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	*Dave Budd, Full Life Care, 206-370-4550, daveb@fulllifecare.org* *Which organizations were involved in developing this project suggestion?*
Project Title	*Day Program with Health Services (DPHS)*

Rationale for the Project

Include:

- *Problem statement*
  Day Programs, with their nursing, rehab, social services, health education, case management, nutrition and caregiver respite, provide a flexible "platform" from which to deliver a variety of evidence-based programs. Full Life operates 4 day programs in King and Snohomish Counties.

  This project will use evidence-based programs to provide 3 tiers of services for individuals with different risk factors:
  --Tier 1: Education and Prevention Services.
  --Tier 2: Transition care (from a hospital or nursing home) and short-term rehabilitation.
  --Tier 3: Long-term support including patient-centered health home

- *Supporting research (evidence-based and promising practices) for the value of the proposed project.*[i]
  The following programs and interventions are rated by *The Washington State Institute for Public Policy* along with the % chance that cost savings will be achieved:

  --Lifestyle interventions to prevent diabetes: 100%
  --Lifestyle interventions to reduce obesity: 66%
  --Transitional care to prevent hospital readmissions: comprehensive programs: 100%
  --Patient-centered medical homes: 87%

  Other evidence based programs that will be offered that are not listed on WSIPP website:
  --Fall prevention: Tai Chi for Better Balance (CDC evidence based)
  --Chronic Disease Self Management Program (CDSMP: Stanford, evidence based)
  --Day program based transition care (Parma Study, Case Western Reserve University)

- *Relationship to federal objectives for Medicaid*[ii] *with particular attention to how this project benefits Medicaid beneficiaries.*
  The above listed programs are all demonstrated to improve health outcomes for Medicaid and low-income populations.

Project Description

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

XX Reduce avoidable use of intensive services

XX 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

XX Care Delivery Redesign

XX 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).*

These 4 Day Programs in King and Snohomish Counties will serve individuals with the following characteristics:

Tier 1: Evidence Based Education and Prevention Services (time limited) enrollees:

--Are at-risk of developing diabetes and associated conditions such as cardiovascular disease.
--Have chronic conditions that they need help in self-managing
--Are obese

Tier 2: Evidence Based Transition care and rehabilitation (time limited) enrollees:

--Are transitioning from a hospital or nursing home
--Need short-term rehabilitation in order to regain function and independence

Tier 3: Long-term health & social service support including patient-centered health home (generally ongoing)

--Have multiple chronic conditions or degenerative conditions that they are unable to manage without skilled intervention and support.
--Have dementia and require health services and/or supervision in order to avoid moving to a higher-level of care
--Have health diagnosis combined with a brain injury or behavioral health diagnosis which makes them unable to safely manage their conditions.
--Have complex health issues and do not currently have a patient-centered medical home.
--Have complex social service needs that affect their health.

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

The Day Program with Health Services (DPHS) will help achieve two of Washington's transformation goals:

Tier 1: Will help with Transformation Goal 2, Improving population health, with a focus on prevention and management of diabetes & cardiovascular disease.

Tiers 2 & 3: Will help with WA Transformation Goal 1: Reducing avoidable use of intensive services and settings such as acute care hospitals & nursing facilities

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

Project goals:

--Preventing diabetes and mitigating its effects
--Reduce obesity and mitigating its effects

--Reducing rehospitalizatin through transitional care
--Reducing hospitalization through patient-centered medical homes
--Fall prevention using Tai Chi for Better Balance
--Reducing hospitalization with the Chronic Disease Self Management Program

Project interventions:
Tier 1: Health education and self-management support
Tier 2: Rehabilitative services, health education and self-management support
Tier 3: Nursing treatments, chronic care management, chronic disease self management, rehabilitative services, social services, health education, health home services, Tai Chi fall prevention

- *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.*

Uncertain at this time.

- *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.*

Full Life welcomes the opportunity to work with other providers and agencies that will make up our Accountable Community of Health. These could include but not be limited to: primary care providers, mental health providers, Home care providers, the HCS and AAA case management system, King County Health Dept.

Core Investment Components

Describe:

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

Proposed activities:
Tier 1: Health education and self-management support.
Cost per person/month (time limited) = $100 - $200

Tier 2: Rehabilitative services, health education and self-management support
Cost per person/month (time limited) = $600 - $1,125

Tier 3: Nursing treatments, chronic care management, rehabilitative services, social services, health education, health home services
Cost per person/month (generally ongoing) = $300 - $1,500

- *Best estimate (or ballpark if unknown) for:*
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented.
    Tier 1: 500+
    Tier 2: 500+
    Tier 3: 1,000+
  - How much you expect the program to cost per person served, on a monthly or annual basis.
    See above answer
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.*
  One year
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*
  Based on WSIPP findings: Benefit to cost ratio range from $4.43 to $8.16

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:* **<u>Key outcomes for Day Program based on the *WA Common Measure Set for Health Care Quality*</u>:** **Immunizations** **Adult Access to Preventive/ Ambulatory Health Services** **Diabetes Care: Blood Pressure Control (<140/90 mm Hg)** **Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)** **Falls with Injury Per Patient Day** **Continuity of Care/Medication Reconciliation** **Assessment of Patient Functional Status: Effective Chronic Illness Management** **Medication Safety: Annual Monitoring for Patients on Persistent Medications (ACE/ARB component)** **Hypertension: Blood Pressure Control** **Hypertension Management** **Ambulatory Care Sensitive Condition Hospital Admissions: Chronic Obstructive Pulmonary Disease** **Potentially Avoidable ED visits** **Catheter-Associated Urinary Tract Infection** **Screening for Depression** • *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]. • *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?

[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.

[iv] 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.