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, Community Health Senior Director, 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:* **Care coordination for Medicaid and dual eligible beneficiaries with chronic disease**
Rationale for the Project	
Include: • *Problem statement – why this project is needed.* **Compared to the adult population in Washington State, the adult population in Yakima County is more likely to have asthma (12.5% compared to 9.7%), diabetes (10.3% compared to 8.8%), chronic obstructive pulmonary disease (8.1% compared to 5.7%), kidney disease (4.8% compared to 3.2%), depression (26.6% compared to 22.3%), had any permanent teeth extracted (44.0% compared to 38.5%), and had all natural teeth extracted (16.8% compared to 11.0%); and to be obese (31.4% compared to 26.8%) and current smokers (20.1% compared to 17.2%).[1] The National Prevention Council recommends enhancing the coordination and integration of clinical, behavioral, and complementary health strategies to reduce death and disability.[2]** • *Supporting research (evidence-based and promising practices) for the value of the proposed project.* **The Washington State Institute for Public Policy (WSIPP) has identified "patient-centered medical homes [which include coordinated care] for high-risk populations" as an evidence-based policy that can lead to better outcomes.[3]** • *Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries.* **The project will: 1) increase and strengthen coverage of low-income individuals as it will provide coordinated care for Medicaid and dual eligible beneficiaries with chronic disease; 2) increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations as it will coordinate care for Medicaid and dual eligible beneficiaries with chronic disease across providers; 3) improve health outcomes for Medicaid and low-income populations as coordinated care reduces chronic disease morbidity and mortality;[4] and 4) increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks as coordinated care reduces cost of care for adults with chronic disease.[4]**	

[1] Source: Centers for Disease Control and Prevention. Accessed December 2015 at https://chronicdata.cdc.gov/health-area/behavioral-risk-factors.
[2] Source: National Prevention Council. Accessed December 2015 at http://www.surgeongeneral.gov/priorities/prevention/strategy/clinical-and-community-preventive-services.html.
[3] Source: WSIPP. Accessed December 2015 at http://www.wsipp.wa.gov/BenefitCost/Program/486.
[4] Source: Agency for Healthcare Research and Quality. Accessed December 2015 at http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/evidence-based-reports/caregap.pdf.

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**

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 Medicaid and dual eligible beneficiaries with chronic disease in Yakima County.**
- *Relationship to Washington's Medicaid Transformation goals.* **The project will: 1) Reduce avoidable use of intensive services and settings as coordinated care decreases hospital admissions, length of stay, and readmissions for adults with chronic disease;[4] 2) Improve population health as care coordination will focus on prevention and management of diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders, and oral health; 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 patient-centered medical homes for high-risk populations is $8.16.[3]**
- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity/reducing health disparities.* **The project goal is to coordinate care for Medicaid and dual eligible beneficiaries with chronic disease in Yakima County. Community Health Workers will provide the following patient-centered medical home tasks: follow-up care following an emergency department visit, educational resources, self-management plans and tools, counseling patients to adopt healthy behaviors, and assessing and addressing barriers. Expected project outcomes include a reduction in the percentage of adults who smoke cigarettes, the percentage of adults reporting 14 or more days of poor mental health, chronic obstructive pulmonary disease hospital admissions, diabetes care: hemoglobin a1c (hba1c) poor control (>9.0%), 30-day all-cause hospital readmissions, potentially avoidable emergency department visits, percent of patients with five or more visits to the emergency room without a care guideline, 30-day mortality: heart attack (AMI), annual state-purchased health care spending growth relative to state GDP, Medicaid per enrollee spending, and inpatient utilization; and an improvement in diabetes care: blood pressure control (<140/90 mm hg), hypertension: blood pressure control, follow-up after hospitalization for mental illness @ 7 days, cardiovascular disease: use of statins, diabetes care: hemoglobin a1c testing, diabetes care: eye exam, diabetes care: screening for nephropathy, and stroke: thrombolytic therapy. Hispanics have a higher prevalence of diabetes than non-Hispanic whites, and their rates of overweight and obese adults are relatively higher than those of non-Hispanic whites.[5]**
- *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.* **The Health Home program provides care coordination**

[5] Source: Pew Research Center. Accessed December 2015 at http://www.pewhispanic.org/2008/08/13/ii-hispanics-and-chronic-disease-in-the-u-s/.

funding for high-cost/high-risk Medicaid adults, but at the time of submission, will only continue through June 2016.[6]

- *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 Yakima County.**

Core Investment Components

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project.* **Proposed activities include follow-up care following an emergency department visit, educational resources, self-management plans and tools, counseling patients to adopt healthy behaviors, and assessing and addressing barriers. The cost estimate is $464,535 per year (5,735 participants x $81 per participant.)**
- *Best estimate (or ballpark if unknown) for:*
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented. **Yakima Valley Memorial Hospital will serve an estimated 5,735 Medicaid and dual eligible beneficiaries with chronic disease per year.**
  - How much you expect the program to cost per person served, on a monthly or annual basis. **The WSIPP estimates that patient-centered medical homes for high-risk populations cost $81 per participant per year.**[3]
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.* **The project is already operating in the region.**
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.* **The WSIPP estimates that patient-centered medical homes for high-risk populations benefits minus costs (net present value) is $579 per participant per year, so the estimated ROI per participant per year is $660 total benefits - $81 costs / $81 costs = 715%.**[3]

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.* **Process measures will include the number of Medicaid and dual eligible beneficiaries with chronic disease in Yakima County who receive care coordination. Given page limitations, please see above for outcome measures.**
- *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.***

[6] Source: Washington State Health Care Authority. Accessed December 2015 at http://www.hca.wa.gov/medicaid/health_homes/Documents/continuation_of_health_homes.pdf.