North Central Accountable Community of Health

NCACH Governing Board Meeting

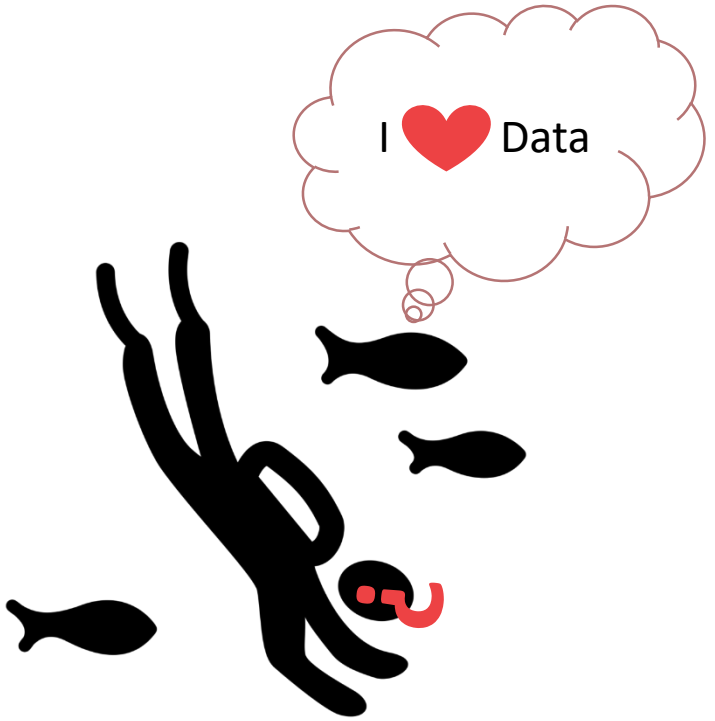
March 2nd, 2020

A data adventure with your guides,
Caroline Tillier and Rick Hourigan

Deep Dive Data Session

North Central Accountable Community of Health

Our goal is to draw on data to inform and engage NCACH Board members



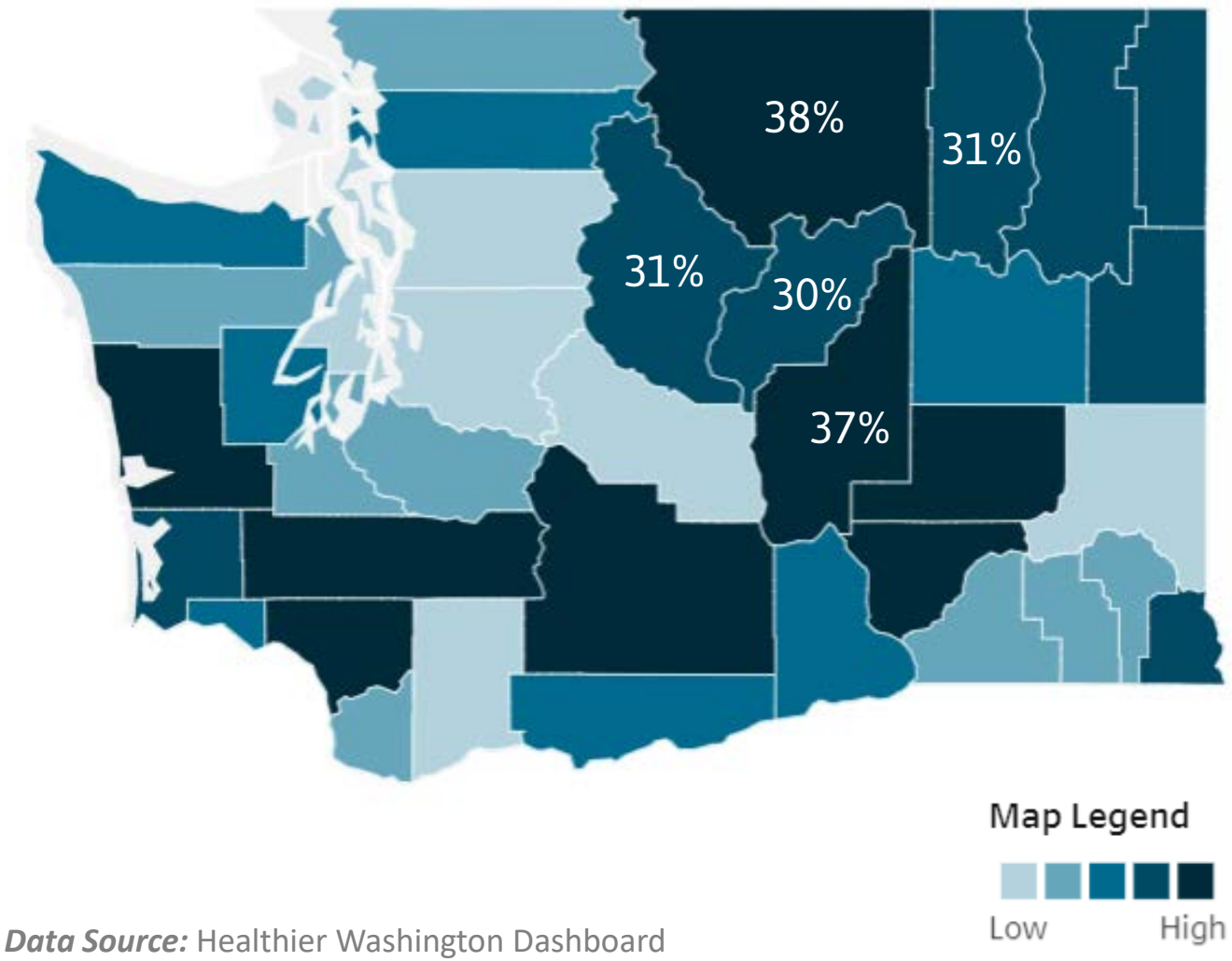
Questions to explore

- What does data tell us about our region?
- Do you understand the metrics and how they link to what we're doing?
- Is any of this data relevant to discussions about post MTP priorities / strategic planning?
- What would you like staff to look into and bring back to the Board (that is useful, not just interesting)?

North Central Accountable Community of Health

Medicaid Population Overview

North Central Accountable Community of Health



Data Source: Healthier Washington Dashboard
Measurement Period: 4/1/2018-3/31/2019

North Central has about 90,000 Medicaid beneficiaries

Our region generally has a higher proportion of residents enrolled in Medicaid

Looking at county-specific rates, Okanogan County ranks third across the state (Adams County 48%, Yakima County 43%)

Demographic Charts: Percent of Medicaid population by group (Number of Medicaid members by group).Demographic Charts reflect population of selected filters.

North Central Accountable Community of Health

Age group

0-17	51% (46,337)
18-64	49% (43,769)
65+	

Gender

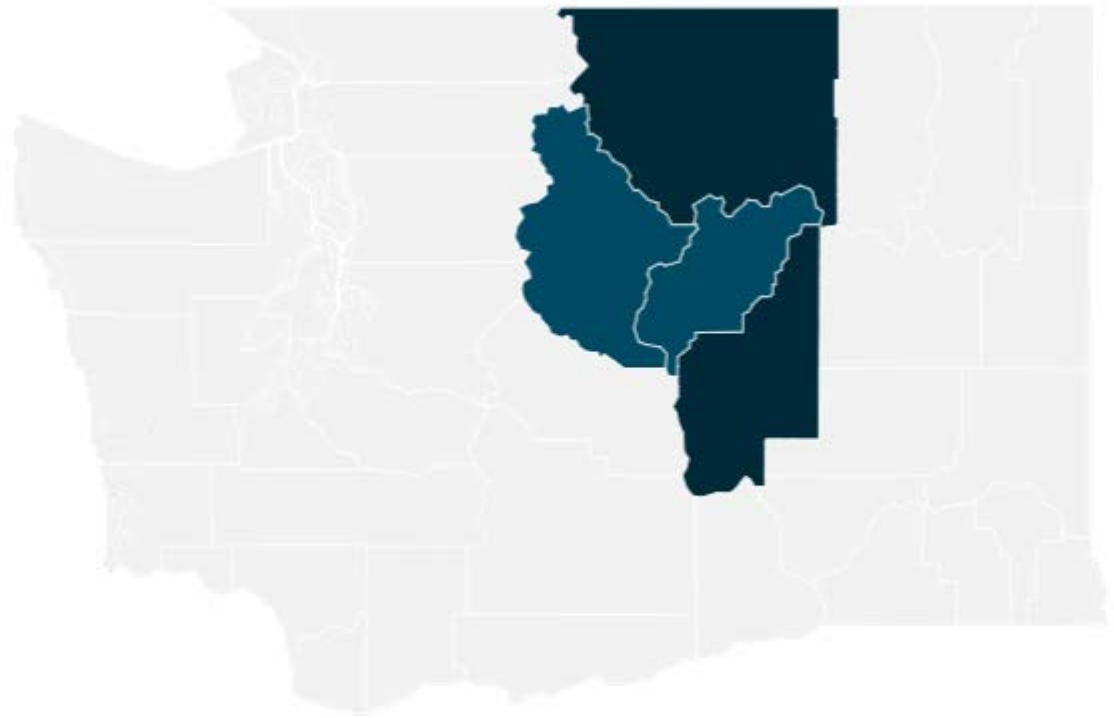
Female	53% (47,327)
Male	47% (42,779)

Exclusive Race/Ethnicity

Any Minority	55% (49,699)
Non-Hispanic White	39% (35,552)
Unknown	5% (4,855)

Inclusive Race/Ethnicity

AI/AN	5% (4,259)
Asian	1% (559)
Black	1% (1,102)
Hispanic	47% (42,660)
NH/PI	0% (440)
Other	24% (21,828)
Unknown	5% (4,855)
White	62% (55,778)



Data Source: Healthier Washington Dashboard
Measurement Period: 4/1/2018-3/31/2019

North Central Accountable Community of Health

CHELAN

Age group

0-17	48% (11,599)
18-64	52% (12,441)
65+	

Gender

Female	52% (12,435)
Male	48% (11,605)

Inclusive Race/Ethnicity

AI/AN	2% (423)
Asian	1% (191)
Black	1% (229)
Hispanic	44% (10,600)
NH/PI	1% (143)
Other	28% (6,760)
Unknown	8% (1,947)
White	58% (13,843)

DOUGLAS

Age group

0-17	54% (6,868)
18-64	46% (5,941)
65+	

Gender

Female	52% (6,708)
Male	48% (6,101)

Inclusive Race/Ethnicity

AI/AN	2% (251)
Asian	1% (110)
Black	1% (121)
Hispanic	49% (6,326)
NH/PI	1% (76)
Other	33% (4,229)
Unknown	8% (982)
White	53% (6,746)

GRANT

Age group

0-17	55% (20,285)
18-64	45% (16,596)
65+	

Gender

Female	53% (19,649)
Male	47% (17,232)

Inclusive Race/Ethnicity

AI/AN	2% (659)
Asian	1% (193)
Black	2% (604)
Hispanic	58% (21,336)
NH/PI	0% (147)
Other	21% (7,629)
Unknown	3% (1,047)
White	71% (26,253)

OKANOGAN

Age group

0-17	46% (7,585)
18-64	54% (8,791)
65+	

Gender

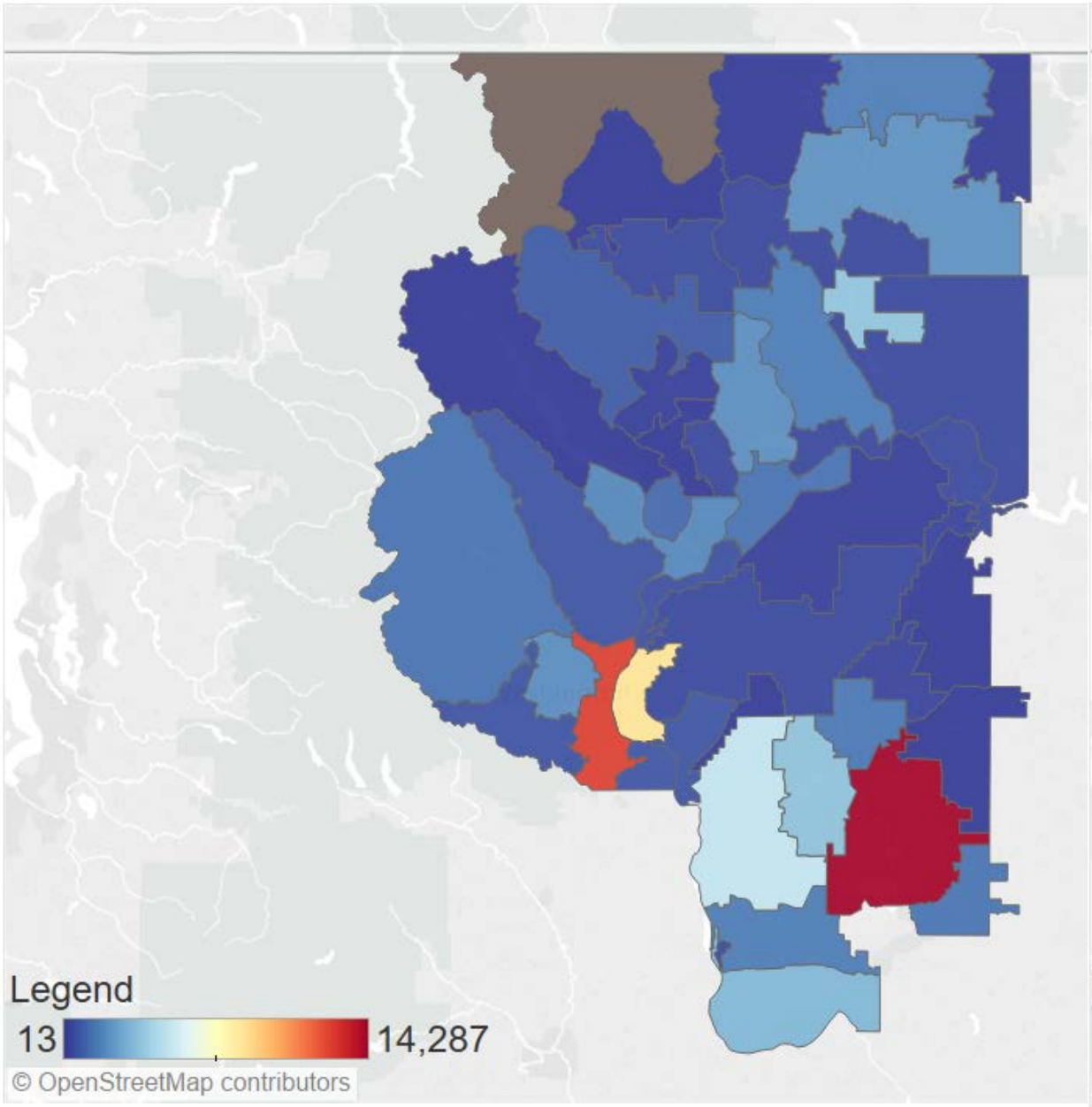
Female	52% (8,535)
Male	48% (7,841)

Inclusive Race/Ethnicity

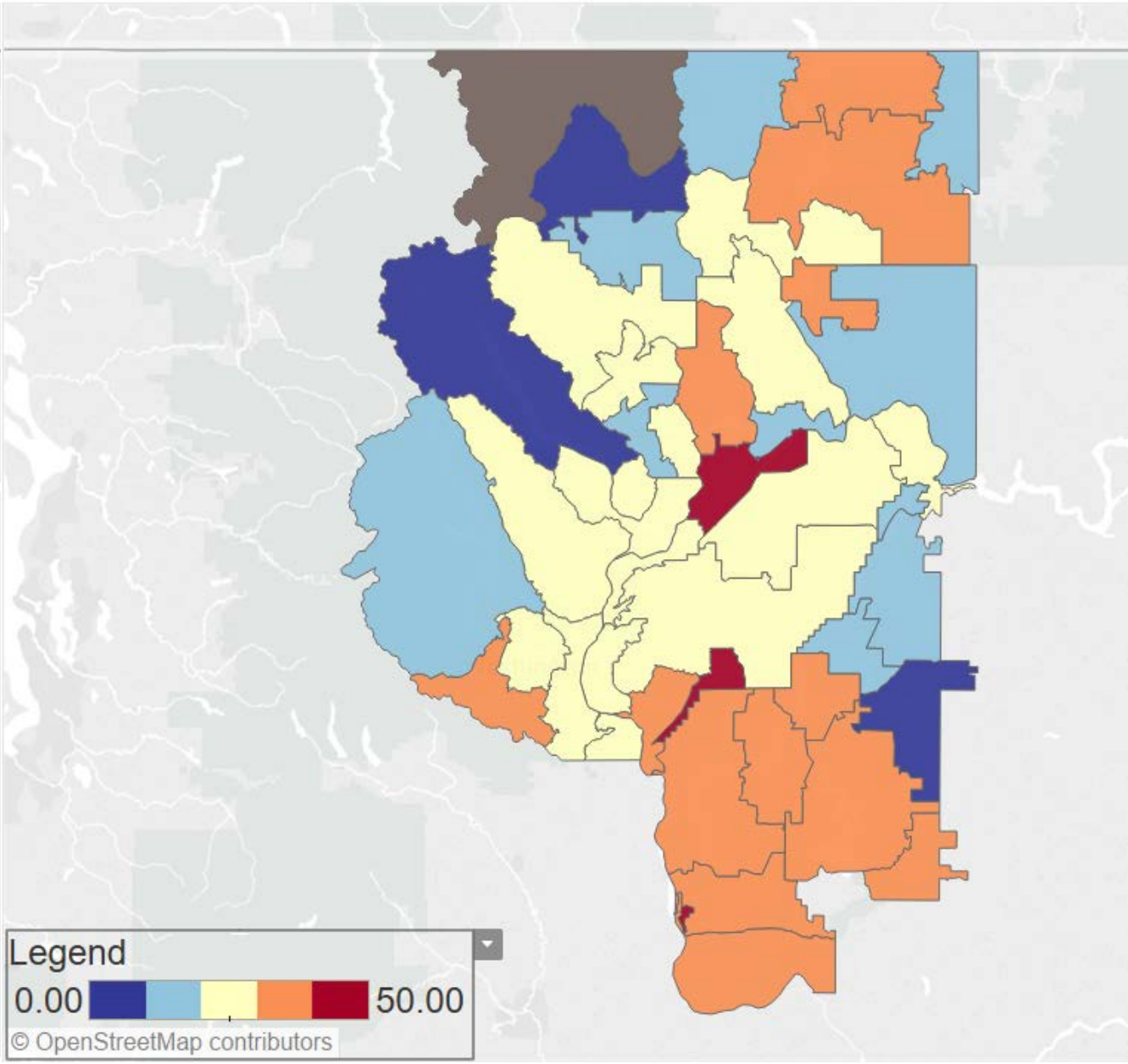
AI/AN	18% (2,926)
Asian	0% (65)
Black	1% (148)
Hispanic	27% (4,398)
NH/PI	0% (74)
Other	20% (3,210)
Unknown	5% (879)
White	55% (8,936)

Data Source: Healthier Washington Dashboard
Measurement Period: 4/1/2018-3/31/2019

Medicaid member counts



Member count as percent of total population



Data Source: Claims Data, All-Payer Claims Database | Population Data: WA Office of Financial Management

Prepared by Public Health Seattle King County

Depression

North Central Accountable Community of Health

At a glance. . .

On average, 16.0% of North Central ACH Medicaid members, had depression in 2017. Chelan (18.7%), Okanogan (16.2%), and Douglas (16.8%) counties had higher rates than the ACH average.

Those top ten ZIP codes with higher prevalence rates account for 4,132 of the 17,122 persons with depression in NC ACH. That is 24.1% of all Medicaid members with depression related care in the region.

Top 10 ZIP Codes

These ZIP codes have the highest rates of depression among individuals with Medicaid in each county:

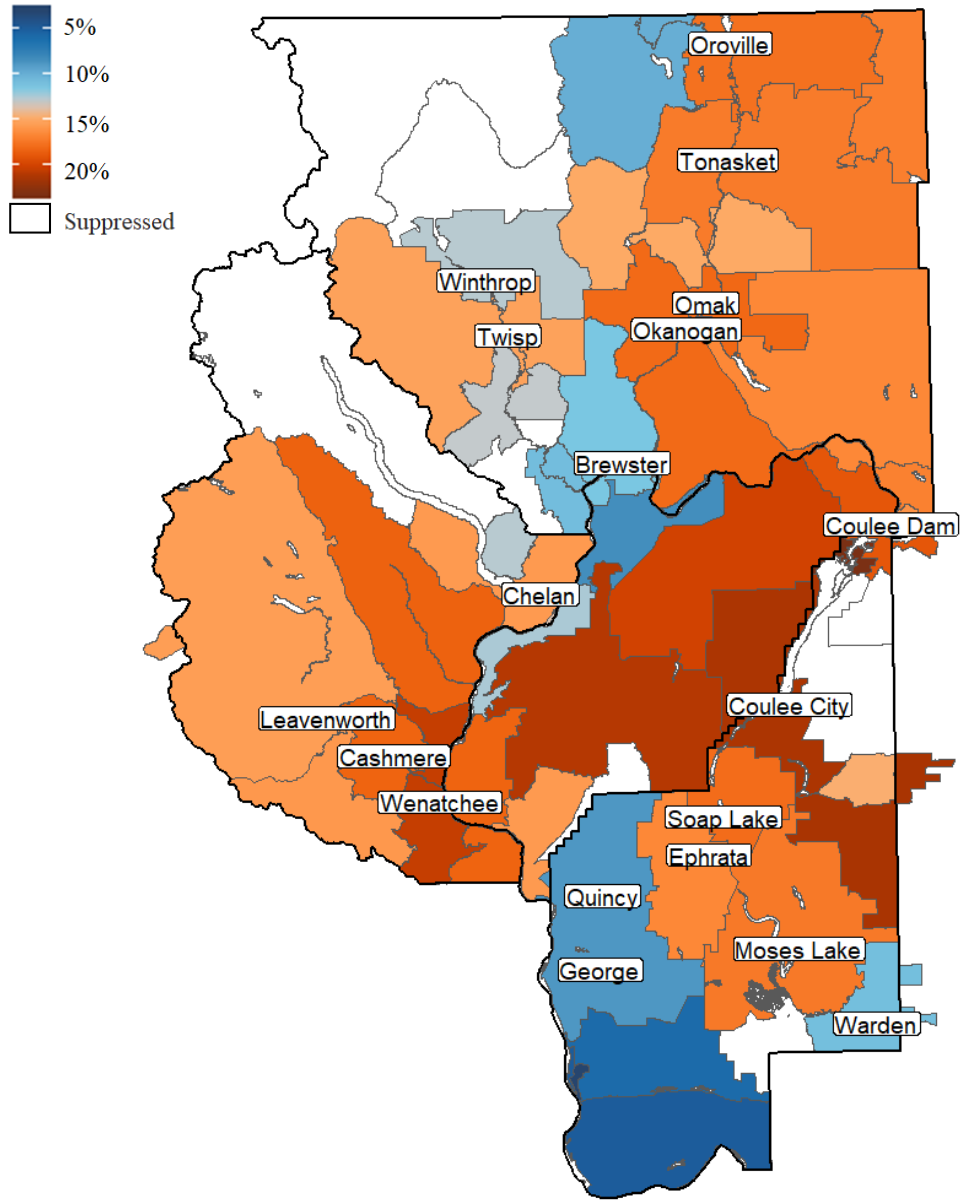
ZIP	Rate	Count	City	County
99123	23.3%	56	Electric City	Grant
98832	21.4%	15	Marlin	Grant
99115	21.3%	64	Coulee City	Grant
98858	21.0%	107	Waterville	Douglas
98801	20.5%	3541	Wenatchee	Chelan
98807	20.4%	38	Wenatchee	Chelan
98830	20.1%	37	Mansfield	Douglas
99133	19.0%	115	Grand Coulee	Grant
98819	18.7%	14	Conconully	Okanogan
98822	18.4%	145	Entiat	Chelan

Some technicalities :

These chronic condition prevalence estimates have been defined using the CMS Chronic Conditions Warehouse definitions.

Persons with an APCD record, who had 1 day or more of Medicaid coverage in calendar year 2017, and resided in NC ACH in 2017are included in these estimates.

- Numerator = Medicaid members who received depression related care during a 1 year lookback (n= 17,122)
- Denominator = individuals with 1 day or more of Medicaid coverage residing in NC ACH during calendar year 2017 (n= 106,994)



Source: WA All-Payer Claims Database | *Prepared by: Public Health Seattle & King County; Assessment, Policy Development & Evaluation Unit, September 2019*

Diabetes

North Central Accountable Community of Health

At a glance. . .

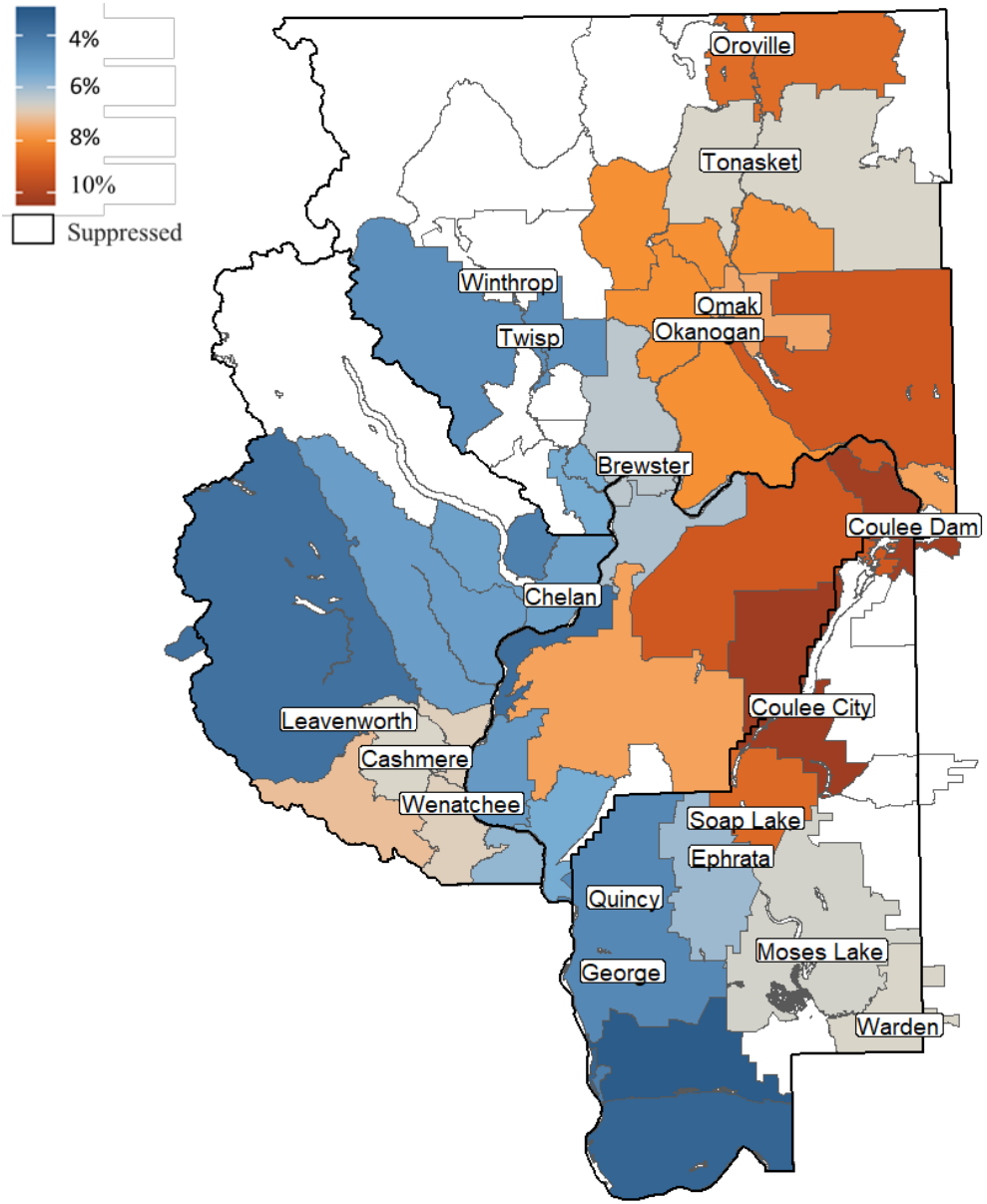
On average, 6.1% of North Central ACH Medicaid members had diabetes in 2017. Okanogan (7.0%) and Chelan (6.2%) counties had higher rates than the ACH average.

Those top ten ZIP codes with higher prevalence rates account for 804 of 6,514 persons with diabetes in NC ACH. That is 12.3% of all Medicaid members with diabetes related care in the region.

Top 10 ZIP Codes

These ZIP codes have the highest rates of diabetes among individuals with Medicaid in each county:

ZIP	Rate	Count	City	County
99115	10.3%	31	Coulee City	Grant
99133	10.2%	62	Grand Coulee	Grant
98807	9.7%	18	Wenatchee	Chelan
98830	9.2%	17	Mansfield	Douglas
99123	9.2%	22	Electric City	Grant
99155	9.2%	69	Nespelem	Okanogan
98851	8.8%	182	Soap Lake	Grant
98844	8.7%	198	Oroville	Okanogan
98840	7.9%	167	Okanogan	Okanogan
98849	7.9%	38	Riverside	Okanogan



Some technicalities :

These chronic condition prevalence estimates have been defined using the CMS Chronic Conditions Warehouse definitions.

Persons with an APCD record, who had 1 day or more of Medicaid coverage in calendar year 2017, and resided in NC ACH in 2017are included in these estimates.

- Numerator = Medicaid members who received diabetes related care during a 2 year lookback. (n=6,514)
- Denominator = individuals with 1 day or more of Medicaid coverage residing in NC ACH during calendar year 2017 (n= 106,994)

Source: WA All-Payer Claims Database | *Prepared by: Public Health Seattle & King County; Assessment, Policy Development & Evaluation Unit, September 2019*

Hypertension

North Central Accountable Community of Health

At a glance. . .

On average, 10.3% of North Central ACH Medicaid members, had hypertension in 2017. Okanogan (12.3%) and Chelan (10.7%) counties had higher rates than the ACH average.

Those top ten ZIP codes with higher prevalence rates account for 1,062 of 11,057 persons with hypertension in NC ACH. That is 9.6% of all Medicaid members with hypertension related care in the region.

Top 10 ZIP Codes

These ZIP codes have the highest rates of hypertension among individuals with Medicaid in each county :

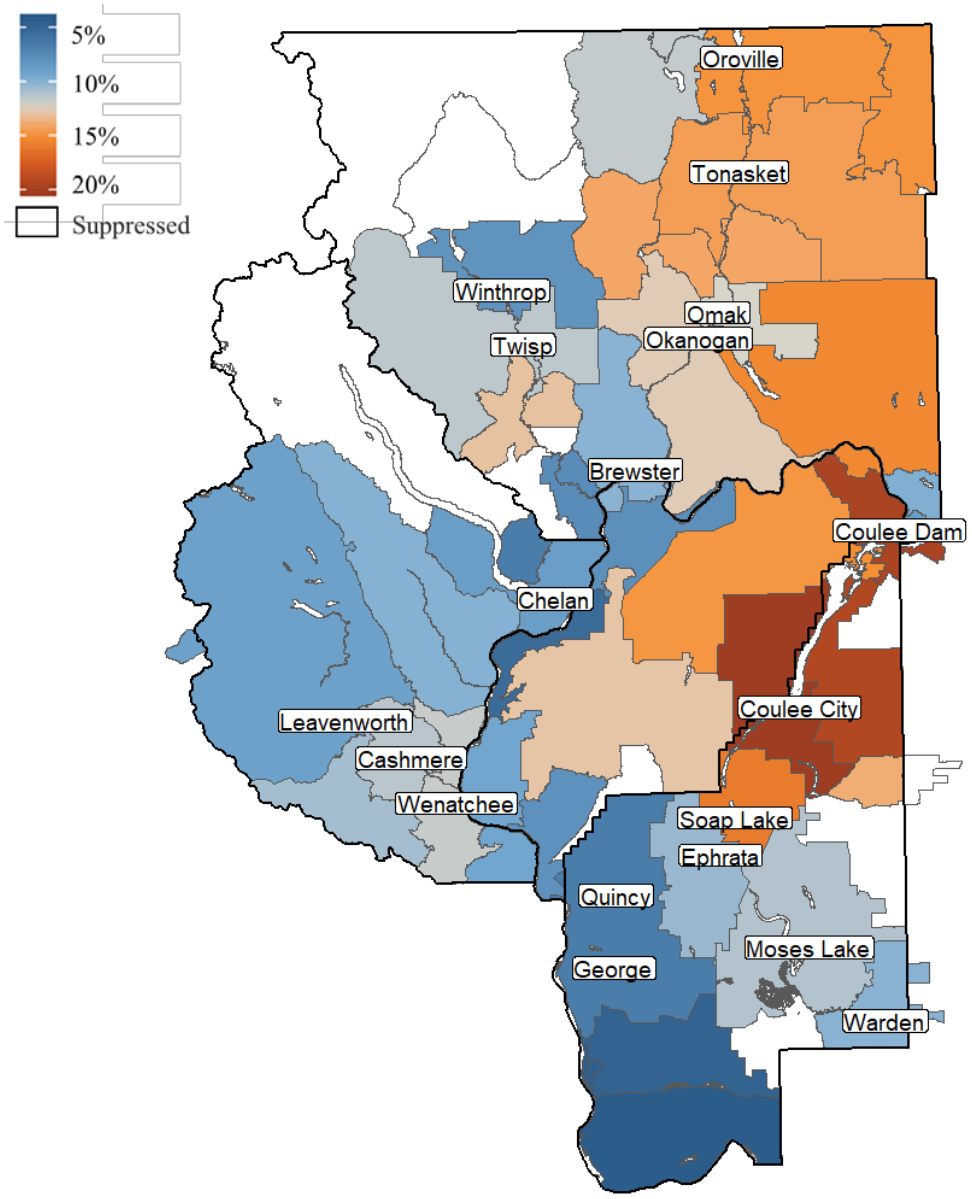
ZIP	Rate	Count	City	County
99115	20.3%	61	Coulee City	Grant
99133	19.7%	119	Grand Coulee	Grant
99135	19.3%	11	Hartline	Grant
98819	18.7%	14	Conconully	Okanogan
98851	16.0%	330	Soap Lake	Grant
99155	15.3%	115	Nespelem	Okanogan
98807	15.1%	28	Wenatchee	Chelan
99123	15.0%	36	Electric City	Grant
98844	14.8%	335	Oroville	Okanogan
98859	14.8%	13	Wauconda	Okanogan

Some technicalities :

These chronic condition prevalence estimates have been defined using the CMS Chronic Conditions Warehouse definitions.

Persons with an APCD record, who had 1 day or more of Medicaid coverage in calendar year 2017, and resided in NC ACH in 2017are included in these estimates.

- Numerator = Medicaid members who were received hypertension related care during a 1 year lookback (n=1,602)
- Denominator = individuals with 1 day or more of Medicaid coverage residing in NC ACH during calendar year 2017 (n= 106,994)



Source: WA All-Payer Claims Database | *Prepared by: Public Health Seattle & King County; Assessment, Policy Development & Evaluation Unit, September 2019*

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MTP Performance Metrics

Summary of NCACH P4P Metrics

North Central Accountable Community of Health

Performance (P4P) Metrics

	2A: Integration	2B: Pathways HUB	2C: Transitions	2D: Diversion	3A: Opioid	3D: Chronic Disease
All Cause ED Visits per 1000 Member Months	■	■	■	■	■	■
Acute Hospital Utilization	■	■	■		■	■
Follow-up After ED Visit for Mental Illness	■	■	■			
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	■	■	■			
Follow-up After Hospitalization for Mental Illness	■	■	■			
Percent Homeless (Narrow Definition)		■	■	■		
Plan All-Cause Hospital Readmissions (30 Days)	■	■	■			
Children's and Adolescents' Access to Primary Care Practitioners	■					■
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	■					■
Comprehensive Diabetes Care: Hemoglobin A1c Testing	■					■
Comprehensive Diabetes Care: Medical Attention for Nephropathy	■					■
Medication Management for People with Asthma	■					■
Mental Health Treatment Penetration	■	■				
Substance Use Disorder Treatment Penetration	■	■				
Antidepressant Medication Management	■					
Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions					■	
Patients Prescribed High-dose Chronic Opioid Therapy					■	
Percent Arrested				■		
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)						■
Substance Use Disorder Treatment Penetration (Opioid)					■	

Efforts contributing to P4Ps

North Central Accountable Community of Health

All Cause ED Visits per 1000 Member Months
Acute Hospital Utilization
Follow-up After ED Visit for Mental Illness
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence
Follow-up After Hospitalization for Mental Illness
Percent Homeless (Narrow Definition)
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Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions
Patients Prescribed High-dose Chronic Opioid Therapy
Percent Arrested
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)
Substance Use Disorder Treatment Penetration (Opioid)

TCDI PARTNERS

What Are Partners Working on?

- Transitional Care Nurse follow up within 48 hours of inpatient discharge
- Workflows to connect patients to outpatient services
- Educating patients on accessing appropriate care for non-emergent issues
- Increased use of Collective Medical platform (EDie), including Electronic Medical Record integration and workflow development
- Efforts to connect with non-clinical partners around SDOH needs

Funded Partners

- Columbia Basin Hospital
- Confluence Health (TCM Trainer)
- Coulee Medical Center
- Lake Chelan Community Hospital
- Mid-Valley Hospital
- North Valley Hospital
- Samaritan Healthcare
- Three Rivers Hospital

Efforts contributing to P4Ps

North Central Accountable Community of Health

All Cause ED Visits per 1000 Member Months

Acute Hospital Utilization

Follow-up After ED Visit for Mental Illness

Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence

Follow-up After Hospitalization for Mental Illness

Percent Homeless (Narrow Definition)

Plan All-Cause Hospital Readmissions (30 Days)

Children's and Adolescents' Access to Primary Care Practitioners

Comprehensive Diabetes Care: Eye Exam (Retinal) Performed

Comprehensive Diabetes Care: Hemoglobin A1c Testing

Comprehensive Diabetes Care: Medical Attention for Nephropathy

Medication Management for People with Asthma

Mental Health Treatment Penetration

Substance Use Disorder Treatment Penetration

Antidepressant Medication Management

Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions

Patients Prescribed High-dose Chronic Opioid Therapy

Percent Arrested

Statin Therapy for Patients with Cardiovascular Disease (Prescribed)

Substance Use Disorder Treatment Penetration (Opioid)

WPCC & PATHWAYS HUB PARTNERS

What Are Partners Working on?

- Increased integration and coordination of primary care and behavioral health
- Increased screening for depression
- Workflows to reach out to patients after release from Emergency Dept.
- Educating patients on accessing appropriate care for non-emergent issues
- Increased use of Collective Medical platform (notifications, care plans) and workflow development
- Community-based care coordination infrastructure building
- SDOH Screenings

Funded Partners

16

Outpatient Providers involved in WPCC (both primary and behavioral health)

Action Health Partners and CSSAs

Efforts contributing to P4Ps

North Central Accountable Community of Health

All Cause ED Visits per 1000 Member Months

Acute Hospital Utilization

Follow-up After ED Visit for Mental Illness

Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence

Follow-up After Hospitalization for Mental Illness

Percent Homeless (Narrow Definition)

Plan All-Cause Hospital Readmissions (30 Days)

Children's and Adolescents' Access to Primary Care Practitioners

Comprehensive Diabetes Care: Eye Exam (Retinal) Performed

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Medication Management for People with Asthma

Mental Health Treatment Penetration

Substance Use Disorder Treatment Penetration

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Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions

Patients Prescribed High-dose Chronic Opioid Therapy

Percent Arrested

Statin Therapy for Patients with Cardiovascular Disease (Prescribed)

Substance Use Disorder Treatment Penetration (Opioid)

WPCC & OPIOID PARTNERS

What Are Partners Working on?

- Increasing capacity for Medication Assisted Treatment for opioid use disorder treatment
  - Adding waivered providers (doctors, nurses)
  - Creating treatment networks
- Expanding prevention efforts (including school-based prevention)
- Increasing recovery resources (e.g. Recovery Coach trainings and network building)
- Awareness campaigns
- Narcan trainings and distribution

Funded Partners

16

Outpatient Providers involved in WPCC (both primary and behavioral health)

17+

Clinical and community partners

Efforts contributing to P4Ps

All Cause ED Visits per 1000 Member Months

Acute Hospital Utilization

Follow-up After ED Visit for Mental Illness

Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence

Follow-up After Hospitalization for Mental Illness

Percent Homeless (Narrow Definition)

Plan All-Cause Hospital Readmissions (30 Days)

Children's and Adolescents' Access to Primary Care Practitioners

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Medication Management for People with Asthma

Mental Health Treatment Penetration

Substance Use Disorder Treatment Penetration

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Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions

Patients Prescribed High-dose Chronic Opioid Therapy

Percent Arrested

Statin Therapy for Patients with Cardiovascular Disease (Prescribed)

Substance Use Disorder Treatment Penetration (Opioid)

WPCC PARTNERS

What Are Partners Working on?

- Clinical case management for complex patients
- Organizing patient and population data to facilitate efficient and effective care (e.g. Population Health Learning and Action Network)
- Increased use of Collective Medical platform (notifications, care plans) and workflow development
- Empowering and preparing patients to manage their health and health care
- Focusing on care gaps especially around care for depression and for diabetes

North Central Accountable Community of Health

Funded Partners

- Cascade Medical
- Catholic Charities
- Children's Home Society of Washington
- Columbia Basin Family Medicine
- Columbia Basin Health Association
- Columbia Valley Community Health
- Confluence Health
- Coulee Medical Center
- Family Health Centers
- Grant Integrated Services
- Lake Chelan Community Clinic
- Mid Valley Clinic
- Moses Lake Community Health Center
- Okanogan Behavioral HealthCare
- Samaritan Healthcare
- The Center for Alcohol and Drug Treatment

NCACH P4P Results

North Central Accountable Community of Health

ACUTE CARE UTILIZATION Measures	2017 Baseline Performance		2018 Baseline Performance		NCACH Relative to State (2017)	NCACH Relative to State (2018)
	NCACH	Statewide	NCACH	Statewide		
Acute Hospital Utilization per 1000 Members ↓	*Inactive*	*Inactive*	54.92	68.16	N/A	🟢
All Cause ED Visits per 1000 MM: Ages 0-17 Years ↓	28.56	35.75	29.42	34.51	🟢	🟢
All Cause ED Visits per 1000 MM: Ages 18-64 Years ↓	50.69	66.49	50.19	66.27	🟢	🟢
All Cause ED Visits per 1000 MM: Ages 65+ Years ↓	57.06	54.75	58.28	51.31	🟡	🟡
Plan All-Cause Hospital Readmission Rate (30 days) ↓	8.06	11.09	8.26	11.19	🟢	🟢

↓ *Lower rate indicates better performance*

Legend

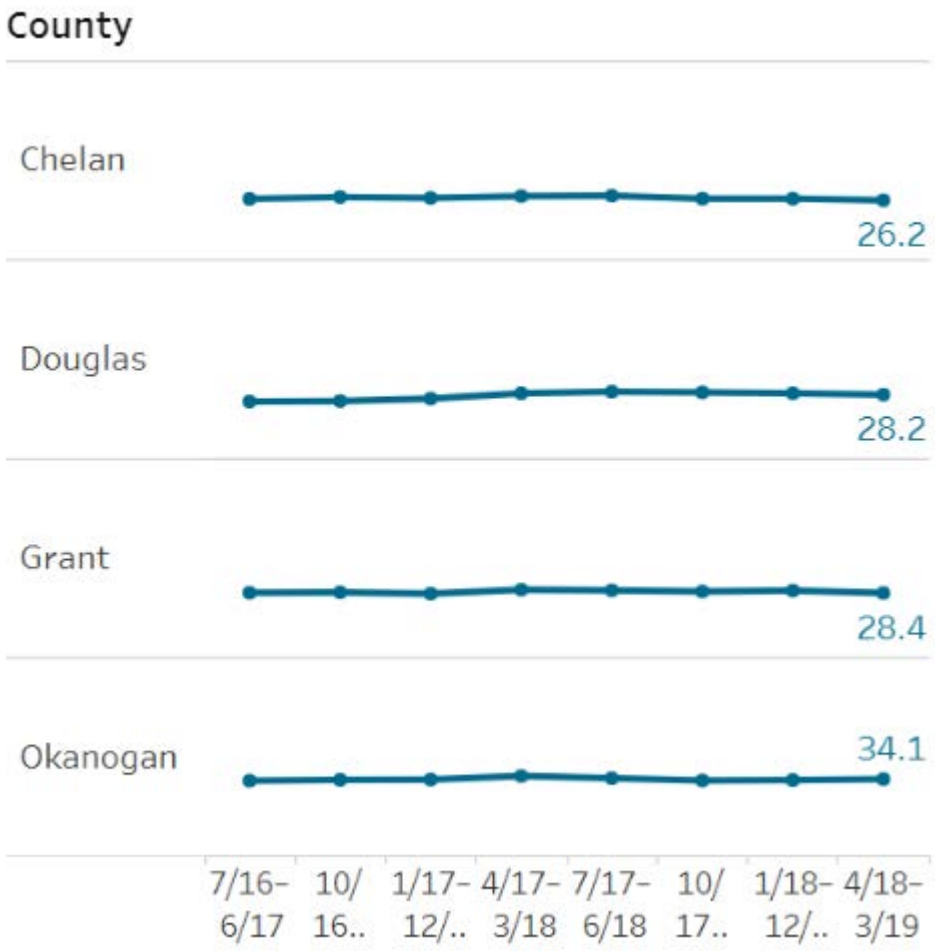
- 🟢 Performance is at or above statewide
- 🟡 Performance is below statewide
- 🔴 Lowest ACH performer in the State

Data Source: Health Care Authority
Measurement Periods: Baseline Year 1 (Calendar Year 2017) and Baseline Year 2 (Calendar Year 2018)
Performance in CY 2019 will be compared to baseline CY 2017
Some measures don't become active until 2020 (compared to baseline CY 2018)

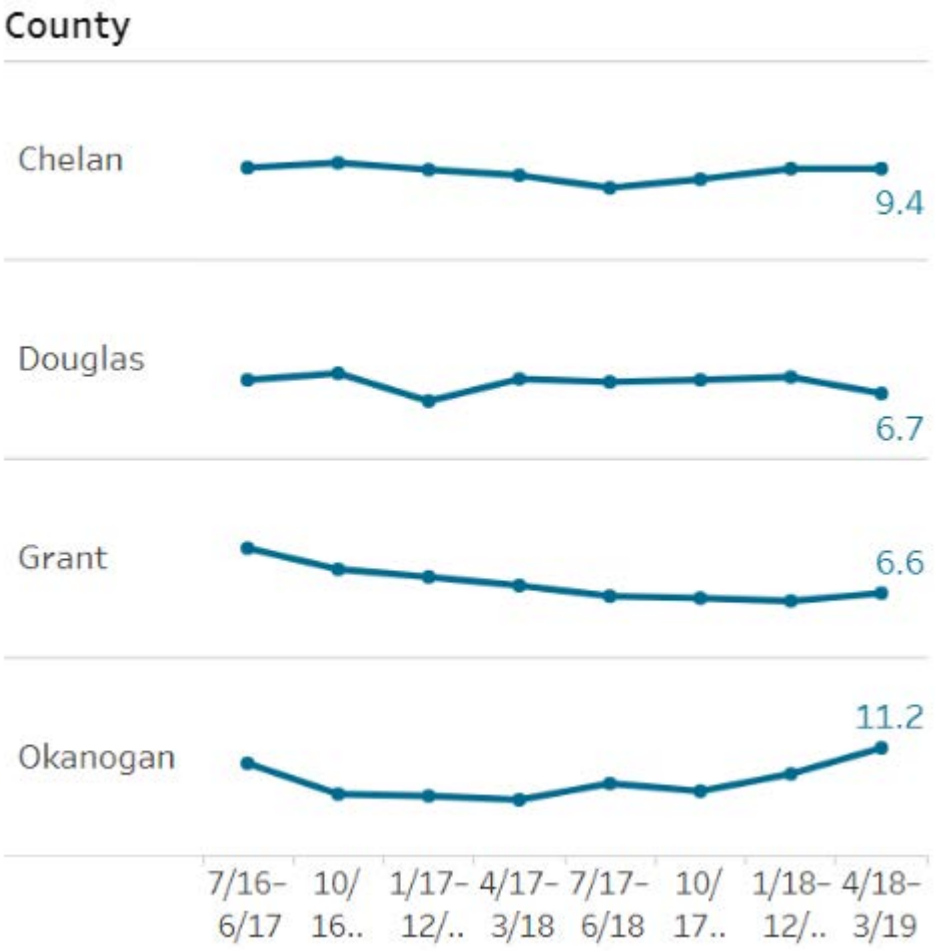
A closer look at acute care utilization

North Central Accountable Community of Health

All Cause ED per 1000MM: 0-17 Yrs



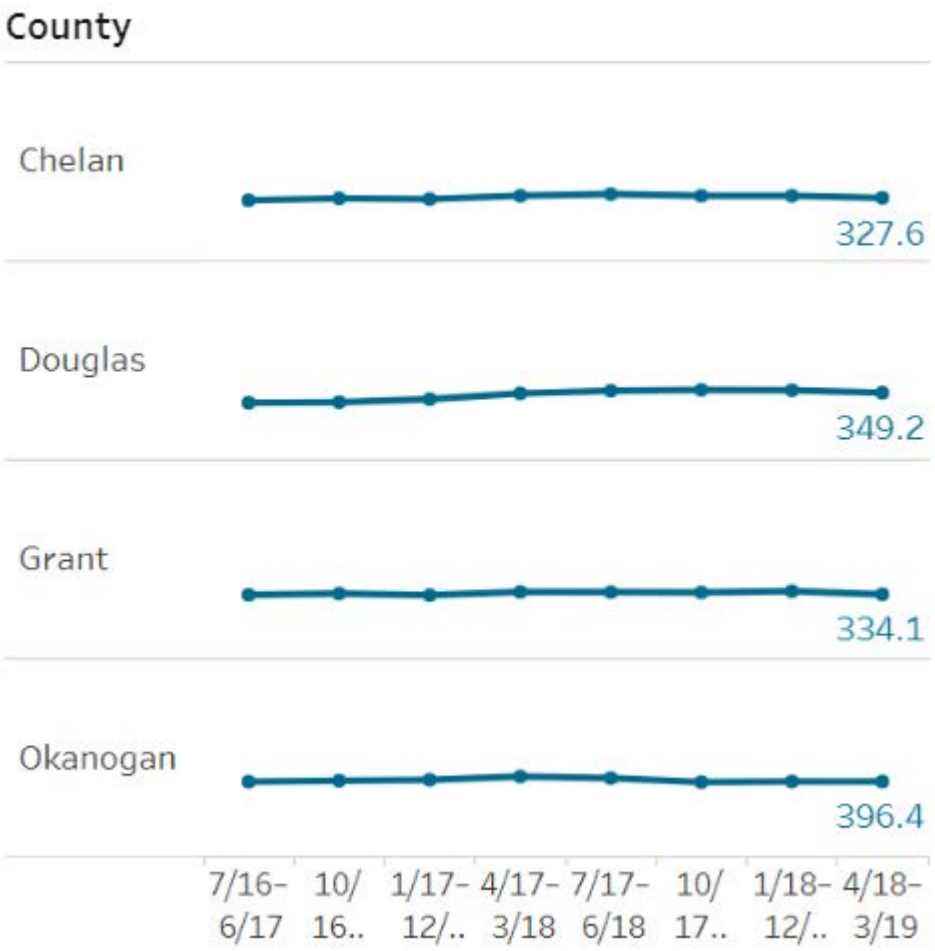
Plan All Cause Hospital Readmission (30 days)



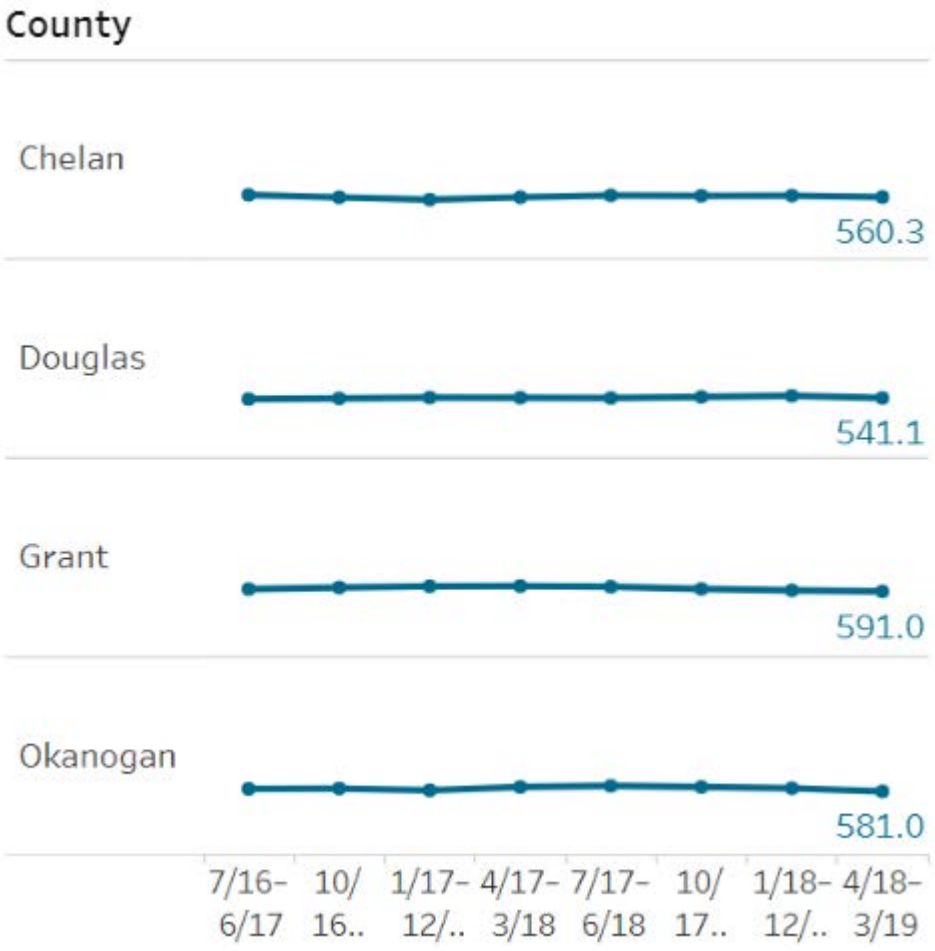
A closer look at acute care utilization

North Central Accountable Community of Health

ED Utilization per 1000 Members: 0-17 Years



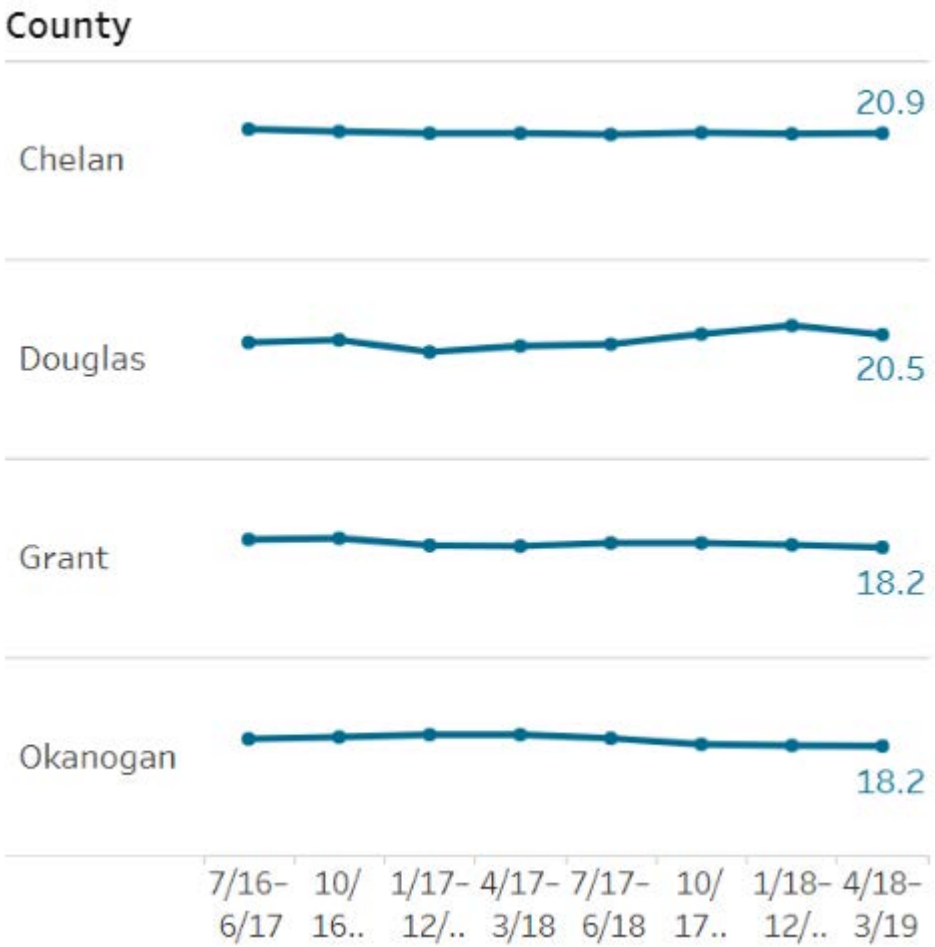
ED Utilization per 1000 Members: 18+ Years



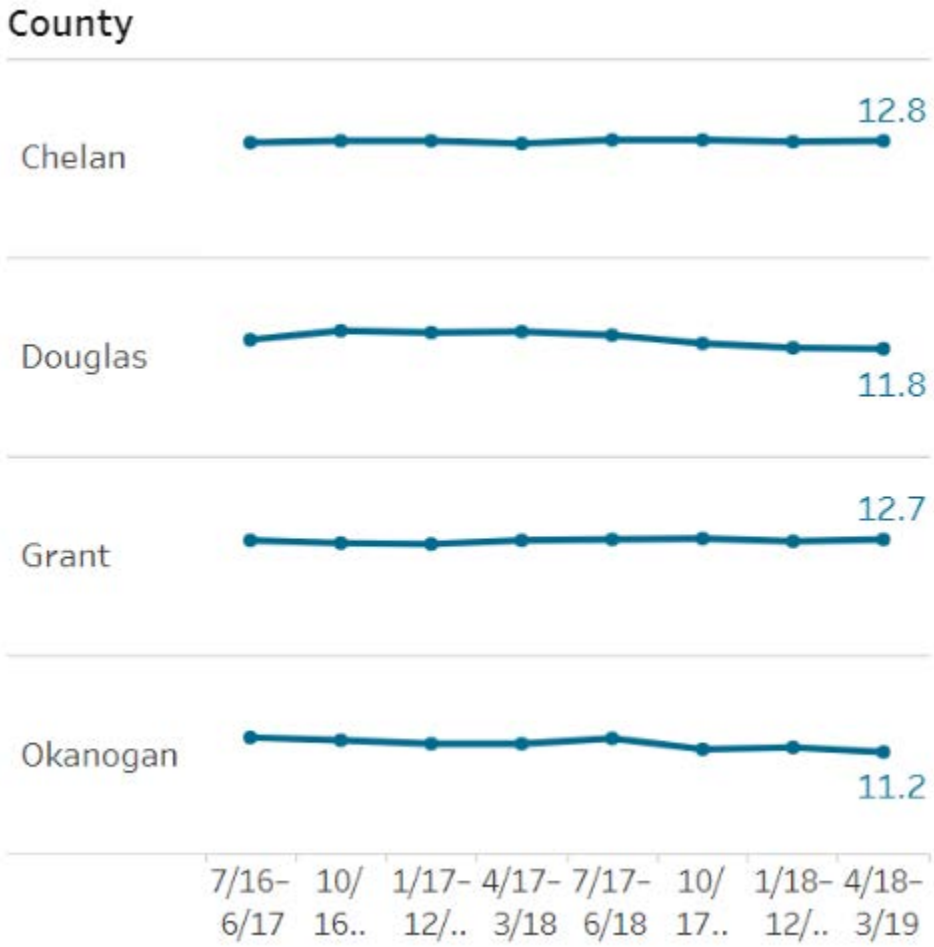
A closer look at acute care utilization

North Central Accountable Community of Health

Potentially Avoidable ED Visits: 1-17 Years



Potentially Avoidable ED Visits: 18+



NCACH P4P Results

North Central Accountable Community of Health

BEHAVIORAL HEALTH AND FOLLOW-UP CARE Measures	2017 Baseline Performance		2018 Baseline Performance		NCACH Relative to State (2017)	NCACH Relative to State (2018)
	NCACH	Statewide	NCACH	Statewide		
Follow-Up After ED for Alcohol and Other Drug Abuse or Dependence: 7 Days	*Inactive*	*Inactive*	15.97	15.46	N/A	🟢
Follow-Up After ED for Alcohol and Other Drug Abuse or Dependence: 30 Days	*Inactive*	*Inactive*	26.39	24.94	N/A	🟢
Follow-Up After ED for Mental Illness: 7 Days	*Inactive*	*Inactive*	76.07	65.32	N/A	🟢
Follow-Up After ED for Mental Illness: 30 Days	*Inactive*	*Inactive*	83.76	75.48	N/A	🟢
Follow-up After Hospitalization for Mental Illness: 7 days	*Inactive*	*Inactive*	75.50	64.43	N/A	🟢
Follow-up After Hospitalization for Mental Illness: 30 days	*Inactive*	*Inactive*	86.09	81.35	N/A	🟢
Mental Health Treatment Penetration: Ages 6-17	63.14	65.76	65.60	68.23	🟡	🔴
Mental Health Treatment Penetration: Ages 18-64	45.43	47.67	48.58	49.49	🟡	🟡
Substance Use Disorder Treatment Penetration: Ages 12-17	30.36	34.38	28.57	33.56	🟡	🟡
Substance Use Disorder Treatment Penetration: Ages 18-64	22.69	30.81	25.78	34.57	🔴	🔴

A closer look at BH treatment

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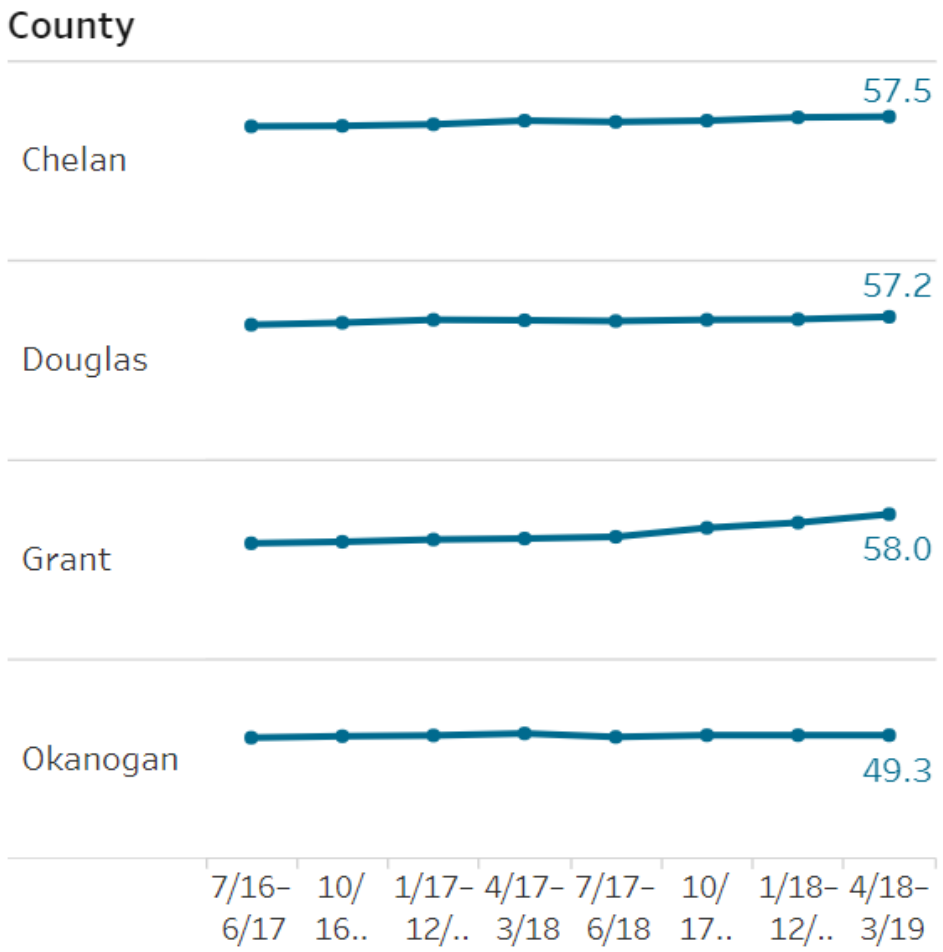
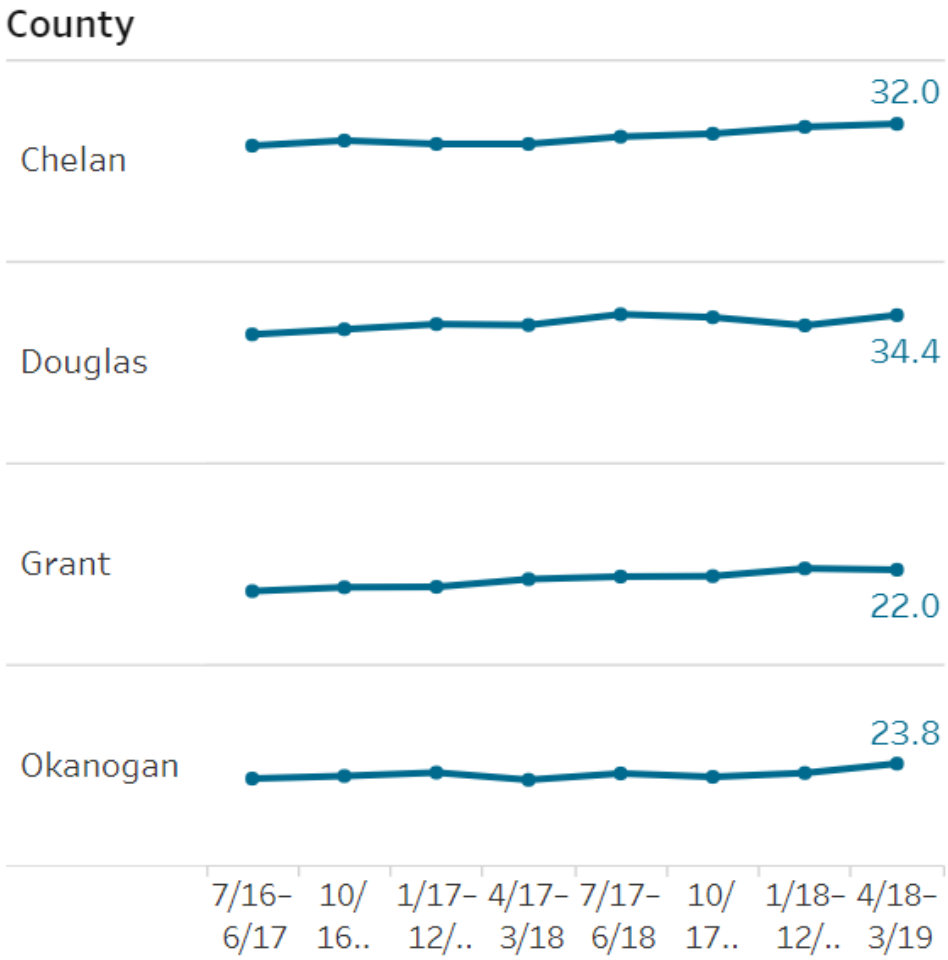
MH Treatment Penetration Ages 6+



SUD Treatment Penetration Ages 12+



NCACH P4P Results

North Central Accountable Community of Health

OPIOIDS & SDOH Measures	2017 Baseline Performance		2018 Baseline Performance		NCACH Relative to State (2017)	NCACH Relative to State (2018)
	NCACH	Statewide	NCACH	Statewide		
Substance Use Disorder Treatment Penetration (Opioid): Ages 18-64	*Inactive*	*Inactive*	43.95	51.64	N/A	🟡
Patients Prescribed Chronic Concurrent Opioids and Sedatives ↓	21.46	22.97	18.30	20.21	🟢	🟢
Patients Prescribed High-Dose Chronic Opioid Therapy: ≥50mg MED ↓	32.53	34.70	32.26	35.25	🟢	🟢
Patients Prescribed High-Dose Chronic Opioid Therapy: ≥90mg MED ↓	15.97	17.90	15.60	17.35	🟢	🟢
Percent Arrested ↓	*Inactive*	*Inactive*	7.11	7.32	N/A	🟢
Percent Homeless: Ages 0-17 ↓	0.21	0.73	0.24	0.71	🟢	🟢
Percent Homeless: Ages 18-64 ↓	2.64	5.10	2.87	5.53	🟢	🟢

↓ *Lower rate indicates better performance*

Data Source: Health Care Authority
Measurement Periods: Baseline Year 1 (Calendar Year 2017) and Baseline Year 2 (Calendar Year 2018)
Performance in CY 2019 will be compared to baseline CY 2017
Some measures don't become active until 2020 (compared to baseline CY 2018)

NCACH P4P Results

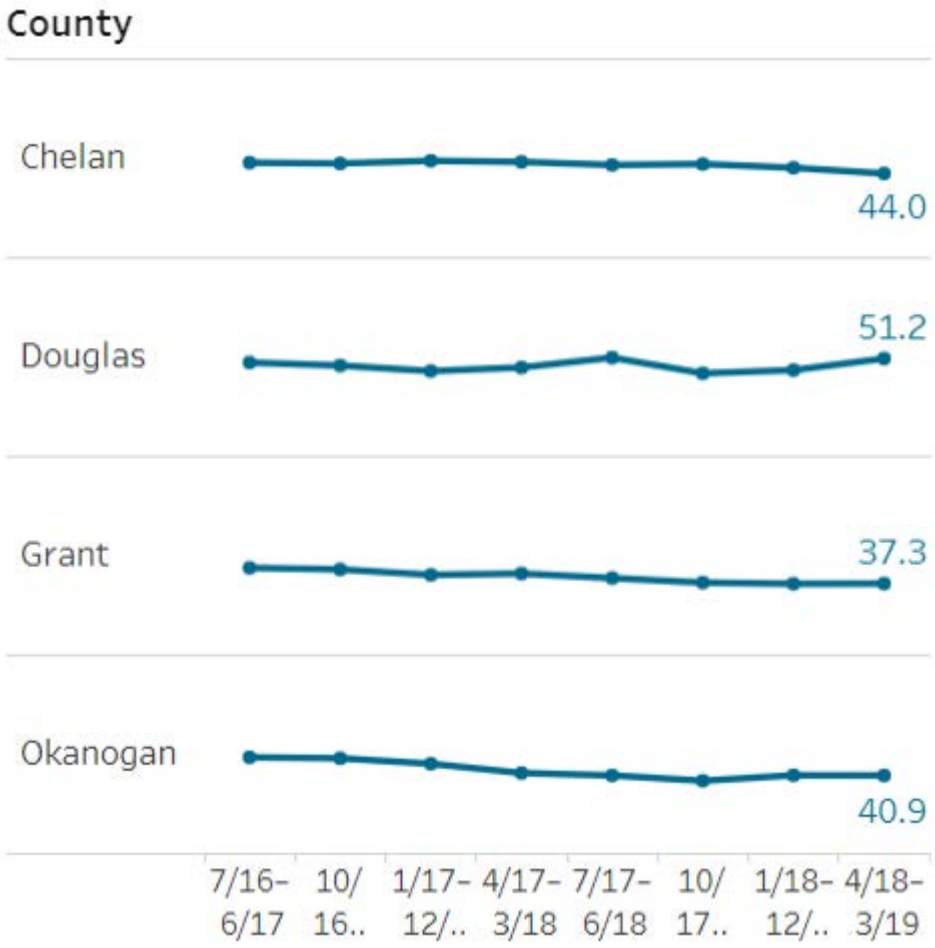
North Central Accountable Community of Health

ACCESS & CHRONIC CONDITIONS Measures	2017 Baseline Performance		2018 Baseline Performance		NCACH Relative to State (2017)	NCACH Relative to State (2018)
	NCACH	Statewide	NCACH	Statewide		
Child and Adolescents' Access to PCP: 12-24 Months	97.36	96.79	98.10	96.82	🟢	🟢
Child and Adolescents' Access to PCP: 25 Months - 6 Years	92.25	87.78	92.18	88.32	🟢	🟢
Child and Adolescents' Access to PCP: 7-11 Years	95.65	92.08	95.57	92.25	🟢	🟢
Child and Adolescents' Access to PCP: 12-19 Years	96.45	92.04	96.33	92.09	🟢	🟢
Antidepressant Medication Management: Acute	46.21	51.30	41.56	50.40	🔴	🔴
Antidepressant Medication Management: Continuation	32.22	35.87	28.68	35.63	🔴	🔴
Asthma Medication Ratio: Ages 5-64	-	-	45.95	52.49	N/A	🔴
Medication Management for People with Asthma (75%)	27.29	32.86	*Dropped*	*Dropped*	🔴	N/A
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	*Inactive*	*Inactive*	54.09	44.52	N/A	🟢
Comprehensive Diabetes Care: Hemoglobin A1c Testing	88.27	84.89	88.86	83.88	🟢	🟢
Comprehensive Diabetes Care: Medical Attention for Nephropathy	89.27	87.08	87.82	86.12	🟢	🟢
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	*Inactive*	*Inactive*	79.43	82.16	N/A	🔴

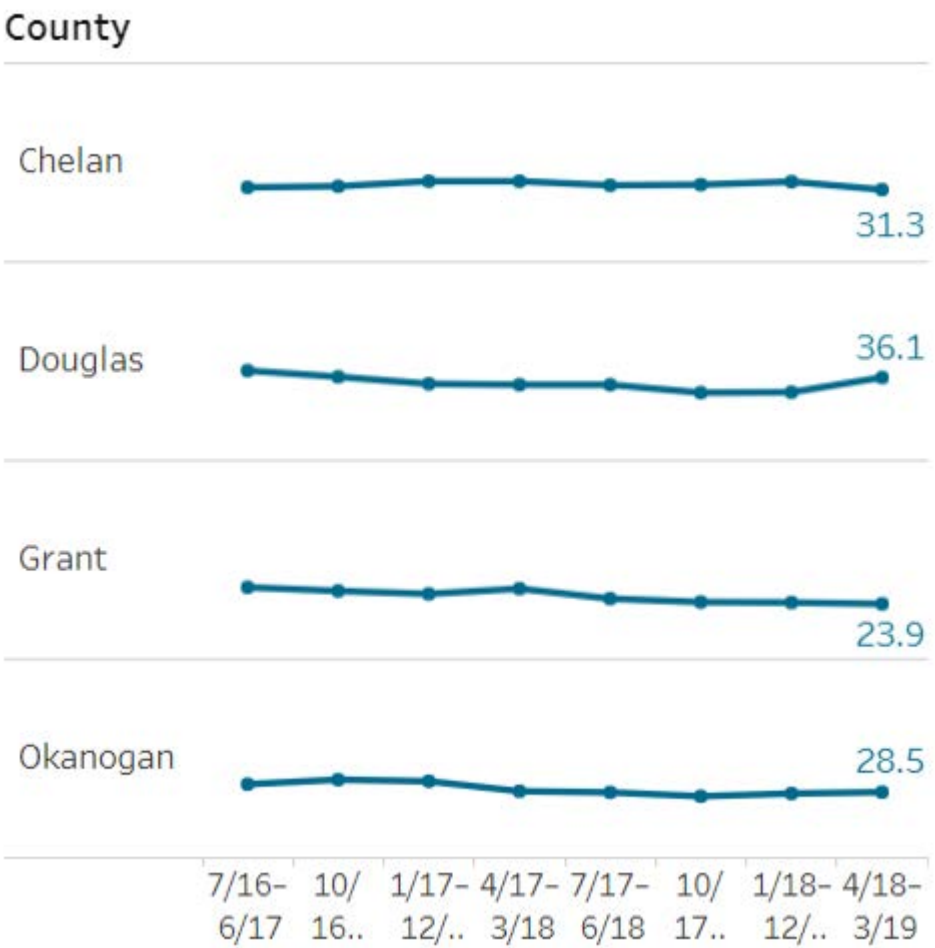
A closer look at antidepressant med mgt

North Central Accountable Community of Health

Antidepressant Medication Management - Acute



Antidepressant Medication Management - Continuation



Questions or Comments?