and reporting of EMS data.

#### Phase 3: January 2019 – December 2019

- 1) North Central Emergency Care Council will work with EMS agencies to implement the plan and the work with the community.
  - a. Work plans will be evaluated on a yearly basis with funding needs identified moving forward
  - b. Reporting and data will be monitored and reported to NCACH as needed.