Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

Email by **January 15, 2016,** to MedicaidTransformation@hca.wa.gov with the subject **Medicaid Waiver Project**.

Contact Information	*Warya Pothan, Community Health Director, Neighborhood House, 206-571-4662,* waryap@nhwa.org. *4410 29th Ave S., Seattle WA 98108* *Which organizations were involved in developing this project suggestion?* Asian Pacific Islander Coalition for Healthy Communities (APICAT), Center for MultiCultural Health, Community Counseling Institute, El Centro De La Raza, Entre Hermanos, Neighborhood House (NH), People of Color Against AIDS Network (POCAAN)
Project Title	***King County Community Health Worker Coalition: Creating Health Equity, Saving Costs and Reducing Chronic Disease***

Rationale for the Project

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

Seattle and South King County are home to pockets of poverty with higher morbidity and early mortality rates, impacting many Medicaid recipients. According to King County's Public Health Community Health Indicators Project, 11% of King County residents (167,000) suffer from "frequent mental distress" (FMD) as defined by the Centers for Disease Control and Prevention, with higher rates in South King County. The burden of FMD falls disproportionately on low-income individuals, 20% of whom experience FMD each year. Ethnic/racial minorities are also disproportionately impacted by FMD, with the Health of King County report (Chapter 10: Mental Health/Drug Abuse) showing the following FMD rates for minorities: African Americans 15.4%, Hispanics/Latinos 13.7%, Asians/PIs 6.1%, and Caucasians 9.0%. In our Metropolitan Statistical Area (MSA), approximately 528,000 persons, or 19% of the MSA population, aged 12 or older used an illicit drug in the past year, compared to 18.4% statewide and 14.7% nationwide (SAMHSA NSDUH Report March 2012). The rate of marijuana use in our MSA in the past year was 13.9%, higher than the statewide rate of 13.4% and the nationwide rate of 10.7%. The rate of nonmedical use of prescription-type pain relievers for our MSA in the past year was 7.0%, higher than the statewide rate of 6.7% and the nationwide rate of 4.9% (SAMHSA NSDUH Report March 2012). More than 20% of King County residents were born outside the U.S.; in some parts of South King County, up to 36% of residents are immigrants and refugees, typically with limited English proficiency. Many come from countries that lack quality medical care, have high rates of infectious disease, or are experiencing armed conflict. Seattle is also home to the nation's second-largest LGBT community, a demographic with unique healthcare and cultural needs. Additionally, our region has a large and growing homeless population at 10,047 (according to the 2015 One Night Count). In 2014, Seattle/King County's homeless population ranked fourth largest among the nation's metropolitan areas; the 2015 One Night Count may have put Seattle in third place, second only to Los Angeles City/County and New York City.

The above population groups need culturally appropriate, community-based medical care, substance abuse, and mental health prevention and treatment services delivered by trusted providers. Otherwise, they are at risk of not receiving preventive care, over-utilizing costly emergency care, and experiencing poor physical and mental health outcomes and associated income loss. While there are several local community based organizations specializing in providing health prevention services to targeted demographic groups, there is currently no organization in King County providing workforce development and coordinating services for Community Health Workers (CHWs) serving ethnically diverse populations. Existing CHW services are limited and currently reach only small pockets of the population in need.

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

According to the Community Health Worker White Paper: Report & and Recommendation produced by the Foundation for Healthy Generations, the use of bi-cultural and/or bi-lingual Community Health Workers (CHWs) has resulted in savings of $4,564 per enrollee in a Medicaid managed care system for heavy utilizers of health resources through reduced emergency room use, days of inpatient care, narcotic use and other prescription drug use. According to the Washington State Institute for Public Policy, substance abuse evidence-based services such as Relapse Prevention Therapy, Cognitive Behavioral Therapy for PTSD, Anxiety and Depression, Motivational Interviews and treatment services can save $23-$18,321 per dollar spent. In another example, a study of WA State's tobacco prevention and control program found that for every $1 spent in 2000-2009, more than $5 was saved through reduced hospitalizations; if doctor visits and medication and rehab costs were counted, the savings would more than double. Additionally, according to the Trust for America's Health, investing $10/person/year in community-based programs addressing physical inactivity, poor nutrition, and smoking could produce $16+ billion in medical cost savings/year within 5 years. There is also ample evidence that the use of Community Health Workers (CHWs) to deliver

interventions is effective in helping clients better manage chronic health conditions including preventing substance abuse, early care services for HIV/Hepatitis, asthma, and diabetes, as well as improve maternal and child health, nutritional status, and physical activity.

This proposal would fund 7 existing service providers who already utilize CHWs and have experience delivering cost effective evidence based programs, to increase their capacity to deliver services and reach more clients. These community based agencies are located within low income communities and have built long term trusting relationships with the communities they serve in order to serve "hard to reach" populations. One lead agency would be awarded additional funding to improve quality of services and to train existing and new CHWs on evidence based practices and core competencies. The lead agency would convene a King County Community Health Worker Coalition with monthly meetings, regular workforce development trainings, certification of core competencies, a managed listserve as well as coordinate CHW services and evaluation with the ACH and disseminate lessons learned and best practices.

This proposal can be scaled up to include additional partners/CHWs in King County or to implement statewide.

- *Relationship to federal objectives for Medicaid[4] and how this project benefits Medicaid beneficiaries.*

Our proposed project responds to the following federal objectives for Medicaid:

- 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 populations through initiatives to transform service delivery networks.
- Reduce and avoid use of intensive services such emergency room and inpatient behavioral health care.
- Improve population health focusing on prevention of diabetes, cardiovascular disease, obesity, smoking, mental illness and substance abuse disorders.

Our interventions will specifically target Medicaid recipients and involve agencies that specialize in serving this demographic.

Project Description

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

X Reduce avoidable use of intensive services
X Improve population health, focused on prevention
☐ 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
X Population Health Improvement – prevention activities

- *Region(s) and sub-population(s) impacted by the project.*

Our project will serve Medicaid eligible clients in Seattle and South King County. We will focus on the following underserved and at-risk populations: low income minority populations, limited English proficient immigrants and refugees (primarily from East Africa, SE Asia and Latin America), homeless individuals and families, clients with substance abuse issues, clients at risk for HIV/Hepatitis, and clients with mental health/co-occurring disorders. Many of our clients live in Seattle and King County public housing, where the residents' average household income is as low as $12,043. Currently the agencies partnering on this proposal serve an estimated 4,000 Medicaid eligible clients per year.

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

The proposed project will respond to at least 3 of the 4 goals, reducing avoidable use of intensive services; improving population health, focused on prevention; and ensuring Medicaid per-capita growth is below national trends. We propose to use Community Health Workers (CHWs) to conduct outreach, connect clients to healthcare and physical activity opportunities, and directly deliver evidence based prevention services. CHWs have been shown to decrease use of intensive services, improve health outcomes, and reduce healthcare costs by facilitating access to primary and preventive care, increasing clients' health knowledge, and connecting clients to social supports in a low-cost, trusted, community-based setting. Some of the health-related services that we will directly provide or connect clients to will include substance abuse prevention and treatment; mental

health treatment, prenatal screenings; well-baby and well-child exams; geriatric care; caregiver support; smoking cessation; and HIV/Hepatitis testing for high risk Medicaid clients, all provided by culturally competent CHWs. We will also help clients access free or low-cost culturally appropriate fitness opportunities. The above activities are expected to result in a reduction in emergency room visits, decreased substance abuse, prevention of new HIV infections, and improvement in physical and mental well-being that reduces the need for costly management of preventable chronic conditions.

Project Goal: Over 5 years reduce the incidence and prevalence of chronic disease and related health care costs through high quality community based prevention programs utilizing Community Health Workers (CHWs) in Seattle and King County.

Interventions	*Outcomes over 5 years*
1) Create Community Health Worker Coalition to: a) provide workforce/professional development to create high quality CHW programs b) train CHW to adapt and implement culturally relevant evidence based and promising prevention programs c) coordinate community health work with the ACH to broadly reach Medicaid eligible clients in King County d) provide technical assistance for evaluation and disseminate best practices and lessons learned to the field	Increased health care efficiency and quality for over 6,000 WA State Medicaid clients through bi-lingual and/or bi-cultural CHWs during the five years of the program Increase access to and strengthen 20 providers and networks available to serve Medicaid clients in low-income and high poverty areas of Seattle/King County during the five years of the program Reduce health disparities by 10% by providing culturally and linguistically appropriate services to 6,000 clients
2) CHWs implement culturally competent evidence based programs to reduce chronic disease including: - Education programs to reduce risk factors for cardiovascular disease, obesity, and diabetes - Increasing access to physical activity opportunities through fitness prescriptions, program scholarships and outreach - Community based and language specific smoking cessation, substance abuse prevention and other direct services - Positive parenting classes to prevent youth substance abuse through evidence based interventions - Youth substance abuse and HIV prevention education through varieties of evidence based interventions - HIV and Hepatitis testing, counseling and referral - HIV prevention education workshops for high risk clients - Well baby and well child exams - Geriatric care and care giver support	70% (4,200) of clients reached will improve health outcomes during the five years of the program Increased health care efficiency and quality for 6,000 Medicaid clients in low-income and high poverty areas of Seattle and King County through CHWs over 5 years Reduce health disparities by 10% by providing culturally and linguistically appropriate services to 6,000 clients
3) CHWs act as peer supporters to help clients navigate health systems, achieve linkage to care and adhere to treatment plans.	70% (4,200) of clients reached will improve health outcomes over 5 years Reduce health disparities by 10% by providing culturally and linguistically appropriate services to 6,000 clients

- *Links to complementary transformation initiatives - those funded through other local, state or federal authorities*

Community Health Worker Taskforce – Foundation for Healthy Generations, City of Seattle – Food and Fitness Prescriptions,

WA State Department of Health-Preventing Underage Marijuana Use, WA State DBHR- Community Prevention and Wellness Initiative, King County Alcohol and Other Drug Prevention Program, White House Office of National Drug Control Policy Drug Free Communities Initiatives, US Department of Health and Human Services, Substance Abuse Mental Services Administration (SAMHSA), and Center for Disease Control and Prevention's Minority AIDS Initiatives for populations at high risk of substance abuse and mental health issues.

- *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.*

APICAT, Center for MultiCultural Health, City of Seattle Parks Department, Community Counseling Institute, El Centro De La Raza, Entre Hermanos, Healthy King County Coalition, King County Alcohol and Other Drug Prevention Program, King County Housing Authority, Neighborhood House, POCAAN, Public Health Seattle & King County, Seattle Housing Authority, Seattle Public Schools, SE Seattle PEACE Coalition, WA State Department of Health, WA State DBHR, Multicare Auburn Medical Center, Seattle and King County Aging & Disability Services, Jewish Family Services, Chinese Information and Service Center, City of Auburn, City of Renton, City of Kent, and City of Tukwila, City of Seattle Office of Sustainability and the Environment and City Seattle Parks and Recreation.

Core Investment Components

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project.*
  - 25 Community Health Workers (full time and part time) from 7 agencies (APICAT, Center for MultiCultural Health, Community Counseling Institute, El Centro De La Raza, Entre Hermanos, Neighborhood House and POCAAN) serving ethnically diverse Medicaid populations in King County will provide community based prevention, peer support group and education services to clients using evidence based interventions, case management, relapse prevention, housing and employment and transportation support, translation, and other direct services.
  - 1 lead agency will convene a Community Health Worker Coalition and provide professional development for CHWs and supervisors to improve quality of care to Medicaid clients.
  - 7 agencies will provide program support (office space, supplies, supervision, evaluation, program consultants, transportation) for Community Health Workers.

  <u>COST ESTIMATES</u>
  Personnel - 25 Community Health Workers @ 15 FTE + Administration and Supervision = $1,000,000
  Community Health Worker Coalition – Workforce Development/Coordination = $150,000/year for King County
  Program Expenses - (Rent, travel, phone, supplies) @ 20% = $230,000

  Total annual costs for scaled program at 25, 35, and 45 Community Health Workers:
  $1,380,000/year for 25 Community Health Workers (15 FTE) serving 1,500 clients per year=$920 per client/year
  $1,880,000/year for 35 Community Health Workers (22.5 FTE) serving 2,250 clients per year=$835 per client
  $2,380,000/year for 45 Community Health Workers (30 FTE) serving 3,000 clients per year = $793 per client

- *Best estimate (or ballpark if unknown) for:*
  - *How many people you expect to serve, on a monthly or annual basis, when fully implemented:*
    Each Community Health Worker FTE will serve 100 clients per year x 15 FTE = 1,500 clients per year.
  - *How much do you expect the program to cost per person served, on a monthly or annual basis.*
    $793-$920 per client served per year depending upon scale of program.
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.*
  Full implementation can occur within 12 months and continue for the length of the five year program.
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*
  Using a conservative estimate Community Health Workers will save over $10 for every dollar spent to directly implement or increase Medicaid client utilization of the following services:
  - Cognitive Behavioral Therapy for PTSD, Anxiety and Depression saves $100+ per dollar spent
  - Relapse prevention therapy save $18,321+ per dollar spent
  - Substance Abuse Treatments save $23-$146 per dollar spent
  - Motivational Interview to enhance HIV and treatment services save $41 per dollar spent
  - Early Substance Abuse Early Intervention (Brief Interventions) save $9-$36+ per dollar spent

- SPORT youth prevention workshops save $39.50 per dollar spent
- Comprehensive tobacco prevention services save $5 per dollar spent
- Guiding Good Choices Parenting Workshops save $3.42 per dollar spent
- General Education to Prevent Emergency Room visits saves $2.04 per dollar spent
- Low intensity in person obesity prevention saves $1.60 per dollar spent
- Case management for unemployment insurance claimants save $20 per dollar spent
- Matrix Intensive Outpatient Model save $1.94 save per dollar spent
- Adolescent Community Reinforcement Approach – Promising Practice
- Many Men, Many Voices is a CDC supported cost effective HIV intervention

Outcomes/Priority Measures

Annual Outcomes For Priority Measures (individual clients may show multiple outcomes and these outcomes are based on 1,500 clients/year).

Increase referrals for Alcohol/Drug/Tobacco Cessation/Mental Health Treatment by 750 clients/year
Increase clients referred for well child visits by 200 clients per year
Increase clients referred for immunizations by 200 clients per year
Increase clients referred for diabetes and cardiovascular prevention visits and fitness/nutritional health by 500 clients per year
Increase high risk clients tested for HIV/Hepatitis and linked to care services by 200 clients per year
Reduce hospital readmission rates for elderly and clients with chronic disease by 100 clients per year