Medicaid Demonstration Project Planning Update

Chelan Douglas Coalition for Health Improvement

9/21/2017 Meeting
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
## Projects and general target populations

<table>
<thead>
<tr>
<th>Bi-Directional Integration</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>General target population (as defined by HCA)</strong></td>
<td>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).</td>
</tr>
</tbody>
</table>
# Projects and general target populations

<table>
<thead>
<tr>
<th>Community-Based Care Coordination (aka HUB)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td><strong>General target population (as defined by HCA)</strong></td>
</tr>
</tbody>
</table>
## Projects and general target populations

<table>
<thead>
<tr>
<th><strong>Transitional Care</strong></th>
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<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.</td>
</tr>
<tr>
<td><strong>General target population (as defined by HCA)</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
### Diversion Interventions

<table>
<thead>
<tr>
<th>Objective</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>General target population (as defined by HCA)</td>
<td>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.</td>
</tr>
</tbody>
</table>
Projects and general target populations

<table>
<thead>
<tr>
<th>Addressing the Opioid Use Public Health Crisis</th>
</tr>
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<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td><strong>General target population (as defined by HCA)</strong></td>
</tr>
</tbody>
</table>
Projects and general target populations

<table>
<thead>
<tr>
<th>Chronic Disease Prevention and Control</th>
</tr>
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<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td><strong>General target population (as defined by HCA)</strong></td>
</tr>
</tbody>
</table>
Results: The CHNA process ultimately resulted in the identification of four health needs for our region:

- Mental Health Care Access: 38
- Access to care: 25
- Education: 25
- Obesity: 16
- Affordable Housing: 15
- Drug and Alcohol Abuse: 14
- Access to Healthy Food: 11
- Diabetes: 5
- Homelessness: 2
- Pre-Conceptual and Perinatal Health: 2
- Transportation: 1
- Suicide: 0
- Accidents/Homicide: 0
- Sexually Transmitted Infections: 0
- Cancer: 0
- Lung Diseases: 0

The results of the CHNA help guide decisions regarding:
- CDHD project choices
- Project selection by the NC ACH
- Hospital community benefit spending
Overall Population Demographics

**Chelan County (N=75,030)**

- **Gender**
  - Female: 50%
  - Male: 50%

- **Race**
  - AI/AN: 2%
  - Asian: 1%
  - Black: 1%
  - Multiracial: 2%
  - NH/PI: 0.2%
  - White: 94%

- **Ethnicity**
  - Hispanic: 29%
  - Not Hispanic: 71%

- **Age**
  - 0-17: 24%
  - 18-24: 8%
  - 25+: 68%

**Douglas County (N=39,990)**

- **Gender**
  - Female: 50%
  - Male: 50%

- **Race**
  - AI/AN: 2%
  - Asian: 1%
  - Black: 1%
  - Multiracial: 2%
  - NH/PI: 0.2%
  - White: 94%

- **Ethnicity**
  - Hispanic: 31%
  - Not Hispanic: 69%

- **Age**
  - 0-17: 26%
  - 18-24: 9%
  - 25+: 66%

*Source: Office of Financial Management (Measurement period = 2015)*
Medicaid Population Demographics

**Chelan County (N=26,097)**

- **Age Group**
  - Adult (19+): 48% (12,538)
  - Child (<19): 52% (13,559)

- **Gender**
  - Female: 52% (13,497)
  - Male: 48% (12,600)

- **Ethnicity**
  - Hispanic: 42% (11,072)
  - Not Hispanic: 58% (9,981)
  - Unknown: 19% (5,044)

- **Race**
  - Al/AN: 1% (237)
  - Asian: 1% (191)
  - Black: 1% (173)
  - NH/PI: 0% (117)
  - White: 52% (13,561)
  - Multiracial: 0% (117)
  - Other: 32% (8,231)
  - Unknown: 15% (3,470)

**Douglas County (N=13,532)**

- **Age Group**
  - Adult (19+): 43% (5,772)
  - Child (<19): 57% (7,750)

- **Gender**
  - Female: 59% (7,117)
  - Male: 47% (6,415)

- **Ethnicity**
  - Hispanic: 47% (6,311)
  - Not Hispanic: 53% (4,947)
  - Unknown: 17% (2,274)

- **Race**
  - Al/AN: 1% (157)
  - Asian: 1% (98)
  - Black: 1% (84)
  - NH/PI: 1% (77)
  - White: 49% (6,665)
  - Multiracial: 1% (92)
  - Other: 34% (4,633)
  - Unknown: 13% (1,746)

*Source: Healthier Washington Dashboard (Measurement period = 10/1/2015 – 9/30/2016)*
Social & Environmental Determinants of Health

Percent of People Living in Poverty

<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>NCACH</th>
<th>Chelan</th>
<th>Douglas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12.2%</td>
<td>15.3%</td>
<td>12.7%</td>
<td>13.5%</td>
</tr>
</tbody>
</table>

Estimated Median Household Income

<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>NCACH</th>
<th>Chelan</th>
<th>Douglas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$64,080</td>
<td>$53,604</td>
<td>$51,400</td>
<td></td>
</tr>
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</table>

Unemployment Rate

<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>NCACH</th>
<th>Chelan</th>
<th>Douglas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.98%</td>
<td>4.91%</td>
<td>4.48%</td>
<td>4.80%</td>
</tr>
</tbody>
</table>

Unaffordable Housing

<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>NCACH</th>
<th>Chelan</th>
<th>Douglas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>37.13%</td>
<td>29.63%</td>
<td>32.30%</td>
<td>29.19%</td>
</tr>
</tbody>
</table>

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

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

*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*
Adult (18+) Chronic Diseases

**Chelan County**
- Cancer: 15 (Chelan), 12 (WA State)
- Arthritis: 25 (Chelan), 25 (WA State)
- Heart disease: 4 (Chelan), 6 (WA State)
- Diabetes: 9 (Chelan), 9 (WA State)
- Asthma: 10 (Chelan), 10 (WA State)

**Douglas County**
- Cancer: 11 (Douglas), 12 (WA State)
- Arthritis: 26 (Douglas), 25 (WA State)
- Heart disease: 9 (Douglas), 6 (WA State)
- Diabetes: 10 (Douglas), 9 (WA State)
- Asthma: 8 (Douglas), 10 (WA State)

Behavioral Health

Behavioral Health Measures Where NCACH Below State Average

- Substance Use Disorder Treatment Penetration
- Mental Health Treatment Penetration (broad)
- Follow-up After Discharge from ED for Mental Health (7 day)
- Follow-up After Discharge from ED for Mental Health (30 day)
- Antidepressant medication management - continuation
- Antidepressant medication management - acute

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

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)

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)
Opioid Treatment

Medication Assisted Treatment Across ACHs

- Percent Receiving Medication Assisted Treatment with Buprenorphine (%)
- Percent Receiving Medication Assisted Treatment with Methadone (%)

[Graph showing the percentage of individuals receiving medication-assisted treatment with Buprenorphine and Methadone across different ACHs.]
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)*
# High-Value Performance Measures

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