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	Winfried Danke, Executive Director CHOICE Regional Health Network, (360) 539-7576 dankew@crhn.org Team Co-Leads: *Michael O'Neill, Cowlitz County Health & Human Services, oneillm@co.cowlitz.wa.us, 360-430-0546; Kat Latet, Community Health Plan of Washington, kat.latet@chpw.org* Organizations associate with this project development: *Cascade Pacific Action Alliance, Child and Adolescent Clinic Cowlitz County, Community Health Plan of Washington, Coordinated Care, Cowlitz County Health & Human Services, Grays Harbor Public Health & Social Services, LifeLong, Mason County Public Health, Mason General Hospital and Family Clinics, Northwest Venture Philanthropy, Ocean Beach Hospital, Providence Health & Services, SeaMar Community Health Services, Summit Pacific Medical Center, Thurston County Public Health & Social Services, other CDSMP Providers in the region*
Project Title	*Increasing Family Resilience, Empowerment, Access, and Literacy (IF-REAL)*
Rationale for the Project	

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

Adverse Childhood Experiences (ACEs) are common in Washington State. ACEs create a population attributable risk ranging from 21% to 67% for 21 health outcomes and behaviors studied in the Washington State Behavioral risk Factor Surveillance System (BRFSS). Prevalence of ACEs is higher for the population with income below $25,000 per year[1]. Having multiple ACEs increases the likelihood of experiencing multiple social and health problems at the same time[2]. This increased acuity associated with high ACE scores creates need for individuals to access multiple systems of care and creates a need for care providers to link clients to all needed community-based services. A growing body of evidence shows that Community Health Workers (CHWs) increase engagement of individuals in preventative care, early intervention care, clinical health services, and increase self-management of chronic health conditions.
This project establishes a model for CHWs to work across multiple community systems, expanding outreach and engagement to children and their families who are impacted by ACEs, and improving the capacity of participating organizations to coordinate and co-manage care for their clients.

- *Supporting research (evidence-based and promising practices) for the value of the proposed project.*[i]
  - Foundation for Healthy Generations CHW Bibliography
  - Recommendations from Healthier Washington Community Health Worker Taskforce
- *Relationship to federal objectives for Medicaid*[ii] *with particular attention to how this project benefits Medicaid*

[1] See Anda & Brown, 2010

[2] See Felitti et al, 1998

beneficiaries.

The expanded workforce of Community Health Workers created through this project can address all four of the stated Medicaid objectives. With elevated exposure to ACEs due to their income level Medicaid beneficiaries could comprise most or all of the individuals served by this project. CHWs help individuals gain insurance coverage. CHW roles become accessible to multiple provider networks, allowing them to more quickly stabilize and expand higher provider functions in the network beyond care coordination. Improved access to care and greater self-management of care, supported by CHWs, create improved health outcomes. Adding CHWs to the community based health team improves outcome data collection, and informs the transformation of service delivery networks leading to greater efficiency and quality of care.

Project Description

Which Medicaid Transformation Goals[iii] *are supported by this project/intervention?*

- ✓ Reduce avoidable use of intensive services
- ✓ Improve population health, focused on prevention
- ✓ Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved?

- ✓ 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).*

Vulnerable children and their families across the state – identified in existing systems (e.g. Schools, early childhood centers and programs, pediatric practices, dental clinics, behavioral health settings, juvenile justice system, homelessness and housing providers). Children and their families are identified by a history including ACEs and/or complex needs partially outside of the identifying organization's scope of services.

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

Better care, improved health outcomes, and lower cost are all associated with CHW projects.

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

Goals/Outcomes:

  - Increase the percentage of children that receive preventative physical, oral, and behavioral health screenings and care
  - Decrease the number of families with children that are homeless and at risk for homelessness
  - Decrease the number of families with children experiencing food insecurity
  - Decrease emergency room visits for children under 18

Interventions:

  - Increase access to care coordination and other CHW services for multiple community systems of care
  - Provide CHW services to vulnerable children and their families, including outreach and engagement, care coordination, case management, system navigation, coaching and social support, and culturally appropriate health education and information
  - Analyze and interpret data collected by CHWs to improve policies and systems across multiple community systems

- *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.*
  - *Data could inform practice transformation efforts led by the Department of Health*
  - *Compliments AAA Intensive Chronic Case Management model, serving a different sub-population*

- *Links to CPAA Youth Behavioral Health Care Coordination pilot project and Youth Marijuana Prevention and Education project*

- *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 Cascade Pacific Action Alliance and other ACHs, BHOs, Early Childhood, K-12 Schools, Clinical providers, public health, juvenile justice, housing & homelessness, Community Action Programs. Local organizations representing these systems in Cowlitz County have been meeting for over a year to develop this project model and are working towards implementation in Cowlitz County.

Core Investment Components

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project.*
  - CHWs are recruited from targeted populations or communities and trained to provide core CHW functions identified by the Healthier Washington CHW Taskforce
  - CHWs are provided additional training specific to CHW functions beyond the core competencies necessary for completing project objectives
  - Each county establishes a team of 8-24 CHWs that provide their services to organizations in the systems of care described in the "Potential partners, systems, and organizations" section above
  - Business associate agreements are established that link the above systems to the CHW program and allow for co-management of care and ensure confidentiality of protected information
  - CHWs link to individuals and their families through the above systems, maintain a caseload of 30 clients they are providing services for, and increase the ability of their clients to generate personal and family resilience and to increase self-management of care plans with the above mentioned systems.

Estimated Cost = $10.6 million to implement in the CPAA region

- *Best estimate (or ballpark if unknown) for:*
  - *How many people you expect to serve, on a monthly or annual basis, when fully implemented.*
    21,000/yr across the CPAA region
  - *How much you expect the program to cost per person served, on a monthly or annual basis.*
    $505 per person served
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.*
  Two years
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*
  - CHW-led care coordination has been shown to reduce the Medicaid cost growth for individuals receiving this service[3]
  - Multiple CHW models have demonstrated an ROI averaging around $3 for every $1 spent[4]

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*

[3] See Felix et al, 2011

[4] See Foundation for Healthy Generations White Paper, 2013

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*?
  - Increase the resilience of vulnerable populations
    - using pre-post measurement conducted by CHWs and organizations
    - increased social & emotional help, practical help, and community reciprocity[5]
  - *Increase the capacity of systems to co-manage care*
    - network centrality measurement of individuals working with CHWs and their connection to multiple care providing organizations
  - *Increase ratio of preventative vs. acute care in specific settings (e.g. well child vs. sick care, lower ED visits)*
    - Increase Medicaid Adolescent well-care visits (from 37%CPAA, 39%State)
    - Reduce potentially avoidable ER visits (from 14%CPAA, 13%State)
  - *Increase effective management of chronic illness in the outpatient setting*
    - Statewide performance measure set

[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.

[5] BRFSS Questions in Healthy Generations report, pp.14-19