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*** Sarah Rafton, Executive Director WCAAP (206)293-3540 srafton@wcaap.org ***Which organizations were involved in developing this project suggestion?*** Washington Chapter of the American Academy of Pediatrics; Washington State Department of Health, Office of Healthy Communities; University of Washington Medical Home Partnerships Project; and Seattle Children's Hospital, WithinReach, Local health jurisdictions CSHCN nurses, Cascade Pacific Action Alliance – ACH, Pediatric Transforming Clinical Practice Initiative grant, Molina Health Homes
Project Title	***Title of the project/intervention*** Pediatric Care Coordination in the Medical Home

Rationale for the Project

Include:

- ***Problem statement – why this project is needed.*** Care coordination saves money and improves health. Care coordination is especially beneficial for families with chronic conditions and/or special health care needs, generally leading to increased family satisfaction, streamlined patient visits, cost savings and improved preventive care. Care coordination can improve adherence to interventions, as well as decrease number and intensity of patient encounters. Investment in children's health provides early and lifespan cost savings and improves lifespan health.

  It is estimated that 15% or 235,920 children in WA have a special health care need.[i] By definition children and youth with special health care needs have a chronic physical, developmental, behavioral, or emotional condition that requires more than routine health and related services.[ii] These children and their families and their providers face myriad challenges including coverage of specialty items, access to pediatric specialists, and navigating the various health and non-health systems. As a result, children and youth with special health care needs (CYSHCN) received fragmented or duplicative services and typically have many more unmet medical needs than other children. [iii] Care coordination is essential to ensuring children and families get the right care, at the right time, in the right setting – this is the basis for achieving the Triple Aim – better quality of care, improved population health, and lower per-person medical expenditures.

  A recent study published in *JAMA Pediatrics* found that children with at least three body systems impacted by a chronic condition had the best outcomes with long-term access to primary care. Continuous access to primary care translated to a 16% reduction in cost for these children[iv]. Proactive care coordination in primary care systematically identifies children with special needs in order to assure these patients receive timely routine well-child care. Care coordination in a healthcare home also:

  - facilitates the provision of comprehensive health promotion and chronic condition care;
  - ensures consistent, proactive implementation of care plans;
  - facilitates communication among family, the medical home, schools, specialists, and community professionals and community resources; and
  - measures and monitors quality outcomes (clinical, functional, satisfaction and cost)[v]

- ***Supporting research (evidence-based and promising practices) for the value of the proposed project.***[vi]
  Below please find multiple resources demonstrating value of the proposed project. There are nationally recognized curricula, most notably Boston's Children's Hospital Curriculum for Pediatric Care Coordination.[vii] CMS has endorsed this in the 2014 publication "Making Connections: Strategies for Strengthening Care Coordination in the Medicaid Benefit for Children and Adolescents."[viii]
    - *http://medicalhome.nichq.org/resources/care-coordination-paper*
    - *http://www.acphd.org/media/217961/best_practices_pres.pdf*
    - *https://www.communitycarenc.org/our-results/ccnc-saves-money/*
    - *http://pediatrics.aappublications.org/content/early/2011/12/21/peds.2011-2662*
    - *https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf*
    - *http://www.ncbi.nlm.nih.gov/pubmed/19564810*
    - *http://www.ncbi.nlm.nih.gov/pubmed/26574588*
    - http://archpedi.jamanetwork.com/article.aspx?articleid=2476188
- ***Relationship to federal objectives for Medicaid***[ix] ***with particular attention to how this project benefits Medicaid beneficiaries.***

✓ Reductions in unnecessary emergency room visits and avoidable hospitalizations;
✓ Increase well child care and immunization rates;
✓ Increase access to and strengthen provider networks that provide services to Medicaid covered clients;
✓ Improve health outcomes such as medication adherence leading to improved diabetic and asthma control;
✓ Early access to screening for mental health and substance abuse and early intervention;
✓ Transform the provision of health care by increasing efficiency and quality of care for Medicaid-covered clients as well as eliminating silos of care;
✓ The investment will support other federal initiatives, most notably the CMS supported Washington State "Pediatrics Transforming Clinical Practice Initiative;"
✓ The investment would support the goals for Healthier Washington by insuring that there is attention toward child health to shift the cost curve by providing early support for children who have not yet incurred high medical expenditures.

Project Description

Which Medicaid Transformation Goals[x] ***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

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).***
- Washington State children 0-19 years, with a special focus on children with special health care needs, adolescent transitions, mental health, obesity, ED utilization and utilization of primary prevention with up-to-date well-child care, dental care, mental and developmental screening, and immunizations. The project will focus on three target populations: 1. Children with special health care needs, 2. Children with adverse childhood

experiences/social complexity identified by providers 3. Adolescents transitioning into adulthood, including adolescents with special health care needs, chronic conditions, mental health concerns and in foster care.

- Target population/goals would focus on prevention of teen pregnancy, smoking, substance abuse, obesity, dental caries, increasing timely access to mental health care and reducing vaccine-preventable disease.

- ***Relationship to Washington's Medicaid Transformation goals.*** Reduce use of ED and other non-indicated intensive services, address childhood obesity, mental and oral health, and improve population health with investment in comprehensive pediatric healthcare.

- ***Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.***
  Project goals include: funding payment for pediatric care coordination in primary care practices with either per member per month payment or payment for care coordination codes for practices who are trained in the Boston Children's Pediatric Care Coordination Curriculum; improving population health with comprehensive care coordination for complex and chronically ill patients; identification of CSHCN by severity using the Pediatric Medical Complexity Algorhythm and PRISM scores, tracking of utilization of primary prevention for the entire practice population (all children), and minimizing inappropriate ED utilization by care coordination as well as education of families on appropriate access to primary care before ED visitation. We will address health disparities which are evident in our Medicaid population and promote equitable care.
  The intervention will be practice-based care coordination services provided by a registered nurse, social worker or LPN trained in the Boston Children's Pediatric Care Coordination Curriculum and linking to WithinReach, cshcn.org and other resources, local public health jurisdiction CSHCN nurses for information on local and regional resources to support patient and family needs.

  Outcomes expected include: Improved patient care, decreased ED utilization, improved family/patient satisfaction, increased linkage to community and supportive services, improved immunization and screening rates, improved percentage of adolescents with a transition of care plan.
- 3 focused populations would be 1. Children with special health care needs, 2. Children with adverse childhood experiences/social complexity 3. Adolescent transitions including adolescents with special health care needs, chronic conditions, mental health concerns, those in foster care, juvenile justice, and homeless.
- ***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.*** Training could be offered through the TCPI-P grant as a training module or through a collaboration with HCA and MCOs with their health home training module. Accountable Communities of Health with early focus on this work will be linked in for community participation in the care coordination training and mapping of community assets and gaps.
- ***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.*** Pediatric primary care providers, MCOs, HCA, DOH, WCAAP, WAFP, WithinReach, Local health jurisdictions CSHCN nurses, Seattle Children's Hospital and Center for Children with Special Needs

Core Investment Components

Describe:

- ***Proposed activities and cost estimates ("order of magnitude") for the project.*** Per member per month investment or payment of care coordination codes such as 99487, 99489 and 99490 will be activated for practices completing the care coordination training.
- ***Best estimate (or ballpark if unknown) for:***
  - **How many people you expect to serve, on a monthly or annual basis, when fully implemented.** Goal to first train high volume practices and to impact ½ of the Medicaid population within 4 years.
  - **How much you expect the program to cost per person served, on a monthly or annual basis**. Other states have funded up to $2-15 PMPM or have tiered payments for complex, chronic and healthy patients. Research suggests that 80% of children are least expensive and need general tracking of well care and immunizations, and assessment of social determinants of health with developmental and mental health screening may need assistance with obesity and contraception 15% with chronic physical and behavioral health problems (asthma, diabetes, ADHD, depression, anxiety, etc) and 4% children with special health care needs (foster care, premature infants, genetic syndromes, autism) and 1% costly complex chronic patients (transplant patients, and patients with hemophilia, cancer, HIV, etc.).
- ***How long it will take to fully implement the project within a region where you expect it will have to be phased in.***
  Expect to phase in over 4 years with initial focus on early adopters and high volume practices with large populations of medically or socially complex patients who provide care for at least 10% Medicaid in their practices.
- ***The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*** Financial returns would be initially based on decreased ED Utilization, potentially decreased foster care costs in Medicaid patients, and improved management of patients with asthma, diabetes, mental health issues, and focus on prevention of teen pregnancy, smoking, substance abuse, obesity, dental caries, untreated mental health issues and vaccine preventable disease. There will be lifespan cost savings with comprehensive primary care and care coordination. Studies have shown that providing Medicaid patients with access to a consistent primary care medical home and providing care coordination, there are proven cost reductions of 15.7%.

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[xi].***
- Key process measures:
  - Practices trained in Boston Children's Care Coordination Curriculum
  - Adolescent transition of care plan rates
  - Mental health referrals and services received
  - Referral tracking – procedures and laboratory services, specialty services, community and support services
- Key outcome measures:
  - Childhood immunization rates
  - Developmental and mental health screening rates
  - Childhood obesity rates
  - ED utilization rates per practice

- Implementation of screening for ACEs or identification of children experiencing ACEs or other social complexity (ACEs screener; I-HELLP screening, etc.)

- Initial childhood immunization and well child data can be accessed for practices as a baseline and progressive improvement will be tracked. ED utilization rates per practice can be tracked before and after interventions and focused interventions/care plans for children with special health care needs can be tracked. Childhood obesity rates, developmental and behavioral health screening rates can be tracked and improved upon. Connection to referrals and mental health can be tracked. Benchmark data can be obtained through a combination of the state immunization registry, practice based electronic health records, and MCO/HCA data.
- ***If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?**

[i] 2009-2010 National Survey of Children with Special Health Care Needs: 15.0% of Washington Children (235,920) ages 0-17 have a special health care need. Retrieved December 22, 2015. http://www.childhealthdata.org/browse/survey/results?q=1792&r2=49

[ii] McPherson M, Arango P, Fox H, et al. A new definition of children with special health care needs. Pediatrics, 1998; 102: 137-140.

[iii] Mayer ML, Skinner, AC, and Slifkin, RT Unmet need for routine and specialty care: Data from the National Survey of children with special health care needs. Pediatrics, 2004, 113_ 109-115.

[iv] http://archpedi.jamanetwork.com/article.aspx?articleid+2476188

[v] McAllister JW, Presler E, Cooley WC. Practice-based care coordination: A medical home essential. Pediatrics. 2007;120(3):e723–33. doi:10.1542/peds.2006-1684

[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] Pediatric Care Coordination Curriculum. http://www.childrenshospital.org/care-coordination-curriculum

[viii] Making Connections: Strengthening Care Coordination in the Medicaid Benefit for. Children & Adolescents. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT-Care-Coordination-Strategy-Guide.pdf

[ix] Medicaid objectives as stated in GAO report 15-239, April 2015, http://www.gao.gov/products/GAO-15-239:

- Increase and strengthen coverage of low income individuals.
- 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 and other low-income populations through initiatives to transform service delivery networks.
- Criteria established for specific demonstrations described through an informational bulletin or State Medicaid Director's Letter – available at: http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html.

[x] 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.

[xi] 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 *Financial returns would be initially based on decreased ED utilization, potentially decreased foster care costs, and improved management of patients with asthma, diabetes, mental health issues, and focus on prevention of teen pregnancy, smoking, substance abuse, obesity, dental caries, untreated mental health issues, and vaccine preventable* 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.