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	*Identify point person, telephone number, e-mail address:* **Bertha Lopez, Senior Director Community Health, Yakima Valley Memorial Hospital, (509) 249-5266, berthalopez@yvmh.org** *Which organizations were involved in developing this project suggestion?* **Greater Columbia Accountable Community of Health**
Project Title	*Title of the project/intervention:* **Diabetes, Obesity, Cardiovascular Disease Prevention and Chronic Disease Self-Management**

Rationale for the Project

Include:

- *Problem statement – why this project is needed.* **According to the American Diabetes Association, patients with co-morbid conditions (such as obesity, diabetes, and high blood pressure combined) absorb exponentially greater health care resources per capita. In the U.S., 75% of healthcare dollars go to the treatment of chronic diseases that are the leading cause of death and disability[1]. The national economic burden of pre-diabetes, diabetes, gestational diabetes and all diabetic complications combined costs the nation $245 billion dollars a year. Diabetes alone is a threat to the health of our country as well as its fiscal stability.[i] The CDC estimates that more than one third of adult Americans and half of all adults age 65 years and older have pre-diabetes.[ii] Pre-diabetes means a person has a blood sugar level that is higher than normal but not high enough to be classified as diabetes. People with pre-diabetes have an increased risk of developing type 2 diabetes that can lead to serious health problems such as vision loss, lower limb amputations, and kidney disease. Nearly 26 million Americans have diabetes and at least 79 million have pre-diabetes. Each year, 11% of individuals with pre-diabetes who make no lifestyle changes will progress to type 2 diabetes, which is associated with obesity and physical inactivity, within 3 years. Nearly 50% of seniors are at risk for developing type 2 diabetes.[iii]**

  In Washington State, Yakima County has higher rates of diabetes and obesity compared to the state average: diabetes prevalence is 9% for Yakima County compared to 7% for Washington State; 1 in 3 adults has pre-diabetes and 1 in 11 adults has diabetes; Yakima County's obesity rate is 32% compared to 27% statewide and 25% nationally, with 1 in 3 adolescents overweight or obese. Pediatric overweight (20.5%) and pediatric obesity (14.9%) are also higher than the state average. These trends continue among Hispanic/Latino subgroups on a national level: 57% of Washington's Hispanic children are overweight or obese, compared to 41% nationally. Moreover, 22.4% of school aged Latinos are overweight and 16.2% are obese, compared to only 18.2% and 13.7% respectively, for non-Hispanics[2].

- *Supporting research (evidence-based and promising practices) for the value of the proposed project.* **A 10-year cost-effectiveness study by the American Diabetes Association estimates that total per capita healthcare expenditures for people with diabetes are $11,744 per year, of which $6,649 is attributed directly to diabetes, but the direct medical cost of care for a man with diet-controlled type 2 diabetes is approximately $1,700 (a 75% reduction).[iv] Research indicates that racial minorities are less likely to seek specialty care,[v] and focused**

[1] CDC: http://www.cdc.gov/chronicdisease/index.htm

[2] Department of Health. Washington State Healthy Youth Survey 2006. Portland June 2007.

interventions for diabetes and other chronic conditions in primary care settings can improve healthcare for minority populations who might not otherwise seek treatment.[vi] Management and prevention programs are a win-win, because they improve health and quality of life while reducing long-term healthcare spending.[vii]

Memorial Hospital has implemented evidence-based diabetes classes and education programs to reach a wider audience through the National Diabetes Prevention Program curriculum offered by the CDC and the International Diabetes Center Management Program.

Memorial Hospital has implemented the ACT! Get Up, Get Moving! childhood obesity program, an evidence-based weight management and fitness program for overweight/obese youth (BMI ≥85%) ages 8 to 14 years and their parents. ACT! (Actively Changing Together) was developed by Seattle Children's Hospital and is practiced in partnership with the local YMCA for the fitness component. The curriculum focus of this replicable model is on proper nutrition, a balanced diet, exercise/physical fitness, and behavior modification. Inclusion of parents is a key component to success in family behaviors for successful weight management intervention targeting children and adolescents, since children rely on parents to purchase food, and model parents' behaviors regarding food choices, meal preparation and exercise[3].

Memorial Hospital has implemented the Stanford University School of Public Health Chronic Disease Self-Management Program (CDSMP) in English and Spanish called "Taking Control of Your Health" (Tomando Control De Su Salud), a curriculum that is evidence-based and culturally and linguistically appropriate[4].

All of the evidence-based programs listed above are offered in both English and Spanish.

- *Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries.* **The project will: 1) increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations by offering preventive health programs at no cost to participants in multiple community settings where people normally and regularly congregate (e.g. community centers, churches, FQHCs, clinics, senior centers); 2) improve health outcomes for Medicaid and low-income populations through disease prevention; and 3) increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks as education to prevent disease offered in multiple, easy to access locations mitigates disease and reduces overall healthcare costs.**

Project Description

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

- ☑ **Reduce avoidable use of intensive services**
- ☑ **Improve population health, focused on prevention**
- ☑ **Accelerate transition to value-based payment**
- ☑ **Ensure Medicaid per-capita growth is below national trends**

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

- ☑ **Health Systems Capacity Building**
- ☑ **Care Delivery Redesign**
- ☑ **Population Health Improvement – prevention activities**

[3] Savoye M, Nowicka P, Shaw M, et al. Long-term results of an obesity program in an ethnically diverse pediatric population. *Pediatrics.* Mar 2011;127(3):402-410.

[4] Stanford School of Medicine: http://patienteducation.s tanford.edu/materials/spanish.html

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).* **The project will impact residents with chronic disease in the Greater Columbia Regional Service Area (RSA).**
- *Relationship to Washington's Medicaid Transformation goals.* **The project will: 1) Reduce avoidable use of intensive services and settings as preventive care decreases emergency department visits, hospital admission/re-admissions, and length of stay; 2) Improve population health, focused on prevention; 3) Accelerate the transition to value-based payment (payment model 2, encounter-based to value-based) as Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals provide services for adults with chronic disease; and 4) Ensure that Medicaid per-capita cost growth is two percentage points below national trends as the benefit to cost ratio of lifestyle interventions for diabetes, adult obesity, and childhood obesity for high-risk populations is $30.35, $6.48, and $0.10 respectively.[5]**
- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.* **Expected project outcomes include a reduction in potentially avoidable emergency department visits, the percent of patients with five or more visits to the emergency room without a care guideline, diabetes care: hemoglobin a1c (hba1c) poor control (>9.0%), blood pressure control (<140/90 mm hg), hemoglobin a1c testing, eye exam, screening for nephropathy, hypertension: blood pressure control, 30-day mortality: heart attack (AMI), medication management, annual state-purchased health care spending growth relative to state GDP, Medicaid per enrollee spending, and inpatient utilization. According to the CDC (Centers for Disease Control), Hispanics are more than twice as likely to develop diabetes compared to Whites, and are 50% more likely to die from diabetes than the general population.[viii] Hispanic Americans have the second highest obesity prevalence among adults.[ix] Children and adolescents from lower socioeconomic income areas are at higher risk for obesity and therefore have higher rates of type 2 diabetes and cardiovascular disease later in life than their more affluent counterparts.[x] Nearly one half of the U.S. population suffers from a chronic condition[xi] and chronic disease rates are disproportionately higher among lower income and racial and ethnic minority populations in the United States, due in large part to fewer treatment options and the health damaging social, behavioral, and environmental health determinants that negatively impact these populations. Memorial Hospital's outreach programs target the region's large Hispanic population (48%) and Native American population (6%), are offered in both English and Spanish, are culturally competent,** and **create clinical-community linkages that address social determinants of health and equity such as Health Behaviors (diet and exercise), Health Education (reading food labels, portion sizes, making good health choices when eating out**, i**nsulin, glucose monitoring, importance of exercise and carbohydrate counting when diabetic), and social factors (the importance of family & social support when making good health choices).**
- *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.* **N/A**
- *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 will engage business, community- and faith-based, consumer, education, food system, health care provider, hospital, housing, local government, philanthropy, public health, social services, transportation, and tribal organizations in the Greater Columbia RSA.**

Core Investment Components

[5] http://www.wsipp.wa.gov/BenefitCost?topicId=6

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project.* **Proposed activities include: follow-up prevention program care following an emergency department visit, disease prevention educational resources, self-management classes, plans and tools, counseling patients to adopt healthy behaviors, assessing and addressing barriers, and reviewing and reconciling medications. The cost estimate is $1,222,600 per year (2,350 diabetes/chronic disease participants x $440 per participant = $1,034,000 + 200 adult & child obesity participants x $943 = $188,600)**
- *Best estimate (or ballpark if unknown) for:*
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented. **Memorial Hospital will serve approximately 5,100 diabetes, obesity, chronic disease participants per year, of which 50% are Medicaid eligible.**
  - How much you expect the program to cost per person served, on a monthly or annual basis. **The WSIPP estimates that diabetes prevention for high-risk populations costs $440 and for adult & childhood obesity costs $943 per participant per year.**[6]
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.* **N/A**
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.* **The WSIPP estimates that prevention for high-risk populations benefits minus costs (net present value) is $12,926 per participant per year for diabetes/chronic disease and $3,077 for adult & childhood obesity, so the estimated ROI is $30,991,500 per year (2,350 diabetes participants x $12,926 per participant = $30,376,100 and 200 obesity participants x $3,077 per participant = $615,400). For every $1.22 spent, the return is $30.99.**[7]

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.* **Outcomes measures will include potentially avoidable emergency department visits, percent of patients with five or more visits to the emergency room without a care guideline, reduction in hospital readmissions for diabetics (who currently make up 30% of readmissions), 65% of the participants to lose between 5-7% of their weight (16.9 average pounds lost per participant), exercise minimum of 150 min per week per participant, average A1c reduction of 1.09%, reduction in blood pressure (mean arterial pressure) of 2.44%, improved control and management of disease, decrease in medications, annual state-purchased health care spending growth relative to state GDP, Medicaid per enrollee spending, and inpatient utilization.**
- *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*? **County-level benchmark performance data are available for the *Washington State Common Measure Set for Health Care Quality and Cost.***

[i] American Diabetes Association. (2014). American Diabetes Association Applauds Congressional Support for the national Diabetes Prevention Program. Retrieved from: http://www.diabetes.org

[6] http://www.wsipp.wa.gov/BenefitCost?topicId=6

[7] http://www.wsipp.wa.gov/BenefitCost?topicId=6

[ii] CDC (Centers for Disease Control & Prevention) National Diabetes Prevention Program from http://www.cdc.gov/diabetes/prevention/about.htm.

[iii] American Diabetes Association, Diabetes Statistics from http://www.diabetes.org/diabetes-basics/diabetes-statistics/

[iv] American Diabetes Association, Diabetes Statistics from http://www.diabetes.org/diabetes-basics/diabetes-statistics/

[v] Snowden, L & Pingitore D (2002). Frequency and scope of mental health services delivery to African Americans in primary care. *Mental Health Srvices Research,* 4, 123-30.

Vega WA, Kolody B, et al. (1999). Gaps in service utilization by Mexican Americans with mental health problems. *American Journal of Psychiatry,* 156, 928-934.

[vi] Schoenbaum M, Miranda J, et al. (2004). Cost-effectiveness of interventions for depressed Latinos. *Journal of Mental Health Policy and Economics,* 7, 69-76.

[vii] American Diabetes Association. (2014). *American Diabetes Association Applauds Congressional Support for the national Diabetes Prevention Program*. Retrieved from: http://www.diabetes.org

[viii] CDC. National Center for Health Statistics, Division of Health Interview Statistics. (2011). *Diabetes Data and Trends*, data from the National Health Interview Survey. Statistical analysis by the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation. Retrieved 6/29/2012 from http://apps.nccd.cdc.gov/ddtstrs/.

[ix] Elder, JP; Arredondo, EM; et al. (2010). Individual, family, and community environmental correlates of obesity in Latino elementary school children. *Journal of School Health*; 80(1): 20-30.

[x] Wells NM, Evans GW, Beavis A, Ong AD. Early childhood poverty, cumulative risk exposure, and body mass index trajectories through young adulthood. *American journal of public health.* Dec 2010;100(12):2507-2512.

[xi] Institute for Health and Aging, University of California San Francisco. (1996). *Chronic Care in America.* Prepared for the Robert Wood Johnson Foundation. Retrieved July 5, 2012 from http://www.rwjf.org/files/publications/other/ChronicCareinAmerica.pdf.