

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>Marguerite Ro Director of Chronic Disease & Injury Prevention, Public Health- Seattle & King County Tel: 206-263-8811 Email: marguerite.ro@kingcounty.gov</p> <p>This proposal was developed with input from Global to Local and is based upon our previous REACH diabetes community-based initiative.</p>
Project Title	<i>Improving diabetes management and outcomes among high risk groups</i>
Rationale for the Project	
<p>Diabetes is the 7th leading cause of death in King County. Seven percent of King County adults reported having been told by a doctor that they had diabetes and 4 percent of King County students in 8th, 10th, and 12th grades had diagnosed diabetes. Diabetes can lead to serious health complications such as heart disease, kidney failure, and lower extremity amputations. The CDC predicts that the prevalence of diabetes and related costs are expected to more than double in the next 25 yearsⁱ.</p> <p>Disparities in diabetes are evident with low income and minority populations. These groups carry a higher burden of the disease. According to CDC's National Diabetes Education Program, the highest rates of type 2 diabetes and its complications exist across particular groups of the population. In addition to older adults, these groups include racial and ethnic minority groups such as African Americans, Hispanic/Latino Americans, American Indians, Native Hawaiians and other Pacific Islanders, and some Asian Americansⁱⁱⁱⁱ. People with low socioeconomic status are also at higher risk.</p> <p>Diabetes self-management is an important component of diabetes care, yet many people do not have the opportunity to learn self-managements skills or do not practice disease self-management. This project proposes to develop a menu of options to support low-income and communities of color in effectively managing type 2 diabetes. This project will offer culturally tailored diabetes education and self-management classes in a community or clinical setting^{iv}, Community Health Worker(CHW) home visits^v, and by incorporating mobile-phone based (Mobile Health Program) support where needed. These three approaches will allow project partners to reach participants who would like the support and social interaction of a group as well as clients who due to emotional and physical challenges would prefer a more individualized approach. In addition, the mobile messaging approach can be used with participants who are very motivated however; these participants may need reminders to follow through on provider recommendations and/or diabetes care.</p> <p><i>Supporting research (evidence-based and promising practices) for the value of the proposed project.</i>^{vi}</p> <p>The CDC's Community Guide to Preventive Services recommends a range of diabetes self-management interventions in home and community settings, and summarizes the decreases in blood glucose, weight, BP, and glycated hemoglobin levels associated with different interventions. Specific supporting evidence for culturally tailored diabetes education and community health workers includes results from the Racial and Ethnic Approaches to Community Health (REACH) program, culturally tailored diabetes education and self-management program focused on eliminating diabetes health-related disparities for African Americans, Asian Americans and Pacific Islanders, and Latinos/Hispanics in King County, WA. (<i>Collier-Garvin et al, 2004</i>); and an upcoming publication that demonstrated that a community health worker (CHW) home-based diabetes self-management intervention among low-income individuals improved glycemic control specifically among participants with poorly controlled diabetes at</p>	

baseline. (Nelson K et al, 2014)

How this project benefits Medicaid beneficiaries:

This proposal relates to increasing the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Project Description

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

- ✓ Improve population health, focused on prevention
- ✓ Ensure Medicaid per-capita growth is below national trends

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

- ✓ Care Delivery Redesign
- ✓ Population Health Improvement – prevention activities

Region(s)

This project will target low-income and minority populations disproportionately impacted by diabetes in King County. Medicaid and low-income people in King County newly diagnosed or with unmanaged diabetes will be recruited to participate. Also, the project could have applicability in regions of the state other than King County given the extent of the diabetes challenge statewide.

Relationship to Washington’s Medicaid Transformation goals Diabetes prevention and management is one of the priority areas of the state’s “Prevention Framework,” and multiple measures of diabetes management are reflected in the Healthier Washington’s Common Core Measures set. In order to make progress on those measures, a significant ramp-up of community-based interventions are needed to complement what occurs in the clinical care setting.

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

Goal: The goal is to support low-income and communities of color in effectively managing type 2 diabetes. For project development and oversight, we propose the formation of a Strategic Action Team that would coordinate further refinement of the diabetes management “menu,” coordinate implementation partners, and seek to build partnerships with managed care organizations. The team would develop a menu of options to support low-income and communities of color in effectively managing type 2 diabetes. This project will offer culturally tailored diabetes education and self-management classes in a community or clinical setting^{viii}, Community Health Worker(CHW) home visits^{ix}, and/or by incorporating mobile-phone based support where needed. These three approaches will allow the initiative to reach participants who would like the support and social interaction of a group as well as clients who due to emotional and physical challenges would prefer a more individualized approach. In addition, the mobile messaging approach can be used with participants who are very motivated but may need support to follow through on provider recommendations and/or diabetes care. Participants would receive tailored messaging that supports their care plan as well as provide psycho-social support (encouragement, troubleshooting, motivation, etc.)

Links to complementary transformation initiatives

The proposed intervention could be intentionally linked and marketed to clients with diabetes who are identified in various other Initiative 1, 2, or 3 projects (integrated clinical care settings, case management for high ED users, and residents of supportive housing, for example). By partnering with those other initiatives, the potential for better health outcomes for their clients with diabetes will increase.

- **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.**

Building upon Public Health’s past coalition-building work in the area of chronic disease prevention, we would seek to partner with community based organizations that serve low-income and communities of color with

disproportionate rates of diabetes (i.e. Center for MultiCultural Health, Global to Local, International Community Health Services, and Sea Mar Community Health Centers) in the further design and implementation of this project. In addition, because participants would be members of Medicaid Managed Care Organizations who may also be involved in providing or arranging community-based diabetes support through community health workers, we would collaborate to avoid duplication and engage MCOs in the development and testing of approaches and partnerships that no one MCO alone could necessarily enable. This will also be key to exploring how to sustain the service after the waiver period ends.

Core Investment Components

Describe:

- **Proposed activities and cost estimates (“order of magnitude”) for the project.**
Formation of a Strategic Action Team
- Train partners using a culturally tailored diabetes education and self-management curriculum(i.e. REACH curricula), including the training of CHWs and diabetes educators
- Recruitment of Medicaid patients who have difficulty managing their diabetes (A1C 8 or above)
- Conduct classes in at least 6 settings, ensuring that classes are culturally tailored to the needs of participants
- Engage CHW in providing home visits and linking patients to community resources
- Work with a mobile carrier (i.e. AT & T) who can provide free phones for participants based upon need
- Set up mobile texting (Mobile Health Program)to provide additional support through tailored messaging

Best estimate (or ballpark if unknown) for:
Annual: \$600,000 - \$1,000,000, depending upon the number of contracted community agencies (5-8 agencies)
served: An estimated 400+ people will be served per year and when additional partners are brought on this number should increase to 700 per year
Estimated cost per person served, on a monthly or annual basis. Approximately \$1500 pp
Implementation time: Since partners are ready to begin, it would take less than one year to fully implement the program
ROI:In a three year retrospective claims analysis of 4 million covered lives, which included 250,000 Medicare beneficiaries, there was a reported Medicare average costs savings of \$135 per month among those beneficiaries who completed a DSME program^x

The Mobile Health Program at Global to Local has seen gradual improvements in participants’ health status through the implemented interventions (i.e., educative cooking classes, supportive case management). Data from the conclusion of the pilot indicated that 36 of the 39 participants who completed the program have had their one year HbA1c tested. From that number, 36% have had an average HbA1c decrease of 1.26% when comparing their baseline and post-one year labs. 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%^{xi}. In addition to this, The data was analyzed by a third party organization, the National Institute for Coordinated Healthcare, and we are proud to share that our pilot yielded a positive ROI of 10% which equates to an average yearly savings of \$556.5 per patient.

Project Metrics

HbA1C-
Systolic blood pressure
Diastolic blood pressure
BMI
Medication adherence

Development of Washington State Medicaid Transformation Projects List – December 2015

ⁱ American Diabetes Association. Economic costs of diabetes in the U.S. in 2012. *Diabetes Care*. 2013;36:1033-46. [PMID: 23468086] doi:10.2337/dc12-2625

ⁱⁱ Peer, ME, Cargill A. Huang ES. Diabetes health disparities: a systematic review of health care interventions. *Med Care Res Rev* 2007; 64(5 Suppl.):101s-56S

ⁱⁱⁱ Closing the gap: effects effect of diabetes case management on glycemic control among low-income ethnic minority populations. The California Medi-Cal type 2 diabetes study. *Diabetes Care* 2004;27(1):95-103.

^{iv} Collier-Garvin, C; Cheadle, A; Chrisman, N; Chen, R; Brunson, E. A Community Based Approach to Diabetes Control in Multiple Cultural Groups. *Ethnicity & Disease*, Volume 14, Summer 2004. S1-83-S1-92.

^v Nelson K, Drain N, Robinson J, et al. Peer Support for Achieving Independence in Diabetes (Peer-AID): Design, methods and baseline characteristics of a randomized controlled trial of community health worker assisted diabetes self-management support. *Contemporary clinical trials*. 2014;38(2):361-369.

^{vi} 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>

^{vii} 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.

^{viii} Collier-Garvin, C; Cheadle, A; Chrisman, N; Chen, R; Brunson, E. A Community Based Approach to Diabetes Control in Multiple Cultural Groups. *Ethnicity & Disease*, Volume 14, Summer 2004. S1-83-S1-92.

^{ix} Nelson K, Drain N, Robinson J, et al. Peer Support for Achieving Independence in Diabetes (Peer-AID): Design, methods and baseline characteristics of a randomized controlled trial of community health worker assisted diabetes self-management support. *Contemporary clinical trials*. 2014;38(2):361-369.

^x Tomky, D. (2013). Diabetes Education: Looking Through the Kaleidoscope. *Clinical Therapeutics*, 734-739.

^{xi} Diabetes Successes and Opportunities for Population-Based Prevention and Control At A Glance 2011. (2011, August 1). Retrieved from <http://www.cdc.gov/chronicdisease/resources/publications/aag/ddt.htm>