TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS

Contact Information	*Bill Rumpf, President, Mercy Housing Northwest - (206) 602-3480* *Which organizations were involved in developing this project suggestion?* ***Mercy Housing Northwest, Global to Local, HealthPoint, Public Health – Seattle & King County, Seattle Housing Authority, Neighborcare Health***
Project Title	*Prevention and Management of Chronic Disease in Low-Income and Immigrant Populations through Community Health Worker Interventions in King County*

Rationale for the Project

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

The proposed project directly addresses the significant health disparities faced by many Medicaid recipients, particularly those from historically underserved communities, including immigrants, refugees and people of color.

Data from the Public Health - Seattle & King County indicates that the incidence of many chronic diseases is higher for those with low-incomes. Compared to middle and upper-income residents, low-income residents of King County:

- Were less likely to have health insurance or a personal physician
- Were far more likely to smoke
- Had lower rates of physical activity
- Had higher rates of obesity, diabetes and heart disease
- Had significantly lower life expectancy

While the recent Medicaid expansion in Washington has resulted in more low-income residents obtaining coverage, many still face cultural and linguistic barriers to accessing quality care, navigating the health care system and understanding how to take steps to improve their health.

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

According to a 2008 report on Community Health Workers (CHWs) published by the National Conference of State Legislatures, "A growing body of evidence suggests that CHWs reduce health care costs for people with chronic diseases…Although the CHW model requires investments in prevention and primary care, these health services are less costly than treating serious and avoidable conditions."

While CHW interventions would benefit from more extensive evaluation, many studies have shown the cost-effectiveness of particular interventions for populations with chronic health conditions. In its May 2015 report to the Legislature, the Washington State Institute for Public Policy presented a cost-benefit analysis of a number of health care interventions. The analysis found that shorter-term lifestyle interventions to prevent diabetes had a benefit-to-cost ratio of $34.76, with an 83% chance that benefits of the intervention will exceed costs.

Global to Local, a project partner, has implemented a mobile phone-based diabetes management program to help low-income residents of Tukwila and SeaTac control their diabetes. A study of the program's first year conducted by researchers from the University of Washington found that "36% of the participants showed an HbA1c decrease of 1.26% from their baseline. These results are significant because it translates into a reduction in the risk of eye, kidney and nerve disease by approximately 40% and diabetes related death by 21%." A separate study by the National Institute of Coordinated Healthcare found that after excluding statistical outliers the program had a net positive ROI of 5.2%.

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

The project directly addresses the Medicaid objective to "Improve health outcomes for Medicaid and low-income populations," targeting low-income residents of affordable and public housing and others living high-poverty neighborhoods in Seattle and South King County. By providing health education, wellness activities, screenings, chronic disease management support and clinical linkages, the project will help activate Medicaid clients and other low-income residents to make positive lifestyle changes and access appropriate care that will improve their overall health outcomes.

Project Description

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

☒ Improve population health, focused on prevention

Which Transformation Project Domain(s) are involved? Check box(es)

☒ Population Health Improvement – prevention activities

Describe:

- *Region(s) and sub-population(s) impacted by the project. Include a description of the target population*

The project will target services to low-income residents of affordable and public housing in Seattle and South King County, together with other residents of high-poverty neighborhoods in those geographies, with a particular emphasis on communities of color, immigrants, refugees and other historically underserved groups.

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

The project is focused on advancing Washington's Medicaid Transformation goal to "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." The project will work to align culturally and linguistically competent community-based services and supports with appropriate clinical care in order to assist low-income residents to prevent and manage chronic health conditions.

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

The project's overarching goal is to reduce health disparities and improve health outcomes for low-income communities of color in Seattle and South King County, with a particular emphasis on immigrant and refugee communities. The project will employ a number of interventions to achieve its objectives, including:

  - Culturally-competent Community Health Workers based in public and affordable housing communities providing direct outreach, health education and prevention activities
  - CHWs based in high-poverty neighborhoods providing outreach and chronic disease management support
  - Tiered diabetes management program, utilizing CHW home visits, mobile phone-based support and community-based prevention activities
  - Linkage to primary care for follow-up and ongoing treatment

CHWs will be based in public and affordable housing properties in Seattle and South King County owned by Seattle Housing Authority, King County Housing Authority and Mercy Housing Northwest. We anticipate scaling the project to include at least ten housing sites with over 7,000 residents. In addition, Global to Local community-based CHWs will serve additional residents in SeaTac and Tukwila.

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

The project is closely linked with the data integration work being carried out by the King County ACH and Public Health – Seattle & King County, which will merge data from public and affordable housing organizations with Medicaid claims and other health data, providing a means to better evaluate the impact of housing-based prevention services on long-term client health outcomes. Pacific Hospital PDA is funding CHW activity with several of the project partners. Transformation resources would be leveraged by PHPDA and housing service funds.

- *Potential partners, systems, and organizations*

King County ACH, Seattle Cancer Care Alliance, Medicaid Managed Care Organizations, health educators, YMCAs and community centers, graduate nursing programs, hospital systems, primary care providers. The project will partner with Public Health on project data and evaluation and with Foundation for Healthy Generations in a statewide CHW learning collaborative focused on prevention of diabetes and hypertension.

Core Investment Components

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

The project is proposing to employ at least 12 Community Health Workers, a Project Coordinator, Eligibility Specialist and Project Director. We anticipate an average annual cost of $700,000 - $800,000 depending on timing of project scale-up. The CHWs will provide outreach and engage low-income residents of affordable and public housing communities in activities to prevent and manage chronic diseases.

The Project Coordinator will supervise and coordinate the work of the CHWs and be responsible for day-to-day project logistics. The Eligibility Specialist determines client eligibility and assists individuals and families in applying for health insurance. The Project Director will oversee planning and implementation of the project and work with project partners and others to build capacity through additional partnerships and ensure the project's success.

- *Best estimate (or ballpark if unknown) for:*
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented.

We anticipate the project will serve 8,000 individuals annually when fully implemented at the end of year two.

  - How much you expect the program to cost per person served, on a monthly or annual basis.

We anticipate an average annual cost of $100 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.*

We anticipate the project will be fully implemented in Seattle and South King County by the end of year two.

- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*

Because the project is primarily focused on prevention, we anticipate that it will take several years to achieve positive ROI after initial scale-up. We expect that the project will be revenue neutral over the five-year period and at that point ROI positive going forward due to the ongoing impact of the prevention activities provided. Cost savings will vary significantly by individual, with higher savings for those with serious chronic conditions participating in targeted interventions, compared to those taking part in more general prevention activities.

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.*

The broad menu of community outreach, education, prevention services and supports provided by the project will directly support achievement of many of the state's Common Measures. Specific measures addressed and tracked will include: 1. Immunization: Influenza – the project will facilitate influenza immunizations on-site at affordable and public housing communities and conduct outreach to encourage residents to get vaccinated; 10. Adult Access to Preventive / Ambulatory Health Services – linkage to a medical home; 11. Adult BMI Assessment – on-site BMI assessments for residents; activities and resources to assist residents in managing their weight, including physical activity and healthy cooking/nutrition education; 13. Colorectal Cancer Screening – on-site colorectal cancer screenings; 14. Diabetes Care: Blood Pressure Control – regular on-site blood pressure checks; reminders to clients via mobile phone; 15. Diabetes Care: Hemoglobin A1C – the project will provide mobile phone-based case management and support to clients to adhere to treatment plans and get regular A1C monitoring; 16. Hypertension: Blood Pressure Control – the project will facilitate regular blood pressure checks as well as numerous healthy living activities designed to help residents control their blood pressure; 24. Screening: Cervical Cancer - on-site cervical cancer screenings; 26. Screening: Breast Cancer - on-site breast cancer screenings; 42. Potentially Avoidable ED Visits – education on appropriate ED usage.

Process Outcome: The project will successfully scale up to include at least ten housing sites by the end of 2018.

Client Outcome (additional outcomes TBD): 500 individuals with diabetes will adhere to treatment plans and lower their A1C from baseline.

- *If no specific benchmark performance data are currently available*, *what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?

The project will work with its clinical partners and Medicaid managed care organizations to gather baseline data on the target population as part of initial project implementation. Concurrently, the project Community Health Worker team will conduct outreach to residents to assess their health status and health care needs. We anticipate that by the end of 2017 the housing/health data integration work being carried out in King County and Washington State will be completed, providing a means to evaluate the impacts of project interventions on healthcare usage and health outcomes for residents of affordable and public housing.