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:* **Diane Patterson, Vice President/Chief Clinical Officer, Yakima Valley Memorial Health, (509) 575-8012, DianePatterson@yvmh.org** *Which organizations were involved in developing this project suggestion?* **Greater Columbia Accountable Community of Health**
Project Title	*Title of the project/intervention:* **Palliative care coordination for Medicaid and dual eligible beneficiaries with terminal illness**

Rationale for the Project

Include:

- *Problem statement – why this project is needed:* **Palliative care reduces hospital admissions, length of stay, and readmissions for Medicaid beneficiaries with terminal illness.[1] However, CMS does not reimburse for palliative care if beneficiaries are also receiving "curative" treatment.**
- *Supporting research (evidence-based and promising practices) for the value of the proposed project.* **The Washington State Institute for Public Policy (WSIPP) has identified "transitional care programs [which include many of the activities associated with palliative care, e.g., coach[ing], patient education, medication reconciliation, individualized discharge planning, enhanced provider communication, and patient follow-up after discharge] to prevent hospital readmissions" as an evidence-based policy that can lead to better outcomes.[2]**
- *Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries.* **The project will: 1) increase and strengthen coverage of low-income individuals as it will provide palliative care coordination for Medicaid and dual eligible beneficiaries with terminal illness; 2) increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations as it will coordinate care for Medicaid and dual eligible beneficiaries with terminal illness across providers; 3) improve health outcomes for Medicaid and low-income populations as palliative care coordination improves quality of life outcomes for patients with terminal illness;[1] and 4) increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks as palliative care coordination reduces costs for Medicaid beneficiaries with terminal illness.[1]**

Project Description

Which Medicaid Transformation Goals 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**

[1] Morrison RS, Dietrich J, Ladwig S, Quill T, Sacco J, Tangeman J, Meier DE. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Aff. 2001 Mar;30(3):454-463.*

[2] Source: WSIPP. Accessed December 2015 at http://www.wsipp.wa.gov/BenefitCost/Program/481.

☑ **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).* **The project will impact Medicaid and dual eligible beneficiaries with terminal illness in Yakima County.**
- *Relationship to Washington's Medicaid Transformation goals.* **The project will: 1) Reduce avoidable use of intensive services and settings as palliative care coordination decreases hospital admissions, length of stay, and readmissions for Medicaid beneficiaries with terminal illness;[1] 2) Accelerate the transition to value-based payment (payment model 2, encounter-based to value-based) as Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals provide palliative care coordination; and 3) Ensure that Medicaid per-capita cost growth is two percentage points below national trends as the benefit to cost ratio of transitional care programs to prevent hospital readmissions is $4.43.[2]**
- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity/reducing health disparities.* **The project goal is to coordinate palliative care for Medicaid and dual eligible beneficiaries with terminal illness in Yakima County. Care Coordinators and other staff will provide counseling, family support, psycho-social assessment, nursing services, medical social services, hospice aide and homemaker services, volunteer services, comprehensive assessment, plan of care, interdisciplinary group, care coordination/case management, and in-home respite care. Expected project outcomes include an improvement in patient experience (inpatient: communication about medicines, discharge information) and home- and community-based long term services and supports use; and a reduction in ambulatory care sensitive condition hospital admissions: chronic obstructive pulmonary disease, 30-day all-cause hospital readmissions, potentially avoidable emergency department visits, the percent of patients with five or more visits to the emergency room without a care guideline, annual state-purchased health care spending growth relative to state GDP, Medicaid per enrollee spending, inpatient utilization, and hospital admissions for congestive heart failure. Latinos experience significant health disparities at the end of life compared with non-Latinos.[3]**
- *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.* **The Health Home program provides care coordination funding for high-cost/high-risk Medicaid adults, but at the time of submission, will only continue through June 2016.[4]**
- *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.* **The project will engage business, community- and faith-based, consumer, education, food system, health care provider, hospital, housing, local government, philanthropy, public health, social services, transportation, and tribal organizations in Yakima County.**

Core Investment Components

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project.* **Proposed activities include counseling, family support, psycho-social assessment, nursing services, medical social services, hospice aide and homemaker services, volunteer services, comprehensive assessment, plan of care, interdisciplinary**

[3] Fischer SM, Cervantes L, Fink RM, Kutner JS. Apoyo con Carino: a pilot randomized controlled trial of a patient navigator intervention to improve care outcomes for Latinos with serious illness. *J Pain Symptom Manage. 2015 Apr;49(4):657-665.*

[4] Source: Washington State Health Care Authority. Accessed January 2016 at http://www.hca.wa.gov/medicaid/health_homes/Documents/continuation_of_health_homes.pdf.

group, care coordination/case management, and in-home respite care. The cost estimate is $96,229 per year (233 participants x $413 per participant.) If additional hospitals in the Greater Columbia Accountable Community of Health Regional Service Area (RSA) also participate, the cost estimate is $234,171 (567 participants x $413 per participant.)

- *Best estimate (or ballpark if unknown) for:*
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented. **Yakima Valley Memorial Hospital will serve an estimated 233 Medicaid and dual eligible beneficiaries per year. If additional hospitals in the RSA also participate, Yakima Valley Memorial Hospital and additional hospitals will serve an estimated 567 Medicaid and dual eligible beneficiaries per year.**
  - How much you expect the program to cost per person served, on a monthly or annual basis. **The WSIPP estimates that transitional care programs to prevent hospital readmissions cost $413 per participant per year.[2]**
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.* **The project is already operating in the region.**
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.* **The WSIPP estimates that transitional care programs to prevent hospital readmissions benefits minus costs (net present value) is $1,414 per participant per year, so the estimated ROI per participant per year is $1,827 total benefits - $413 costs / $413 costs = 342%.[2]**

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.* **Process measures will include the number of Medicaid and dual eligible beneficiaries in Yakima County or the Regional Service Area who receive palliative care coordination. Outcome measures will include the percentage of Medicaid and dual eligible beneficiaries who are satisfied with inpatient experience (communication about medicines, discharge information), use home- and community-based long term services and supports, have ambulatory care sensitive condition hospital admissions for chronic obstructive pulmonary disease, have 30-day all-cause hospital readmissions, have potentially avoidable emergency department visits, have five or more visits to the emergency room without a care guideline, have inpatient utilization, and have hospital admissions for congestive heart failure; and the annual state-purchased health care spending growth relative to state GDP and Medicaid per enrollee spending.**
- *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*? **County-level benchmark performance data are available for the *Washington State Common Measure Set for Health Care Quality and Cost.***