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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Project Title	Care transitions intervention model to reduce 30 day hospital readmissions for persons with chronic health conditions

Rationale for the Project

- *Problem statement:*
  Improving care transitions between care settings is critical to improving individuals' quality of care and quality of life and their outcomes. While much work has been done for Medicare beneficiaries to effectively reduce hospital readmissions, improve health outcomes, and utilize value-based purchasing; the same cannot be said for Medicaid-only individuals. The data from Medicare beneficiaries, including those that are dually eligible, demonstrate that effective care transitions: Prevent medical errors; Identify issues for early intervention; Prevent unnecessary hospitalizations and readmissions; Support consumers preferences and choices; and Avoid duplication of processes and efforts to more effectively utilize resources.

  When efficacy is maintained, the Care Transitions Program® imparting self-management skills pays dividends long after the 30-day program ends, resulting in a five-to-nine-month reduction in hospital readmission. Patients that receive this program are also more likely to achieve self-identified personal goals around symptom management and functional recovery, identified through Patient Activation Measure (PAM) increases of 1 or more points. We also propose following up with person-centered options counseling and family caregiver support consultations, and connecting individuals to community-based, low-cost services and supports for at-risk populations to delay or avoid entry into the Medicaid LTSS. Note: While there is only allegorical information available, prior work in Washington State indicated that the skills developed by coaches could also be applied to individuals at-risk of hospitalization or institutional care in order to help stabilize their health and plan of care.
- *Supporting research (evidence-based and promising practices) for the value of the proposed project.*
  - *The Care Transitions Program®*
  - *CTI® Coaching Decreases Re-admission and Costs for Medicare patients,*
  - *The Family Caregiver Activation in Transitions (FCAT) Tool: A New Measure of Family Caregiver Self-Efficacy, Coleman EA, Ground KL, Maul A. Joint Commission Journal on Quality and Patient Safety 41(11): 502-507*
  - *The Impact of Kaua'i Care Transition Intervention on Hospital Readmission Rates, Fenfang Li, PhD; Jing Guo, PhD; Audrey Suga-Nakagawa, MPH; Ludvina K. Takahashi, BA; and June Renaud, Bed; American Journal of Managed Care, 2015:21 (10):e560-e566*
  - *Finger Lakes Health System Agency demonstrates significant reduction in readmissions sustained for at least 90 days, Smirnow AM, Wendland M, Campbell P, Bartock B, Chirico J, Cohen E, & Beckman H, Finger Lakes Health Systems Agency; Rochester Area Community Foundation; Visiting Nurse Service of Rochester and Monroe Co., Inc.; Lifetime Care; University of Rochester; Abstract from the 2014 AcademyHealth Annual Research Meeting (ARM)*
  - *Disseminating Evidence-based Care into Practice, Coleman EA, Rosenbek S, Roman SP. Population Health Management. 2013 Aug; 16(4): 227-34. PMID: 23537156. doi: 10.1089/pop.2012.0069*
  - *Qualis Health: Communities for Safer Transitions of Care Regional Performance Reports (Medicare data)*
- *Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid*

beneficiaries.

- *Increase and strengthen coverage of low income individuals: through regular, sometimes daily coordination with hospital or nursing facility staff and information systems, the Care Transitions Intervention® (CTI) coaches will be available for deployment prior to discharge as an expected part of the individual's plan of care and discharge process, providing an added person-centered aspect to their coverage.*
- *Increase access to, stabilize, and strengthen provider networks available for serve Medicaid and low income populations: Providing coach training and mentoring within an ACH region to a wide range of community-based Medicaid Access points and Medicaid providers will increase availability of this service to persons from diverse cultures and spoken languages, as well as those with a variety of disabilities. In addition to training for coaches, provider administrators and program managers will be trained in program administration, hiring and mentoring of coaches, oversight, required data collection, negotiated outcomes, and reporting requirements, and quality improvement processes.*
- *Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks: Under this project, CTI coaching will be both a regular and an initial service, available to individuals discharging from a hospital setting. As a proven evidence-based and person-centered intervention, it will be incorporated ongoing with regular data collection and quality improvement processes.*

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*
  Building on previous work in care transitions for Medicare beneficiaries, work statewide with the 16 CMS/QIO Communities for Safer Transitions in Care to impact Washington's adult Medicaid population that is at risk for hospital readmissions. These communities are subareas of the proposed nine Accountable Communities of Health (ACHs) where further coordination will occur. To adequately impact the system, the intervention would not be limited to specific diagnoses, and will serve those with limited cognitive ability that also have a family caregiver willing and available to participate in the process.
  Relationship to Washington's Medicaid Transformation goals.
  - *Reduce avoidable use of intensive services and settings: statewide deployment of the evidence-based Care Transitions Program® will reduce avoidable hospital readmissions.*
  - *Improve population health: Evidence indicates a 5-9 month return on a 30 day investment - Patients that receive this program are also more likely to achieve self-identified personal goals around symptom management and functional recovery, increasing self-efficacy and self-care*
  - *Accelerate the transition for value-base payment: in parallel with Medicare payment processes under the ACA, the state could use readmission rate performance for value based payments.*
  - *Ensure the Medicaid per-capita cost growth is 2 percentage points below national trends: ensuring individuals at risk of readmission are helped with care transitions followed by person-centered options counseling and family caregiver consultation will help individuals avoid/ delay accessing higher cost options.*
- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.*
- *Reduce hospitalization*

- *Reduce emergency room utilization*
- *Reduce readmission to nursing facilities*
- *Links to complementary transformation initiatives: Links will be made with the ACH's; Qualis Health (CMS QIO) Communities for Safer Transitions; Washington's Hospital Engagement Network (HEN); Health Homes; CMS' ACA Section 3026 (CCTP) demonstration projects; Washington's ACL/CMS/VA initiative for No Wrong-Door Access points/ADRCs (called Community Living Connections); and other state waiver programs.*
- *Potential partners, systems, and organizations needed to be engaged to achieve the results of the proposed project: Community-based disability, health, and social service providers (e.g. Area Agencies on Aging, Independent Living Centers, Mental health providers; Medicaid information and access points; hospitals, nursing facilities, Home and Community Services regional offices, Area Agencies on Aging, ACH participants, health homes, physician networks and associations, VA medical centers and nursing facilities, Indian Health organizations, and tribal governments*

Core Investment Components

- *Proposed activities and cost estimates ("order of magnitude") for the project.*
  Trainings on Evidence Based Practice model: $60,000; $550 per care transitions intervention.
  Best estimate (or ballpark if unknown) for:
  - *Annual number of people served when fully implemented: scalable;*
  - *Annual cost per person served:– anticipate $688/person (1.33 interventions/person/year)*
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.*
  12-24 months
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*
  In Washington State, cost savings from a variety of improvements in care transitions for Medicare beneficiaries since January 2013 to the first quarter of 2015 were $26.1 Million. Adjustments would be needed for ramp-up, population differences, and limiting the model; to expect possibly $15 million ROI by end of Year 3, although more research is needed.

Project Metrics

Process and outcome measures:

- *Key process and outcome measures: Plan All-Cause Hospital Readmission Rates will be negotiated based on past performance and expected improvement of up to 10% over the five-year period. Avoidable use of institutions will be added over time.*
- *Benchmark Medicaid hospital admission and readmission data will obtained in coordination with the CMS QIO, Qualis Health; Washington State DSHS, and/or CMS: the best method will be dependent on ease of ongoing access and initial data obtained by/before project initiation. Note: Qualis statewide dual eligible data from claims data on a variety of hospital and community-based care transition models is pending.*