Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

For projects to be considered for inclusion in the Medicaid Transformation Project List, please provide the information requested in the template. We are looking for summarized information – **2-3 pages maximum per project**.
Please email completed templates by **January 15, 2016,** to MedicaidTransformation@hca.wa.gov with the subject **Medicaid Waiver Project**. Thank you for your interest and support.

Contact Information	*Identify point person, telephone number, e-mail address* *Federico Cruz-Uribe, MD, MPH* *Vice President of External Affairs* *Sea Mar CHC* *(206)-788-3287* *federicocruz-uribe@seamarchc.org* *Kyle Davidson, MPH* *Director of Population Health Management* *Sea Mar CHC* *(206)-788-3289* *kyledavidson@seamarchc.org* *Which organizations were involved in developing this project suggestion?* *Seattle Indian Health Board, International Community Health Services, Sea Mar Community Health Services*
Project Title	*Title of the project/intervention* PEER POWER: Community Health Workers Supporting Primary Care

Rationale for the Project

Include:

- *Problem statement – why this project is needed.*

Persons served by Community Health Centers (CHC's), including those enrolled in Medicaid, often experience multiple barriers to improved health outcomes and/or sustained engagement in services to assist with such improvement. These barriers may include homelessness, lack of insurance, immigration status, mental illness, substance abuse, addiction, lack of food security, language barriers, poverty and social marginalization. Yet the three CHC's putting forward this transformation project operate with a specific expertise for certain subpopulations within those traditionally served by CHC's and have established histories partnering with patients to foster resilience, increase engagement and improve outcomes. These sub-populations include American Indian and Alaska Natives, Asian Pacific Islanders and Latinos. Data for King County indicate Communities of Color, Limited English Proficiency populations and those born outside of the US experience disparate outcomes and unique challenges to health status, including increased levels of stress, higher rates of obesity, diabetes and cardiovascular disease.[1]

The mechanisms for reaching these and other communities rely on racially diverse and culturally competent teams, linguistic fluency, a patient centered approach, rigorous assessment and data driven programmatic decision making. Funding Community Health Worker (CHW) teams within these existing health systems allows an expansion of current efforts to reach and engage these populations and subpopulations so critical to the success of Medicaid

transformation. The PEER POWER project proposes employing peer-based Community Health Workers serving in either community or clinical settings within the existing structure of CHC's or other primary care providers and focusing on patients living with or at risk for chronic disease, particularly stress, obesity, diabetes and cardiovascular disease. In addition, the project proposes developing a global assessment process to better engage with patients on their own terms and to address their specific priorities. The assessment will be patient centered and include ethno-cultural elements, in addition to clinical factors.

- *Supporting research (evidence-based and promising practices) for the value of the proposed project.*[i]

  Addressing Chronic Disease through Community Health Workers, A Policy and Systems Level Approach, Centers for Disease Control. http://www.cdc.gov/dhdsp/docs/chw_brief.pdf

  Community Health Worker Policy, NYU/CUNY Prevention Research Center, http://www.med.nyu.edu/prevention-research/health-promotion-research/policy-research/community-health-worker-policy

- *Relationship to federal objectives for Medicaid*[ii] *with particular attention to how this project benefits Medicaid beneficiaries.*

  The proposed project includes elements of engagement and retention in care capable of increasing and strengthening the coverage of low income individuals by reinforcing and supporting their engagement with their assigned primary care provider. Project CHW's will direct their community based efforts at engaging patients assigned to primary care but somehow lost to that care.

  A principle benefit of this work includes increasing access to/stabilize and strengthen provider networks by strengthening their connection with patients. Project CHW's working within primary care settings will join existing multi-disciplinary care teams including providers, nursing staff and others to increase the peer level engagement with the patient in a clinical setting.

  Existing research supports the positive effect of increased engagement in primary care toward improving health outcomes for Medicaid and low income populations.

  By engaging the knowledge and skills of CHW's, the project leverages the peer component toward increasing the efficiency and quality of care through initiatives to transform service delivery networks. In effect, the proposed project is a transformation of service delivery networks.

Project Description

Which Medicaid Transformation Goals[iii] *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 (If tied to existing capitation or outcomes)
- ✓ 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. Include a description of the target population (e.g., persons discharged from local jail facilities with serious mental illness and or substance use disorders).*

The project is scalable to any primary care health system network. Community Health Centers operate across the state of Washington and represent a rich potential resource for Medicaid Transformation projects. The CHW model could be implemented as needed and the target populations would be Medicaid recipients assigned to primary care clinics and yet to present for care, or those at risk or living with chronic diseases, particularly stress, obesity, diabetes and cardiovascular disease.

- *Relationship to Washington's Medicaid Transformation goals.*

The proposed project includes elements of engagement and retention in care capable of reducing avoidable use of intensive services and settings, improvements in population health and ensuring appropriate Medicaid per-capita cost growth. If reimbursements for aspects of the program or CHW FTE could be tied to outcomes or existing capitation, the project could also accelerate the transition to value based payment.

Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.

Project goals include a sufficient number of patient encounters and patients served to indicate productivity and impact. Particular focus will be placed on those patients yet to present for care or who show a less successful engagement in care. Post intervention evaluation would seek indication of initial or renewed service engagement and subsequent chronic health condition improvement (population health): i.e. weight measurements, blood sugar, blood pressure, etc. Other goals include reduction in institutionalization and hospitalization and thereby bending the Medicaid cost curve over time.

- *Links to complementary transformation initiatives - those funded through other local, state or federal authorities (such as the health home program and Early Adopter/Behavioral Health Organization regional purchasing) and/or Medicaid Transformation initiatives # 2 and 3.*

The project offers the opportunity to create better linkages within the health care system, as stipulated under Transformation Initiative 2, Long Term Services and Supports. By engaging patients lost to care in the community and bringing the peer perspective into multidisciplinary teams within the primary care setting, linkages are strengthened both within and without the health care system.

- *Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.*

This project brings the potential to further cement the relationship between CHC's and ACH's throughout the state. The current ACH's touched by the three partners here include, King, Pierce, North Sound, CPAA and SW Regional ACH, but the project is scalable in any community or primary care setting.

Core Investment Components

Describe:
Proposed activities and cost estimates ("order of magnitude") for the project.

Community based outreach activities include home visits, community connections with those patients identified yet to present or experiencing challenges in accessing primary care. This outreach could include ER's or other high risk milieus.

Clinic based activities include individual sessions, group level interventions utilizing basic health education and motivational interviewing strategies to support behavior change and linkages to other clinic resources, (care coordination.)

The three partners in the application currently operate 10 clinics in King County capable of housing at least one CHW, although the project is scalable to larger areas and other systems.

Best estimate (or ballpark if unknown) for:
How many people you expect to serve, on a monthly or annual basis, when fully implemented.

50 individuals per month, per CHW. (600 patients annually.)

How much you expect the program to cost per person served, on a monthly or annual basis.

Estimated cost per CHW: $52,000 annually, salary + benefits. 600 people served. Cost per person $87 annually.

How long it will take to fully implement the project within a region where you expect it will have to be phased in.

12 months from initial investment to full implementation.

The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.

Return on investment to result from decrease in avoidable use of intensive services and settings and improvements in population health. One study in a peer reviewed journal found ROI for CHW's to be 2.28:1.00.[2] Using this rubric, the program stands to save $118,560 per CHW, per year.

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[iv].*

The project's success will depend on leveraging the peer-based skill set to generate further engagement from communities into primary care settings and thereby improve measures of population health and reduce outlays associated with poor management of chronic conditions. Outcome measures include Cardiovascular monitoring for

people with cardiovascular disease, comprehensive diabetes care and monitoring, mental health treatment penetration and utilization of intensive services and settings such as hospitals, nursing facilities, traditional LTSS and jails.

Community Based Outreach outcomes measured: Number of patients contacted, method of patient contact, number of clinic visits generated, amount of intensive service utilization prior and post intervention

Clinic Based, Population Health outcomes measured: Number of patient encounters, method of encounter i.e: group or individual, chronic disease measurements pre and post intervention including weight, blood pressure, blood sugar, and patient centered, ethnographic self-assessment, pre and post intervention.

- *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?

n/a

[i] The Washington State Institute for Public Policy, http://www.wsipp.gov, has identified "evidence-based" policies that can lead to better outcomes; Behavioral health research reports developed by the Research and Data Administration are available at: https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/decision-support-and-evaluation

[ii] Medicaid objectives as stated in GAO report 15-239, April 2015, http://www.gao.gov/products/GAO-15-239:

- Increase and strengthen coverage of low income individuals.
- Increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations.
- Improve health outcomes for Medicaid and low-income populations.
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.
- Criteria established for specific demonstrations described through an informational bulletin or State Medicaid Director's Letter – available at: http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html.

[iii] 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.

[iv] 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.

1. Communities Count, Social and Health Indicators Across King County. http://www.communitiescount.org/index.php?page=stress

2. Measuring Return on Investment of Outreach by Community Health Workers. Journal of Healthcare for the Poor and Underserved. 2006 Feb; 17(1 Suppl):6-15.