

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	<p>Identify point person, Ed Dwyer-O'Connor, Senior Manager, Downtown Projects Harborview Medical Center (206) 744-1515, capeo@uw.edu</p> <p>Which organizations were involved in developing this project suggestion? Harborview Medical Center, Seattle/King County Public Health [SKCPH], Plymouth Housing Group, REACH Program Evergreen Treatment Services and other members of the Edward Thomas House Steering Committee</p>
Project Title	Medical Respite and Homeless Palliative Care
Rationale for the Project	
<p>Include:</p> <ul style="list-style-type: none"> • Problem statement <p>People living in shelters and on the streets are three to four times more likely to suffer premature death than people who are housed. They also have a higher incidence of hospitalization than the general public with longer inpatient stays. However, the lack of a stable home environment diminishes the effectiveness of their hospital care, and they endure more complications and an increased probability of re-hospitalization after discharge.</p> <p>The Edward Thomas House [ETH] Expanded Medical Respite program meets the needs of homeless people by providing a safe place for medical care and improving access to primary care, eligibility funding, mental health and chemical dependence counseling, and housing after a hospitalization. As a community partnership, it was developed by a broad coalition of homeless and housing advocates including UW Medicine and other local hospitals, Seattle/King County Public Health, and the Healthcare for the Homeless Network.</p> <p>However, the ETH cannot keep up with the demand for respite care in King County. More respite care is needed to adequately meet the demand as homeless and “at risk” [unstable housed] patients are not able to be admitted in a timely manner. The current respite program works closely with the REACH program from Evergreen Treatment Services to accept patients referred from respite for case management in the community. These patients are all homeless with significant chemical dependency and health problems.</p> <p>The current project would include partnerships with the Homeless Palliative Program, which is funded through a HRSA expansion grant from SKCPH and provides palliative care for patients on the streets, in shelters and tents and those in Permanent Supportive Housing. In the past year this program has provided care for 65 homeless patients in Seattle and has worked with many agencies and programs in the downtown core. The Homeless Palliative Program will place patients in respite for stabilization until suitable housing can be located. That housing will be provided by Plymouth Housing which has agreed to set-aside 4 apartment units in the 7th and Cherry building which will be finished in 2017. Patients will be placed there for comfort care and support as they cope with a life-limiting illness.</p> <ul style="list-style-type: none"> • Supporting research (evidence-based and promising practices) for the value of the proposed project.ⁱ <p>Several research studies have demonstrated that programs like ETH that provide a respite care option for homeless patients immediately following hospital discharge reduce future hospitalizations. For example, a 2006 Chicago study found that homeless patients discharged into respite care required less than one-half of the hospital days within the 12 months following their hospital discharge than homeless patients who had similar demographic characteristics, admitting diagnoses,</p>	

and patterns of medical care but who were denied admission to respite because beds were unavailable when they were discharged from the hospital.¹ Another Chicago study documented a 60% reduction in hospital utilization during the 12 months following a respite program stay as compared to hospital utilization in the 12 months immediately preceding the respite stay for a cohort of 161 homeless patients. The absolute reduction in hospital days was 4.9 days per person after controlling for gender, race, diagnosis, and prior utilization of services. A control group that was similar in terms of gender, race, diagnoses, and prior utilization of health services but that was denied admission to respite care because beds were not available showed no such reduction in hospital utilization.² Other studies have documented a strong correlation between respite stays and a significant reduction in the risk of hospital readmission.³ In 2012, a study of hospital utilization for ETH patients conducted for a University of Washington research project found a significant reduction in utilization post-respite program discharge compared to pre-respite program admission. The study focused on 69 unduplicated respite patients who entered ETH after discharge from an inpatient stay at Harborview Medical Center. It compared total HMC inpatient days for these patients for the 180 days after successful completion of these patients' stays at ETH to total inpatient days for these patients for the 180 days prior to ETH admission and found: 70% reduction in HMC total inpatient hospital days; 67% reduction in HMC surgeries and procedures ; 50% reduction in HMC inpatient admissions from the emergency department.

Supporting research (evidence-based and promising practices) for the value of the proposed project.ⁱⁱ

Homeless patients are generally hospitalized many times during the last year of life. "Many homeless people have numerous encounters with the health care system in the year prior to their death".¹

Studies have shown that counseling with Advanced Care Planning can help homeless persons prepare for death.² Simple interventions have shown that homeless persons can be engaged to continue autonomous behavior and dignity preserving behavior.³ These simple strategies can have a dramatic impact at the end of someone's life, especially someone who lacks the love and support of caring friends and family.

1. Hwang, S.W., O'Connell, J. Journal of Health Care and Poor and Underserved. 2001, Feb 12. Health Care Utilization among homeless adults prior to death.
2. Song, J., E.R., Wall, M.M., Bartels, D.M., Ulvestad, N., Petroskas, D., West, M., Weber-Main, A.M., Grengs, L., Gelberg, L. [2010]. Effects of an End-of-Life Planning Intervention on the completion of advance directives in homeless persons: a randomized trial. *Annals of Internal Medicine*, 20[2]: 76-84.
3. Song, J., Wall, M.M., Bartels, D.M., Ulvestad, N., Gelberg, L. [2008]. Engaging Homeless Persons in End of Life Preparations. *J Gen Intern Med*, 23[12]: 2031-2045.

- Relationship to federal objectives for Medicaidⁱⁱⁱ with particular attention to how this project benefits Medicaid beneficiaries.

This project would have significant benefit for Medicaid beneficiaries by reducing re-admissions; inpatient hospitalizations and use of intensive and high cost services. .. Currently, 7 local hospitals including Harborview Medical

¹¹ Buchanan, D., Doblin, B., Sai, T. & Garcia, P. *The Effects of Respite Care for Homeless Patients: A Cohort Study* American Journal of Public Health Vol. 96, No. 7: 1278-1281, 2006.

² D Buchanan, D., Doblin, B., MD, & Garcia, P. April 2003 *Respite Care for Homeless Patients Reduces Future Hospitalizations*. *Journal of General Internal Medicine* v. 18 (S1) .

³ Kertesz SG, Posner MA, O'Connell JJ, Swain S, Mullins AN, Shwartz M, Ash AS. *Post-hospital medical respite care and hospital readmission of homeless persons*. *Journal of Prevention and Intervention in the Community*. Vol. 37, No 2: 129-42, 2009.

Center make referrals to Medical Respite and going forward this process would continue with the new project. The close involvement of 7 hospitals and the MCOs allow for a unique situation of shared risk for these highly vulnerable patients in the respite program.

The Respite Care Providers Network, as part of the National Health Care for the Homeless Council, has developed “Standards” for respite care. These “Standards” are being presented soon to the Center for Medicaid and Medicare Services for approval. The goal is to become a reimbursable service within the continuum of care in all communities and allow Medical Respite to be recognized for all of its contributions to the underserved.

Project Description

Which Medicaid Transformation Goals^{iv} 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).
This project could have significant impact across the state with respite programs in Seattle, Yakima, Spokane and being developed in other areas of the state. The number of homeless patients in need has increased in the past few years particularly in the Seattle area. Both African Americans and Native Americans are significantly over-represented in the homeless population.
- Relationship to Washington’s Medicaid Transformation goals.
This project will help reduce avoidable use of intensive services by stabilizing patients in the recuperation process and reducing their utilization of inpatient hospitalization services. This project will improve population health by focusing on the homeless and disadvantaged who are also over-represented with minority populations. These populations will experience improved health through this medical and behavioral intervention.
- Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.
The goal is to provide high quality medical and behavioral care for homeless and disadvantaged patients who are not sick enough to be in the hospital but too sick for the streets and shelters. The outcomes expected include improved health and a significant reduction in the use of intensive inpatient services. Linking patients to housing is a goal of respite and would help patients experience more long-term improvement in their medical and behavioral health. This project will help reduce the health disparities of minorities and homeless.
- 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 ETH in Seattle partners with the REACH program to case manage substance dependent, behavioral patients after discharge from respite. This team helps stabilize patients further in the community and gets them placed in treatment and housing. ETH also partners with Plymouth Housing for access to available Permanent Supportive Housing where patients are placed with built-in social and medical supports. The development of community based options for post-acute care support the development of alternatives to institutional care sought in Initiative #2 and the development of a Supportive Housing benefit in Initiative #3.
- 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 proposal will build upon the existing partnerships seek additional partnerships with community based Supportive Housing providers as these are developed in Medicaid Transformation Initiative #3... Housing is the key to medical and social stability for the long-term for these patients. The current partners in the ETH include; SKCPH, REACH, Plymouth, HMC, UWMC, Swedish, Virginia Mason, Northwest, Valley Medical Center and representatives of the managed care plans.

Core Investment Components

Describe:

- *Proposed activities and cost estimates (“order of magnitude”) for the project.*
 1. Establishment of a Leadership group to guide the development of the program.
 2. Leasing of a space suitable for the delivery of care for these patients.
 3. Hiring of staff and program development. This will include not just the hiring of medical and behavioral staff but also the development of partnerships with referring hospitals and clinics plus the agencies providing follow up for patients upon discharge. The key partners at the back door include Permanent Supportive Housing and case management services for behavioral challenges [both mental illness and substance use]. Many relationships already developed at the ETH can be leveraged to scale for this additional respite program.
 4. Key data indicators also need to be developed to learn the impact of the care model and any adjustments in service provision that need to be made. Clinical outcomes need to be measured to ensure quality care.
 5. Annual Budget: Approximately \$3.7 million for a 30 bed unit that includes all medical and behavioral services. Approximate length of stay would be three weeks at cost of \$350 per day. It will take between 4-6 months to fully staff and develop the program. Likely there will be a need for capital investment to remodel with a placeholder of \$250,000 for that purpose.
 6. Explore the feasibility of seeking Adult Residential Care or other facility certification to further stabilize the delivery model and sustainability. This would be done in concert with the Transformation Initiative #2 for post-acute care non-institutional options.
- *Best estimate (or ballpark if unknown) for:*
 - How many people you expect to serve, on a monthly or annual basis, when fully implemented.
Approximately 500 people per year.
 - How much you expect the program to cost per person served, on a monthly or annual basis.
Approximately \$7,350 per person on an annual basis..
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.*
To fully implement will take at least 6 months. This includes hiring and training and development of partnerships.
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*
Based on the 2012 examination of 69 respite patients, we would estimate that there would be approximately a 70% reduction in future inpatient hospitalizations after the respite stay. This would translate into significant cost reduction above and beyond the cost of respite care. The model would test the financial sustainability of this model with shared investments by the hospitals; managed care organizations and local initiatives targeted for this vulnerable population.

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^v.
Year 1 key process metric include: hiring of medical and behavioral staff, establishment of a representative Steering Committee to monitor the progress and inform the development of the respite unit. Outcome measures that would be

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gathered on a daily basis include: linkage to primary care, and completion of housing referrals, linkage to behavioral case management services, referral to Chemical Dependency treatment [Methadone maintenance] Coordination with referring hospitals and Managed Care Organizations. Gathering careful demographic data to inform the Steering Committee.

- If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation?
- We will benchmark as much as possible with other respite programs across the country for all outcomes and cost data [primary care connection, case management, housing, benefits]. We will make sure to participate in the Respite Care Providers Network, a national organization dedicated to the development of respite programs.

ⁱThe 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>

ⁱⁱThe 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>

ⁱⁱⁱ 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>.

^{iv} 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.

^v This includes the statewide common measure set for tracking health care quality and cost across multi-payer public and private health delivery systems: http://www.hca.wa.gov/hw/Documents/pmcc_final_core_measure_set_approved_121714.pdf and the subset of 2016 Medicaid contract common performance metrics. It also includes priority measures for critical behavioral health and community support services recommended by the 5732/1519 Steering Committee and reported to the Legislature in “*Service Coordination Organizations – Accountability Measures Implementation Status*”, (page 36) at: http://www.hca.wa.gov/documents_legislative/ServiceCoordinationOrgAccountability.pdf.