Attachment A: **Integrating Community and Social Services into Care Coordination**

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| **Contact Information** | *Identify point person, telephone number, e-mail address*<br>Duncan West, Chief Data Analyst, 360 982 2415, duncanw@min-ns.org<br>*Which organizations were involved in developing this project suggestion?*<br>Medical Information Network – North Sound |
| **Project Title** | Integrating Community and Social Services into Care Coordination |

**Rationale for the Project**

- *Problem statement – why this project is needed.*
  In an effort to support the elderly and disabled living independently there are a number of social and community services and programs available, from food and meal delivery to care coordination and chore services. Those 'social' services are focused on ameliorating social determinants of health at the individual and community levels.
  They are not connected directly or indirectly to the care delivery community which can lead to individual care that is uninformed about a patient's living condition. At a population and community health planning level decisions are made without a whole picture of community and population health and needs.
  The goals of this project are in keeping with the intent of proposed legislation SB 6327, "Providing for hospital discharge planning with lay caregivers."
- *Supporting research*
  There is a robust body of research about social determinants of health as major contributors to poor health and attendant high cost care.
  Coordinating care at the individual patient level and assuring that the client/patient divide of social and healthcare services is properly bridged will help keep Medicaid enrollees in their homes and apartments.
  Securely capturing and storing individual social needs with clinical diagnoses will create data which can be used to define patterns of care need.
  Including the efforts of volunteer organizations will add immensely to the richness of the current HCA and DSHS analysis efforts.
- *How this project benefits Medicaid beneficiaries.*
  This project will coordinate and link important, but disconnected federal, state, county and private social welfare programs in real time. It will provide a regulatory compliant legal and technical infrastructure for secure feedback to the medical and behavioral community from regular home visits by EMS, social work and volunteer visitors to those most in need of help.
  The project will ensure that there is a well understood, clearly defined, trustworthy, two way communication pathway among care providers and social service providers. The path must support each agency and organization and provider in making the delivery of their mission more efficient and effective. Otherwise it will not be adopted.

**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**
- ✓ **Accelerate transition to value-based payment**
- ✓ **Ensure Medicaid per-capita growth is below national trends**

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

- ✓ **Care Delivery Redesign**
- ✓ **Population Health Improvement – prevention activities**

*Describe:*

- *Region(s) and sub-population(s) impacted by the project.*
  * The medically indigent and challenged living at home with the support of chore services, hot meal and food

distribution.
* The homeless supported in shelters and drop in centers.
* Working poor in receipt of food and transportation assistance

- *Relationship to Washington's Medicaid Transformation goals.*
  Unify and connect the delivery of traditionally separate medical, social service and community volunteer resources to pinpoint problem patients and problem community patterns before they fester and drive expensive, intensive services.
  By linking ongoing prevention activities with medical and behavioral data in a secure way, care can be coordinated in innovative ways. Medical home based care coordinators can deal directly with community resources, ensuring patients are referred to the right services. They can follow up if the patient does not become a client of appropriate agencies.
  Conversely, social service counselors can gather and share field gathered data about their clients with clinic-based care coordinators.
  Existing organizations such as the Skagit County Population Health Trust and the regional NSACH will have secure access to de-identified data about social and medical need at a level of geographic and demographic specificity not available from any one system or view of the community.
- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.*
  Document current social service deliveries such as chore services, EMS home visits, Meals on Wheels and food deliveries and correlate clients with their attachment to and use of the healthcare system.
  Capture and track referrals from healthcare providers to social services agencies.
  Capture and track reports of social service delivery, with special attention to clients avoiding or not availing themselves of community support - putting themselves as risk for medical emergencies.
  Once baselines are established, increase the use of the referral and reporting infrastructure
- *Links to complementary transformation initiatives* -
  HRSA rural telehealth grants for integration of telehealth into social service care delivery for rural facilities (parts of Skagit, Whatcom and Snohomish Counties and all of Island and San Juan Counties)
  Explore use of USAC funding for qualifying care providers in rural and non-rural settings to provide ongoing subsidies for connecting care in rural settings.
- *Potential partners, systems, and organizations.*

| Entities | MIN-NS HIE Relationship |
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| **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 |
| **Community Action of Skagit County** | Prospective Partner |
| **Skagit County Community Services** | Prospective Partner |
| **DSHS, HCA** | Prospective Interchange Partner |

**Core Investment Components**

- *Proposed activities and cost estimates ("order of magnitude") for the project.*
  Development of Social Service/Medical/Behavioral Community sharing agreements in support of coordinating care: $5.3 to $7.9 million over 5 years

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| $300K | Develop and support lightweight data sets and questionnaires to gather community agency and social service volunteers. Use existing Fire Department Cares, Falls Assessment and other home visit forms as the basis of the work |
| $250K | Develop tools for HIE infrastructure to manage registries of social service clients and the restricted privileges of social service staff |
| $50K | 200 hours of HIPAA privacy attorney time to negotiate client facing, and agency agreements about data sharing via the MIN-NS |
| $200K | second year to develop mobile implementation of social service data gathering |
| $300K | Exchange subscriptions for 5 agencies in each of 30 counties |
| $500K | Develop, pilot and train community service staff to gather and report client contacts for the medical community. Develop and deliver replication program materials to additional regions. |
| $625K | Program management, 5 years at $125K/year |
| 50% cost allocation $3,075K<br>Full cost allocation $6,150K | Regional HIE license for 20 local Public Hospital Districts, estimated 15 qualify for USAC rural subsidy<br>(HIE membership supports CDR, EDIE, LabCorp, Cordant Lab, and other connectivity, as well as support for sibling Social Services Coordination Project) |

- *Best estimate (or ballpark if unknown) for:*
  In Skagit County, a conservative estimate found that one large community service agency serves over half the Medicaid enrollees in the county (21K of 36K) with one or more of their programs. This count does not include Meals on Wheels, Senior Center, Food Bank, church-related services, or the Area Agency for the Aging.
- *How much you expect the program to cost per person served, on a monthly or annual basis*.
  Focusing on counties with less than 40K Medicaid enrollees as of December 2015, there are over 400K Medicaid enrollees. If half are served by local community service and Area Agency on Aging groups, then the program would impact just over 200K enrollees at a cost of under $.45 to $.66 a month per enrollee, with costs per client scaling down the more clients contained in the system.
- *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 begins to 20 rural counties.
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*
  There are two timelines for ROI: immediate and long term.
  Immediately we would expect a decrease in ED use because client/patient decline and problems can be found before they become crises.
  Longer term, we will be able to document and focus efforts on amelioration of problems in social determinants of health.
  Even longer term we will have 'big data' about diagnoses in the HCA, social service spend in Prism, and local agency interactions in the regional exchanges which will allow evaluation of program efficacy for different populations and support smarter referrals.
  Gathering the big data will also allow regional partners in care to understand their costs and dependencies, better enabling them to understand costs and outcomes so they can make more informed decisions about the costs and risks of adopting value-based care models.

| **Project Metrics** |
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| *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.*<br>*Wherever possible describe:*<br>• *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].<br>• *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?<br>Establish benchmarks about ED and ambulatory care use, with a decrease in one and an increase in the other..<br>Work with HCA and DSHS to document use of social support services for dual eligible and track the use of clinical, social, and community resources in the population with an emphasis on shifting costs to the lowest cost solutions.<br>Define a series of organizational and personal agreements and training that supports secure and privacy regulation compliant exchange of relevant client information.<br>Define 'whole person' care plan that includes social and clinical goals and can be kept up to data and monitored so that interventions can be monitored and planned. |

[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.