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.

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| **Contact Information** | Sarah Rafton<br>Executive Director, Washington Chapter of the American Academy of Pediatrics<br>srafton@wcaap.org<br>(206)293-3540 |
| **Project Title** | Pediatric Primary Care 24/7 Telehealth |

**Rationale for the Project**

Emergency Departments are frequently utilized for routine, non-emergent healthcare issues by pediatric patients rather than their primary care medical home. Use of the Emergency Department (ED) for routine health problems not only increases the cost of care but fragments care, and represents a lost opportunity for better preventive interactions, education and population management from within the medical home.

National Center for Health Statistics data makes it clear that a large proportion of ED visits are primarily driven by the fact that the doctor's office is not open and influenced by the fact that the ED is the closest provider.
Data

- 24.8% of children on Medicaid visited the ED at least once in the past year
- 3/4 of ED visits by children were at night or on the weekend
- 1/3 of ED visits were not due to the seriousness of the health issue
    - 89% of these reported the reason of "the doctor's office was not open"
    - 30% of these reported the reason that "Emergency Room is closest provider"

Source:
http://www.cdc.gov/nchs/data/databriefs/db160.pdf

A report of Washington State ED use released in 2015 reported that Medicaid patients aged 1 to 9 years have the highest rate of potentially avoidable ED visits amongst Medicaid beneficiaries. Most common reasons for avoidable ED visits for Washington children are respiratory infection, earache, and urinary tract infection. The report points to many solutions to this problem, including offering patients access to virtual visits with clinicians to diagnose and treat the many children with common problems and to rapidly identify the few children who may have more serious problems and must be triaged to a higher level of care.

Source:
http://www.wacommunitycheckup.org/Media/Default/Documents/Right%20Care%20Right%20Setting%20Avoidable%20ER%20Visits.pdf?AspxAutoDetectCookieSupport=1

Creating a 24/7 primary care triage and telehealth access that functions as a direct extension of "the doctor's office" could lead to a substantial decrease in ED use for patient's seeking care that isn't due to the seriousness of the condition and improve continuity of care. Families with Medicaid who went to the ED were far less likely than those with commercial insurance to go because a health provider told them to go. This strongly suggests that there exists an opportunity to decrease ED use substantially by providing better triage and better options for families.

In additional to providing care for patient's currently seeking ED care for healthcare that isn't due to the seriousness of the condition, there are opportunities through telehealth to reduce ED utilization when there is concern about the seriousness

of the condition. Only 36.3% of pediatric Medicaid patients go to the ED because a health provider said to go. After hours triage has been shown to result in only 22% of after-hours concerns being referred to after-hours care (ED, Urgent Care) when it is utilized. After hours triage reduces referrals for after-hour care even further (down to 11%) when a secondary level physician triage evaluates the patient after the initial assessment. (Source: Kempe)

Telehealth models and in particular, the information-rich connected care model can complete upwards of 90% of acute care visits. (Source: McConnochie)

A Pediatric Primary Care 24/7 Telehealth option for patients would not only improve after-hours management reducing overutilization of the ED, but provide an opportunity for triage and telehealth during routine hours. Use of telehealth during routine office hours could be used when an in-person visit is not necessary, increasing the convenience for the family and improving office access for face-to-face care for other patients.

**Project Description**

Under this project, parents access a self-triage/symptom checker online tool that utilizes Barton Schmitt's triage and parent education content. Parents may utilize or bypass this self-symptom checker to next access 24/7 after hours video care (via families' smart phone devices or home computers) provided by pediatricians, family physicians, or advance practice pediatric providers. The intervention relies on a community of primary care providers working together across larger geographic distances to staff the online acute care system as a collaborative virtual call group. Pediatric providers would be paid for these virtual visits. The intervention assures continuity and quality by utilizing a network of pediatric providers in a child's region, including but not exclusive to providers from the patient's own primary care office. This network utilizes primary care provider delivered care based on quality guidelines rather than third party service. The technology supports documentation integration with the medical home's EMR or secure email options for closed-loop communication between on-call providers and the primary care provider. It also includes the capability to send a secure flagged email to the patient's PCP about needed follow-up when the office opens. Language interpretation through qualified medical interpreter services is available for the video service. Of particular importance for children with complex chronic problems, after hours providers will have access to care plans and details regarding status and management of these problems for children with special health care needs.

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

✓ **Reduce avoidable use of intensive services**

Supported by information above

✓ **Improve population health, focused on prevention**

By integrating the telehealth care with the medical home through a shared call-group of Primary Care Providers, and a shared EMR platform which can integrate with their primary EMR, this model will improve continuity and reduce fragmentation of care.

✓ **Accelerate transition to value-based payment**

By creating a method for face-to-face care through a video connection, providers will be able to move more easily toward alternative payment models such as shared savings and partial or full risk contracts.

✓ **Ensure Medicaid per-capita growth is below national trends**

Since this model will have a direct and significant impact on Medicaid recipients use of high cost intensive services, there will be significant savings in the cost of care.

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

✓ **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).*

- *Relationship to Washington's Medicaid Transformation goals.*
- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.*
- *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.*
- *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 project would be best implemented at the ACH regional level, and is applicable to any ACH. The application has particular relevance in rural areas with less access to primary care due to population density and geography, as well as more urban areas of the state with less timely access to primary care due to shortages of providers accepting Medicaid. Several groups of pediatric care providers join together to serve multiple areas. An ideal pilot size is establishing a provider group of 30-40 providers to serve 50,000-60,000 children.

The project employs technology that can help assure access for children of color and families living at low incomes. Some 86% of African Americans ages 18-29 are home broadband adopters. African Americans' home broadband use across education and income levels is well above the national average for broadband adoption, and identical to whites of similar ages, incomes, and education levels. Source: http://www.pewinternet.org/2014/01/06/african-americans-and-technology-use/) Smartphone ownership is higher for African Americans and Hispanics than for whites. Seventy percent of African Americans, 71% of Hispanics and 61% of whites own smartphones. Source: http://www.pewinternet.org/2015/04/01/chapter-one-a-portrait-of-smartphone-ownership/) A larger percentage of low income individuals use their smart phone for health information than those making more than $30,000 per year. Source: (http://www.pewinternet.org/2015/04/01/chapter-one-a-portrait-of-smartphone-ownership/)

The project strongly supports the waiver goal of reducing avoidable use of intensive services in hospitals, as well as improving population health for Washington children. The project is an innovative way to engage primary care providers in reducing utilization of avoidable and expensive ED services, and accelerating the system to adoption of value-based payment.. Finally the project would make significant contributions to reducing Medicaid per-capita cost below national trends.

The goals of the project include:

- Reduced avoidable ED utilization and associated cost reduction
- Improved continuity of care with medical home for after-hours care received
- Expanded after hours capacity of primary care providers for a large regional community
- Improved community-level pediatric population health
- More convenient care during regular office hours, by enabling parents to stay at work while their children are cared for at school or childcare and allowed (because they have been seen by a physician) to stay there.

Potential partners include community pediatricians, family physicians, HCA, Medicaid contracted Managed Care Organizations, local hospitals, and regional pediatric hospitals.

**Core Investment Components**

*Describe:*

- *Proposed activities and cost estimates ("order of magnitude") for the project.*
- *Best estimate (or ballpark if unknown) for:*
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented.
    We would recommend starting this innovation with approximately 50,000 children and approximately 30-40 pediatric providers for a pilot year. Beyond the pilot year, the project could be replicated at the ACH-level, to multiple regions, as rapidly as provider groups could be formed. Within the waiver period, the service could be available to all Washington children enrolled in Medicaid. In a given year, the volume of care through this model would be estimated to be 1,000 calls per community-based provider.
  - How much you expect the program to cost per person served, on a monthly or annual basis.

Upfront one-time technology investment is $150,000 and annual cost for local champions and outreach is $60,000 per year until the innovation is taken to scale at a state level.

- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.*
  We would recommend starting this innovation with approximately 50,000 children and approximately 30-40 pediatric providers for a pilot year. Beyond the pilot year, the project could be replicated at the ACH-level, to multiple regions, as rapidly as provider groups could be formed.
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*

It is estimated that 25% of avoidable emergency department visits could be replaced by video care, saving approximately $440 per avoided emergency department encounter, after the cost of the video encounter ($60.) For a population of 50,000 children, on an annual basis, we estimate we could reduce avoidable emergency department encounters by 4,350, for a reduction of $1.9 million in emergency department costs avoided.

**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 application* http://www.hca.wa.gov/hw/Documents/waiverappl.pdf *pages 46-47*[ii].
- *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?

Outcome Measures:

The top five reasons for avoidable pediatric emergency department visits for Washington children would be tracked for children covered in the video project; comparing their baseline avoidable ED use one year before video to use one year after initiation of the video project. Avoidable ED costs and cost of video care would also be measured.

Process Measures:

1) Number of pediatric providers engaged in virtual care networks, providing video services.
2) How many families utilize the service in a given region of primary care practices.
3) Does utilization vary by region, child age, race, ethnicity, language.

[i] 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.

[ii] 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.