Attachment A: **Coordinating Jail Transitions and Care for Medicaid Enrollees**

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Project Title	**Coordinating Jail Transitions and Care for Medicaid Enrollees**

Rationale for the Project

- *Problem statement – why this project is needed.*
  Inmates to county and city jails transition in and out of incarceration and among confinement settings. Often they have medical, behavioral and substance abuse conditions which require attention and coordination so they have no untoward incidents while incarcerated.
  The goals of this project are in keeping with the intent of proposed legislation HB 2501, "Concerning the communication of information to continue health services for confined persons."
- *Supporting research (evidence-based and promising practices) for the value of the proposed project.*
  40% of patients with serious mental illnesses have been in jail at some time in their lives
  2010 studies show 16% of inmates have serious mental illness, up from 6.4% in 1983
  Pew Trust and MacArthur Foundation found prison costs for medical care grew 86% in Washington state 2001-08.
- *Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries.*
  Medicaid beneficiaries return to civilian life after receiving coordinated care while incarcerated care better informed about their condition(s) and able to continue PCMH defined treatment regimens. Should the inmate be incarcerated in part from failure of or non-compliance with a treatment regimen, care in jail will be informed by that regimen. While incarcerated the regimen can be modified, managed and communicated to the civilian care team.
  Continuity of care regardless of care setting can be communicated across the multiple payor responsibilities each inmate moves.

Project Description

Which Medicaid Transformation Goals[i] are supported by this project/intervention? Check box(es)

- ✓ Reduce avoidable use of intensive services
- ✓ Improve population health, focused on prevention
- ✓ Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

- ✓ Health Systems Capacity Building
- ✓ Care Delivery Redesign
- ✓ Population Health Improvement – prevention activities

Describe:

- *Region(s) and sub-population(s) impacted by the project.*
  Inmates admitted and discharged with medical and behavioral issues who need continuity of care as they move through the system.
  Need is great in rural areas where there are already shortages of providers. Telemedicine can provide cost effective consults and care handoffs at release.
- *Relationship to Washington's Medicaid Transformation goals.*
  Use time incarcerated to break cycles of seeking medical care in acute care setting both during and after incarceration using telehealth, and an organized hand off of care at release.
  Improve health when returned to civilian life and Medicaid coverage with a documented, shared care plan and assessment of patient's willingness to change health behaviors, and a fully documented electronic record of care in C-CDA format.
  Accelerate transition to value based payment already in place during incarceration, as incarcerating jurisdictions look to manage their medical costs.

Ensure growth below 2% - better informing jail and post-release care can reduce jails as vector of disease and transform them to a vector of improved health.

- *Project goals, interventions and outcomes expected during the waiver period….*
  Access existing longitudinal records of care for every inmate booked, from regional and EMR-based Health Information Exchanges, the HCA CDR, and EDIE care plans
  Contribute to those same longitudinal records of care for every inmate released with a C-CDA document forwarded to the former inmates PCMH
  Use of Direct messaging to communicate among medical professionals and wardens charged with care
  Reduction of ED visits by inmates by while incarcerated and post-release
  Reduction of behavioral, substance treatment and specialist consult costs using telehealth into jails.
  Increase in continuing of behavioral and substance plan adherence post release
- *Links to complementary transformation initiatives*
  HRSA Rural telehealth grants for integration of telehealth into jail care for facilities located in federally designated rural areas.
  Explore use of USAC funding for qualifying care providers in rural and non-rural settings for ongoing subsidies aimed at connecting care in rural settings.
  Connection to EDIE in place and exploring a shared connection to the HCA CDR making their information available to jail providers.
- *Potential partners, systems, and organizations*

Entities	HIE Relationship
Island Hospital and Clinics	Founder and customer
Skagit Regional Health	Founder and customer
Whidbey General Hospital and Clinics	Customer
Northwest Regional Council (NWRC)	Customer
Emergency Department Information Exchange	Interchange Partner
Skagit County Population Health Trust	Member
North Sound Accountable Community of Health	Prospective Partner
Island and Skagit County Sheriff's Departments	Prospective Customer
One HealthPort and HCA Clinical Data Repository	Prospective Interchange Partner
Cities of Mount Vernon, Anacortes, Burlington, Skagit and Island Counties	Prospective Partner
North Sound Mental Health Administration	Prospective Customer
Sea Mar	Customer
Association Washington Public Hospital Districts	Prospective Partner

Core Investment Components

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project.*
  $5 to $8 million over 5 years covering 20 of the 30 counties with less than 40K Medicaid Enrollees

$147K	Telehealth to jails (20 rural jails for an average of 3 years at $15K/jail first year, $3K/jail second through nth years with 65% USAC rural subsidy)
$42K	Regional HIE portal membership (20 rural jails for an average of 3 years at $2K/jail per year with 65% USAC rural subsidy)
$126K	Regional HIE integrated membership (10 rural jails for an average of 3 years $30K first year, $3K 2nd through nth years with 65% USAC subsidy)
$200K	Connection to statewide CDR in 2017 with 4 years of maintenance
$100K	Program expansion 2017-18 to NSACH
$100K	Integration with Spillman and other data systems used in jails
$625K	Program management, 5 years at $125K/year
$200K	Development and delivery of training and documentation for new workflows
50% cost allocation $3,075K Full cost allocation $6,150K	Regional HIE license for 20 local Public Hospital Districts, estimated 15 qualify for USAC rural subsidy (HIE membership supports CDR, EDIE, LabCorp, Cordant Lab, and other connectivity, as well as support for sibling Social Services Coordination Project)

Estimates are focused on rural areas where regional connections with single or limited number of providers ensures immediate returns and provides an on ramp for rural care delivery systems to connect easily to the HCA CDR for their entire Medicaid population.

- *Best estimate (or ballpark if unknown) for:*
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented.
    Jail populations statewide are roughly 12,000 at any one time, but have a high degree of turnover because of their mission of short term confinement, with longer term incarceration provided in DOC prisons.
    A measure of turnover can be found in publicly available weekly census reports from the Skagit County jail from March, 2015, in which the an average of 44% of the jail population was booked or released every week (83-85 bookings or releases each week with an average census of 193 inmates). An average of 76 bookings were turned away each week because of soon to be solved capacity issues.
    An extrapolation of the March 2015 booking numbers suggests a rate of annual bookings at current capacity of 4300 and if there were no capacity issues, over 8,000.
    Assuming that ½ to 2/3rds of those booked are on Medicaid that gives a count of 2150 to 5500 Medicaid enrollee bookings (this works out to bookings equal to 6% to 15% of total Medicaid enrollment in Skagit County, recognizing that the same person may be booked multiple times during a year).
  - How much you expect the program to cost per person served, on a monthly or annual basis.
    The allocated cost for from the budget figures above would range from $3 to $5 a booking based on the statewide adoption in 20 counties with ~400K Medicaid enrollees. Assume 15 of those eligible for USAC rural subsidies.
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.*
  Immediately in 2 counties, within 18 months in NSACH, then replication statewide replication can begin, with a focus on rural areas who can leverage the HIE connectivity for statewide CDR and EDIE connectivity.
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*
  The total cost of the program will be covered if 1800 to 2800 ED visits a year at $767 avoided and the patient made an $187 outpatient visit.

This can be accomplished by more complete screening of inmates at booking so that ED visits during incarceration are avoided, and more organized handoff of care to PCMHs as part of the release process.

Project Metrics

The state will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Each project will require clearly defined outcomes that relate to the goals and specific process steps.

Wherever possible describe:

- *Key process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured. Include priority measures sets described in the Waiver application* http://www.hca.wa.gov/hw/Documents/waiverappl.pdf *pages 46-47*[ii].
- *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?

  Establish benchmarks about ED use while incarcerated, and subsequent to incarceration for Medicaid enrollees, the uninsured, and those privately insured.

  Work with HCA, local jail jurisdictions and DOC to establish records of care and cost while incarcerated and correlating that to pre and post incarceration care and case management.

  Define care transition documents for hand off of patients at release to a PCMH.

  Track use of care transition document creation and delivery to PCMH on release of inmates who received care while incarcerated.

[i] Transformation goals as stated in Washington's Medicaid Transformation waiver, http://www.hca.wa.gov/hw/Documents/waiverappl.pdf:

- Reduce avoidable use of intensive services and settings such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional LTSS and jails.
- Improve population health, with a focus on prevention and management of diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders and oral health; that is coordinated and whole-person centered.
- Accelerate the transition to value-based payment, while ensuring that access to specialty and community services outside the Indian Health system are maintained for Washington's tribal members.
- Ensure that Medicaid per-capita cost growth is two percentage points below national trends.

[ii] This includes the statewide common measure set for tracking health care quality and cost across multi-payer public and private health delivery systems: http://www.hca.wa.gov/hw/Documents/pmcc_final_core_measure_set_approved_121714.pdf and the subset of 2016 Medicaid contract common performance metrics. It also includes priority measures for critical behavioral health and community support services recommended by the 5732/1519 Steering Committee and reported to the Legislature in "*Service Coordination Organizations – Accountability Measures Implementation Status*", (page 36) at: http://www.hca.wa.gov/documents_legislative/ServiceCoordinationOrgAccountability.pdf.