2D: Transformation Project Description: Diversion Interventions

Introduction Current State

Throughout the North Sound region, many of our most vulnerable and medically compromised residents have overlapping physical health, mental health, substance use disorder, housing instability, and legal challenges, resulting in repeated, often avoidable contact with the emergency system, including emergency medical services (EMS) and law enforcement. While reducing the likelihood of individuals receiving coordinated and consistent care and increasing their risk of homelessness, arrest, and serious illness, this frequent contact also has a negative impact on health and community systems such as hospital emergency departments (ED) and our county jails -- overburdening staff and increasing costs.

These costs are felt by the Medicaid system as a whole, and costs are disproportionately impacted by high-risk, "high utilizer" individuals' use of health systems and resources: a recent study published by Kaiser Permanente Community Benefit indicated that high utilizers account for only 5% of Medicaid enrollees, yet account for more than 50% of overall program spending.[1] Local emergency medical care and law enforcement systems also lack the staff and administrative capacity to provide the high-intensity, cross-sector care planning needed to provide appropriate, effective care and result in positive health outcomes for high utilizer community members with complex needs.

Throughout our region, many of the most vulnerable and medically compromised residents have overlapping legal, medical, behavioral health, and housing instability issues compounded by chronic disease that result in repeated, expensive, and often avoidable contact with the emergency medicine, crisis care, and criminal justice systems. However, health systems and EMS partners across the North Sound ACH region believe that the avoidable use of these high-cost health care resources can be prevented by providing appropriate alternatives through EMS and community-based care coordination.

Target Population

The target population for Diversions Intervention strategies is Medicaid eligible and Medicaid enrolled persons in the North Sound region who have complex medical and social needs, as well as frequent contact with law enforcement and/or EMS providers. In our region, this population will include individuals with complex co-occurring diagnoses including mental health challenges, substance use disorder, or chronic illnesses (such as diabetes, heart disease, or asthma), individuals who access the EMS system for a non-emergent condition, who may also be experiencing social barriers to health like housing instability, transportation barriers, and lack of employment.

As required during the 2018 planning period, North Sound ACH staff will conduct further statistical analysis and facilitate planning processes necessary for final target population selection due in June 2018. The North Sound ACH will work with implementation planning teams, Community Leadership Council and the Data and Learning Team to use the best available research, regional data, and community input to identify a final high-need target population, with consideration for how strategic investments can impact performance metrics during the Medicaid Transformation Project period.

Targeted Universalism[2] will be used throughout the planning phase as an approach and analysis framework for selecting target populations to ensure that health equity features strongly in this process. Targeted

[1] https://www.chcs.org/media/HighUtilizerReport_102413_Final3.pdf

[2] Targeted Universalism is a different way—a powerful way—to make the transformational changes we need. Changes we need to improve life chances, promote inclusion, and enhance and sustain equitable policies and programs. Means setting

Universalism will be applied when measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriately targeted strategies.

North Sound ACH staff will continue to collaborate with ACH's across the state and the Health Care Authority's AIM Team to identify shared data-driven processes and target population selection methodology. To maximize the reach and impact of the demonstration projects and increase the likelihood of region-wide success in moving the metrics, the North Sound ACH aims to align target populations across the project portfolio.

The North Sound ACH used a common format for each project area to summarize the anticipated reach of target population(s) and identify performance metrics and health disparities project strategies aim to impact, as follows below.

<table>
<tr><th colspan="2">North Sound Project Area Reach & Impact
Project Area 2D: Diversion Interventions</th></tr>
<tr><td colspan="2">Potential Target Population Reach:
• 7,418 Adults (18+) who experienced homelessness
• 4,715 Adult (18+) who were incarcerated
• 40,626 diagnosed with a Mental Illness and one or more chronic condition
  ○ 14,651 diagnosed MI and any cardiovascular condition
  ○ 14,238 diagnosed MI and any pulmonary condition
  ○ 4,330 diagnosed MI and Type 1 or Type 2 Diabetes
• 20,135 diagnosed with a Substance Use Disorder and one or more chronic condition
  ○ 8,335 diagnosed SUD and any cardiovascular condition
  ○ 7,410 diagnosed SUD and any pulmonary condition
  ○ 2,001 diagnosed SUD and Type 1 or Type 2 Diabetes
• 52,634 diagnosed with Serious Mental Illness (SMI)
  ○ 10,893 Disabled, 5,970 Non-Disabled Adults, 20,297 Newly Eligible Adults, 12,374 Non-Disabled Children, 3,100 Elders
• 37,279 diagnosed with asthma, COPD (Pulmonary, low)
  ○ 5,997 Disabled, 3,280 Non-Disabled Adults, 11,406 Newly Eligible Adults, 13,159 Non-Disabled Children, 3,437 Elders
• 32,100 diagnosed with hypertension (Cardiovascular, extra low)
  ○ 6,727 Disabled, 2,620 Non-Disabled Adults, 11,406 Newly Eligible Adults, 461 Non-Disabled Children, 7,688 Elders
• 22,390 diagnosed with Type 1 or 2 diabetes
  ○ 5,868 Disabled, 1,501 Non-Disabled Adults, 8,080 Newly Eligible Adults, 608 Non-Disabled Children, 6330 Elders</td></tr>
<tr><td>Project Area Impact:</td><td></td></tr>
<tr><td>Performance Measures
• Average of 44 ED visits per 1,000 member months</td><td>Geographic Disparities
• Island County has an average of 59 visits per 1,000 member months (15 visits higher than ACH average)</td></tr>
</table>

universal goals that can be achieved through targeted approaches. Ultimately, this approach shows how a universal goal can be a good thing, but a one size fits all approach is not always the solution. John Powell, Haas Institute, 2017

• Of the 7,940 Medicaid patients arrested in 2015, 4,715 had mental health service needs.
• 12% of the 7,418 homeless had mental health service needs
• Rates of homelessness among Medicaid enrollees has increased since 2014
	• Snohomish county has the highest rate (6%) of enrollees with SUD and more than one chronic condition.
	• 12% of enrollees with a mental illness have more than one chronic condition with in Whatcom and Island counties.
	Demographic Disparities
	• Among the 27,596 Medicaid enrollees diagnosed with depression:
	  o 77% are White
	  o 66% are women
	  o 85% were adults (19+)
	• American Indian/Alaskan Natives were 2x more likely to not receive follow-up care after hospitalization for mental illness
	• Individuals identified a Black (68% more likely) or American Indian/Alaskan Native (39% more likely) are more likely to have experienced homelessness.
	• 38% more likely to be arrested if self-identified Black and 156% more likely to be arrested if self-identified as American Indian Alaskan Native.
	Co-morbid Disparities
	• Patients with Substance Use Disorder almost 5 times more likely to be arrested.
	• Greater than 3 Emergency Department Visits:
	  o 2x more likely if any Mental Health Need
	  o 2.5x more likely if Severe Mental Illness
	  o 3.4x more likely if Substance Use Disorder Treatment Need
	  o 4.5x more likely when Co-Occurring MI/SUD"
	  o 3x more likely if diagnosed with Type 1 Diabetes, w/o complications
	  o 2x more likely if diagnosed with Type 2 Diabetes and Asthma/COPD.

Data Sources: 1) RHNI Starter Kit, HCA, released May 8, 2017. 2) Measure Decomposition Data, RDA/DSHS, released July 7, 2017. 3) ACH Toolkit Historical Data, HCA, released August 17, 2017. 4) ACH Profiles: ESA Profiles Program Participants, RDA/DSHS, released September 22, 2017. 5) BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017.	

Alignment with Regional Priorities

This project area aligns with regional priorities as identified in the most recent Community Health Needs Assessments, Community Health Improvement Plans, and Community Health Assessments conducted by counties, hospital systems, and community-based organizations in our region - specifically around reducing homelessness and increasing access to supportive housing services, improving regional safety, and increasing access to crisis care for behavioral health. Additionally, many local communities have identified homelessness as a growing crisis, and have dedicated (or are planning to dedicate) significant resources toward addressing this issue. Strategies in the Diversion Interventions project area will focus not only on

reducing unnecessary Emergency Department Utilization, but also reducing homelessness and unnecessary criminal justice encounters.

Project Strategies

Recognizing the current burden to North Sound's health and community systems due to the lack of high-intensity, cross-sector care plans that address high utilizers' needs, North Sound ACH will support coordinated and wrap-around care through community paramedicine and complex case care coordination. Both strategies will improve health outcomes for high-risk, high utilizer individuals in our region, and use a patient-centered, evidence-based approach to meeting the complex needs of these community members, as well as address regional priorities like homelessness. Both strategies engage first responders as key partners, on both the Fire and Police continuums.

The goals of this project are to improve health outcomes for the target population by supporting the development and implementation of coordinated systems that address the complex needs of high utilizers. This includes improving access and care coordination for people with complex needs, which should also result in reduction of unnecessary cost and inappropriate utilization in health care, social service, criminal justice, and emergency systems.

1. Expansion of Community Paramedicine Program

While emergency services are a critical component of the health care system, they are too frequently used to treat unmet, rather than emergent, needs with high-cost, short-term solutions. Connecting patients with appropriate care that address complex medical needs using long-term, coordinated solutions is essential to improving health outcomes while also reducing unnecessary cost and utilization. This ultimately impacts individual outcomes, while also ensuring resources can be targeted to population health needs by enabling health systems to respond in effective and efficient ways.

Community Paramedicine programs serve as a bridge between Emergency Departments (EDs) and long-term case management and care providers. Community Paramedics act as an alternative to EDs, by working in partnership with other social service agencies to expedite coordinated care and referrals. Because community paramedics can meet community members where they live, they are better able to identify and address barriers to accessing care and addressing health challenges, as well as broader social determinants of health. Successful community paramedicine programs focus on efficiency and effectiveness in connecting people with timely and appropriate levels of care, therefore reducing the overall strain placed upon the emergency health care system. Community Paramedicine programs also have the potential for decreasing the burden placed on clinics, allowing them to offer more in-home care options, resulting in improved overall care management and enhancing the patient experience.

Community Paramedicine programs have the potential to significantly improve the health of underserved and vulnerable populations, which has been demonstrated by current pilot projects within the North Sound region, in Snohomish and Whatcom counties.

Existing Work

There are two community paramedicine programs currently in operation in the North Sound region: one in Whatcom County, and one in Snohomish County.

- *Community Paramedic Program in Whatcom County (Bellingham Fire Department):* The Community Paramedic program of the Bellingham Fire Department was established in 2014. The purpose of the program is to help connect frequent utilizers of 911 services for non-emergent medical needs to more appropriate services. The benefit of the program is two-fold-- citizens are connected to medical and social services that better meet their needs and it creates capacity for the Fire

Department to more quickly respond to true emergencies. The Community Paramedic program most frequently serves citizens dealing with complex medical issues including substance abuse, mental illness and complications related to aging, disability, fall-risk and homelessness by assessing their needs and coordinating their care with appropriate community resources.[3]

- *Snohomish County (Fire District 1):* The Community Paramedic Program in Fire District 1 began in 2014 as the first program of its kind in the state. It is funded by a grant from Verdant Health Commission. South Snohomish County Fire & Rescue (SSCFR) partners with Compass Health to identify and assist area residents whose needs go beyond a simple medical fix. Patients who have called 911 two times in 24 hours or three times over 30 days are automatically referred to the program. Hospital and social service staff may also make referrals. The community paramedic follows up with at-risk patients through a telephone call or a home visit to identify underlying causes and needs related to the use of 911 services. In addition to a medical assessment, a home safety survey is conducted to prevent falls and other risks. A mental health counselor and a peer counselor from Compass Health work out of SSCFR headquarters to assist in responding to behavioral and social service needs. SSCFR partners with more than 50 social service agencies that can provide patients with non-medical assistance that is often less costly and more effective in meeting their true needs. The goal is to help clients remain in their home. The program is free to patients – part of the services paid for through property taxes that support SSCFR. The Snohomish County Community Paramedic program currently serves around 300 individuals.[4]

2. Care Coordination Collaboratives for Complex Cross-System Cases

When persons in the target population require engagement efforts that exceed the scope of the Community Paramedic program, they will be referred for Care Coordination of Complex Cross System Cases. The cross-system diversion and care management component of this project area is a collaborative among existing and developing local hub-and-spoke networks engaged in cross-system identification and care coordination of complex cases, to enhance and link networks. The intent is to support local care coordination structures by pooling resources for shared functions and utilities, particularly around tools for information sharing and methods of engagement of complex, high-cost individuals.

Two programs will be used as the models for this project: the Chronic-Utilizer Alternative Response Team (CHART) in Everett for cases referred from law enforcement, fire, hospital and corrections, and the Ground-level Response and Coordination Engagement (GRACE) in Bellingham which provides intensive case management for people experiencing homelessness and 911 high utilizers. Both programs have been operating in some capacity for more than two years, demonstrating promising results that will be expanded to meet the Project 2D performance metrics across the North Sound Region.

Existing Work

There are currently two community paramedicine programs in operation in the North Sound region: GRACE in Whatcom County and CHART in Snohomish County.

- *Ground-level Response and Coordinated Engagement (GRACE):*
  GRACE blends elements of the Law Enforcement Assisted Diversion model (LEAD) and the Jail Transition and Emergency Department Diversion models, while incorporating homeless outreach strategies to address unmet needs of high utilizers before arrest or contact with EMS. GRACE represents a partnership among the City of Bellingham, Whatcom County Health Department, the Opportunity Council, PeaceHealth St. Joseph Medical Center, and Whatcom Alliance for Healthcare Advancement targeting Whatcom County residents who have frequent contact with police, fire,

[3] https://www.cob.org/gov/dept/fire/Pages/community-paramedic.aspx

[4] http://www.firedistrict1.org/our-services/emergency-medical-services/community-paramedic

hospitals, courts and jail. GRACE provides connections to behavioral and physical health services and treatment to address underlying causes, or unmet needs, that result in avoidable high-utilization of services. Community-based case managers coordinate with law enforcement, fire, corrections, emergency medical providers, and hospitals to collaborate on strategies to meet patients utilizing multiple systems, in order to provide a coordinated approach to services, prevent unnecessary use of emergency departments, reduce duplication, and track and manage care.

- *CHronic-Utilizer Alternative Response Team (CHART):*
  The CHART program consists of a team of criminal justice, emergency response, social service, and research partners collaborating to reduce the impact of chronic utilizers on those systems. CHART also contains elements of the LEAD and the Jail Transition and Emergency Department Diversion models. The CHART program's goal is to decrease the system impacts associated with the disproportionate overlapping service utilization by high-risk, high utilizer individuals, and improve the lives and health outcomes for these individuals. In Snohomish County, a core team consisting of representatives from the Everett Police Department, Everett Fire Department, Snohomish County Department of Human Services, Snohomish County Jail, the Everett City Attorney's Office, and Providence Regional Medical Center Everett works with patients to help craft an alternative care plan for high utilizers, such as connection to substance use disorder treatment and mental health services, public defenders, social workers, or other medical professionals. The CHART program has identified five systems that were typically over utilized: Police, Fire, Courts, Jail and the Emergency Department. Their clients were those who had more than six contacts with three or more of the systems above in a six-month time frame. Many of the clients had no interaction with services outside of the five systems listed above, and due to lack of information sharing between the five agencies, little was known about the severity of needs. Many clients were using jail as a housing option, and with little to no family or other source of support, many relied on EMS to meet their medical needs that could be otherwise met in a physical health care setting, exacerbating ED usage and overburdening EMS services. CHART has shown great promise in meeting its goal of reducing unnecessary and repeated systems' utilization among the target population and early results are promising, including a 78% decrease in arrests, an 80% decrease in Emergency Medical Service contacts and a 92% decrease in jail days for CHART participants, saving costs to taxpayers and freeing up those services to respond to emergencies.[5]

The North Sound ACH plans to build on successes in other regions as well. For example, the Harborview High Utilizer Case Management Team in King County has shown success with a Care Coordination for Complex Cross System Cases project, and reports that regular meetings of providers across sectors has resulted in better care for high-risk, high utilizer patients. Two programs similar to CHART and GRACE, King County's Familiar Faces program and a high utilizer care collaborative through Pierce County Fire & Rescue have shown promise at meeting the needs of complex high utilizers, improving health outcomes, and reducing the burden to EMS and law enforcement systems. Collaborating across regions will be essential to identifying and implementing best practices and lessons learned to ensure high-quality, high-impact programs that improve the lives of North Sound residents and Washingtonians.

Population Health Management and Data Sharing

Taken together, the two components of this project area (Community Paramedicine and Care Coordination of Complex Cross System Cases) are expected to significantly impact the performance measures associated with this project area (Outpatient ED visits per 1000 member months, Percent Homeless, and Percent Arrested). However, true project success will be difficult to achieve without changing the way that health information is shared across sectors. A key transformative piece of this Diversions project, in conjunction

[5] https://everettwa.gov/DocumentCenter/View/6958

with other proposed projects of the North Sound ACH, is the potential for organizing cross-system, patient-centered collaboration among local networks, supported by real-time data sharing and care planning technologies, as well as the opportunity to braid funding from multiple sources (city, county, state, federal and private) on behalf of shared goals for health and public safety. Existing Health Information Exchange technologies in use in this region will be examined to assess if they can be expanded or used more effectively to support high utilizer populations, such as EDIE/Pre-Manage and Image Trend. Health information Technology and data sharing transformation in this project area will link closely with similar efforts happening in all project areas, especially the Community-Based Care Coordination (around the Pathways Community HUB), Transitional Care, Bi-Directional Integration, Addressing the Opioid Crisis, and Chronic Disease.

Intersection with Pathways Community HUB Model

The expectation is that these strategies, once implemented, will ultimately link with the regional Pathways HUB, serving as contracted care coordination agencies (CCAs), and using interoperable or shared data systems and standard pathways operational protocols. Likely pathways utilized will be Behavioral Health, Housing, Medical Home, Medication Management, and Social Service Referral. Partners already engaged in five communities in the North Sound region (Everett, South Snohomish County, Lynnwood, Whatcom County, and Skagit County) include first responders (fire, paramedic and law enforcement), hospital systems, health providers, social service providers, corrections, housing agencies and local government.

ACH Role & Supports to Partners

The North Sound ACH will improve health in the region by supporting the creation of community supports for high-risk, high-utilizer Medicaid enrollees that prevents and provides alternatives to the Emergency Department and incarceration. This work will occur in the highest-risk, highest-cost settings of care. Partner organizations directly serving Medicaid enrollees who engage with emergency services or law enforcement will implement the strategies selected for this project area, and the North Sound ACH's role will be to support them in doing so successfully and with maximum impact in the target populations (which will be finalized in 2018).

Examples of roles the ACH will play in establishing the diversion infrastructure in the North Sound Region include:

- Working with partners to identify and address challenges in engaging the target populations;
- Acting as convener for regular cross-sector collaboration meetings during the planning and implementation phases;
- Working with leadership of partner organizations to:
    - increase protected time for trainings (including trainings in cultural humility, which the ACH would likely not lead, but can assist in connecting providers with trainers and potentially provide financial support)
    - identify opportunities for partners to see organizational budget savings based on improved efficiency
    - achieve buy-in to transformative change of front-line staff;
- Developing and brokering relationships between emergency service providers and social service providers to expand the resources available to Medicaid enrollees;
- Collaborating with MCOs and delivery system leadership to develop funding mechanisms that solve reimbursement challenges;
- Facilitating the use of interoperable HIT and Release of Information agreements across partners;
- Demonstrating the financial value of these interventions to funders, health systems, and other stakeholders who can potentially provide additional, sustainable financial support;

- Considering the needs of the entire North Sound Region to ensure that strategies are implemented which promote access to services for Medicaid enrollees in rural and remote areas as well as urban areas;
- Sharing learnings from other ACH regions with planning partners when developing implementation plans.

Metrics

The strategies in this project area are intended to positively impact the Outpatient ED visits measure. Both strategies will address Pay for Reporting metrics like active care plans, HIE, scaling up the number of partners participating, and increasing partner capacity. The Care Coordination for Complex Cross System cases will be the primary strategy to address the Pay for Performance metrics of Percent Homeless and Percent Arrested, but collaboration with work happening across project areas will be essential to truly impacting these outcomes.

Health Equity

This project will serve populations experiencing complex health challenges, including poverty, housing instability, chronic pain, addiction, mental health challenges, and more. Often, the communities hardest hit by these challenges are people of color, and people who have come from generational poverty. Dedicating resources to meet the needs of these populations and think creatively about mechanisms to improve systems to better help people and their families find health and stability can make a significant impact on health disparities and inequity in our communities. Paramedics and care coordinators will need to be trained in cultural humility, motivational interviewing, and how to recognize implicit bias when supporting patients.

Lasting Impacts

By demonstrating success in diverting high utilizers from Emergency Departments and law enforcement when appropriate, as well as establishing coordinated care teams across sectors to support high-need community members, this project has the potential to create lasting change, and significantly improve health outcomes while reducing costs for hospitals, law enforcement, and emergency medical service providers. Additionally, this project will likely increase the target population's connection to physical health care providers, reduce jail time and prevent additional criminal charges, while providing an important connection to social services, including housing.

This project is also poised to provide benefits to the Medicaid population in the North Sound region through increasing the capacity of EMS and emergency departments to respond to other emergency needs; by dramatically reducing costs across the Medicaid system; and by implementing care coordination for high-risk community members, which can result in decreased homelessness, a priority for the North Sound region.

2D: Partnering Providers

The organizations and stakeholders listed in the Partnering Providers Tab of the Supplemental Workbook represent partners who have been substantively engaged in the project planning workgroups to date, or that we expect will be engaged in the planning phase in 2018. Some, but not necessarily all of these partners will eventually be entered into the financial executor portal to receive payment.

In the Diversion Interventions project area, the North Sound ACH has a high level of engagement from the region's Emergency Medical Services (EMS) leadership, especially regional Fire Chiefs, as well as representatives of county governments responsible for institutional oversight for target facilities and essential

to realizing a successful project plan. Workgroup leads includes representatives from the Arlington Fire Department, and Whatcom County Human Services.

In Spring 2017, the North Sound ACH began moving from broad stakeholder engagement into workgroups, comprised of potential partnering providers who serve or are interested in serving the Medicaid population. Eight workgroups were formed, with an open invitation extended to providers and stakeholders who wanted to engage. These included behavioral health and substance use disorder (SUD) providers, community-based organizations, county health and human services and public health leaders, physical health care providers, tribal partners, health systems, and Managed Care Organizations. Two or more subject matter experts were invited to serve in a lead role for each workgroup, which were supported by North Sound ACH staff. As information from HCA became available, the focus and process for workgroups evolved accordingly. An initial inquiry was made for workgroup members and coalitions to draft *Statements of Interest* highlighting their individual interest and ideas for project frameworks. Staff and workgroup leads compiled these submissions to produce the outlines of a regional approach in each area.

Workgroups further honed these ideas at monthly face-to-face meetings with remote access for those who could not join in person. North Sound ACH staff encouraged workgroups to focus on guidance from the Project Toolkit, including indicated target populations and seeking a strategy capable of incorporating participation from partnering providers, aiming to move the region's Pay for Performance metrics. This dialogue included the subpopulations indicated in the toolkit and the partnering providers necessary to reach them. Due to the open and inclusive nature of stakeholder engagement in the workgroups, a broad spectrum of partnering providers are represented in the Supplemental Workbook and remain a value for future engagement.

Concurrently, a self-formed group of health system primary care leaders agreed to become an advisory body to staff, wherein staff facilitate regular meetings, assist with scheduling, agendas and note-taking. This Health System Advisory Coalition includes leadership from the largest hospital systems providing primary care in the region, regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. The group has self-reported coverage of more than 205,000 Medicaid primary care assignees in the region. Staff are continuing with further outreach to other partnering providers, including those located in more rural settings and smaller in size. These efforts form the foundation of the strategy to assure inclusion of physical health providers serving a significant majority of the Medicaid population, similar to the reach that the North Sound BHO has with providers working in BH and SUD settings.

The North Sound ACH recognizes the importance of Managed Care Organizations to the success of Medicaid Transformation in our region. Managed Care Organization partners are engaged at the Board of Directors, the Program Council and represented in each of the workgroups, including serving as leads in the areas of Care Transitions and Chronic Disease. MCO partners have thus provided significant expertise and guidance to the project planning to date and will continue to do so throughout. In the case of Care Coordination, the North Sound ACH has participated in a series of meetings with MCO partners and representatives of the region's Health Home providers regarding coordination of these services in the development of the Pathways HUB. Through existing channels of governance and the workgroup format, the North Sound ACH will consult and leverage MCO expertise in project planning and eventual implementation, while simultaneously avoiding duplication.

2D: Regional Assets, Anticipated Challenges and Proposed Solutions

Assets

The foundation of the regional assets that will support this project is the collaborative nature of the diverse partners working to improve health in the North Sound region. Since the inception of the North Sound ACH,

organizations that have traditionally competed with each other have come together to collaboratively plan the transformation of our regional health system. Diversion intervention strategies will build on the many assets in our region, including strong commitments from diverse partners to meet the needs of complex, high-need community members and connecting them to appropriate support services, while reducing strain on emergency services and the criminal justice system.

Key assets for this project area include:

- **Pending Legislation**
  Legislation is pending that would support Community Paramedics, including legislation that would provide legal liability release for EMS to allow paramedics to transport patients to a non-Emergency Department destination such as a physical health care clinic or behavioral health provider and legislation that would allow EMS providers to be reimbursed for community work. The North Sound ACH will continue to advocate for policy change that will enable our systems to more effectively meet the needs of community members.

- **Pilot Program Success**
  The success of pilot programs for both Community Paramedicine (in Whatcom and Snohomish counties) and care coordination for complex cross-system cases (CHART and GRACE) present strong assets for this project area. These programs have a strong potential for scalability and broader scope of practice. Lessons learned from these pilots will guide the planning and implementation phases for this project area.

- **Broad Cross-Sector Support**
  The North Sound region has a strong network of diverse partners that will work together to support some of our community's highest need, vulnerable members. This support includes both dedicating staff time, expertise, resources, and funding toward standing up and sustaining Community Paramedicine and Care Coordination for Complex Cross-System Cases beyond the Medicaid Transformation Project.

Additional regional assets include (but are not limited to):

- **Clinical Service Delivery and Expertise**
  Our region has many medical and behavioral health providers, particularly emergency care providers, that are an asset to work in this project area:
  - 911 Emergency Support Services
  - Advanced Life Support (ALS) providers across five counties
  - Community Paramedicine programs (Bellingham and Snohomish County)
  - Hospitals and Emergency Departments (such as Providence, PeaceHealth, Skagit Regional, Swedish, and Island)
  - Primary Care Providers (such as Family Care Network)
  - Federally-Qualified Health Centers (such as Sea Mar, Unity Care NW, and Community Health Center of Snohomish County)
  - Behavioral Health Service providers (such as the North Sound BHO, Compass Health, and Sunrise Services)
  - Skilled Nursing Facilities
  - Tribal Health Clinics (including substance use disorder treatment)
  - Managed Care Organizations

- **Nonclinical Service Providers and Expertise**

In the North Sound region, there are community-based organizations with extensive experience in serving high-risk, high utilizer populations with culturally appropriate services. Many of these organizations work closely with EMS/Fire and law enforcement agencies including:

- Law Enforcement (Police and Sheriffs, including Tribal law enforcement)
- Jails (including Tribal jails)
- Court Systems
- County Human Service departments
- Community Action Agencies (the Opportunity Council, Community Action of Skagit County, Snohomish Community Action Partnership)
- Homeless Outreach Service Providers
- Transportation services (such as taxi services, public transit)
- Housing services (such as the Opportunity Council, Lydia Place, Catholic Community Services, Mercy Housing, etc.)
- Homeless shelter providers (such as Lighthouse Mission)
- Other social service organizations
- Charitable faith-based organizations
- Food Banks
- Veteran Support Services

- **Data, Analytic Tools, and Infrastructure**
  Many systems and tools are in place in our region that can be leveraged or expanded on, both to improve communication between providers and systems, and provide rich sources of relevant population and patient-level data that can help the North Sound ACH target and monitor key populations, house analytic and reporting infrastructure, etc., including:
  - Emergency Department Data (EDIE)
  - EMS Data (ESO, etc.)
  - Fire Data (ESO, ZOLL, etc.)
  - Primary Care and other hospital data (EPIC, EDIE/Pre-Manage, ZOLL, etc.)
  - Jail Data (Jail Inmate Lookup Service (JILS))
  - Arrest Data (from police and sheriff departments)
  - Behavioral Health Data
  - Housing and homelessness data (Point In Time Counts, Homeless Management Information System (HMIS)

- **Workforce and Human Capital Assets**
  There is a robust clinical, and nonclinical workforce across the North Sound region, including:
  - Community Paramedics
  - Basic Life Support, Advanced EMT, Paramedics
  - Community Health Workers
  - Law enforcement (police, sheriff)
  - Jail service providers
  - Social Workers and Case Managers
  - Law-enforcement embedded social workers
  - Outreach services (for example, Opportunity Council's Homeless Outreach Team)

This region also has several education and training programs to support development of a qualified workforce, including:

- Everett Community College
- Whatcom Community College

- Skagit Valley College
- Bellingham Technical College
- Edmonds Community College
- Western Washington University

Financial Resources

The North Sound ACH intends to establish a braided funding model to support diversion services in the North Sound region, supplemented by Medicaid Transformation project funding and including the following sources:

- Managed Care Organizations
- Philanthropic and Community Development foundations such as Verdant Health Commission, United Way, Chuckanut Health Foundation, etc.
- City, county, and state funding
- Revenue from proposed state legislation

Community Relationships

Many relationships and coalitions are assets to this project in the North Sound Region. The following relationships between health care systems, emergency service providers, social service providers, law enforcement, city and county governments, and more can be leveraged to engage target communities, support patient engagement, and foster community buy-in, such as:

- Cross-Sector Coordinated Care programs for high utilizers, such as CHART and GRACE
- County Coalitions on Homelessness

CHALLENGES AND STRATEGIES TO OVERCOME THEM

Below are several of the challenges inherent in these strategies and an early assessment of ways to mitigate issues arising. All of these will depend on continuous performance monitoring and application of quality improvement techniques to resolve problems.

Anticipated Challenges	Proposed Solutions
Project has difficulty meeting performance metric targets, especially Percent Arrested and Percent Homeless	• The ACH will engage implementation planning teams in embedding tracking mechanisms in their implementation plans, including surveys, regular automated or manual reports of metrics, and other means for tracking success. Quality Improvement Plans will be integrated into the implementation strategy using rapid-cycle process improvement strategies to identify points of failure and improvement early for quick response. Quality Improvement teams will also convene, based either in the implementation planning teams or the data and learning team, to regularly review metrics and assess areas of change or improvement. • The ACH Data and Learning team will support the strategy through the development of a suite of monitoring and evaluation measures that provide an ongoing, actionable dashboard for

	project progress. Included in this will be ongoing survey-based assessments of training effectiveness and project implementation to partnering providers, regular review of clinical quality measures aligned with toolkit pay for performance measures, HCA reports on performance measure benchmarks, and other heuristic metrics for assessing project implementation success. Clinical quality measures will be pulled for tracking and quality improvement purposes, based on reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform or cloud-based registries. • Modifications to project plans will occur after the data and learning teams or implementation planning teams identify and report gaps or areas of improvement to the Program Council. ACH staff and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Managed Care Organizations could be engaged in this component, to assist ACH staff and partners in workflow redesign and lean process improvement activities. • The ACH will identify potential sources of outside technical assistance to support this process, including Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations. • Work with project partners to identify and understand barriers or limitations that contribute to the inability to meet these metrics. • Outreach to other ACHs, as well as state and national experts on reducing arrest and homeless rates, to learn successful strategies to address performance issues. • Consider investing ACH resources (including staff time) in more upstream efforts to reduce homelessness and arrest rates (investing in housing, advocacy at the city, county, and state levels, etc.)

Geographic barriers, resulting in limited capacity in more remote/rural areas and transportation barriers for Medicaid enrollees in these areas.	• The North Sound ACH will prioritize flexibility when developing implementation plans, and ensure that mobile services (such as mobile dentistry, mobile needle exchange/substance use disorder treatment, etc.), telehealth, and home visiting services are possibilities for populations in particularly rural or remote areas (such as the San Juan Islands or east Whatcom, Skagit, and Snohomish counties). • Allocate ACH resources to improve access to, use of, and reimbursement for Medicaid Transport services. • Utilize monitoring and continuous improvement processes to quickly identify when geographic barriers are impacting access to services.
Lack of affordable, available housing in the North Sound region resulting in inability to reduce homelessness, and unstable housing limits improvement in health outcomes.	• Outreach to other ACHs, as well as state and national experts on reducing homelessness, to learn successful strategies to address performance issues. • Consider investing ACH resources (including staff time) in more upstream efforts to reduce homelessness rates (investing in housing, advocacy at the city, county, and state levels, etc.)
Challenges with reimbursement for services by Apple Health (services not covered/reimbursement rate is insufficient/lack of provider understanding around billing procedures)	• Exploring sustainability with the local Managed Care Organizations will be needed to continue integrated services. • Work together with the HCA to increase the number of covered services that will support movement of performance metrics, including community-based services and EMS services • Work together with the HCA to ensure that reimbursement rates for services (especially for behavioral health services, or services for Medicaid adults) are sufficient for providers to cover their costs and continue to provide services for Medicaid patients. • Leveraging expertise from the UW-AIMS center and cross sector workgroup support can provide information on proper billing and coding.
Health Information Technology/Exchange (HIT/HIE) challenges, including interoperability of multiple systems, implementation challenges with new systems (such as Pathways), barriers to data sharing between providers/systems (including	• Utilize a mutually agreed-upon Release of Information (ROI) that can be used by partner providers in this project area, to ensure that patients' Protected Health Information (PHI)

protected health information), concerns around public disclosure and liability issues	can be shared across agencies and agencies remain HIPAA-compliant. • Set up regular data/HIT round tables with partner providers to identify concerns around HIE, data sharing, and challenges around implementing new systems. • Work together with the HCA to ensure that reimbursement rates for services (especially for behavioral health services, or services for Medicaid adults) are sufficient for providers to cover their costs and continue to provide services for Medicaid patients. • The ACH will work with partners to identify any legal or regulatory barriers to sharing data and health information across providers or systems (laws around Public Disclosure; criminal history sharing; 42 CFR Part 2, Confidentiality of Substance Use Disorder Patient Records, for example), and advocate where possible to remove these barriers. • There are some legal barriers to data sharing, including but not limited to Public Disclosure, HIPAA, and criminal history sharing, that many partners are concerned about. These concerns and legal issues will need to be addressed before the project is implemented. • Engagement with partner providers for evaluation of current capacity and needs around Medicaid reimbursement and billing. Connect partner providers with the Healthier Washington Practice Transformation Support HUB and resources through the project plan could mitigate this barrier. • In late 2017 and 2018, North Sound ACH (as the Pathways HUB) and the MCOs will design a data-sharing system that facilitates eligibility determinations and protects privacy, and the North Sound ACH will describe this arrangement in contracts with the MCOs. The ACH can draw on the experience and expertise of other Pathways HUBs and Pathways experts in doing so. • Work with leaders of the Pathways Community HUB to ensure that Pathways technology is able to integrate with existing HIT in use by partner providers.

	• Potentially leverage ACH resources to pay for data migration costs and set up of new systems, as well as staff training on the new system.
Many programs/initiatives with shared goals make it difficult to avoid overlap, or define boundaries between existing services and new services	• Meet with leadership of existing programs/initiatives to understand areas of overlap and potential synergies, as well as clear boundaries. • Tailor ACH projects to eliminate areas of overlap and target strategies to further the goals and public impact of both initiatives. • Set up regular round tables of both ACH project partners and stakeholders in this work to share learnings, avoid overlap and duplication, and identify opportunities to increase impact for all programs.
Challenges identifying long-term funding outside the Medicaid Transformation Project	• Utilizing monitoring and continuous improvement processes, regularly evaluate project performance to be able to clearly communicate project impact to potential outside funders, as well as demonstrate a commitment to effectiveness. • Collaborate with MCOs to identify opportunities that align long-term objectives and achieve total cost of care savings in line with needed investments. • Dedicate ACH resources to Identify additional funding sources, including in-kind support, local community development foundations, philanthropic foundations, other state and federal programs and “angel investors”. • Partner with other ACHs to achieve economies of scale. • Facilitate site visits for stakeholders and decision makers with ability to provide needed funds, so that the value of the models can be experienced first-hand. • Perform cost effectiveness calculations that demonstrate short and long-term savings for care settings due to transitional care planning. • Advocate for city, county, and state-level allocation of funds to cover Diversion programs for “high utilizers”, including Community Paramedicine and Cross-Sector Coordinated Care Teams. • Work together with the HCA to increase the number of covered services that will support

	movement of performance metrics, including community-based services and EMS services.

2D: Monitoring and Continuous Improvement

Summary

The North Sound ACH will implement a monitoring and continuous improvement plan, which will include quality improvement processes, that leverages existing infrastructure, such as internal clinical quality improvement (QI) teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data, as well as identifying gaps in information and explore opportunities for data collection systems with multiple ACH's. The identification and use of measures for monitoring and continuous improvement will emphasize pragmatic, real-time measurement data sources that track progress through automated systems without requiring a heavy burden of manual measurement and tracking. Methodologies used will include embedded evaluation tools and continuous quality improvement techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles, and run charts to track project success and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis in order to determine success of evidence-based approaches. When projects or approaches are identified as in need of improvement or modification by stakeholders through a deliberative process, ACH will consult with Program council and implementation planning teams to provide assistance and explore solutions before engaging with the Health Care Authority (HCA) engage in a project plan modification.

Information Management & Data Sources

Tracking measures for monitoring and continuous improvement will include data from ongoing survey-based assessments of training effectiveness and implementation milestones to partnering providers, regular review of clinical quality measures aligned with toolkit pay-for-performance measures, HCA reports on performance measure benchmarks, and other proxy metrics for assessing implementation success. While some measures will require manual tracking, such as training enrollment forms, tally sheets for workflow revisions, and manual chart review, special consideration will be given to measures that can provide real-time, automated tracking of progress that have a low-impact on partner organizations' staff time.

Project Managers will serve as liaisons and primary contacts with implementation partners, ensuring that monitoring and continuous improvement measures are submitted or collected on a monthly or quarterly basis for review by the data and learning team. As stated in Section I, Sub-section Governance, Project Managers will be assigned specific projects and groups of providers to monitor. Functions performed by Project Managers will include site visits, meetings with providers to identify successes and challenges, and periodic surveys to measure progress toward contractual goals.

The North Sound ACH will collaborate with partners to identify and capture clinical quality measures and related proxy measures for tracking and quality improvement purposes, based on automated or custom-built reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform, syndromic surveillance systems, or cloud-based registries. Because these measures use data directly managed from HIT systems they provide a nearly real-time (within 24 hours) view of performance, the ACH Data and Learning team will be able to quickly identify and respond to delays in implementation or gaps in performance. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems. A full inventory of available data sources for monitoring of implementation progress will be developed as part of the ACH current state

assessment process. Selection of measures within these data sources will be informed by the planning processes among the Implementation Teams and the North Sound ACH Current State Assessment.

As illustrated in Figure 1, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular monitoring of community feedback and indicators by the Project Managers in their capacity as Activity Leads. In the latter case, surfacing performance gaps will be a primary function of the Activity Teams. Independently and in cooperation with the team, Leads will routinely probe for indicators of lagging achievement, employing site visits, meetings with providers, and periodic surveys. When a performance gap is identified through either signal path, the Lead (i.e. the responsible project manager) will lead the Activity Team to develop a remediation plan.

In some cases, adequate remediation may be inhibited by resource constraints or sub-optimal coordination within the ACH or the community. If Leads are unable to resolve these impediments themselves (e.g. through cross-team problem solving), they will elevate unresolved issues to the Executive Director (ED). The ED will then make prioritization decisions and provide direction as necessary. When high-level or systemic obstacles are at play, the ED will request Board assistance to resolve them and then translate Board decisions into instructions for Leads to implement.

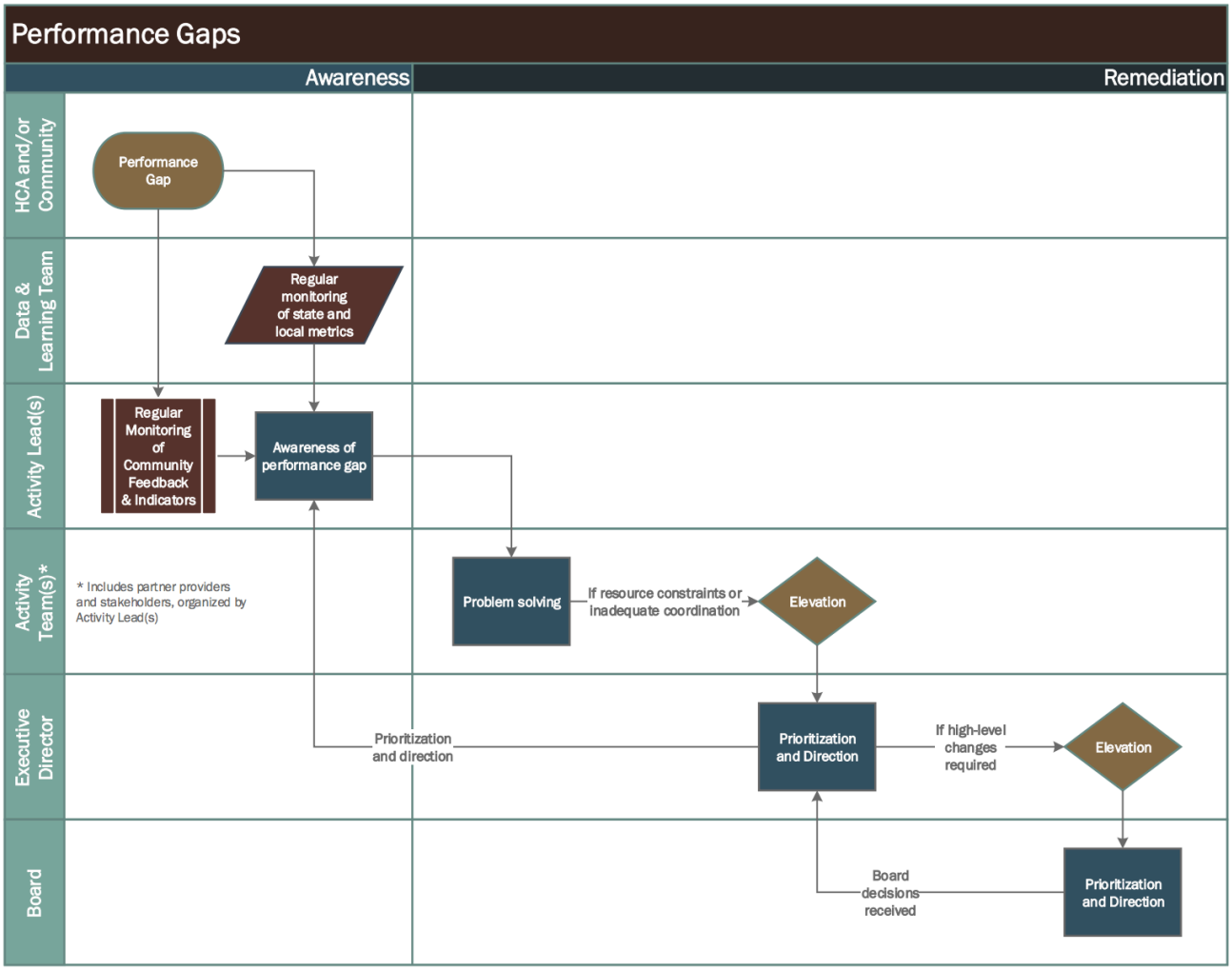

Figure 1: Performance Gaps Process Map

Quality Improvement Planning Process

Internal or embedded implementation teams will work with the most immediate data, based on quality improvement plans, internal quality improvement tracking mechanisms such as clinical quality measures, provider dashboards, and tally sheets. These will be reported to Project Managers and shared with the data and learning team for oversight. Additionally, the data and learning team will continuously identify and use HIT and HIE systems for tracking performance data such as hospital admission, ED utilization, and immunization status based on population health management technologies such as CMT's EDIE/PreManage platform, immunization registries, syndromic surveillance, and third party registries. These platforms can provide a picture of regional performance on some monitoring and continuous measures with a delay as small as 24 hours. When these systems identify performance gaps, the data and learning team will collaborate with implementation teams via the Project Managers to solve the challenges. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems, such as a performance management portal.

The North Sound ACH implementation planning teams will embed continuous tracking mechanisms in their implementation plans as part of their quality improvement planning process, to include surveys, regular automated or manual reports of metrics, and other means for tracking success. This quality improvement planning will emphasize rapid-cycle process improvement strategies that will identify points of failure and improvement for quick response through PDSAs or workflow redesign. The ACH will engage existing quality improvement teams at clinical or community-based implementation partners to provide expertise and support ongoing, real-time review and improvement of evidence-based approach implementation. Where possible, implementation partners will be encouraged to use these internal quality improvement teams to track their performance and PDSA improvements as needed.

The North Sound ACH Data and Learning team will support this strategy through the development of a suite of monitoring and evaluation measures for each evidence-based approach that provide an ongoing, actionable dashboard for tracking progress. The Data and Learning team will convene to regularly review metrics and assess implementation delays or gaps in performance that require changes or improvements.

Process Improvement and Project Plan Modification

Implementation delays will be identified through regular monitoring and oversight of performance and tracking measures by internal implementation teams at partner organizations. When implementation is delayed or encounters a barrier, these teams will first attempt rapid cycle improvement processes including Plan-Do-Study-Act (PDSA) cycles to solve these challenges and report outcomes to Project Managers. If this method does not lead to improvement, Project Managers will collaborate with implementation partners, the data and learning team, program council, and technical assistance consultants to address implementation delays.

When changes or improvements are identified as necessary by the ACH Data and Learning Team, the North Sound ACH staff will first work to support project implementation teams through internal QI activities, workflow redesign, PDSA cycles, resource allocation, staff training, collaborative conversations across sectors and ACHs, and other forms of assistance to improve performance (Figure 2). Technical assistance, trainings, and other resources will be supplied as needed to partner organizations and individual providers for these additional supports based on data and a deliberative process between North Sound ACH staff, the Data and Learning team, and implementation partners, as well as with feedback from the program council.

Modifications to project plans will occur after the North Sound ACH staff and implementation planning team leads report to the Program Council that a project has gaps, delays, or areas of improvement that could not

be solved through other forms of assistance, as described above. North Sound ACH staff, project partners, key stakeholders, and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Prior to applying for a project plan modification in these instances, the North Sound ACH will coordinate with the Health Care Authority to identify potential alternative solutions.

Technical Assistance

Potential sources of technical assistance in developing our quality improvement plans, training our teams in continuous improvement, and identifying tracking measures include Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations.

2D: Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
XX	

2D: Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
XX	

2D: Project Sustainability

The North Sound ACH is committed to working with partners in our region to develop strategies and initiatives that will move the metrics outlined in the Project Toolkit, and achieve long-term sustainability while impacting Washington's health system transformation beyond the Medicaid Transformation Project period. A virtuous cycle results when clinical transformation improves provider performance on clinical quality measures in value-based contracts, payers such as Managed Care Organizations reap savings, and reinvestments can be made back into the community, and community-based organizations to address

upstream, social determinants of health. To ensure lasting impact, we will optimize project strategies that not only result in improved health, but hold promise for additional financial earnings and substantial buy-in from both clinical and community-based partners. The implementation of projects will foster meaningful relationships across partnering providers, to ensure sustainable transformation beyond the Medicaid Transformation project.

The North Sound ACH plans to leverage its unique position as a regional convener and facilitator to identify additional long-term supports for transformative changes to our health systems. Whenever possible, the North Sound ACH will seek to braid together DSRIP earnings with other sources, including Managed Care Organization partners. Additionally, philanthropic support and investment from foundations and community development organizations at the local, state, and federal level will be pursued and leveraged wherever possible.

Within the clinical environment, the North Sound ACH will work with partnering providers to foster systems transformation, evidence-based practices and team-based workflows to drive performance on clinical quality measures and thereby increase reimbursements for value-based contractual agreements, both current and future as the state moves toward HCA goals for increased VBP adoption. Improving utilization of non-clinical staff in the clinical environment can increase the ability to pursue payments for additional services billable to Medicaid, such as those supporting behavioral health practitioners performing assessments or other interventions. Finally, establishing improved linkages and care coordination between clinical settings and community based resources can improve patient engagement and satisfaction, also bolstering clinical quality measure performance and subsequent reimbursements. Through the Pathways and other models incentivizing value-based or population health models over fee-for-service models ensures a more holistic approach to achieving health equity in the region.

The North Sound ACH plans to advocate at city, county, and state level for policies that will support this work, and reduce regulatory barriers to successful project implementation. This includes advocacy for policies that impact bi-directional integration and clinical transformation, social determinants of health, such as housing, access to transportation, childcare, employment, food access, environmental pollutants, etc. Additionally, the ACH will advocate for changes in programs and policies within partner organizations and systems, to support the implementation of services that support Medicaid Transformation and address health disparities.

Domain 1 areas of Workforce and Population Health Management offer substantial opportunities to ensure long-term sustainability and transformation. Training new members of the health workforce (or retraining current members) is an upfront and self-sustaining investment, particularly if partners are able to train staff in-house, building long-term capacity for these providers. Supporting implementation of systems for Health Information Technology or Exchange (HIT/HIE), is an up-front investment and will help defray costs over the long-term. Additionally, improved interoperability, communication and patient service resulting from improved technology and systems will reduce costs and improve patient satisfaction in the long-term, likewise driving increases in reimbursements for value based contractual agreements.

Specific to Diversions, substantial opportunities for sustainability exist by improving the ability of systems, including clinical, community-based and criminal justice to better serve a high-risk, high-cost target population. Reducing ED utilization through Community Paramedicine and better connecting target populations with physical health care through care coordination will create savings that can be reinvested to support long-term sustainability.