TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTION

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Project Title	Implementing and spreading collaborative care (COMPASS) for high risk complex Medicaid and Medicare enrollees in primary care settings.

Rationale for the Project

1. *Problem statement:* Multi-condition complex enrollees are typically 20% of the enrollment but consume 80% of the resources (80/20 rule). Research identifies that 30% of the expense is due to waste, rework and redundancy within the health care delivery system. Average costs range from $1200 pmpm to $5000 pmpm as a result of current limitations due to FFS reimbursement. Collaborative care for high risk complex enrollees requires interventions beyond the primary care visit and can best be achieved by providing resources within the primary care setting to address many of the concomitant stressors affecting the enrollee. Behavioral patterns and social circumstances are 60% of the determinants to health and include mental health, substance abuse and social/economic stressors that result in 23% avoidable Emergency Department (ED) visits and a 70% higher readmit rate over baseline for discharges from inpatient facilities. For Medicaid enrollees, behavioral patterns and social/economic stressors result in increased homelessness, morbidity and mortality of health. CHI/Franciscan Health and the independent provider community have inadequate resources to meet the complex needs of our patient population due to silo's and lack of alignment of funding (FFS). This project will provide a patient engagement model that integrates best practices within primary care and is high touch/high communication with enrollees suffering from poly-chronic conditions through weekly systematic case review. This project also transitions practices to value based care by focusing on quality (HEDIS/Stars), outcomes and satisfaction. https://www.icsi.org/

2. RHN has prioritized integrating post-acute delivery, home care and long term care with the acute care delivery system supporting primary care management. This proposal provides comprehensive care management to bridge to the integrated delivery systems while supporting the primary care provider to reduce existing silo's of care and to improve continuity, communication and coordination for complex enrollees with multiple complex conditions.

Supporting research (evidence-based and promising practices) for the value of the proposed project.[i] Studies have shown that providing access to and addressing behavior patterns/ social economic factors with enrollees suffering from multiconditons in primary care settings: reduces avoidable ED visits and re-admits within 30 days, improves HEDIS bundled metrics for chronic illness, reduces depressive symptoms (PHQ 9) and improves satisfaction of the enrollee and provider. Collaborative Care interventions are more effective than usual care for depression, anxiety disorders and co-morbid medical conditions such as heart disease, diabetes and cancer. Implementation has resulted in lower total cost of care, reduced HBA1c, reduced BP and HDL and PHQ 9 scores.

1. *Collaborative Care for Patients with Depression and Chronic Illnesses*, Katon,W., New England Journal of Medicine, 2010;363. (*https//www. nejm.org/* n engl j med 363;27 december 30, 2010)

2. *Systematic Case Review: Improving Treatment for Complex Mental and Medical Conditions*, Trevis, J.,

Minnesota Physician, Oct. 2014, vol. No 7.

3. *Cost-effectiveness of a Multicondition Collaborative Care Intervention,* Katon,W. Arch. Gen. Psychiatry.2012 May; 60(5).

4. *Community-Integrated Homebound Depression Treatment for Older Adults*, Ciechanowski, P., JAMA, April 2004.

5. *https://www.icsi.org/about_icsi/our_history/*

6. *http://www.samepage.samepagehealth.com/home/outcomes*

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

As compared with usual care, an intervention involving trained staff who provides guideline-based, patient-centered ca management of depression and chronic disease significantly improves control of medical disease and depression for enrollees. This program increases primary care access and capacity and addresses the following federal objectives for Medicaid enrollees:

- Increase and strengthen coverage of low income individuals.
- Increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-inc 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 init to transform service delivery networks.

Project Description

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

X Reduce avoidable use of intensive services
X Improve population health, focused on prevention
X Accelerate transition to value-based payment
X Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

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

Describe:

3. *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).* CHI Franciscans will pilot and spread program in three counties; King, Pierce and Kitsap. CHI Franciscans is one of the largest health systems in the Pacific Northwest with *nine hospitals* (***St. Joseph Medical Center****, Tacoma;* ***St. Francis Hospital****, Federal Way;* ***St. Clare Hospital****, Lakewood;* ***St. Elizabeth Hospital****, Enumclaw;* ***St. Anthony Hospital****, Gig Harbor;* ***Highline Medical Center****, Burien;* ***Harrison Medical Center****, Bremerton & Silverdale;* ***Regional Hospital****, Burien)* and over 200 clinics in Washington in King, Pierce, and Kitsap counties. The target population is Medicaid and dual eligible enrollees Medicare/Medicaid and Medicare MSSP with complex comorbidities including both chronic illness and behavioral health and high-risk ED utilizers, (typically top 20% of utilizers in the enrollment). There are 1.8 M Medicaid enrollees statewide. King, Pierce and Kitsap have 400,000

adults of which the top 20% medical utilizers are targeted.

4. *Relationship to Washington's Medicaid Transformation goals*. Increasing access to comprehensive collaborative care services (systematic case review) to enrollees with multiple chronic conditions in the primary care setting removes barriers to care, reduces silo's of care, and total cost of care while improving outcomes, quality, and satisfaction with care received. Collaborative care is a low-risk, evidence-driven turnkey solution for providers to effectively take-risk on chronically ill patients– changing patient behaviors that improve measurable outcomes, quality metrics (HEDIS/STARS) while reducing medical expenses. Collaborative Care provides providers the ability to transition to value-based care delivery while billing for CPT code 99490 (FFS) for care management services. *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.*
    1. HEDIS bundles: e.g. Diabetes: HbA1c < 8%, Blood Pressure <140/90 mmHg, Cholesterol LDL < 100 mg/dL, Depression, PHQ-9 <10
    2. Annual Depression Screening (PHQ 2): 80% of enrollee population,
    3. Annual substance abuse (AUDIT 2): 80% of enrollee population
    4. ED visits, 30 day all cause re-admits savings
    5. Pharmacy, imaging savings
5. *Links to complementary transformation initiatives* –
    - *o* Washington State's Health Homes Program, MHIPs/AIMs
6. *Potential partners, systems, and organizations.* Three regional ACH's (covering King, Pierce and Kitsap Counties), social service agencies, mental health and substance abuse providers, housing, transportation, health plans, local service providers.

Core Investment Components

Describe:

Proposed activities and cost estimates ("order of magnitude") for the project. As compared with usual care, an intervention involving trained staff that provide guideline-based, patient-centered management of depression and chronic disease significantly improves control of medical disease and depression. Components of the program included systematic case review, treat-to-target methodology and behavioral health strategies. For patients completing the program, case managers provide approximately 16 contacts/patient on a weekly basis - 95% of contacts telephonic and 5% in-person. A multi-condition collaborative care program was implemented locally in eleven primary care clinics, enrolling patients with a mean of 9.6 chronic conditions, including depression and out-of-target diabetes and hypertension.

7. *Best estimate (or ballpark if unknown) for:*
   - How many people you expect to serve, on a monthly or annual basis, when fully implemented. Typically, the top 20% of enrollees utilizing costs with 2 chronic diseases are enrolled from the total enrollment. CHI has approx. 32,000 Medicare, 20,000 Medicaid and dual eligible Medicare/Medicaid to start with.
   - How much you expect the program to cost per person served, on a monthly or annual basis.

The cost of nurse contacts, including administrative time, and cost of systematic case review for a full complement of reviewers including 2 MDs (PCP/Psych.), 1 pharmacist, 1 diabetes educator and 1 patient navigator, meeting 2 hours/week to review 20-40 high risk enrollees to achieve treat to target metrics and providing comprehensive case management is $96 pmpm for the enrolled cohort (not for the entire Medicaid enrollment). Additional expenses include training and certification of navigators (approx. $75,000/year for 8) and reviewers (approx.$35,000 for teamCare including spot training, etc.) .

8. *How long it will take to fully implement the project within a region where you expect it will have to be phased in.* Three months for planning, training of staff, logistics and target enrollment strategies. Two-three additional months to implement and build caseloads working with PCP's and complex care team.

9. *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.* The financial return approx. for commercial and Medicare populations has been > 200-300%. Locally a >120% return on effort targeting the top 20% of utilizing enrollees with multiple diagnosis measuring just ED and imaging savings. Savings began within 3 months of enrollment to program by reducing unnecessary utilization including: $117 pmpm ED savings, $15 pmpm imaging savings. Additional savings accrue from reduced pharmacy expenses and re-hospitalizations over time. HEDIS quality indicators and health status improves as well. Additional $41.98 pmpm revenue from CPT 99490 is available for care management for eligible enrollees. The practices transition to value-based care capable of taking medical risk for enrollees in a sustainable manner using both CPT codes for care management and shared savings.

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:

10. *Key process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured.* Key processes measures include: strategic rollout of collaborative care to primary care clinics, identification and enrollment of targeted enrollees, identification of team members, training and certification of navigators, nurses, and other teamCare members (e.g. COPE HCTI, ICSI, Samepagehealth). Specific benchmarks include: comprehensive diabetes care, mental health penetration and all-cause readmits. Existing data from collaborative care implementation with teamCare training:

- HbA1C tests/year increased from 2.9 to 4.1/year for cohort
- PHQ 9 evaluation increased from .9 to 7.9/year for cohort
- PHQ 9 > 10 decreased from 73% to 36% (50% reduction)
- HbA1C control > 9% reduced from 61% to 40% (35% reduction)
- BP > 140/90 mmHg reduced from 23% to 16% (29% reduction)
- ED visits for +1/year decrease 36%: +2/year decreased 56% (total annual 1.48 visits to .74 for cohort)
- Imaging reduction

11. All cause re-admits and pharmacy baseline performance for cohort will be established and tracked.

[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.