MEDICAID WAIVER TRANSFORMATION PROJECT

Contact Information	**Primary Contact:** Alison Carl White, Better Health Together, 509-499-0482 **Organizations Involved in Developing Project Suggestion:** Better Health Together, Empire Health Foundation, Providence Health Care, Volunteers of America, Catholic Charities, City of Spokane, Spokane Fire Department
Project Title	*Radically improving the health of our region through Community Health Workers*

Rationale for the Project: Problem statement – why this project is needed

- 1% of people account for 20% of all health care spending, Almost 25% of that is waste due to overtreatment, duplication of services and/or poor care coordination[1]
- $4 billion dollars spent on Health Care in Better Health Together ACH region[2]
- During the Homeless Community Count in 2015 there were over 1200 people identified as homeless[3]
- Health Status in our ACH region is some of the worst in the state[4]

The dilemma for the most vulnerable people in our community is not the unavailability of services, but is instead the challenge of consistent engagement with the existing system of providers and services. For example, our client Joe has been homeless for ten years, has an untreated mental illness and has battled drug addiction for many years. This has resulted in an inability for Joe to work regularly, retain housing and he therefore has limited credit history. We are fortunate in our community to have services that address each of these conditions, however, these services are siloed and uncoordinated. This greatly reduces the chances that Joe, who is focused on the daily task of survival, may ever be able to stabilize each condition simultaneously.

Supporting Research (evidence-based and promising practices) for the value of the proposed project
Better Health Together (BHT) launched its Community Cares Community Health Worker (CHW) program in March 2014 in partnership with Empire Health Foundation, Providence Health Care, Washington Dental Service Foundation and the City of Spokane with the goal of reducing Emergency Room utilization and improving health status for some of Spokane's most vulnerable individuals. This CHW program links individuals who were accessing the Emergency Room for inappropriate reasons to community resources and coordinated care.

Hot Spotters & the Health, Housing, Homelessness partnership*:* The Hot Spotter and H3 program, similar to the King County Familiar Faces program, engages high need patients who present to emergency rooms and emergency responders with a complex blend of social, medical, mental health and/or substance abuse issues. This program aims to improve health outcomes and reduce costs for medically vulnerable individuals through an innovative pairing of a Community Health Worker with medical and community resource care

In 2015 we enrolled 146 clients;

- 100% of client referred were enrolled in Health Insurance
- 100% of clients developed/are developing a Health Action Plan to improve their health status (we expect to see a 20% increase in their Patient Activation Measures within one year)
- 46 clients were secured housing
- For H3 clients there was a 22% reduction in ER visits from previous 3 months before enrollment

The following estimates actual savings for 4 Hot Spotter Clients and estimates more than $2.5 million in

[1] http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_82.pdf
[2] www.lettingthedataspeak.com/county-health-care-costs-washington-state-example/
[3] https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_WA_2015.pdf
[4] http://www.countyhealthrankings.org/app/washington/2015/overview

savings for ER/EMS usage for the Hot Spotter and H3 program in 2015.

	Pre CHW engagement ER/EMS Usage	Estimated COST to ER & EMS	Post engagement ER/EMS Usage	Cost Post CHW engagement	Est SAVINGS ER/EMS usage
Client #1	9	$10,547.62	2	$2,343.92	$8,203.70
Client #2	33	$36,202.00	3	$3,291.09	$32,910.91
Client #3	21	$16,966.00	0	$-	$16,966.00
Client #4	11	$12,915.00	1	$1,174.09	$11,740.91

Dental Emergencies Needing Treatment (DENT): connects patients to dental care and expands the network of dental providers accepting Apple Health. Our Community Health Worker team receives referrals from the Emergency and connects patients with Medicaid accepting dentists, provides behavioral coaching and ensuring that patients have the support to follow their dental care plan. We are also working to recruit new dentists to accept Apple Health patients. In 2015 we received 4,000 clients referred from Providence ER:

- 100% of eligible clients were enrolled in Health Insurance
- 93% of referred clients were scheduled with a Medicaid Accepting Dentist;
- Medicaid Accepting Dental Network increased from 22 providers to 53 providers
- Emergency Dental Appointments increased from 51 to 225

BHT estimates DENT has generated over $2 million in savings from avoidable Emergency Room (ER) readmissions costs in the first 18 months of this program through the following assumptions:

- On average, the hospital billed $650 per ER visit
- Past data shows that a dental patient, who does not get adequate dental care, will return to the Emergency Room four times
- A majority of DENT clients do not return to the ER for dental issues, resulting in at least $650 in savings per enrolled client.

While the BHT CHW program is an emerging program in the Spokane Region, there is growing evidence to demonstrate the added benefit to the patient/client and savings to the health care system. The following table (courtesy of Foundations for Health Generations) demonstrates these savings:

Program	*Target Population*	*ROI/Savings*	*Impact*
Denver Health	Underserved men	$2.28 return on investment per dollar spent, annual savings of $95,941	Shifted inpatient and urgent care to primary care
Arkansas Community Connector Program	Underserved Medicaid-Eligible adults	$2.92 return on investment per dollar	Connected adults with unmet long-term care needs to agencies and services
Molina Health Care in New Mexico	Medicaid patients who are high consumers of health resources	Savings of $4,564 per enrollee in a Medicaid Managed Care system	Reduced emergency room use, days of inpatient care, narcotic use and other prescription drug use

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

According to a December 2015 Health Care Authority Report, there are 191,093 Medicaid Beneficiaries in our ACH region. To date, 81% of clients served by our Community Health Workers are Medicaid Eligible,

This model offers the opportunity to target the most vulnerable people in our community, who are often Medicaid beneficiaries, and reduce their use of avoidable medical care and/or more appropriately connect them to the services that will allow them to improve their health and reduce costs.

Project Description

Which Medicaid Transformation Goals[ii] are supported by this project/intervention?

Reduction in avoidable use of intensive services – Through the use of Community Health Workers, we will reduce avoidable health care costs (such as overuse of the Emergency Department) and manage long term chronic conditions that left untreated will increase risk for intensive services.

Accelerate transition to value-based payment – Many examples look to manage health and cost of care through better care coordination and management. Providing a region wide network of Community Health Workers integrated with current best-practice and evidence-based programs such as Health Homes that are designed to operate under a per member, per month system will accelerate the successful transition to value-based payment.

Ensure Medicaid per-capita growth is below national trends – Reductions in the use of unnecessary health care services will be a key element to controlling Medicaid (and other payment systems) cost.

Which Transformation Project Domain(s) are involved?

- Care Delivery Redesign

The Better Health Together Community Health Worker will radically improve the health of our region. This program is comprised of several key elements:

- Centralized community effort to provide best practice, client-centered wrap-around services and cross community care coordination for complex, high utilizers;
- Promotion of a collaborative effort of outreach to high utilizers of system resources;
- Use of flexible funds to meet unique and multiple needs to prevent poor outcomes or stabilize a client;
- Development of a multi tiered CHW program that provides a range of support from medical care coordination to benefit enrollment to chronic disease management;
- Standardization of training, technical assistance and support to ensure each of our community health workers are prepared to provide appropriate care for vulnerable populations; and
- Evaluation and tracking of outcomes to ensure a strong Return on Investment

Relationship to Washington's Medicaid Transformation goals.

Through the use of a Community Health Worker workforce that will connect wrap-around support services such as housing, food, and income stability with behavioral coaching, we will achieve these local outcomes:

- Reduction of Emergency Room Utilization by 50% by 2018;
- Reduction of EMS Utilization by 25% by 2018; and
- Reduction in Medicaid spending by 15% by 2018.

This aligns with Washington's Medicaid Transformation goals to reduce avoidable use of intensive services and settings and ensure that Medicaid per capita cost growth is two percentage points lower than the nation trend.

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

The above describes activities and interventions, we will achieve the following measurements in year 1 for all BHT enrolled clients:

- 3,750 clients served by 15 CHW;
- 100% of BHT enrolled and eligible clients have Health Insurance;
- 100% of BHT enrolled clients will have access other eligible benefits (Social Security, Food Benefits);
- 100% of BHT enrolled clients have a Primary Care Provider.

For Hot Spotter enrolled Clients:

- 100% of BHT clients have a Health Action Plan;
- 80% of BHT clients will show an increased Patient Activation Measure increase of 10% (this is our current measure for health status improvement, we expect to evolve this during 2016);
- 80% of BHT clients that we house remain in housing one year after enrolling.

For DENT enrolled Clients:

- 100% of referred clients are contacted within 48 hours;
- 90% of referred clients are connected to a Medicaid Accepting Dental Provider;
- 50% increase in available Emergency Dental Appointments to 450 per month; and
- 75 Medicaid Accepting Dentists in our DENT Provider Network.

Better Health Together develops all programs with a focus on increasing health equity across ethnicity, soci-economics and geography. The CHW program is intentionally designed to ensure that all individuals have access equitable care.

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.

Better Health Together will align these efforts with a region wide Health Home Program There is a natural link of the Health Homes program with clients enrolled in our Community Health Worker programs. This offers a great opportunity to leverage additional resources and savings.

We will explore partnerships to place Community Health Workers at:

- ***Housing First units*** that are scheduled to open starting in July of 2016
- ***Community Court***: a community effort to find alternatives to jail-time for non-violent offenders who commit quality-of-life offenses. These clients often have untreated health issues that are contributing to their arrests);
- ***Children's Administration's Family Assessment Response program***: an alternative to out of home placements for low to moderate risk reports of child neglect case and developing efforts to create a similar program with the Office of the Public Defenders office. This efforts pairs a Social Worker with a CHW to address untreated health issues that are contributing to the neglect of their children.)
- ***The Zone:*** a soon to be designated area in Spokane with the highest concentration of poverty and health disparities
- ***School Based Clinics*** throughout the region, such as the proposed clinic at Rogers High School in Spokane, one of the highest concentrations of poverty and health disparities schools in our region.

Additionally, we are excited to work with our statewide partners to leverage our local efforts. We are specifically interested in collaboration between the projects submitted by the Washington State Hospital Association for **ER is for Emergencies Best Practices 3.0: Linking to Community Care for Patients with Behavioral Health and Chronic Care Needs** and Washington Dental Services Foundation project for the expansion of **Dental Emergencies Needing Treatment**.

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.

- Providence Health Care and Rockwood Health Care
- Spokane Housing Authority, Catholic Charities, Volunteers of America and other housing providers
- SNAP & Rural Resources: our region's Community Action Organization
- City of Spokane, Spokane County and other city and counties from around the region
- Spokane Fire Department and other Emergency Management Services from around the region
- Spokane School District and NEWESD 101
- Empire Health Foundation & Spokane County United Way

Core Investment Components

This is a program that will be ready to scale up as soon as funds are available. We would add 10 CHW in 2017 and 10 in 2018. Community Health Worker salary ranges from $35,000-$50,000 depending on experience and credentials. We calculate a 20% cost in benefits. We will leverage this salaried position with other local resources to supplement needed wrap-around services such as housing vouchers, rent deposits, energy assistance, food benefits, clothing donations, educational training and increasing income security. We expect every CHW to carry a caseload of 25 clients per month and serve 90 clients annually. An average cost per CHW is $54,000 (salary and benefits) to serve 90 clients annually, resulting in a total cost per client of $600. If we reduce one emergency visit per client, this is likely to have paid for the CHW coordination.

Project Metrics

In addition to the above described metrics, we will implement a set of broader outcome measures based on the Washington State Common Measure Set on Health Care Quality and Cost.[5] Such as:

- Access to Primary Care and Prevention – Adults: Adult Access to Primary Care Providers
- Behavioral Health: Adult Mental Health Status
- Effective Management of Chronic Illness in the Outpatient Setting
- Ensuring Appropriate Care: Avoiding Overuse

[i] 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.

[ii] 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.

[5] http://www.hca.wa.gov/hw/Documents/measures_list.pdf