COMMUNITY CONNECTOR HUB

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Project Title	**Community Connector HUB** Partner organizations: Whatcom County Health Department, Unity Care NW, Opportunity Council, Sea Mar Community Health Center, Washington Dental Service Foundation

Rationale for the Project

THE SITUATION

1. **Healthcare is expensive**: We spend 17.4% of our Gross Domestic Product (GDP) on healthcare, a number that is expected to grow to 19.6% by 2024.
2. **Healthcare is only one driver of health**: Healthcare accounts for 10% of health outcomes.
3. **Healthcare spending is unequal**: Healthcare expenditures are concentrated in a small subset of the population.
4. **Care coordination is fragmented:** A single individual may have multiple people from separate organizations attempting to coordinate their care, with little communication between providers. This could result in duplication of efforts, confusion and disengagement, and poor outcomes.
5. **Accountable Communities of Health** present a unique opportunity to work across sectors to facilitate connections at the community level

PROJECT SUMMARY: COMMUNITY CONNECTOR HUB ("HUB"): The HUB is a community-based system that identifies the high-need, high-cost individuals and families in a community and connects them with the right services they need in a timely manner. The HUB is designed to capture and analyze data to allow for continuous quality improvement and to avoid duplication of services by capitalizing on local resources and organizations that are broadly representative of the community and diverse in perspectives.

EVIDENCE BASE: The HUB model has been implemented in Ohio and Oregon and has demonstrated decreased Medicaid costs per member per month (data presented by Care Coordination Systems 9/25/2015, Bonnetto). It has been endorsed by AHRQ (publication No. 09(10)-0088, 2010), the National Institute of Health, Rockville Institute, Communities Joined in Action, Institute for Healthcare Improvement, and others. With ACHs now up and running and the Medicaid waiver on the way, Washington is in a unique position to adapt this model to our landscape.

LEVERAGING INVESTMENTS: By making swift, hard-wired connections, the HUB leverages existing investments in care coordination by the State (e.g., the Health Home Program), healthcare systems (e.g., NCQA patient-centered medical home care coordination), housing (e.g., supportive housing case management), long term services and supports (e.g., COPES), and newer initiatives such as community health workers, community paramedics, jail transitions, and MCO-based care coordination. The Hub will leverage planned investments of Healthier Washington by collaborating directly with the Practice Transformation Hub, drawing analytic support from Providence Core and AIM, linking to projects within all three Medicaid Transformation Initiatives. It will also leverage other private (philanthropic) and public (state and federal) resources.

ALIGNED GOALS WITH MEDICAID: 1) increase coverage, 2) increase access to care providers, 3) and improve health outcomes for low-income populations.
ALIGNED MEDICAID TRANSFORMATION GOALS: 1) Reduce avoidable use of intensive services, 2) Improve population health, focused on prevention, 3) Ensure Medicaid per-capita growth is below national trends
ALIGNED TRANSFORAMTION PROJECT DOMAINS: 1) Population Health Improvement – prevention activities, 2) Care Delivery Redesign

Project Description

THE HUB APPROACH

The HUB is community-based, operating in partnership with multiple organizations to act as a local point of patient identification, connection, and quality assurance. There are three components of the HUB:

1) Find. → quickly identify high-risk individuals and families
2) Connect. → connect these individuals with appropriate clinical and social services
3) Measure. → measure progress on the individual and program level

Recognizing the impact social determinants have on health outcomes, the HUB integrates hospital, primary care dental, behavioral health, housing, education, employment, social services, public health and prevention, across the private, non-profit, governmental and tribal sectors.

In Whatcom County, WAHA has collaborated with partner organizations (listed above) to develop the HUB concept with the aim of serving all populations, with a focus on the Medicaid population. The HUB adopts high-utilizer criteria from partner organizations. Examples include:

- PeaceHealth St. Joseph Medical Center has an automated, risk-stratification tool directly embedded in its EMR that identifies individuals with a high probability of readmission in the inpatient setting
- The emergency department uses a similar tool within the EDIE system
- EMS has a community paramedic program with its own criteria for high EMS utilization
- The Whatcom Homeless Service Center utilizes a vulnerability tool allocate housing and supportive case management benefits.
- The Re-Entry Specialist from the jail refers to the HUB based on frequency of incarceration
- FQHCs have a registry of high-utilizing patients who have not recently engaged with preventative care
- The Health Home Program relies on the PRISM system to identify high-utilizing Medicaid beneficiaries

By definition, individuals who meet one or more of the above criteria are experience disparities in health, many of whom are living in poverty and/or are geographically isolated

These systems operate in multiple settings with staff from multiple organizations; however a single organization serves as the backbone for the HUB, providing coordination, communications, analytic infrastructure, administrative support, and oversight, and ensuring alignment with the ACH and Healthier Washington. In Whatcom County, WAHA has started to play this role.

The HUB identifies high utilizers and connects them with needed and appropriate medical and social service providers in the community and remains the interface between these providers as needed.

Table 1: Examples of evidence-based services and programs leveraged by the HUB

Social services	**Medical, behavioral and oral health care services**	**Health and wellness**	**Ancillary services**
Employment coaching and training	Chronic disease care management*	Tobacco cessation*	Care transition services
Supportive housing case management	Community paramedic	Healthy eating	Jail transition services
Schedule appointments	Attend provider appointments	Youth wellness activities*	Health Home Program
Energy assistance	Sign up for insurance	Weight control programs*	Home visits
Transportation assistance	Advance care planning	Nurse Family	Telephone follow-up

	(Respecting Choices ™)	Partnership ™	
Maternity support*	Medication reconciliation and prescription assistance		Coordinate care between providers
	ABCD (access to baby and child dental)		

** Benefits offered by Medicaid Managed Care Organizations (MCOs)*

Within the **Accountable Community of Health (ACH)**, there may be multiple HUBs, all operating in coordination with the ACH. The HUBs help identify local pain points and health priorities for integration into the ACH-driven Regional Health Assessment and Improvement Plan. The ACH will support each HUB in aligning measures and outcomes with statewide Healthier Washington goals in order to maximize opportunities for community reinvestment through shared savings and regional health care purchasing. In addition, the ACHs will pass through opportunities for shared learning, technical assistance, funding, professional development, and data and analytic infrastructure development.

Core Investment Components

The HUB in Whatcom County kicked off in January 2015 and was operational by May 2015 in the ED, hospital, and WAHA settings. The HUB is still under development: we have applied for several grants to support the build out and IT infrastructure of all of the components based on the model endorsed by AHRQ. In the meantime, the HUB has already connected 621 ED patients and 365 admitted patients, and 2500 WAHA clients. We have made over 100 connections to the State Health Home Program, 600 connections to primary care, 300 connections to behavioral health care, 130 connections to housing and basic needs, and 1550 connections to health insurance, as examples.

When fully implemented, we anticipate the HUB will be able to serve the top 20% of utilizers of the Medicaid population. In Whatcom County, this translates to approximately 10,680 people per year. The average per unit cost is approximately $60 dollars, assuming multiple connections per person. This translates to an annual operating cost of $640,800 in Whatcom County. In the North Sound region, there are approximately 270,200 Apple Health enrollees, of whom we would connect 54,040. Assuming, with economies of scale, we can reduce the case rate to $50, we estimate an annual budget of $2,702,000 to scale the HUB model to the entire North Sound region.

In Whatcom County, we believe we can get the HUB fully operational in six months. If endorsed by the North Sound ACH, Whatcom will collaborate with the other four counties to bring a HUB online, or to join with an existing HUB in a contiguous county.

Increasingly, the evidence suggests that many of the programs listed in Table 1 each have an independent effect on total cost of care and health outcomes. By connecting people to evidence-based services such as supportive housing, Care Transitions Intervention, the Health Home Program, Nurse Family Partnership, Access to Baby and Child Dentistry, and others, the HUB will improve health and reduce the total cost care among Medicaid beneficiaries. Furthermore, the extent to which the HUB can **increase** engagement between Medicaid beneficiaries and these programs, the effects will be exponential. For example, the Health Home Program, which is a new Medicaid benefit that has already shown a return on investment (ROI), has only managed to engage approximately 15% of assigned beneficiaries. The same can be said for ABCD, which has a utilization rate of 51% for children less than six years of age. For both of these programs, if the HUB were to increase utilization even just by ten percentage points, the impact would be even greater.

Project Metrics

Table 2. Community Connector HUB: Goals and Outcomes

HUB GOALS	HUB Measurable Outcomes	State Alignment	Sources
1. Reduce utilization of the ED for low acuity conditions	• Potentially avoidable ED visits	• WA Common Measure Set (HB 2572) • Behavioral health and community support service measures (ESHB 1519) • In State Apple Health and/or BHP contract	• WA Health Alliance • Providence Core • Other possible sources TBD
2. Reduce unnecessary readmissions to the hospital	• 30-day all-cause readmission		
3. Enhance linkages to community care management systems, primary care, behavioral health care, and social services and supports	• Access to primary care (children, adolescents, and adults) • Diabetes care • Alcohol/drug treatment penetration • Mental health penetration • Home and community-based long term services and supports • Homeless point-in-time count • Other measures aligned with 2572, 1519, or state contracts		

The HUB will need a tracking and evaluation system that is accessible or interoperable with other systems, particularly EPIC. The HUB coordinating organization confirms clients are enrolled into the HUB, connected to evidence-based care, and then measures the results, and provides the evaluation and analytic infrastructure to support the network of partner organizations within the HUB. This includes producing a series of dashboards for local oversight groups and the ACH. Each dashboard is a living document designed for ongoing operations management. A dashboard could be shared with the review committee upon request.