# Agenda

## 1. Welcome & Introductions
**Eric Skansgaard**

- **Time**: 10:00
- **Goals**:
  - Review of last meeting minutes
  - Update on Goals of Meeting

## 2. Small Group Updates
**Subgroup Members**

- **Time**: 10:10
- **Goals**:
  - TCM - Review process and funding associated with TCM (Determine next steps to approve process – Approve if ready to proceed forward)
  - ED Diversion - Review current plan (Goal is to have defined process by July meeting)
  - Paramedicine – Update of current work occurring with NCECC
  - Will include updating group on discussions with Law Enforcement Diversion

## 3. NCACH Workgroup Updates

- **Pathways Hub Workgroup** (10 min)

- **Time**: 11:00
- **Goals**:
  - Discuss alignment between projects/workgroups

## 4. Roundtable/Adjournment
**Eric Skansgaard**

- **Time**: 11:10
- **Goals**:
  - Meeting format for July/August/September
  - Roundtable of workgroup members in room and on phone

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**Next Meeting:**

- **July 26th, 10AM – 11:30AM**
- **Location:** Grant County? Conference Call?

**Goals for meeting:**

1. Approve process for TCM Engagement
2. Finalize (approve if possible) process for ED Diversion Engagement
## Agenda

<table>
<thead>
<tr>
<th>Proposed Agenda</th>
<th>Goals</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **1. Welcome & Introductions**  
  John Schapman | • Review of last meeting minutes | **Attendance**: Laurie Bergman, Linda Parlette, Rick Hourigan, Brooklyn Holton, Patrick Furlow, Sherill Castrodale, John Schapman, Caroline Tillier, Christal Eshelman  
  **Phone**: Kelly Allen, Nicole Samaratin, Dina Goodman, Molly Morris, Tracy Miller, Nancy Nash, Laina Mitchell, Karen Hughes, Shannon Mack  
  Vicki Polamus  
  John reviewed the minutes from the last meeting. |
| **2. Data Review and Target Population Discussion**  
  Caroline Tillier | • Review data and discuss potential target populations with workgroup members  
  • Rank as workgroup members your preferred target population | **Emergency Medical Services Protocols**  
  • Developing protocols to triage individuals who are inappropriately utilizing EMS and other acute healthcare services  
  • Working with providers to assist in the transition of patients out of Acute Care settings  
  **Emergency Department Diversion**  
  • Follow up appointments and education for those inappropriately utilizing the Emergency Department  
  • Naloxone prescription in the Emergency Departments |
Transitional Care Model
- Follow up phone calls for Patients discharged from inpatient hospital setting

Data Caroline: Caroline explained how the tactics are different from Pathways to TCDI. Discussed the opportunity to synergize the projects. The sub groups will continue to meet and help to implement this work.

Group should be thinking of what the key metrics that we should be focusing in on.

ER for Emergencies:
Do we want to target people with 6+ ED visits and substance abuse or 6+ visits plus some other physical health conditions?

- Vicki feels that we need to narrow it down to 6+ and one other aspect.
- Kelly there needs to be some value added to narrow it down to something more manageable for organization. The staff will want to know why they are doing this?
- What is the end goal? Need to define what we are trying to achieve? Do we just want a follow up appointment scheduled? In ED, Mental Health patients are no longer considered a low acuity patient for them. No resources: Nowhere to put them.
- What do others other than ED want to see? Panic attacks are using the ED a lot, lower level suicidal ideation. If there was somewhere else to put them…could they be evaluated at urgent care? If the patient already has a provider, where is the plan? Once the BH patients hit the ER, they are obligated to use a set of resources. A lot of this will be education after the 2nd or 3rd visit.
- Tracy - Finding time to do these things is the biggest barrier. A little education goes a long way with these patients. They get report every morning about who was seen in the ED and they do a follow up phone call.
- We could start with Low acuity physical health and build on it after we work out the kinks.
- Diabetic and Pulmonary are the patients that they see most in the case management world.
- There is a real opportunity for the diversion piece with the non-clinical providers.
- Transitional Care: Do we want to target a population or have a process among discharge - everyone. It needs to be a standard process.
3. **Small Group Updates**
   - **Subgroup Members**
     - a. Transitional Care Subgroup Update
     - b. Paramedicine Update
     - c. ED Diversion Update

   - **Update from Small Group meetings, recommendations, and next steps**

   - **Transitional Care Model Group:** Went on site visits to Confluence Health. Have been looking at the C-Trac Model and the model the Confluence uses. Had a follow up call to discuss thoughts on the model. Group decided to adopt the model that Confluence uses as a starting point.
     - Quality of the EMR effects
     - Develop a communication piece for the nursing staff
     - Linda said that she is going to have her team go through this tour, there is a lot of potential with the pharmacy piece.

   - **ED Diversion:** Group met on 5/21 have had 2 phone calls with ED leads. Talking about different strategies that we can get involved with. The list has not been approved by the group yet. See an opportunity for ED, CBO, Primary Care and MCO to be sending the same message.

   - **Para medicine:** Governing Board approved EMS Plan for Phase one. One request was to look at Mobile Integrated Services. Developing a MOU, working closely with Aero Methow in Twisp to complete some of this work.

   - **Law Enforcement Meeting:** Core Component of the Approach.

   With respect to the Transitional Care and Diversion Interventions work group, law enforcement wants to utilize an Integrated Systems Data Analyst to enhance the collection of information from initial phone call to final resolution of visit.

   There is a meeting this afternoon with Law Enforcement to work out a plan for transport to Parkside.

4. **Data Review and Target Population Discussion**
   - **Caroline Tillier**

   - **Review rankings of the workgroup and final discussions**

   Went over the upcoming milestones due to the Health Care Authority.

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Due Date</th>
</tr>
</thead>
</table>

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*Decision: Target population is everyone that is discharged from ED.*
### Assess Current State Capacity to effectively deliver Interventions
- June 30th, 2018

### Select target population and approach informed by regional needs
- June 30th, 2018

### Identify, Recruit and secure commitments for participation of implementation Partners (Registration in portal)
- June 30th, 2018

### Develop Project Implementation Plan
- September 30th, 2018

#### 5. Roundtable/Adjournment

<table>
<thead>
<tr>
<th>John Schapman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roundtable of workgroup members in room and on phone</td>
</tr>
</tbody>
</table>

Brooklyn: We need to focus on what the education piece will look like. Especially outside of the provider walls. How do we share that information?

Meeting adjourned at 11:25 AM
Meeting Agenda

Welcome & Introductions 10:00 AM
• Review goals and agenda items
• Update on final selected approaches & target populations

Small Group Updates (TCM & ED Diversion) 10:10 AM
• Update on subgroup progress
• Application process and potential partner funding

EMS Update 10:50 AM
• Update on project planning with NCECC

NCACH Workgroup Updates 11:00 AM
• Update on Pathways Hub & Target Population

Adjourn 11:30 AM
## TCDI Selected Approaches Summary:

<table>
<thead>
<tr>
<th>NCACH Approach</th>
<th>Evidence Based Approach</th>
<th>Target Population</th>
<th>Implementation Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Diversion</td>
<td>Projects that support the ER is for Emergencies Seven Best Practices</td>
<td>Medicaid beneficiaries presenting at the ED for non-acute condition with 3+ visits in one year</td>
<td>Emergency Departments</td>
</tr>
<tr>
<td></td>
<td>Community Paramedicine*</td>
<td>Medicaid beneficiaries who access the EMS system for a non-emergent conditions</td>
<td>EMS Providers</td>
</tr>
<tr>
<td>Transitional Care Services</td>
<td>Local Transitional Care Model (CH – TCM)</td>
<td>Medicaid beneficiaries discharged from acute care to home or to supportive housing</td>
<td>Inpatient Hospitals</td>
</tr>
</tbody>
</table>

*Community Paramedicine will not be an HCA selected approach buy tied into how we support ED Diversion and Transitional Care Approaches*
Project Update – TCM & ED Diversion

Transitional Care Management:
• Approved Approach
• Developed draft budget proposal
• Creating toolkit for region to utilize
• Finalizing Engagement Documents

Emergency Department Diversion:
• Selected initial approaches
• Draft application for engagement
• Draft budget including incentive funds for partners engaged
Next Steps - TCM and ED Diversion

1. Finalize an engagement document for regional providers
2. Finalize recommended funding mechanism to support implementation partners
3. Outline timeline for partners to engage in work
Applications for Engagement TCM and ED Diversion

**Goals:**
- Review materials today and provide comments to application process
- Share with Governing Board at July 9th Board meeting
- Approval from workgroup on application and funding at July meeting
- Approval of process and funding of Governing Board at August 6th meeting
TCM and ED Diversion Application

Eligibility:

10 Hospital Emergency Departments within North Central Region:
These include:

1. Cascade Medical Center
2. Columbia Basin Hospital
3. Confluence Health (Central Hospital)
4. Coulee Medical Center
5. Lake Chelan Community Hospital
6. Mid-Valley Hospital
7. North Valley Hospital
8. Quincy Valley Medical Center
9. Samaritan Healthcare
10. Three Rivers Hospital
Application Process – TCM and ED Diversion

• Partners will complete a brief application to ensure they are willing to participate in this work

• Applications will outline requirements to receive funding including:
  • Expectations for regional collaboration
  • Reporting requirements and data that needs to be submitted to NCACH
  • Timeline for completing work

**Question:** Does the workgroup recommend having two separate applications for both projects or one application per organization?

* First Draft of application is attached for ED Diversion as an example
## Combined vs. Separate Application

<table>
<thead>
<tr>
<th>Type of Application</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Combined</strong></td>
<td>• Encourages collaboration within the organization</td>
<td>• One Department that is less motivated could inhibit progress of whole organization</td>
</tr>
<tr>
<td></td>
<td>• Allows for an organization to fill out information in one application</td>
<td>• Managing two subgroups with one application may be more difficult</td>
</tr>
<tr>
<td><strong>Separate</strong></td>
<td>• Easy process to proceed forward – no major changes to process</td>
<td>• Encourages projects to remain in a silo</td>
</tr>
<tr>
<td></td>
<td>• Will be able to implement discrete projects more rapidly</td>
<td>• Trainings that could benefit both sides of the organization (ED and Inpatient) would be missed or potentially duplicated</td>
</tr>
</tbody>
</table>
Funds Distribution (Partner Distribution Recap)

• Subgroups define a common list of goals/barriers to help implement projects within the region.

• NCACH develops a plan to address barriers and implement changes including:
  • Training needs
  • Direct Organizational investments (i.e. funding to offset staff cost to train)
  • Enhancements in workforce training and health information exchange (i.e. help with the implementation of EDIE/Pre-Managed across region)
Regional training and infrastructure investments that improve all projects

Available Funds
~$500K/yr

*Direct Implementation Partner Support*

TCM
ED Diversion
EMS

Training and support of other partners

Focus on next funding slides
Transitional Care Management – Estimated Budget

- Organization – Direct costs to staffing, backfill, training to complete work
- Regional Training Cost – Cost to have CH be a regional trainer
- ACH Direct Expenses – Additional cost absorbed by NCACH (i.e. initial RN Care Coordination certification cost)

<table>
<thead>
<tr>
<th>Type of Cost</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization Reimbursement</td>
<td>$240,000 ($30,000 each)</td>
</tr>
<tr>
<td>(8 Organizations)</td>
<td></td>
</tr>
<tr>
<td>Training Cost (Regional Trainers)</td>
<td>$55,000</td>
</tr>
<tr>
<td>ACH Direct expenses</td>
<td>$10,000</td>
</tr>
<tr>
<td>Total</td>
<td>$305,000</td>
</tr>
</tbody>
</table>
ED Diversion – Estimated Budget

- Organization – Direct Costs to staffing, backfill, training to complete work are factored into these numbers
- Expenses that are not currently reflected are NCACH direct expenses for items such as trainer time to help ED staff better integrate EDIE into their system

<table>
<thead>
<tr>
<th>Type of Cost</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Inappropriate ED visits</td>
<td>$7,000</td>
</tr>
<tr>
<td>Patient Education</td>
<td>$5,000</td>
</tr>
<tr>
<td>Staff Training on EDIE</td>
<td>$8,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$20,000</strong></td>
</tr>
<tr>
<td><strong>10 Hospitals</strong></td>
<td><strong>$200,000</strong></td>
</tr>
</tbody>
</table>
Bonus Payments – Potential Recommendation

• Bonus payments would be used to incentive organizations that do the following:
  • Collaborate across projects within an organization
  • Collaborate with partners across their geographical region

<table>
<thead>
<tr>
<th>Collaboration Between projects</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration Between projects</td>
<td>$5,000</td>
</tr>
<tr>
<td>Collaboration between partners</td>
<td>$2,000</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$7,000</strong></td>
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<tr>
<td><strong>10 Hospitals</strong></td>
<td><strong>$70,000</strong></td>
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</table>
Total Cost of TCM and ED Diversion Projects

- This would be cost through December 2019
- This is below originally anticipated cost for two projects

<table>
<thead>
<tr>
<th>Estimated Cost</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCM</td>
<td>$305,000</td>
</tr>
<tr>
<td>ED Diversion</td>
<td>$200,000</td>
</tr>
<tr>
<td>Bonus Incentive</td>
<td>$70,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$575,000</strong></td>
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<tr>
<td><strong>Without Bonus</strong></td>
<td><strong>$505,000</strong></td>
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</table>
EMS Update

Cindy Button
Pathways Community HUB Update
Pathways Community HUB

• NCACH has selected Community Choice to be our HUB lead agency

• Initial Target Population and Location
  • ≥3 ED visits in past 12 months
  • Is on Medicaid or Medicaid Eligible
  • Moses Lake (specifically 98837)

• Preliminary Expansion Plan

<table>
<thead>
<tr>
<th>Grant County</th>
<th>Chelan/Douglas</th>
<th>Okanogan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late 2018</td>
<td>Mid 2019</td>
<td>Late 2019</td>
</tr>
</tbody>
</table>

• Next Steps
  • Identify Care Coordination Agencies
  • Develop a Referral System
  • Launch the HUB
    • Target date: October 1, 2018
Member Roundtable
### NCACH PERFORMANCE

<table>
<thead>
<tr>
<th>Measure</th>
<th>NCACH</th>
<th>Statewide</th>
<th>Chelan</th>
<th>Douglas</th>
<th>Grant</th>
<th>Okanogan</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-cause Emergency Department Utilization (per 1,000 member months)</td>
<td>37</td>
<td>50</td>
<td>36</td>
<td>33</td>
<td>37</td>
<td>41</td>
</tr>
<tr>
<td>Follow up after Discharge from ED for Alcohol or Other Drug Dependence (7 day)</td>
<td>24%</td>
<td>23%</td>
<td>27%</td>
<td>19%</td>
<td>18%</td>
<td>25%</td>
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<tr>
<td>Follow up after Discharge from ED for Alcohol or Other Drug Dependence (30 day)</td>
<td>31%</td>
<td>31%</td>
<td>36%</td>
<td>33%</td>
<td>18%</td>
<td>33%</td>
</tr>
<tr>
<td>Follow up after Discharge from ED for Mental Health (7 day)</td>
<td>78%</td>
<td>60%</td>
<td>88%</td>
<td>86%</td>
<td>66%</td>
<td>81%</td>
</tr>
<tr>
<td>Follow up after Discharge from ED for Mental Health (30 day)</td>
<td>83%</td>
<td>71%</td>
<td>94%</td>
<td>86%</td>
<td>73%</td>
<td>84%</td>
</tr>
<tr>
<td>Follow up after Hospitalization for Mental Health (7 day)</td>
<td>78%</td>
<td>80%</td>
<td>79%</td>
<td>N/A</td>
<td>78%</td>
<td>78%</td>
</tr>
<tr>
<td>Follow up after Hospitalization for Mental Health (30 day)</td>
<td>88%</td>
<td>87%</td>
<td>88%</td>
<td>N/A</td>
<td>88%</td>
<td>89%</td>
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<tr>
<td>Inpatient Hospital Utilization (per 1,000 member months)</td>
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<td>65</td>
<td>60</td>
<td>48</td>
<td>54</td>
<td>63</td>
</tr>
<tr>
<td>Plan All-Cause Readmission</td>
<td>13%</td>
<td>14%</td>
<td>12%</td>
<td>11%</td>
<td>16%</td>
<td>8%</td>
</tr>
<tr>
<td>Percent Homeless</td>
<td>3%</td>
<td>5%</td>
<td>3%</td>
<td>2%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Percent Arrested</td>
<td>7%</td>
<td>7%</td>
<td>6%</td>
<td>6%</td>
<td>8%</td>
<td>7%</td>
</tr>
</tbody>
</table>

**Measurement Period:** July 2016 – June 2017 (Q2 2017)

*Derived from dashboard produced by CORE. Data sources used include: Healthier Washington Data Dashboard & RDA Measure Decomposition Reports*

↓ Lower rate indicates better performance
NCACH Emergency Department Diversion Application:

Introduction:
NCACH will work with ED partners to implement process improvement efforts across the region to support reduction in inappropriate Emergency Department Care and enhancement of the “ER is for Emergencies Seven Best Practices.”

Through this process Emergency Department partners have identified basic strategies to implement to help move the Medicaid Transformation project measures. As partners collaborate on initial projects and gain a better sense of ED utilization in the region, they will work together to identify additional work that could be done on a regional basis to improve patient care.

Model Selected:
Strategies to enhance the “ER is for Emergencies Seven Best Practice Approaches”

Summary of Emergency Department Process Improvement Tactics:
Through input from the Emergency Department representatives across the region, NCACH has identified high priority approaches for our region, listed below. These approaches were selected for their alignment with the ER is for Emergencies Seven Best Practice Approaches.

1. Reduce inappropriate ED visits by collaborative use of prompt (72 hour) visits to primary care physicians and improving access to care;
2. Patient Education of how to Access Appropriate Care
3. Work with Emergency Departments to Integrate EDIE into their department workflows

Target Population:
High utilizers of the ED system (3+ visits/year) due to inappropriate utilization of care

Length of Project Period:
The project period will start October 1st 2018 and run through December 31st, 2019. Additional funding will be available in future years to partners through an additional application process.

Award Size:
Anticipated total available funding for the Emergency Department work for the period (October 2018 – December 2019) will vary based on the initiatives and budget accepted by each organization. Organizations can choose to select all approaches attached to this application and will be funded according the respective up to amounts:

- Reduce inappropriate ED visits: $7,000
- Patient Education: $5,000
- Emergency Department Training of EDIE: $8,000
- Bonus Incentive: $5,000 (see additional considerations in application)
- Total Available: $25,000
Funding:

- NCACH will pay for regional trainings provided by contractors (i.e. EDIE Training). Training cost will be billed directly to NCACH by the contracted organization.
- NCACH funds directly given to partners will cover the cost of staff time to implement the work and staffing cost to ensure the system is integrated into your organizations. Partner funding is outlined in the estimated budget funding (up to $20,000).

Eligibility:

10 Hospital Emergency Departments within North Central Region: These include

1. Cascade Medical Center
2. Columbia Basin Hospital
3. Confluence Health (Central Hospital)
4. Coulee Medical Center
5. Lake Chelan Community Hospital
6. Mid-Valley Hospital
7. North Valley Hospital
8. Quincy Valley Medical Center
9. Samaritan Healthcare
10. Three Rivers Hospital

Reporting Requirements:

1. NCACH will require periodic written and verbal reports from implementation partners. Those reports will include:
   a. Detailed plan outlining plans for implementation of Emergency Department Diversion tactics in their organization
   b. Measures the organization will track and provide to NCACH to help in program evaluation across the region.
2. Reporting requirements will be detailed in Memorandums of Understanding between the NCACH and each partner.

Expected Measures:

Implementation partners may develop specific measurements for program evaluation but should expect Diversion programs will help improve the following quality measures.

- Outpatient Emergency Department Visits per 1000 member months
- Follow-up After Discharge from ED for Mental Health
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence

Application Submission Information:

Email completed applications to John Schapman (john.schapman@cdhd.wa.gov) by [insert date] If you need technical assistance filling out the template, please email John Schapman or call 509-886-6435.
## Application for NCACH Emergency Department Diversion

### Organization Information

<table>
<thead>
<tr>
<th>Organization Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding Requested: $</td>
<td></td>
</tr>
<tr>
<td>Contact Name:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Physical Mailing Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Counties Served: (check all that apply):</td>
<td>Chelan</td>
</tr>
</tbody>
</table>

### Priority Approaches

Check all application approaches you wish to address

**Reduce inappropriate ED visits by collaborative use of prompt (72 hour) visits to primary care physicians and improving access to care:**

1. Develop a program to have Patient’s discharged from Emergency Department receive a follow up phone call.
2. Schedule follow up appointments with partners (Primary Care and Behavioral Health) upon discharge from Emergency Department
   a. Initial Stage: Each organization would develop the process for patients referred to a clinic in your own organization.
   b. Second Stage: The group would help to identify how this process could also be done with providers outside of their organization

**Patient Education of how to Access Appropriate Care**

- Education on appropriate use of Primary Care, Urgent Care, and Emergency Departments, and where to access off hours of care to patients
  1. Better referral/connection to care coordination agencies to assist patients with follow up appointments
  2. Follow up call for patients after discharge from Emergency Department (Same tactic as outlined in Goal #1)

**Training on better utilization and integration of EDIE system**

1. Work with Emergency Departments to Integrate EDIE into their department workflows
   a. Develop a common training program that Emergency Departments can use for their staff to utilize the EDIE system in patient care
   b. Ensure EDIE is integrated with EMR systems
   c. Ensure workflows include routine input of information into EDIE system
2. Set up EMR/EDIE system to notify PCP when a patient arrives in the ED
Project Description (suggested word count – 500 - 1000 words)
(Complete for each Box you check)

Project Description:
Provide a description of the project including how you plan to implement the selected approaches above. Provide justification for selecting this project.

Project Scope:
Please describe who this project will serve, and what community partners you will engage with. Will you pilot with a specific demographic first?

Timeline:
Describe the timeline and major milestones for implementing this project? How will you monitor project implementation progress and address delays?

Sustainability:
How will you ensure sustainability of this project and/or sustainable change beyond the project period?

Social Determinants of Health:
Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Some examples of social determinants include: safe housing, education, job opportunities, access to health care services, transportation, public safety, social support, and socioeconomic conditions. How will this project address the social determinants of health?

Project Budget
Provide an estimated project budget using the template provided including information about additional funding applied for or obtained for this and related initiatives. Provide a budget narrative (suggested word count 200-300 words; maximum word count is 500 words)

<table>
<thead>
<tr>
<th>Project Budget: July – December 2018</th>
<th>NCACH funded</th>
<th>Other funding</th>
</tr>
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<tbody>
<tr>
<td>EXPENSES</td>
<td></td>
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<tr>
<td>Salaries, wages, and benefits</td>
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<tr>
<td>Travel</td>
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<tr>
<td>Other Expenses (itemize):</td>
<td></td>
<td></td>
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<tr>
<td></td>
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<tr>
<td><strong>Total</strong></td>
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</tbody>
</table>
Additional Considerations (suggested word count – 500 words)

The following questions are optional. While non-responses will not count against your total score, strong responses can improve your overall score.

Enhancing connections with Community Behavioral Healthcare and Primary Care Providers:
Mental Health place a large role in high Emergency Department utilization. How will the work you complete help to ensure patients that are discharged from the Emergency Department utilization is getting linked up with a Behavioral Healthcare Provider?

Whole Person Care:
Whole Person Care recognizes that a person’s state of health is influenced by much more than the health care they receive. Health is affected by health care, genetics, environmental factors (such as housing, employment) and personal behaviors (such as diet, exercise, substance abuse, etc.) Whole Person Care requires us to pay attention to and address all of these factors. Whole Person Care more effectively connects patients with resources outside the clinic which help address health-related social issues such as housing, education, and other social determinants of health. Whole Person Care also eliminates the divide between behavioral health and medical care. How will this project promote Whole Person Care in our region?

Health Equity:
Describe how this project will advance health equity in the community?

Measurement, Evaluation, and Reporting

Measurement and Evaluation:
In order to measure progress, it is important to track process and outcome metrics. What key indicators will you utilize to measure baseline, progress, and success of this project? How will you know the project has been impactful?

Reporting:
Attest that you understand and accept the responsibilities and requirements for reporting. These responsibilities and requirements include:
- Semi-annual written reports on project implementation progress
- Providing updates on ED calls every other month
- Presenting at the NCACH Annual Summit in 2019

☐ Yes  ☐ No

Appendices
- TBD
NCACH Transitional Care Model Work:  
Summary of Implementation Partner Expectations

**Introduction:**

The North Central Accountable Community of Health Transitional Care and Diversion Intervention Workgroup has identified the regional Transitional Care Management Model (adopted by Confluence Health) as the approach we will implement across the region specific to Transitional Care. The attached document provides details on the model and outlines how organizations can engage in developing a regional Transitional Care Management process as part of the Medicaid Transformation Project.

**Model Selected:**

Transitional Care Management (As adapted by Confluence Health)

**Summary of Model:**

Prior to discharge, hospital staff organize follow-up services and address patients' financial and psychosocial barriers to receiving needed care, drawing on community resources as needed. The bedside RN and inpatient case manager discuss instructions with the patient. The patient is sent home with written material that has all of this included on it in addition to a patient-specific summary of the visit. That document is called an AVS (After Visit Summary). The AVS summary is also used by the transitional care management RN’s (TCM-RN) who make the post discharge hospital follow up phone call.

The TCM-RN makes a 24-48 hour (2 business days) post discharge phone call that affirms that the patient has a follow up appointment with their PCP, medication review, if they have all of their post hospital services arranged i.e.: DME, O2, HH/Hospice, AFH/ALF, and or caregiver help. Any problems identified will be worked on and then directed to the PCP’s office. Patients are instructed to call their provider with certain red flags or 911 for immediate medical attention for some symptoms.

The TCM-RN identifies patients from a daily discharge report excluding discharged to hospice, assisted/skilled nursing facility or patients receiving hemodialysis or those that are in another case-managed program. Patients who have a follow-up appointment the day after discharge are not called.

A prompt follow-up visit with their outpatient provider provides follow-up care, ongoing symptom and medication management and continuous access for the 30 day post-discharge period.

**Target Population:**

Patients discharged from impatient hospital care to home or supportive housing.
**Expected Measures Transitional Care Models Should Target:**
Implementation partners may develop specific measurements for program evaluation but should expect transitional care programs will help improve the following quality measures.

- Follow-up After Hospitalization for Mental Illness
- Inpatient Hospital Utilization
- Outpatient Emergency Department Visits per 1000 member months
- Plan All-Cause Readmission Rate (30 Days)

**Transitional Care Models Reporting Requirements:**

1. NCACH will require periodic written and verbal reports from implementation partners. Those reports will include:
   a. Business plan outlining implementation plans for TCM in their organization
   b. Measures the organization will track and provide to NCACH to help in program evaluation across the region.
   c. Partners will be required to submit written reports electronically through an online portal.

2. Reporting requirements will be detailed in Memorandums of Understanding between the NCACH and each partner.

3. TCM partners will be expected to share with other hospital partners every other month on progress of implementation, best practices, and other potential issues.

**Eligibility:**

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

**Funding Identifications:**

Approximate funding to implement the transitional care model for organizations will be $35,000 over the course of implementation. This funding will cover the cost of staff time to implement the work and the cost to ensure the system is integrated into your organizations.
**Timeline: Model Implementation (Expected Implementation timeline per organization: 6 – 9 months)**

**Stage I – June - July 2018**

**NCACH will:**
- Develop a reference guide for partners to utilize to assist in implementing the model within an organization by June 31st, 2018.
- Develop an initial engagement document for partners to utilize in joining the process

**Agencies will:**
- Complete a current state assessment of each the organization due July 13th, 2018

**Stage II: August – November 2018**

**Agencies will:**
- Develop a work plan to implement the TCM in their organization
  - The work plan should include the following components
    - Timeline to implement the approach
    - Approximate number of patients the approach plans to address and the process to address patient population
  - Partners must commit to share work plans across the region to help other hospital entities refine the model for their facility and develop regional best practices
- In conjunction with the Workgroup, the Implementation partners will identify
  - What data should be collected regionally to monitor TCM programs
  - What aspects of the implementation plan can be supported regionally

**Phase III: January 2018**

**Agencies will:**
- Implement the business model designed in the initial three months
- Commit to meet and share progress with other organizations implementing the model

*New Organizations will come on board over the course of 2019*

**Attachments:**

A. Transitional Care Management Model (Adopted by Confluence Health)
B. Transitional Care Management Survey
C. Estimated Costs for Implementation