Medicaid Demonstration Project Planning Update

Chelan Douglas Coalition for Health Improvement

9/21/2017 Meeting

North Central Accountable Community of Health

Goals

- Presentation goals
  - Review 6 selected Demonstration projects
  - Revisit data on healthcare and social needs in our region
  - Discuss potential priority populations for Medicaid Demonstration projects
  - Share your concerns and recommendations

- What will happen with your feedback?
  - Will be shared with regional project workgroups and Governing Board
  - Will inform projects, including selected approach and priority populations

North Central Accountable Community of Health

Projects and general target populations

Bi-Directional Integration	
Objective	Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers. Will support bringing together the financing and delivery of physical and behavioral health services, through MCOs, for people enrolled in Medicaid.
General target population (as defined by HCA)	All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).

Projects and general target populations

Community-Based Care Coordination (aka HUB)	
Objective	Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
General target population (as defined by HCA)	Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as, arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke), **or** mental illness/depressive disorders, **or** moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization).

Projects and general target populations

Transitional Care	
Objective	Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.
General target population (as defined by HCA)	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.

Projects and general target populations

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.
General target population (as defined by HCA)	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.

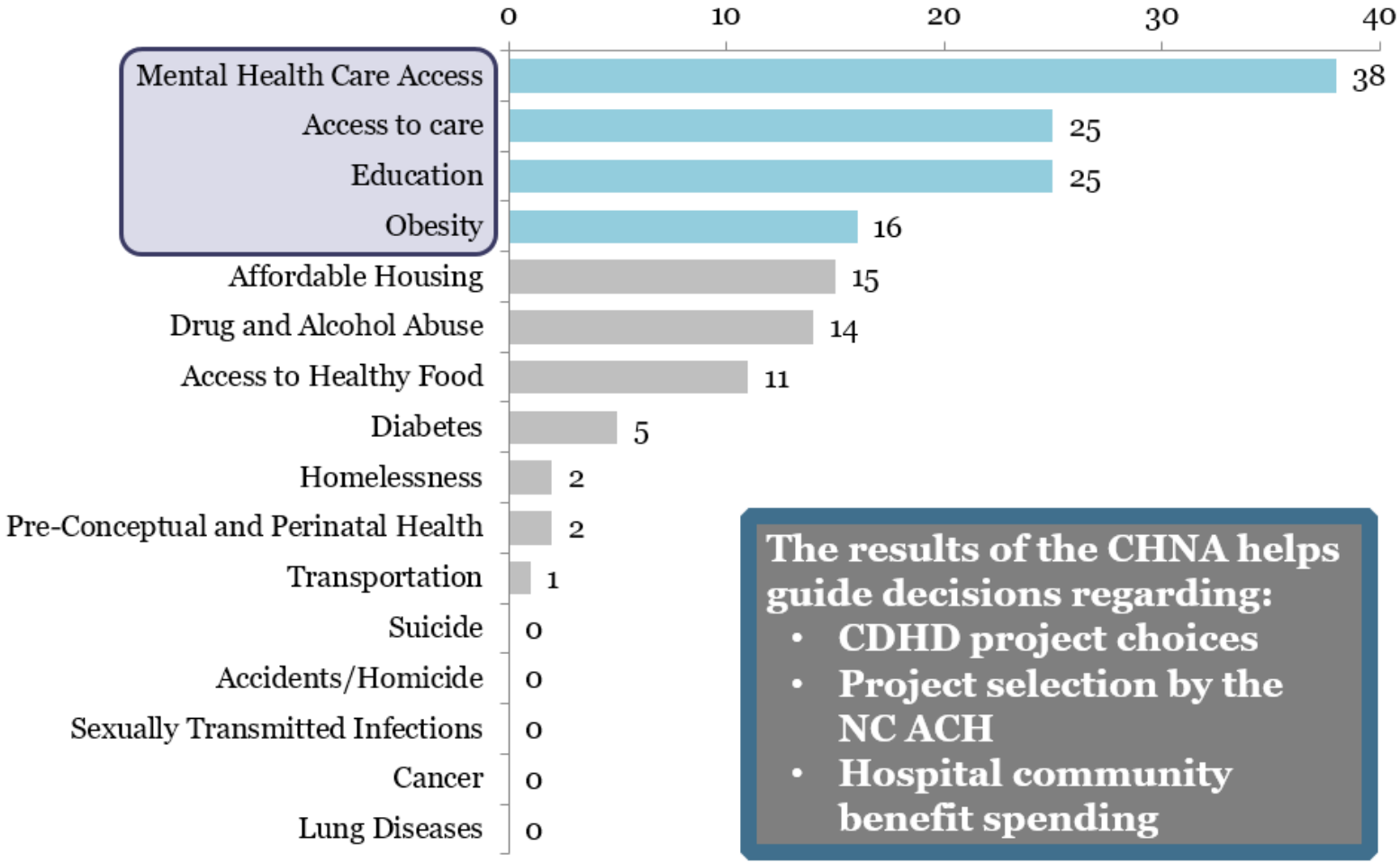
Projects and general target populations

Addressing the Opioid Use Public Health Crisis	
Objective	Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.
General target population (as defined by HCA)	Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.

Projects and general target populations

Chronic Disease Prevention and Control	
Objective	Integrate health system and community approaches to improve chronic disease management and control.
General target population (as defined by HCA)	Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.

Results: The CHNA process ultimately resulted in the identification of four health needs for our region:

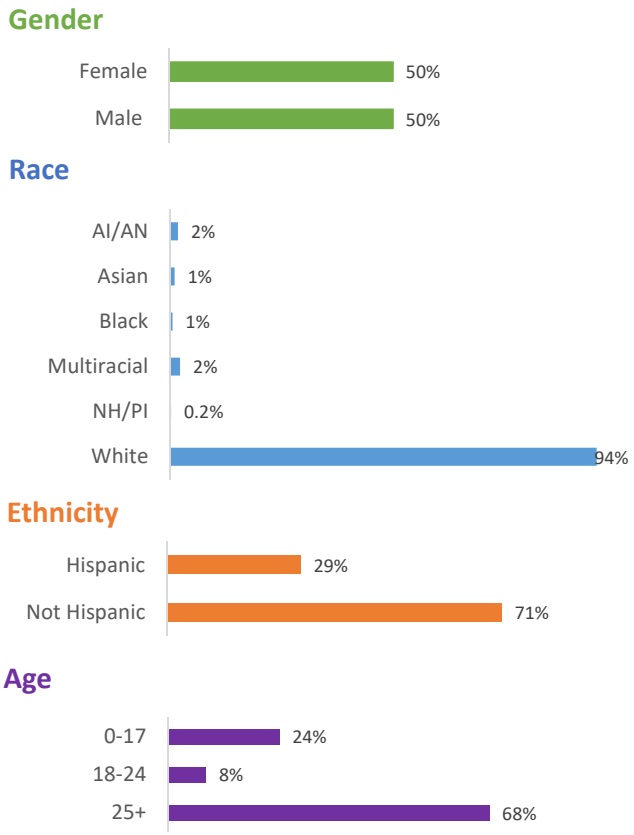


The results of the CHNA helps guide decisions regarding:

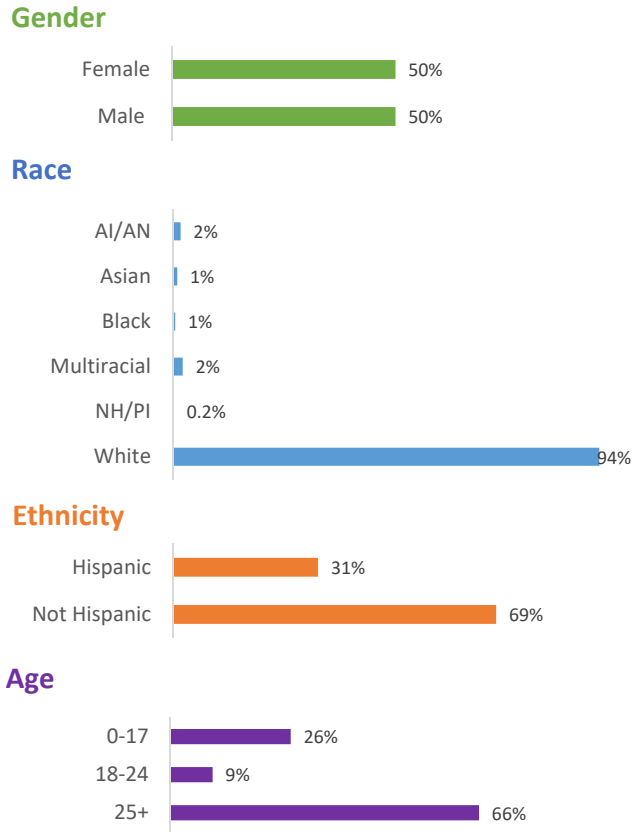
- **CDHD project choices**
- **Project selection by the NC ACH**
- **Hospital community benefit spending**

Overall Population Demographics

Chelan County (N=75,030)



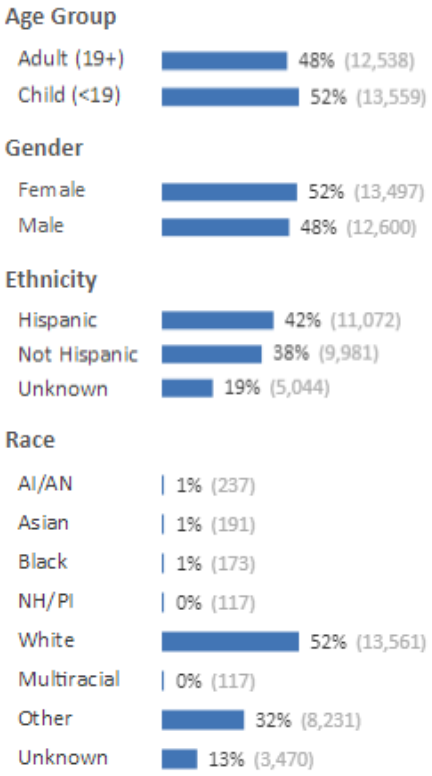
Douglas County (N=39,990)



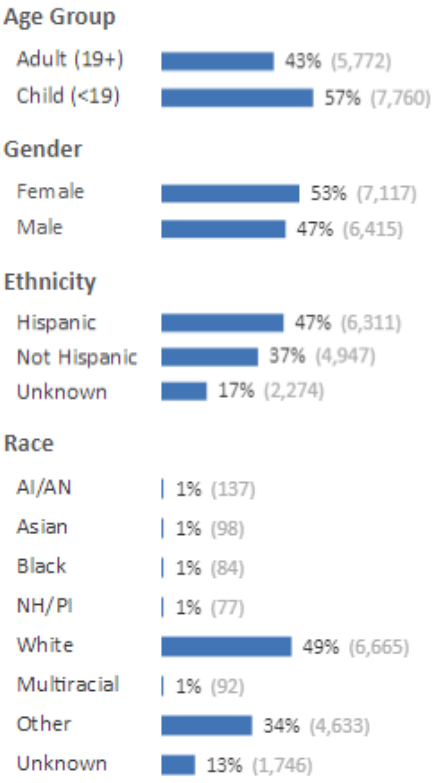
Source: Office of Financial Management (Measurement period = 2015)

Medicaid Population Demographics

Chelan County (N=26,097)

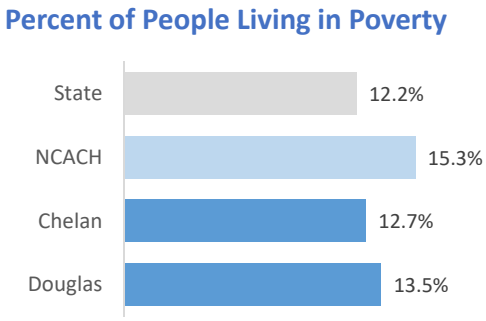


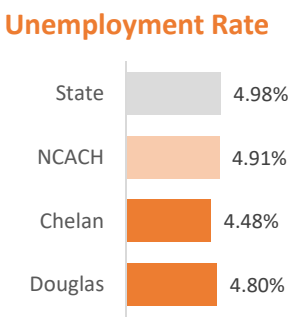
Douglas County (N=13,532)

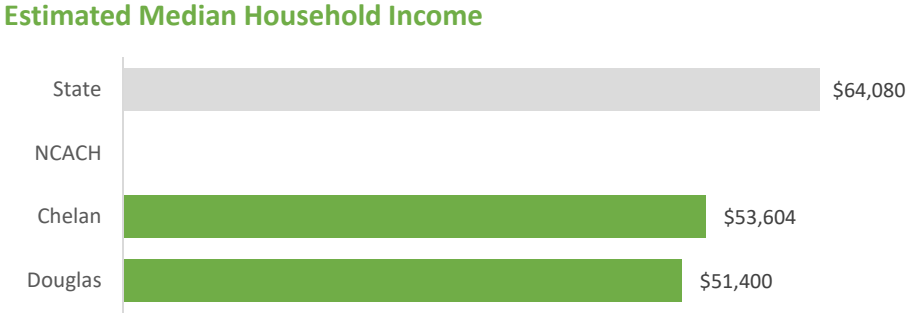


Source: Healthier Washington Dashboard (Measurement period = 10/1/2015 – 9/30/2016)

Social & Environmental Determinants of Health







Source: Health Care Authority Starter Kit, drawn from U.S. Census Bureau, Employment Security Department and Washington Tracking Network

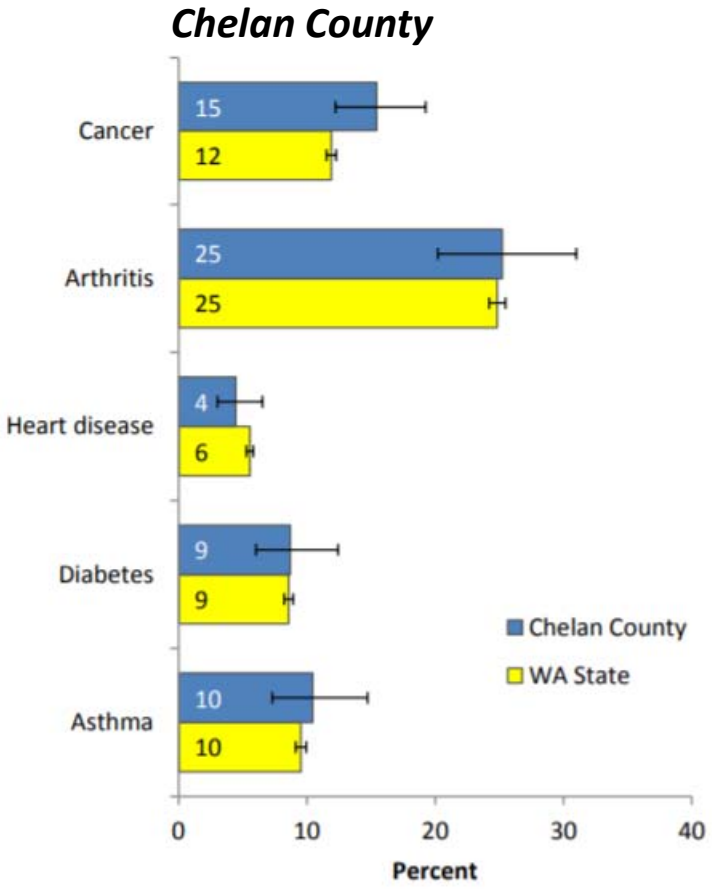
Top Ten Most Common Causes of Acute Hospitalizations Among Medicaid Recipients

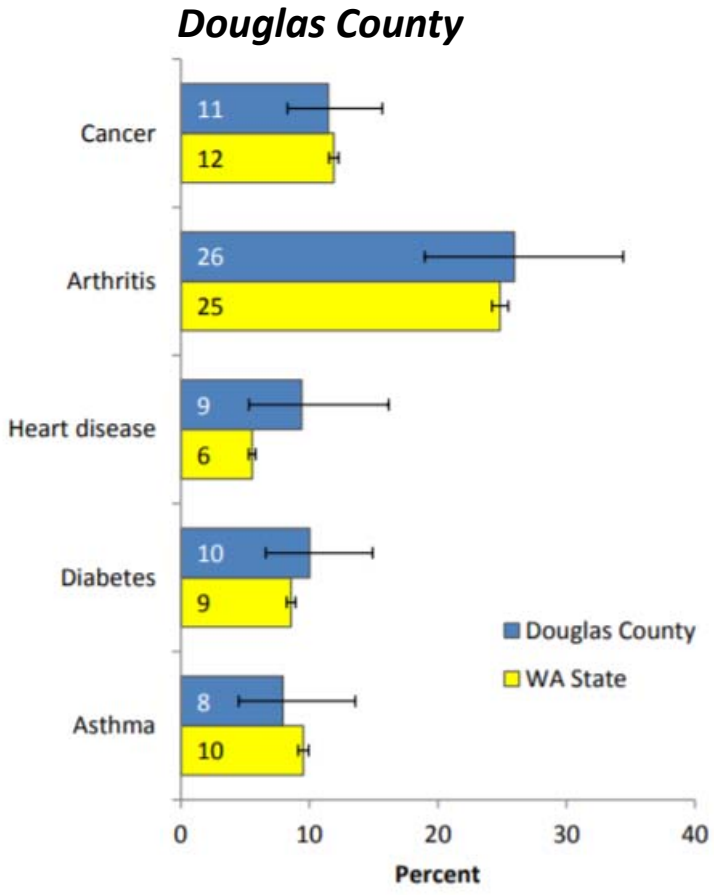
Rank	Cause of Acute Hospitalization	Count	%	State Rank
1	Injury and Poisoning	266	12.1	2 *(9.4%)*
2	Mental and Behavioral Disorders	171	7.8	1 *(18.2%)*
3	Diseases of Heart	135	6.1	4 *(5.7%)*
4	Respiratory Infections	132	6.0	9 *(3.6%)*
5	Diseases of the Musculoskeletal System and Connective Tissue	115	5.2	5 *(4.5%)*
6	Substance Use Disorder	105	4.8	6 *(4.6%)*
7	Septicemia	105	4.8	3 *(7.4%)*
8	Cancer/Malignancies	102	4.6	8 *(3.6%)*
9	Diabetes	94	4.3	
10	Diseases of Liver, Biliary Tract, and Pancreas	84	3.8	7 *(3.7%)*

Data for North Central ACH, Excluding Pregnancy and Child Delivery Related Hospitalizations (Jan 1, 2015 - Oct 31,2015)
Source: Health Care Authority Starter Kit, determined by primary diagnosis field in HCA ProviderOne Medicaid Data System

North Central Accountable Community of Health

Adult (18+) Chronic Diseases



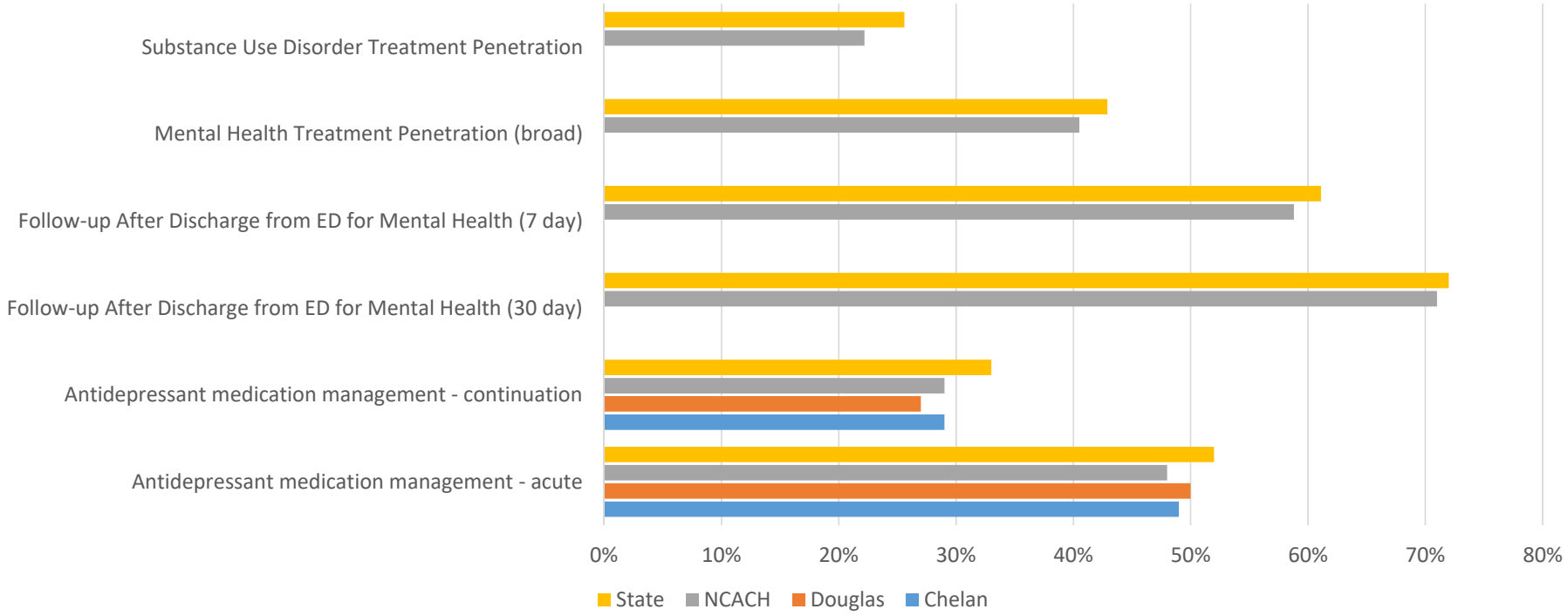


North Central Accountable Community of Health

Source: Washington Dept. of Health Chronic Disease Profiles (2017), drawing from Washington Behavioral Risk Factor Surveillance System 2013-2015

Behavioral Health

Behavioral Health Measures Where NCACH Below State Average



Data for North Central ACH from Health Care Authority – based on demonstration measures

North Central Accountable Community of Health

Risk Factors for Arrests

5-6 times more likely to exhibit one of these risk factors

- Substance abuse (not including alcohol)
- SUD treatment need
- Co-occurring mental illness/substance use disorder

Source: DSHS Research and Data Analysis cross-system outcome measures
Date specific to Medicaid members

North Central Accountable Community of Health

Risk Factors for Homelessness

3-4 times more likely to exhibit one of these risk factors

- SUD treatment need
- Co-occurring mental illness/substance use disorder
- Substance abuse (not including alcohol)
- Psychiatric (bipolar)

Source: DSHS Research and Data Analysis cross-system outcome measures
Date specific to Medicaid members

North Central Accountable Community of Health

Risk Factors for ED Utilization

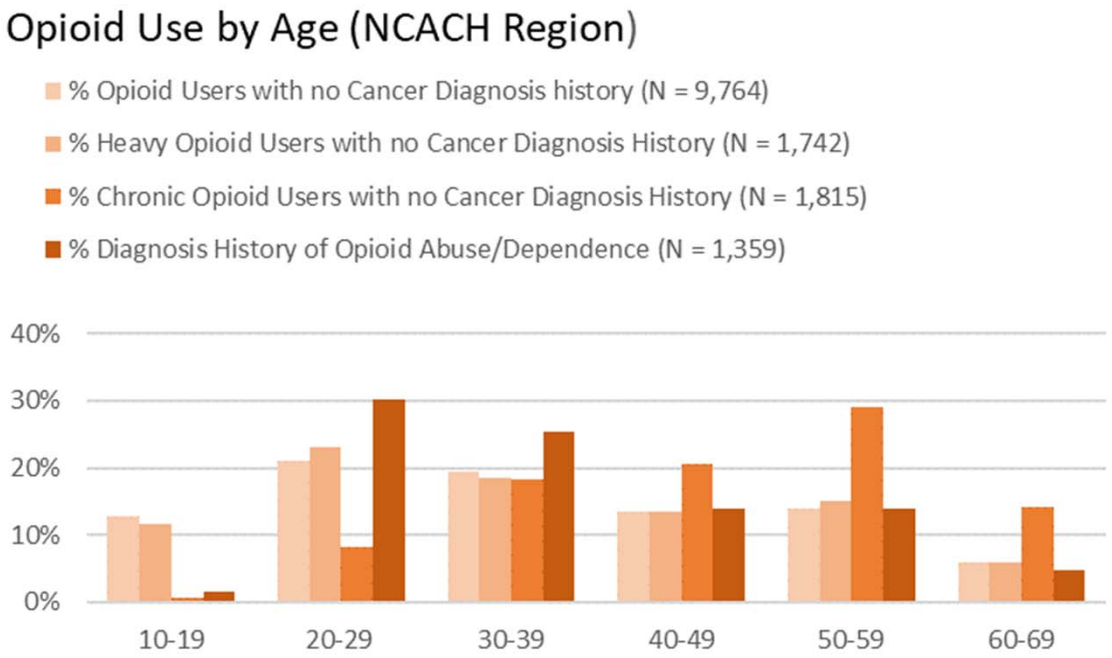
5-7 times more likely to exhibit one of these risk factors, if have 3+ ED visits

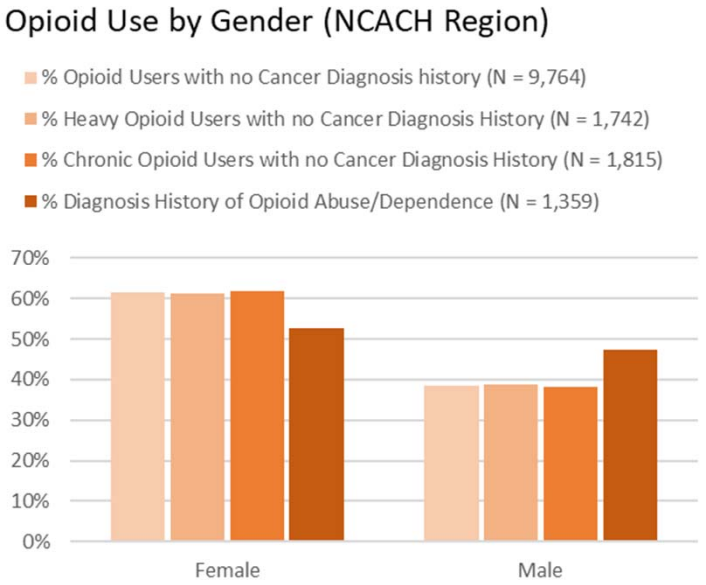
- Type 1 diabetes
- Pulmonary
- Cardiovascular
- Renal
- Liver disease
- Co-occurring mental illness/substance use disorder
- Substance abuse (low)

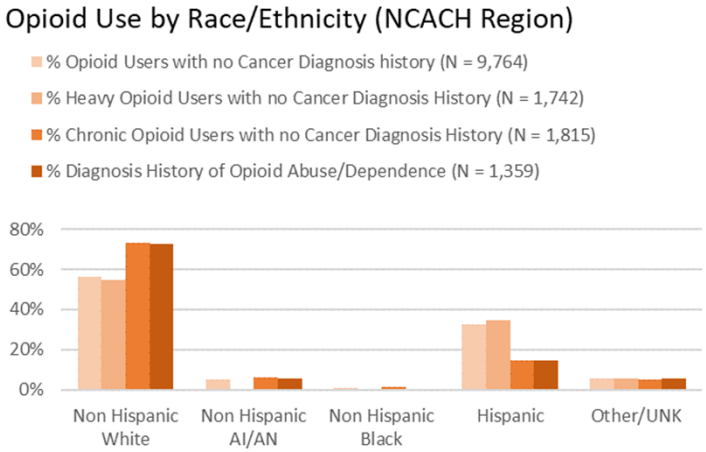
Source: DSHS Research and Data Analysis cross-system outcome measures
Date specific to Medicaid members

North Central Accountable Community of Health

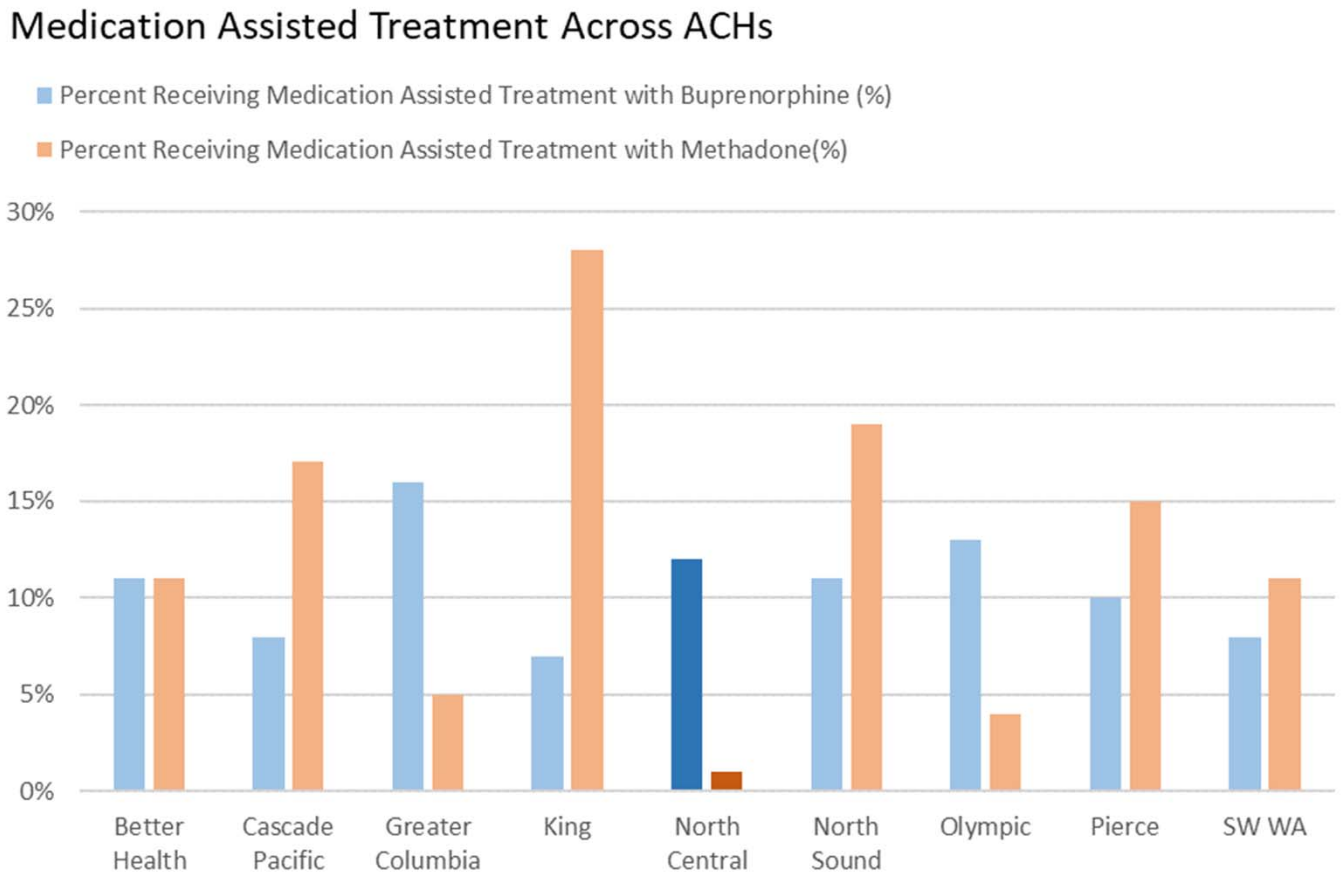
Opioid Use


Opioid Use by Age (NCACH Region)
% Opioid Users with no Cancer Diagnosis history (N = 9,764)
% Heavy Opioid Users with no Cancer Diagnosis History (N = 1,742)
% Chronic Opioid Users with no Cancer Diagnosis History (N = 1,815)
% Diagnosis History of Opioid Abuse/Dependence (N = 1,359)
40%
30%
20%
10%
0%
10-19
20-29
30-39
40-49
50-59
60-69


Opioid Use by Gender (NCACH Region)
% Opioid Users with no Cancer Diagnosis history (N = 9,764)
% Heavy Opioid Users with no Cancer Diagnosis History (N = 1,742)
% Chronic Opioid Users with no Cancer Diagnosis History (N = 1,815)
% Diagnosis History of Opioid Abuse/Dependence (N = 1,359)
70%
60%
50%
40%
30%
20%
10%
0%
Female
Male


Opioid Use by Race/Ethnicity (NCACH Region)
% Opioid Users with no Cancer Diagnosis history (N = 9,764)
% Heavy Opioid Users with no Cancer Diagnosis History (N = 1,742)
% Chronic Opioid Users with no Cancer Diagnosis History (N = 1,815)
% Diagnosis History of Opioid Abuse/Dependence (N = 1,359)
80%
60%
40%
20%
0%
Non Hispanic White
Non Hispanic AI/AN
Non Hispanic Black
Hispanic
Other/UNK

Opioid Treatment



North Central Accountable Community of Health

Project Performance Measures

- Antidepressant Medication Management*
- Child 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
- Follow-up After Discharge from ED for Mental Health
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence
- Follow-up After Hospitalization for Mental Illness
- Inpatient Hospital Utilization
- Medication Management for People with Asthma (5 – 64 Years)*
- Mental Health Treatment Penetration (Broad Version)
- Outpatient ED Visits per 1000 Member Months
- Plan All-Cause Readmission Rate (30 Days)
- Substance Use Disorder Treatment Penetration
- Percent Homeless (Narrow definition)
- Percent Arrested
- Medication Assisted Therapy (MAT): With Buprenorphine or Methadone*
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedatives prescriptions
- Substance Use Disorder Treatment Penetration (opioid)
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)*

North Central Accountable Community of Health

High-Value Performance Measures

Metric	2A: Integration	2B: Pathways	2C: Transistional	2D: Diversion	3A: Opioid	3D: Chronic	Demonstration Projects
Outpatient Emergency Department Visits per 1000 Member Months	1	1	1	1	1	1	6
Inpatient Hospital Utilization	1	1	1		1	1	5
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence	1	1	1				3
Follow-up After Hospitalization for Mental Illness	1	1	1				3
Percent Homeless (Narrow Definition)		1	1	1			3
Plan All-Cause Readmission Rate (30 Days)	1	1	1				3
Substance Use Disorder Treatment Penetration	1	1					2
Mental Health Treatment Penetration (Broad Version)	1	1					2
Child and Adolescents' Access to Primare Care Practitioners	1					1	2
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	1					1	2
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1					1	2
Comprehensive Diabetes Care: Medical Attention for Nephropathy	1					1	2
Medication Management for People with Asthma (5-64 years)	1					1	2

Discussion Questions

As our project workgroups work on recommending evidence-based approaches and priority populations…

- What potential populations do you recommend they target?
- What populations/issues should they look further into?
  - e.g. gender, race/ethnicity, age, specific health conditions
- What questions and data gaps should they dig into?
- Any other takeaways you want us to relay to workgroups?

North Central Accountable Community of Health