Dec. 10, 2019

The Honorable Laurie Jinkins
Speaker of the House
Post Office Box 40600
Olympia, WA 98504

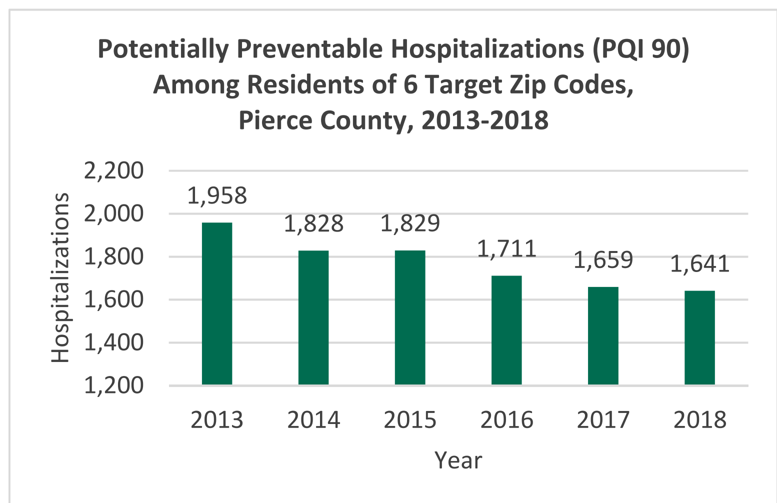
The Honorable Steve Conway
Senate Health Care Committee
Post Office Box 40429
Olympia, WA 98504

Dear Speaker Jinkins and Senator Conway:

Thank you for the opportunity to improve the rate of potentially preventable hospitalizations (PPH) in Pierce County. This report fulfills the requirement stated in Consolidated Contract, Amendment 9, Contract Number CLH18263.

Major Findings

The overall trend in potentially preventable hospitalizations in the 6 target zip codes is declining.



Successes

- Increased access to bacterial pneumonia and flu vaccines for homeless, uninsured and under-insured community members.
- Improved access to preventive services by training community medical providers to screen for depression, alcohol, tobacco, other drug use and refer for treatment.
- Implemented the evidence-based Screening, Brief Interventions, and Referral to Treatment (SBIRT) model by training staff in more than 50 community-based organizations.
- Strengthened relationships and understanding among community partners and health systems through improved data sharing.
- Leveraged year 1 funding through $463,506 in-kind donations from partners.

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Challenges

- Gaps exist in how partners use Washington Immunization Information System (WIIS) to document adult immunizations. Many patients do not receive bacterial pneumonia vaccinations because of lack of access to current immunization status. Project work will continue to support medical providers to use WIIS.
- Partners can be inconsistent in practices for screening for alcohol, tobacco, other drugs and depression. Some providers are hesitant to fully implement SBIRT because of the lack of operational readiness. SBIRT project focus will shift to increased technical support for implementation.
- Data integration among partner agencies is difficult without a shared health information system. Project work will focus on improved data sharing.
- Although the overall trend in potentially preventable hospitalizations is declining, it is still increasing for certain conditions, especially heart failure. Future project work will address this.

Background

A 2017 Washington State Office of Financial Management report showed Pierce County's 27th and 29th legislative districts have the highest statewide rates of potentially preventable hospitalizations.

> Potentially preventable hospitalizations are those that could have been prevented through earlier prevention, management or treatment in a primary care setting. Common causes are dehydration, worsening chronic conditions like diabetes or COPD, or the flu.

We saw an opportunity to improve health and reduce downstream healthcare costs and joined forces with a team of partners committed to making change—CHI Franciscan Health, Community Health Care, Kaiser Permanente Washington, MultiCare Health System, Northwest Physicians Network, Sea Mar Community Health Care Centers, Coordinated Care, Pierce County Accountable Community of Health and Korean Women's Association.

We analyzed the data to find the best place to focus our efforts. Robert Wood Johnson Foundation's 2018 County Health Rankings and our 2015 Equity Assessment showed in the 2 legislative districts, 6 zip codes—98404, 98405, 98408, 98409, 98418 and 98444—had the poorest health outcomes and disparities.

Together we developed a plan to improve health in these key areas.

We learned from the data and from our experiences and modified our planning to meet the needs of the community.

Originally, we believed we could use data from emergency room records to identify populations at greatest risk of hospitalization, but the data lacked the necessary details. As a result, we shifted our strategy to develop new sources of data to inform our planning.

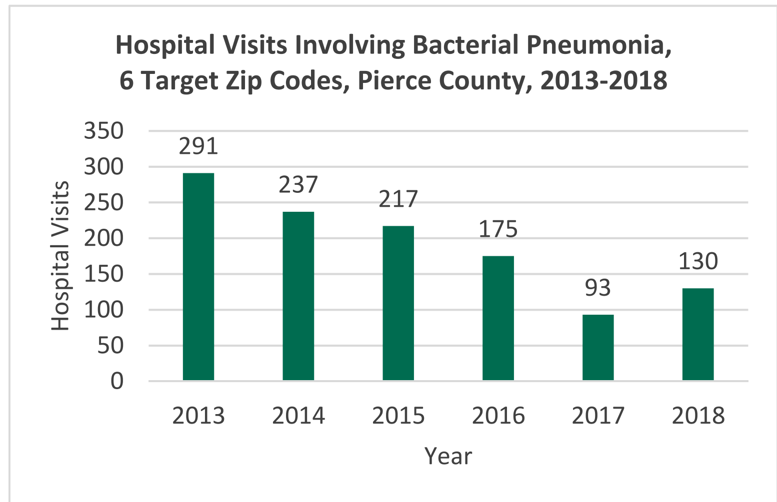
Strategies

Immunizations

Washington State Office of Financial Management's 2017 report classified bacterial pneumonia hospitalizations as potentially preventable.

The flu is a risk factor for bacterial pneumonia. To reduce these hospitalizations, we worked to increase bacterial pneumonia and flu vaccination rates.

PPH provided more than 1,000 doses of vaccine to community partners. The partners vaccinated people more likely to wind up in the hospital because they lack access to primary care—like people living homeless, uninsured or under-insured. For the 2019 flu season, we're partnering to conduct 13 immunization clinics in the 6 target zip codes in sites including churches, homeless service sites and senior centers. So far, of those getting a flu shot, about 70% reported they did not receive a flu vaccine the previous year.



We supported greater use of WIIS to monitor adult immunizations. Northwest Physicians Network clinic, Dr. Felino B. DeLeon's office, had not entered data into WIIS in the past. After our public health nurses provided training, the practice entered 100% of its adult immunizations into the system.

Care Coordination and Data

Based on the data, we added this strategy in year 2 to ensure people get the healthcare services they need in an efficient way. We are learning how other agencies use data, what data they routinely collect, and what are the opportunities to share data to improve patient care. Current work includes developing a common picture of access to primary care in the 6 target zip codes and promoting the use of the Collective Ambulatory in primary care.

PPH is partnering with Collective Medical and partner agencies to launch this tool. We will facilitate a streamlined process for data sharing agreements, contracts with Collective Medical, and training with our partners. This tool builds upon an existing system that supports Emergency Department clinicians to access patient records.

Screening, Brief Intervention, and Referral to Treatment and Motivational Interviewing data

The 2017 Washington State Office of Financial Management report indicated worsening chronic conditions as a cause of potentially preventable hospitalizations.

Research shows people with mental health or substance use challenges face more difficulty managing their chronic health conditions.

To reduce these hospitalizations, we worked to increase the use of SBIRT in the target area. SBIRT is a tool used to connect people with the help they need for mental health or substance use challenges, improving their ability to manage other chronic health conditions and stay healthy and out of the hospital.

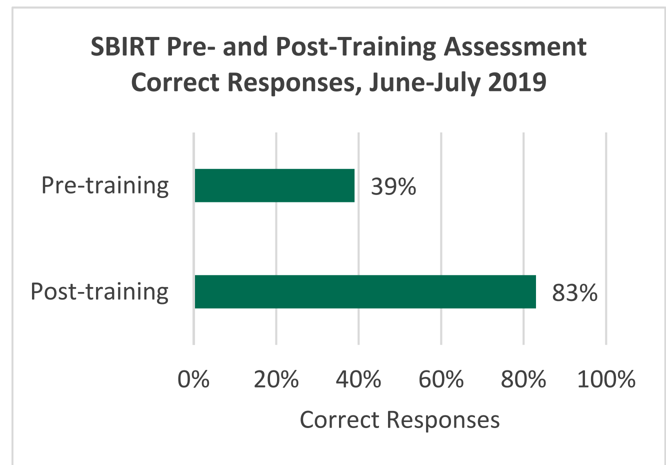
Our work with partner agencies showed a need for training on what SBIRT is and how to use it.

We coordinated 6 SBIRT training sessions. More than 200 people attended, representing CHI Franciscan Health, Community Health Care, MultiCare Health System, Sea Mar Community Health Care Centers,

Comprehensive Life Resources, Greater Lakes Mental Health, private practices, Tacoma Housing Authority, Pierce County District Court Probation, Tacoma Public Schools and Bethel School District.

Pre- and post-training assessments show participants increased technical expertise. These providers have the tools they need to help their patients stay healthy and out of the hospital.

PPH staff follow up with participating provider offices to provide ongoing technical support to implement and sustain SBIRT.



Summary

This project implemented strategies to improve health outcomes and reduce healthcare costs in the 6 target zip codes in Pierce County. Our partnership is driving health system transformation. Because of these strengthened relationships, we will request continued funding for year 3 of a 5-year plan, with these outcomes in mind:

- Using the data analyzed over the last 2 years, continue to support provider and clinic implementation of SBIRT and protecting people through immunizations. Ensure other areas of the county and state can duplicate the strategies.
- With a better understanding of the data and the overall decline of preventable hospitalizations, focus on individual conditions that do not follow this trend. Analyze heart failure data to identify subpopulations and risk factors. Use this data to determine targeted interventions potentially with the Community Health Worker Exchange Pilot and the Community Hub at Elevate Health.
- Provide resources to achieve results and support collaboration across local healthcare systems and providers.

Sincerely,

Anthony L-T Chen, MD, MPH
Director of Health

cc:
Representative Eileen Cody, Chair, House Health Care and Wellness Committee
Representative Melanie Morgan, 29th
District Senator Jeannie Darneille, 27th District
Representative Jake Fey, 27th District