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:*** Tom Waltz, Contracts and Development Manager Area Agency on Aging and Disabilities for Southwest Washington 360-735-5716, waltz@dshs.wa.gov ***Which organizations were involved in developing this project suggestion?*** • Area Agency on Aging and Disabilities of Southwest Washington • Washington State University • Sea Mar Community Health Centers • HomeWatch Caregivers • Legacy Health Systems Salmon Creek • PeaceHealth Southwest Washington Medical Center • HealthSaaS, Inc.
Project Title	***Title of the project/intervention:*** Technology to Support Aging in Place (TSAP)

Rationale for the Project

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

  Statement: Washington's network of Long Term Services and Supports (LTSS) lacks Medicaid authorization to purchase, deploy and receive payment for Telehealth Remote Patient Monitoring technologies even when working in collaboration with physicians caring for chronically ill patients who require access to essential social supports largely only available through the LTSS network. The proposed concept is intended to address this problem in order to achieve better health outcomes, improved quality of care, and reduced healthcare costs for Medicaid beneficiaries with the greatest potential for avoiding ongoing intensive care.

  Discussion: Elderly Medicaid beneficiaries depend on the availability of Long Term Services and Supports (LTSS) provided through a network of agencies and organizations to meet their needs for activities of daily living, and, with increasing frequency, to help manage chronic health conditions in consultation with healthcare providers. For example, of the 4,100 Medicaid beneficiaries receiving Title XIX case management services through the Area Agency on Aging and Disabilities of Southwest Washington in 2015, those with one or more chronic conditions accounted for more than 39% (1,600 individuals). As the elderly Medicaid population continues to grow, demands for services and costs will increase, which will reflect the numbers of individuals with chronic conditions. Employing a Telehealth Remote Patient Monitoring model (TSAP) through the LTSS network will enable Medicaid beneficiaries to access health care, social supports and avoid the need for intensive interventions. (This concept is based on a model designed by the organizations identified above.)

  Washington state's Medicaid Program is one of 19 state programs nationally that allow for the reimbursement of telehealth (including Remote Patient Monitoring) under the direction of clinicians (WAC 388-551-2000 through WAC 388-551-2220). However, Medicaid precludes both (1) the role of non-clinical LTSS in terms of Medicaid reimbursement for telehealth related services in general, and (2) the payment for devices and time spent to monitor and support a systematic telehealth approach.

  Seniors receiving Medicaid, particularly those in isolated situations or those who require intensive in-home services are at greater risk for severe complications, injury or premature death as a result of their physical

limitations and/or chronic health condition(s) than are similarly aged persons not receiving Medicaid. The proposed TSAP concept will enable a range of caregivers represented among the LTSS network to monitor clients' health conditions through remote data collection devices, provide alerts if a threshold is breached and transmit advisories to caregivers for appropriate action. In the event that a participating client's symptoms become severe, a care escalation pathway will result in proper intervention(s) by the patient's healthcare team, which includes healthcare providers, case managers and caregivers. Such interventions may include client reassessment, modification of services, education, services enhancement, and additional consultation with the patient's physician and/or healthcare team.

As a Medicaid Transformation Waiver concept, Technology to Support Aging in Place (TSAP) will address existing telehealth barriers within the State's Medicaid Program that prevent the widespread application of telehealth among providers represented among the LTSS network, and establish a process for integrating LTSS and healthcare systems to provide patient-centered Remote Monitoring Services for Medicaid beneficiaries with specific chronic condition(s). The model will support elderly Medicaid beneficiaries to successfully age in place, and result in avoidable hospital readmissions. See project goal and intended outcomes below.

- *Supporting research (evidence-based and promising practices) for the value of the proposed project.*[i]
  Discussion: The below cited research represents a small sampling of a substantial body of evidence, including randomized controlled studies, that demonstrates the effectiveness of Telehealth Remote Patient Monitoring (RPM) in terms of improved patient health outcomes, improved quality of care and reduced care costs.

  1. **Integrated Telehealth and Care Management Program for Medicare Beneficiaries with Chronic Disease Linked to Savings:** Treatment of chronically ill people constitutes nearly four-fifths of US health care spending, but it is hampered by a fragmented delivery system and discontinuities of care. This study examines the impact of a care coordination approach, which integrates a telehealth tool with care management for chronically ill Medicare beneficiaries. Savings among patients who used the telehealth program was associated with spending reductions of 7.7% to 13.3% ($312–$542) per person per quarter. http://content.healthaffairs.org/content/30/9/1689.full.html
  2. **Care Coordination/Home Telehealth: the systematic implementation of health informatics, home telehealth, and disease management to support the care of veteran patients with chronic conditions:** Routine analysis of data obtained for quality and performance purposes from a cohort of 17,025 CCHT patients shows the benefits of a 25% reduction in numbers of bed days of care, 19% reduction in numbers of hospital admissions, and mean satisfaction score rating of 86% after enrolment into the program. The cost of CCHT is $1,600 per patient per annum, substantially less than other NIC programs and nursing home care. http://www.ncbi.nlm.nih.gov/pubmed/19119835
  3. **Emerging Heart Failure Strategies Improve Outcomes and Reduce Readmissions (**May 2015), a retrospective analysis of the Medicare patient population, demonstrated a 58% reduction in all-cause 30-day readmissions for these remote monitored patients. Additionally, for patients with heart failure and reduced ejection fraction (HFrEF) already on guideline-directed medical therapy, a retrospective analysis showed that it reduced mortality by 57%. http://www.modernhealthcare.com/article/20150501/SPONSORED/150509999
  4. **Telemonitoring reduces readmissions 44 percent in 4-year, 500-patient study** (October 2014) A study from Pennsylvania's Geisinger Health Plan shows that remote monitoring of congestive heart failure patients can reduce readmissions by 38% to 44%, and produced a return on investment of $3.30 on the dollar. http://mobihealthnews.com/37076/telemonitoring-reduces-readmissions-44-percent-in-4-year-500-patient-study

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

  - Federal Objective for Medicaid - *Increase and strengthen coverage of low income individuals*: TSAP technology will strengthen individuals' coverage by including access to technology advances that are seldom available to low income individuals.

- Federal Objective for Medicaid - *Increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations*: A key component of TSAP is to build capacity (i.e., networks) using a collaborative approach involving healthcare providers and the LTSS to promote, deliver and observe Medicaid beneficiaries' health condition using stored and real time data.
- Federal Objective for Medicaid - *Improve health outcomes for Medicaid and low-income populations*: The proposed TSAP model focuses on high cost/frequent utilizers of the healthcare system. A component of TSAP is the establishment of a RPM Care Plan developed with participant's physician as a means of keeping the patient healthy by virtue of setting parameters for patient action and care escalation.
- Federal Objective for Medicaid - *Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks*: TSAP represents a significant advance in terms of the process and efficiency in which Medicaid beneficiaries (together with healthcare and LTSS providers) will be able to monitor their chronic condition(s) and respond to symptoms before advancing to the stage requiring emergency care and/or hospitalization. Additionally, the TSAP model facilitates engagement between representatives of LTSS organizations and healthcare providers; whereas such interactions tend to be infrequent and associated with a patient's unavailability to receive home care services because their health condition has resulted in a hospital readmission.

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 (e.g., persons discharged from local jail facilities with serious mental illness and or substance use disorders).

Region(s): Initially, TSAP would benefit LTSS agencies and healthcare providers throughout the Southwest Washington region (Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum Counties), and the concept has significant potential for implementation in other regions or statewide (e.g., the King County AAA has expressed an interest in the TSAP concept).

Target population: The target population for TSAP includes individuals with the following characteristics:

- Age 60 and older, and
- Medicaid recipient, and
- Live in a private residence (as opposed to an adult care facility), and
- Have one or more of the following chronic conditions: heart failure, COPD, diabetes, hypertension, obesity.

Subpopulation: A subpopulation of this project includes disabled adults meeting the following criteria:

- Age 18 or older but under age 60, and
- Receive Medicaid, and
- Live in a private residence, and
- Have one or more of the following chronic conditions: heart failure, COPD, diabetes, hypertension, obesity.

General observation regarding the target population: Though it is not within the scope of this Transformation Concept, TSAP technology (and its resulting benefits) could be replicated across all age groups and communities where there are system capacities and supports in place.

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

  WA Medicaid Transformation Goal - *Reduce avoidable use of intensive services and settings*: TSAP will enable patients, caregivers and providers to engage in appropriate levels of health care before reaching the critical symptomatic stage in which hospital readmission is unavoidable.

  WA Medicaid Transformation Goal - *Improve population health*: TSAP technology creates an environment that is conducive to improved population health by incorporating health literacy and education for persons with chronic conditions, and facilitates their access to a system of care that includes LTSS and healthcare providers.

  WA Medicaid Transformation Goal - *Ensure that Medicaid per-capita cost growth is two percentage points below national trends*: As an initiative that has been demonstrated to improve the health of individual participants, TSAP technology is supported by a data collection platform that enables patient information to be collected and analyzed on an individual and aggregate basis. This capability will support evaluative activities necessary to demonstrate success, and support a data driven system of care that enables evaluators to access multi-variant conditions.

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

  The goal of TSAP is to establish a network of LTSS and healthcare providers serving Medicaid patients to address the fundamental challenges of safely aging in the home environment through the use of cost-effective Telehealth Remote Patient Monitoring devices for elderly Medicaid clients with a chronic health condition.

  - Expected Outcomes

    1. Identify the characteristics of adult Medicaid recipients (age 60 and above) who would benefit from in-home remote monitoring devices (i.e., telehealth services) based on client health condition and the kind(s) of LTSS.
    2. Identify and overcome challenges associated with the use of telehealth monitoring devices for the subject Medicaid population from the perspectives of patients, caregivers, healthcare providers and the LTSS network.
    3. Address steps necessary to put telehealth monitoring systems in place, including policies and procedures, interlocal agreements, training, care escalation protocols, outreach and enrollment, technical capacity, risk assessment and avoidance, etc.
    4. Evaluate the efficacy of telehealth Remote Patient Monitoring in terms of improved patient health and wellbeing, Client willingness and ability to adopt the technology and adhere to the monitoring regime.
    5. Improve health outcomes and reduce hospital admissions among the target population.
    6. Improve quality of life based on changes in PRISM and/or PAM scores.
    7. Identify costs associated with monitoring clients based on chronic health condition(s) and device(s) used, and determine the greatest opportunities for cost savings (ROI) as a result of TSAP.
    8. Collect data to support a better understanding of the role of TSAP interventions to support aging in place and improve the interrelationships between LTSS and healthcare providers.
    9. Identify system changes that may be necessary to implement TSAP use among patients, caregivers and LTSS and healthcare service providers.

  "Project goals, interventions and outcomes" will be addressed further in a full TSAP proposal, if requested.

- *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 has direct links to the following transformation initiatives, including:

  - Washington Health Home Program
  - Accountable Communities of Health

- Targeted Foundational Community Supports

In addition, there are linkages to State and local programs that would have a direct role in the project, including:

- Area Agencies on Aging
- Title XIX Case Management services
- Home Care Agencies serving Medicaid beneficiaries

- *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.*

  As listed on page one of this template, several local partners have been engaged in the development of TSAP since June 2015 (three of these organizations are represented on the Southwest Washington Regional Health Alliance (ACH) Board. Additional partners would include other ACH participants, local clinical specialty providers, and additional AAA-contracted home care agencies.

Core Investment Components

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project.*

  - The following are project related expenses associated with the activities of TSAP. These activities were determined as part of a pilot study conducted in Southwest Washington during 2015.
    - Contracts with Home Care Agencies to support the cost of patient monitoring: Home care agencies contract with the AAA to provide services to the target population. These organizations would be trained and supported as a part of TSAP to deliver monitoring to patients that they are serving.
    - Process activities to support program setup prior to implementation: This includes policies and procedures, protocols, care planning documents, patient agreements, outreach and enrollment, staff and client education, and care-escalation pathways developed in collaboration with various care teams to address each of the five chronic conditions (heart failure, COPD, diabetes, hypertension, and obesity)
    - Remote patient monitoring devices, : This includes devices to support Remote Patient monitoring for each of the five chronic conditions (heart failure, COPD, diabetes, hypertension, obesity). Included are Bluetooth enabled personal bath scales, blood pressure cuff, pulse oximeter, glucometer, electronic journal, and electronic medipak. Also included is a plug-in 2net hub device to transmit data, maintenance costs and portal activation.

- *Best estimate (or ballpark if unknown) for:*

  - How many people you expect to serve, on a monthly or annual basis, when fully implemented.

    For a regional approach (involving Southwest Washington only) we expect to serve 1,357 people based on 80% of the eligible individuals served by the Area Agency on Aging in 2015 x 6% growth. *We have had conversations with the King County AAA, and there is an expressed interest in expanding the project to this region as well. Cost estimates for King County are not included.*

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

    The gross estimated expenditure per patient would be approximately $3,200. This does not include costs for patient follow up (these elements are currently the subject of further study). Estimates would be generated based on additional study if a full proposal is requested.

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

  Recent experience gained through a pilot project in Southwest Washington focused on Heart Failure patients indicates that the base amount of time (from concept to launch) is seven months. This includes establishing interlocal agreements, convening community partners, staffing, device planning and procurement, data design, patient recruitment and informed consent, staff training, client outreach and enrollment.

  Additional implementation information for TSAP will be submitted with a complete proposal, if requested.

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

  - **TSAP Pilot Project:** The estimated ROI, based on the TSAP pilot project and national hospital admissions data is substantial for heart failure patients alone. For example, the TSAP pilot project gross expenditure per heart failure patient is $794 for heart failure monitoring, while the readmission costs for a person experiencing complications from heart failure are $13,000 (*Becker's Hospital Review, 2009).*

  - **Readmissions Lead to $41.3B in Additional hospital Costs:** Some 1.8 million readmissions cost the Medicare program $24 billion; 600,000 privately insured patient readmissions totaled $8.1 billion; and 700,000 Medicaid patient readmissions cost hospitals $7.6 billion, according to the AHRQ. These numbers result in a similar per re-admit cost between Medicare and Private Insured of $13.5k per with Medicaid slightly lower at $10.8k per. http://www.fiercehealthfinance.com/story/readmissions-lead-413b-additional-hospital-costs/2014-04-20

  Research cited on page 2 provides addition information on the potential for cost saving associated with the TSAP concept. Additional ROI information for TSAP will be submitted with a complete proposal, if requested.

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].

  TSAP will generate data to measure performance based on two of the ten Standardized measures, including:

  - Comprehensive Diabetes Care
  - Plan All-Cause Admission Rate

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