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	*Ann Christian, CEO, Washington Council for Behavioral Health(WCBH)* *206.628.4608 ex 14; achristian@thewashingtoncouncil.org* *Organizations Involved in Developing Project:* • *WCBH Board of Directors and member community behavioral health organizations across the state* • *UW Department of Psychiatry AIMS Center, Jürgen Unützer MD, Lydia Chwastiak MD* • *Joe Parks MD, Director, Missouri HealthNet (Medicaid) and Missouri Coalition for Community Behavioral Healthcare, implementers of Missouri's health home program*
Project Title	**Whole Person Care in Community Behavioral Health: *Improving Health Outcomes for Adults with Serious Behavioral Health Disorders***

Rationale for the Project

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

This project addresses all three components of the Triple Aim—Better Health, Better Care, Lower Costs—for a Medicaid population that has received little focused attention or investment in the area of improved health outcomes. People with serious mental illness and/or substance use disorders continue to experience multiple chronic health conditions and dramatically reduced life expectancy while also constituting one of the highest cost, highest risk groups among Medicaid enrollees.

Bidirectional integration of primary and behavioral health is a foundational strategy within the Healthier Washington Initiative. This project offers an evidence-based model for integrating primary care into behavioral health settings where these patients already receive care. Most integration initiatives and investments in-state and nationally have focused on integrating behavioral health into primary care settings, which works well for many individuals. For others with more complex behavioral health disorders, there are tremendous barriers to accessing effective primary care, and they need services not available in primary care. There are opportunities to strengthen and bring to scale a model for integrating whole person care in behavioral health settings to meet these needs.

Better Health

Health disparities among people with behavioral health disorders have been well-documented for decades. A February 2015 meta-analysis reports an average reduction in life expectancy ranges of 10.1[1] years, and a November 2015 study indicates that people with schizophrenia are losing 27 years of life due to preventable medical conditions such as high blood pressure, high cholesterol, diabetes, and heart disease.[2] The data about mental illness and early mortality are often used as a rationale for integrated care. What's missing is a targeted, systematic health improvement intervention that targets health needs of adults with serious behavioral health disorders.

Better Care

Perhaps most significantly, this project could provide a unifying focus for practice transformation in community behavioral health provider settings by building a baseline core competency in whole person care (care management, primary care consultation, health screening) and a focus on key physical health measures within the specialty behavioral health system. According to the HRSA/SAMHSA Center for Integrated Health Solutions, *care management is central to the recent shift away from focus on episodic acute care to focus on health management of defined populations, especially those living with chronic health conditio*ns. The care experience for patients would be improved by increased patient engagement through a focus on patient-defined personal health goals and wellness.

Lower Costs

There is ample evidence that people with co-existing behavioral health disorders make up a disproportionate share of the 5/50 population, the 5% of the population who account for approximately 50–60% of expenditures:

- Within Medicaid, 80 cents of every $1 is spent on chronic conditions[3] and Medicaid beneficiaries with severe mental illness are two to three times more likely to have a chronic medical condition.[4]
- Also, "Mental illness is nearly universal among the highest-cost, most frequently hospitalized beneficiaries . . . and the presence of mental illness and/or drug and alcohol disorders is associated with substantially higher per capita costs and hospitalization rates."[5]
- In 2012, the two most common reasons for hospitalization among Medicaid super-utilizers were mood disorders and schizophrenia and other psychotic disorders; three of the top 10 diagnoses for hospital stays for Medicaid super-utilizers were mental and behavioral health conditions.[6]

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

The emerging literature about models that integrate primary care into behavioral health settings are extremely promising and support the benefit of adding this component to an integrated delivery system. Examples include:

Missouri Community Mental Health Center (CMHC) Healthcare Homes

The first 18 months of CMHC health home operation demonstrated decreases in blood pressure, blood cholesterol and Hemoglobin A1c levels, and increased medication possession ratios for psychiatric, cardiovascular, and asthma/COPD medications.[7] During this same period, costs decreased by $76.33 PMPM, yielding a total health cost reduction of $15.7M.[8] The number of clients with one or more hospitalizations decreased by 9.1% during first year..

Milliman Report, April 2014, Economic Impact of Integrated Medical-Behavioral Healthcare[9]

Medical costs for treating patients with chronic medical and comorbid behavioral health disorders can be 2–3 times higher than those with no behavioral health condition. Most of the increased cost is incurred in medical services. Milliman estimates that 5–7% of this additional spending may be saved through effective integration of care.

SAMHSA's Primary Care Behavioral Health Initiative (PCBHI) Grant Program

A preliminary evaluation conducted by the Rand Corporation[10] demonstrated improved outcomes in key health measures—blood sugar levels, LDL, and total cholesterol and blood pressure—for participants with serious mental illness. Similarly, two Washington PCBHI projects (DESC and Harborview Mental Health & Addiction Services) documented improvements in blood pressure, BMI, LDL, and Hemoglobin A1c levels.

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

We expect to improve population health for an underserved health disparities population—adults with serious mental illness and/or substance use disorders—by transforming the community behavioral system to a focus on total health. Through establishment of a system-wide core competency in care management, behavioral health providers will take responsibility for managing the full array of physical health needs, providing routine basic health screening, and ensuring integrated primary care by advocating for, actively coordinating with, or providing onsite primary care. Project outcomes will be aligned with CMS' Core Set of Adult Health Care Quality Measures as well as Washington State's statewide common measure set, 2016 Medicaid contract common performance metrics, and other cross-system performance measures identified by the 5732/1519 Steering Committee. By providing upstream identification and intervention for physical health needs we will reduce the use of high cost acute care resources.

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
☒ 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.***

This project will target adults age 18 and older with complex behavioral health needs and at least one co-occurring chronic medical condition. Phase I will include implementation in a starter set of clinics (2–4); Phase II will systematically scale and spread the program to cover all regions in the state by end of waiver period.

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

This project addresses all four of the Medicaid Transformation goals. Rather than focusing primarily on behavioral health symptom management, upstream health interventions made possible through basic health screening, access to physical health information, active coordination with primary care providers, and team-based care infused with total health perspective can reduce the use of avoidable intensive services and improve population health. Project metrics will focus on identified population health priorities, including diabetes and cardiovascular disease, and will help cultivate a culture of "treating to target." Additionally, value-based payment via a case rate with accountability for identified outcomes will accelerate movement in the value vs. volume shift. Finally, as demonstrated in the supporting literature, the proposed model of bidirectional integration is cost-effective and should reduce per capita costs for this population.

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

Goal 1: Improve health outcomes and reduce health disparities for adults with serious mental illness and/or substance use disorders.

Goal 2: Transform clinical practice in community behavioral health settings by incorporating whole person care management as a core competency and advancing skills in population health management.

Goal 3: Demonstrate the clinical and financial benefits of behavioral health-based integration, adding to the state and national knowledge base on delivery system integration.

Phase I Interventions:

- Develop a whole person care management model based in behavioral health settings and designed to complement primary care-based models. This work will be informed by experience of Washington's health homes program, Missouri's extensive 'proof of concept' work through CMHC Healthcare Homes, the Mental Health Integration Program and other UW AIMS Center models, and SAMHSA'S Primary Care Behavioral Health Integration program. Model development includes a customized training curriculum.
- Implement training and clinical model in a starter set of 2–4 clinics to refine and flesh out the clinical model, create health informatics tools and assess financial model assumptions.

Phase II Interventions:

- Scale and spread on a regional basis in collaboration with ACH priorities and readiness.

Outcomes: There is an emerging body of evidence that a focus on physical health outcomes in behavioral health settings will improve both physical and behavioral health outcomes. Patient outcome measures for the project will incorporate priority health outcome measures related to cardiovascular disease, diabetes, and medication adherence. Critical process measures such as linkage with a primary care provider will also be incorporated.

Health Equity and Health Disparities: A fundamental purpose of this project is to reduce health disparities for people with co-occurring behavioral health disorders. See also problem statement above and supporting literature.

- ***Links to complementary transformation initiatives - funded through other local, state or federal authorities***
  - Primary care-based integration initiatives such as IMPACT, MHIP, PCBH: This project will be designed to complement these essential initiatives by addressing the needs of patients not easily engaged in primary care settings and serving as a resource for those needing a more intensive level of behavioral healthcare; partnership with UW AIMS Center in development and implementation of the project will ensure complementary approach and avoid duplication of effort and resources.
  - Early Adopter: Equip behavioral health agencies to be capable health system partners by collaborating with member behavioral health agencies re: care coordination and care management efforts in SWWA.
  - Health Homes: Serve as a resource for behavioral health patients who may not fit the narrower construct of the health home project; learn from member agencies who are active health home CCOs.
- ***Potential partners, systems, and organizations***
  - Primary care providers
  - Key connection with ACHs to coordinate local implementation and ensure that project and ACH serve as 'mutual resource' to each other
  - MCOs and BHOs to identify best ways of using existing benefit structures, where there are gaps, and where the flexibility of waiver affords greatest opportunity
  - Counties, law enforcement, EMTs and other first responders, hospitals

Core Investment Components

- ***Proposed activities and cost estimates ("order of magnitude") for the project.*** Complex care management costing approximately $21.6 million per year at full implementation
- ***Best estimate (or ballpark if unknown) for:***
  - *How many people you expect to serve, on a monthly or annual basis, when fully implemented. 20,000 per month.* Per SCOPE-WA reports CMHAs in the state serve approximately 40,000 Medicaid adults aged 18-59 per month. Approximately 18,000 children under the age of 18 and an additional 6,500 Medicaid adults age 60+ are served each month as well. We have used a conservative estimate of 20,000 individuals served monthly at full implementation, primarily adults with serious mental illness who use CMHAs as their primary provider.
  - *How much you expect the program to cost per person served, on a monthly or annual basis.* We estimate $90 per month per person served, assuming 1 FTE program supervisor and 1 FTE administrative support per 500 clients, and 1 FTE nurse care manager per 250 clients.
- ***How long it will take to fully implement the project within a region where you expect it will be phased in.*** Phase I activities described above will take approximately 12 months to implement; additional regional clinic cohorts would take an additional 12 months and would be phased in based on available resources, ACH priorities and commitment, and clinic readiness.
- ***The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*** Based on similar work in Missouri, we believe a conservative ROI of 250% or $54 million per year at full implementation is a very reasonable expectation. It will be critical to clearly articulate reinvestment loops for this project in which investments made in behavioral health settings are expected to generate significant savings in physical health costs.

Project Metrics

Wherever possible describe:

- *Key process and outcome measures.*
  - Metabolic screening (BMI, BP, HDL, cholesterol, triglycerides, and HbA1c) benchmark goal of 80% of patients age 18 and older
  - Diabetes: HbA1c Control – benchmark goal of 60% of patients with a diagnosis of diabetes with Hemoglobin A1c<8.0%
  - Medication adherence – medication possession ratio 0.8 or higher for 80% of patients
- *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

[1] Walker ER, McGee RE, Druss BG. Mortality in Mental Disorders and Global Disease Burden Implications: A Systematic Review and Meta-analysis. JAMA Psychiatry. 2015 Feb 11. doi: 10.1001/jamapsychiatry.2014.2502. [Epub ahead of print]

[2] Mark Olfson, MD, MPH1; Tobias Gerhard, PhD2,3; Cecilia Huang, PhD2; Stephen Crystal, PhD2; T. Scott Stroup, MD, MPH1, Premature Mortality Among Adults With Schizophrenia in the United States. JAMA Psychiatry. December 2015

[3] Gerard Anderson, *Chronic Care: Making the Case for Ongoing Care* (Princeton, N.J.: Robert Wood Johnson Foundation, 2010), www.rwjf.org/content/ dam/farm/reports/reports/2010/rwjf54583.

[4] Joseph Parks, Tim Swinfard, and Paul Stuve, "Mental Health Community Case Management and its Effects on Healthcare Expenditures," *Psychiatric Annals* 40, no. 8 (2010): 415-419.

[5] Faces of Medicaid: Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations

[6] *H. Joanna Jiang, Ph.D., Marguerite L. Barrett, M.S., and Minya Sheng, M.S. Characteristics of Hospital Stays for Nonelderly Medicaid Super-Utilizers, 2012*. Healthcare Cost and Utilization Project (HCUP) *November 2014.*

[7] Parks, Joseph M.D. Achievements of Missouri's CMHC Healthcare Homes: How Far We've Come, January 2015

[8] Progress Report: Missouri CMHC Healthcare Homes. November 1, 2013

[9] Economic Impact of Integrated Medical-Behavioral Healthcare. Milliman American Psychiatric Association Report. April 2014

[10] Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program. Rand Corporation. 2014