TRANSFORMATION PROJECT SUGGESTIONS

Contact Information	***Identify point person, telephone number, e-mail address*** Dr. Kathleen Burgoyne, Foundation for Healthy Generations, 206-498-2993, Kathyb@healthygen.org ***Which organizations were involved in developing this project suggestion?*** Foundation for Healthy Generations, Healthy Living Collaborative of Southwest Washington, CHOICE Regional Health Network, Cascade Pacific Action Alliance (Accountable Community of Health), Area Agency on Aging and Disabilities of Southwest Washington, Sea Mar Community Health Centers, PeaceHealth, Uncommon Solutions, Cowlitz County Public Health and Community Services, Providence Medical Group, Providence CORE, UnitedHealthcare and Washington Dental Service Foundation.
Project Title	*Community Health Workers Linking and Engaging Difficult-to-Locate and High Utilizers to Community-Based Care Coordination Services*

Rationale for the Project

Problem Statement: The majority of Medicaid costs are attributable to a small portion of the Medicaid population: the highest-spending 5% account for 53% of total expenditures.[i] The top spenders (i.e., "high utilizers" or "super utilizers") are high-need, complex patients: 83% of the highest-spending 1% have at least three chronic conditions.[ii] Beyond health problems, they are often facing other social and behavioral challenges. At a "Super-Utilizer Summit", David Mancuso of Washington State Department of Social and Health Services shared that of the top most frequent ED utilizers, 9 of 10 have a substance abuse problem and 10 of 10 have a mental illness.[iii] These complex patients need services beyond medical care and support beyond the traditional office-based medical team.

Supporting research (evidence-based and promising practices) for the value of the proposed project. Studies have shown that community-based care coordination activities can reduce costs by decreasing ED visits and hospitalizations, and increasing primary care and prevention. Washington's Chronic Care Management Program provided intensive care coordination and management to high-risk, complex Medicaid patients and found significant reductions in in-patient hospital costs among enrollees.[iv] Care coordination done in partnership with a community health worker (CHW) is an effective strategy and has been shown to reduce costs and improve outcomes, such as increased primary care visits, improved health status, and increased medication adherence.[v] [vi] [vii] [viii] A CHW is "a trusted member of and/or has an unusually close understanding of the community served."[ix]

Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries. The integration of CHWs into care coordination teams can further the Affordable Care Act's triple aim. CHWs act as liaisons and care extenders in whole person care. CHWs share similar cultures, languages, and life experiences of their clients, and "this trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."[x] CHWs connect high-cost patients with community-based care coordination efforts to address appropriate ED use, establish relationships with primary care and other appropriate settings, overcome barriers to care, and promote prevention and better disease self-management, thereby improving health and decreasing utilization of costly acute care services, which subsequently reduces Medicaid spending.

Project Description

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

X 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)

X Health Systems Capacity Building
☐ Care Delivery Redesign
☐ Population Health Improvement – prevention activities

Describe Intervention: This intervention targets complex, high-need, high utilizers/super utilizers. The most commonly used definition of frequent ED use is four or more visits per year.[xi] **TARGETING STRATEGY.** We will build upon the work and successes in Southwest Washington through the Healthy Living Collaborative and the current efforts to integrate physical, behavioral and oral health into whole person care. We will also leverage the existing Southwest CHW Network to hire and train CHWs and support the network's capacity to identify community problems and solutions. CHWs will help coordinate care for high utilizers who face significant social determinants of health challenges. **Tactic 1: PROGRAMMATIC APPROACH: ACTIVATE COMMUNITIES THROUGH CHWs.** We will recruit and train CHWs who will assist care teams in locating, engaging and serving high utilizers. They will also help develop new community-based strategies addressing the root causes of poor health. **Tactic 2: SYSTEMIC APPROACH: CONNECT COMMUNITIES TO REFORM THROUGH**

ACCOUNTABLE COMMUNITIES OF HEALTH. We will connect CHWs and the CHW network directly to larger reform efforts through Accountable Communities of Health (ACH). The CHWs bring local ideas to the table; the ACHs act as a platform to develop systems and policy changes, such as developing an integrated data system used by all partners in care coordination. The regional network will also support the Washington CHW Task Force in making recommendations on integration of CHWs into care teams. **Tactic 3: SYSTEMIC APPROACH: CONNECT CARE COORDINATORS.** We will work with the ACHs to develop a systems approach to coordinate care coordinators who are working with super utilizers. In this way super utilizers will not be inundated by multiple care coordinators.

Relationship to Washington's Medicaid Transformation goals: The successes of community-based care coordination efforts continue to be documented, both fiscally and by improved health outcomes. It is imperative to be able to locate hard-to-find clients who need the most help. CHWs can be integral in locating these clients. Complementing current coordinated care efforts by adding the CHW component will fast track the ability to integrate treatment for chronic health conditions, including mental illness, addiction and dental disease.

Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity/reducing health disparities: By integrating CHWs into the identification of high utilizers in order to provide whole person care, health and social service care teams can address not only the presenting medical conditions, but the barriers that may be preventing successful self-management of chronic conditions. The Institute of Medicine supports the use of CHWs to provide better care to diverse and underserved populations and reduce health inequities.[xii] CHWs are particularly valuable in connecting populations with limited English proficiency and those who are distrustful of the medical establishment to primary and preventive care and linking them to needed supports in the community. Project goals include integrating CHWs into care teams as the locators of high utilizing patients and connectors to appropriate service providers, including mental and oral health services, thereby reducing the spending of high utilizing patients, and establishing coordinated, high-quality care. Project outcomes include improved patient health, both in preventive care and the management of chronic disease; decreased non-urgent ED utilization, preventable hospitalizations, and other avoidable high-cost services; regular ongoing primary care visits; reduced costs per patient; patient satisfaction with care quality; improved health outcomes; and the creation of an opportunity to explore innovative ways to leverage partnerships and reinvest funds into community-based prevention with the goal of maximizing population health by understanding the specific needs of target populations.

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: This project proposal is linked to all transformation initiatives, including 1422 grantees and the Accountable Communities of Health.

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. A number of organizations have expressed interest in partnering, including: Area Agency on Aging & Disabilities of Southwest Washington (AAADSW), CHOICE Regional Health Network, Sea Mar Community Health Centers, PeaceHealth, Cowlitz County Public Health and Community Services, Providence CORE, UnitedHealthcare, and Washington Dental Service Foundation.

Core Investment Components

Describe: Proposed activities and cost estimates ("order of magnitude") for the project. Activities include: protocol development (e.g., referrals, documentation); CHW hiring & training – CHW role, role on care team, EMR; orientation of host agency/care coordination team; supervisor training; identification of potential partners and referral sources; identification of high utilizers; CHW service provision [outreach - home visits; support implementation of care plan with patient; coordinate with local health and human service providers for services; patient advocacy; provide appropriate health education/coaching (e.g., disease self-management); connect to sources of social support]. Cost estimates may vary dependent on caseload, intensity of service provision, "retention" and other factors, from $70 to $9,514 per individual.[xiii] Dependent on economies of scale a relative estimate is $565,600 for 1,500-2,800 individuals.

Best estimate for: **How many people you expect to serve, on a monthly or annual basis, when fully implemented. How much you expect the program to cost per person served, on a monthly or annual basis.** Based on historical tracking of pending client referrals and client program take-up/opt out rates, AAADSW estimates that there are as many as 1,300 client referrals where CHW partnerships would be beneficial in location and engagement in care

coordination services across the four counties of the SW region. Across 7 counties in the Cascade Pacific Action Alliance (CPAA) region there are approximately 1,500 potential clients who meet criteria of being high-spending (top 1%), with at least 3 or more chronic conditions. Combined, across 9 counties and 2 regions there are approximately 2,800 potential clients to serve with this program. We estimate that CHWs could do outreach to approximately 37 individuals per month (some programs have a sense of expected monthly caseload and rate of "retention" of those cases and ability to outreach to new people – this is critical to overall estimates of engagement rate and total number of individuals engaged). We will use a similar approach to estimating potential people served as we partner with interested providers in both the Cascade Pacific Action Alliance region, as these two regions have two cross-over counties. In a similar intervention there was a savings of $4,564 per enrollee in a Medicaid managed care system.[xiv]

How long it will take to fully implement the project within a region where you expect it will have to be phased in. We anticipate full implementation of the project in the Southwest region in six months, 8 months for the CPAA region.

The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline. Based on previously cited evidence, the greatest potential for ROI lies in identifying changes in health care cost and utilization before and after program engagement. To test the fidelity of the model, the outcomes listed in this proposal plus program-tracked process measures related to length/level of exposure to the program, plus carefully tracked program costs will allow for a robust return on investment analysis and outcomes evaluation. If there is access to claims data we can additionally identify people that meet program criteria but are not engaged (particularly through clinics without a CHW) and create comparison groups.

Project Metrics

The state will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Key process measures include developing a protocol, hiring CHWs, training CHWs and non-CHW staff, and identifying partners and referral sources. Key outcome measures for this project from the Healthier Washington Statewide Common Core Set of measures for 2016 include: alcohol/drug treatment retention, alcohol/drug treatment penetration, cardiovascular monitoring for people with cardiovascular disease and schizophrenia, comprehensive diabetes care, mental health treatment penetration, plan all-cause readmission rate, psychiatric hospitalization readmission rate, and access to primary care for adults. Patient self-reported outcomes related to health, well-being and satisfaction with care could be collected via survey.

***If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?** Baseline measures that come from claims data could potentially be obtained by leveraging the state's ProviderOne data solution being developed by Providence CORE under the direction of the Health Care Authority. The data solution can be leveraged for outcomes measurement purposes within region through the ACH. Additional development and funding to accomplish these baseline estimates would managed and funded regionally. Accurate baseline measures can be created by limiting the measure to individual clients meeting claims-based program target population criteria. Criteria could be a combination of historical health care utilization and cost, and/or diagnoses. Baseline measures that are self-reported by the client engaged by the program could be collected through survey administration. Baseline access to social determinants of health related resources could be collected by CHW's upon client engagement.

---

[i] Kaiser Family Foundation. *Medicaid Moving Forward.* March 2015.

[ii] Center for Health Care Strategies, Inc. *The Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions.* October 2007.

[iii] Center for Health Care Strategies, Inc. *Super-Utilizer Summit: Common Themes from Innovative Complex Care Management Programs.* October 2013.

[iv] Xing J, Goehring C, Mancusco D. Care Coordination Program for Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs. Health Affairs. 2015 Apr;34(4):653-61.

[v] The Commonwealth Fund. *Transforming Care: Reporting on Health System Improvement.* December 2015.

[vi] Johnson D, Saavedra P, Sun E, Stageman A, Grovet D, Alfero C, et al. Community Health Workers and Medicaid Managed Care in New Mexico. J Community Health. 2012 Jun;37(3):563-71.

[vii] Whitley EM, Everhart RM, Wright RA. Measuring return on investment of outreach by community health workers. J Health Care Poor Undeserved. 2006 Feb;17(1 Suppl):6-15.

[viii] Babamoto KS, Sey KA, Camilleri AJ, Karlan VJ, Catalasan J, Morisky DE. Improving diabetes care and health measures among Hispanics using community health workers: results from a randomized controlled trial. Health Educ Behav. 2009 Feb;36(1):113-26.

[ix] American Public Health Association. Community Health Workers. Available here: www.apha.org/apha-communities/member-sections/community-health-workers

[x] Id.

[xi] LaCalle E, Rabin E. Frequent users of emergency departments: the myths, the data, and the policy implications. Ann Emerg Med. 2010 Jul;56(1):42-8.

[xii] Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Brian D. Smedley, Adrienne Y. Stith, Alan R. Nelson, editors; Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Board on Health Sciences Policy, Institute of Medicine.

[xiii] Viswanathan M, Kraschnewski J, Nishikawa B, Morgan LC, Thieda P, Honeycutt A, Lohr KN, Jonas D. Outcomes of Community Health Worker Interventions. Evidence Report/Technology Assessment No. 181 (Prepared by the RTI International–University of North Carolina Evidence-based Practice Center under Contract No. 290 2007 10056 I.) AHRQ Publication No. 09-E014. Rockville, MD: Agency for Healthcare Research and Quality. June 2009.

[xiv] Johnson D, Saavedra P, Sun E, Stageman A, Grovet D, Alfero C, et al. Community Health Workers and Medicaid Managed Care in New Mexico. J Community Health. 2011;37(3):563-71.