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	*Bea Rector, Director, Home and Community Services, ALTSA* 360-725-2272 Bea.rector@dshs.wa.gov *SMEs: Todd Dubble- ALTSA/HCS 360.725.2562* dubblgt@dshs.wa.gov *Sara Eve Sarliker- DOH*
Project Title	*Chronic Disease Self- Management Education*

Rationale for the Project

- *Problem Statement*- Washington has one of the most rapidly aging populations in the country. By 2020, over 1 million people in Washington will be age 65 or older – almost twice the number of people in that age group in 2002. Rates of chronic disease have also increased rapidly over the last decade among adults across age groups, but in particular, about 80% of people age 65 or older have at least one chronic condition; about 50% have at least two conditions. People with chronic conditions are high utilizers of the health care delivery system, especially when conditions are not self-managed. Chronic conditions account for three-fourths of all health-related costs nationally. This intervention is not limited to individuals who are older but is targeted to individuals living with chronic conditions.
- *Supporting research (evidence-based and promising practices) for the value of the proposed project.*[i]
  - Participants in Chronic Disease Self-Management Education, when compared to those who did not participate, demonstrated significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. They also spent fewer days in the hospital, and there was also a trend toward fewer outpatient visits and hospitalizations. These data yield a cost to savings ratio of approximately 1:4. Many of these results persist for as long as three years. http://patienteducation.stanford.edu/programs/cdsmp.html
  - Findings from analyses showed significant reductions in ER visits (5%) at both the 6-month and 12-month assessments as well as hospitalizations (3%) at 6 months among national CDSMP participants. This equates to potential net savings of $364 per participant and a national savings of $3.3 billion if 5% of adults with one or more chronic conditions were reached. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3878965/
  - Department of Health has partnered with Department of Social and Health Services to grow and sustain these programs with federal funding between 2003 and 2015. In 2014, there were more than 100 implementation sites across the state, and more than 1,375 Washington residents completed a Chronic Disease Self-Management Education workshop. This was an increase from 2013, when more than 875 participants completed a workshop.

- This is an example of a successful project that has proven a strong return on investment, however access to the intervention needs to be brought to scale in terms of building the community capacity necessary for eligible individuals to access the training. This is an excellent example of building community and clinical linkages.

- This project is directly in line with the federal Medicaid objective to improve health outcomes for Medicaid and low-income populations.

Project Description

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

X Reduce avoidable use of intensive services

X 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

X 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 Chronic Disease Self-Management Education has been studied and implemented in diverse settings with adult populations. Any Accountable Community of Health is encouraged to use Chronic Disease Self-Management Program to address one or more chronic health conditions. Programs are available that address any chronic health condition, or specifically, chronic pain and diabetes.
  - Audiences for these programs include people with ongoing health programs and their caregivers, with a focus on older adults and adults with disabilities. The program has been implemented in Tribal settings under the name "Wisdom Warriors." Settings for these programs include culturally diverse community environments.
- *Relationship to Washington's Medicaid Transformation goals.*
  - This project has a strong Relationship to Washington's Medicaid Transformation goals in that it seeks to increase community prevention and health promotion for Medicaid beneficiaries related to chronic disease. The adoption of Chronic Disease Self-Management by ACHs will empower regions to establish a model for continued maturation, responsibility and accountability within the community.
- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.*
  - Improve access to the evidence-based practice of CDSMP for hard to reach, aging populations on both sides of the state that experience a disproportionate burden of chronic diseases
  - Develop a statewide database of CDSMP workshop providers, increase our state pool of CDSMP trainers and leaders, and build a sustainable web-based resource for CDSMP
  - Assure sustained efforts through expanding partnerships and networking on regional basis to improve health and health systems, focusing on social determinates of health, clinical –community linkages, and whole person care.
- *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.*
  - *National Council on Aging- http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/CDSMP*
  - Aging and Disability Services Administration- http://www.adsa.dshs.wa.gov/news/2009/10-20-09.htm
  - A Living Well with Chronic Conditions in Washington State- http://www.livingwell.doh.wa.gov
- *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.*
  - Accountable Communities of Health
  - Health Care Authority
  - Department of Health
  - Tribal Governments
  - Department of Social and Health Services
    - Aging Long-term services and supports Administration(ALTSA)
    - Research and Data Analysis (RDA)

- Stakeholders- Area Agencies on Aging, Senior Services, Community Organizations, Chronic Disease Self-Management Education license holders, hospitals, population health specialists

Core Investment Components

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project. Best estimate (or ballpark if unknown) for:*
  - The number of people served depends on the capacity per region. A minimum of 1,000 people with one or more chronic health conditions have been served annually under the previous period of grant funding.
  - Costs are estimated at approximately $400 per participant for the 6-week series; operating costs for organizations administering the program may be higher by $100 or more in some areas of the state.
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.*
  - The implementation of Chronic Disease Self-Management Education in Washington can happen quickly – trained program leaders and organizations holding licenses are already operating throughout the state.
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*
  - Findings from analyses showed significant reductions in ER visits (5%) at both the 6-month and 12-month assessments as well as hospitalizations (3%) at 6 months among national CDSMP participants. This equates to potential net savings of $364 per participant and a national savings of $3.3 billion if 5% of adults with one or more chronic conditions were reached. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3878965/
  - Building upon the National Study of CDSMP's documented potential savings of $3.3 billion in healthcare costs by reaching 5% of adults with one or more chronic conditions, two heuristic case examples were also explored based on different population projections. The case examples show how a small county and large metropolitan city were not only able to estimate healthcare savings ($38,803 for the small county; $732,290 for the large metropolitan city) for their existing participant populations but also to project significant healthcare savings if they plan to reach higher proportions of middle-aged and older adults. http://www.ncbi.nlm.nih.gov/pubmed/25964946

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.

- Data collected in previous years through the National Coalition on Aging's Data Entry Portal provides benchmarks by organization offering workshops on completion rates, basic demographics, and other measures. Historically, 75% of program participants achieve completion (defined as a minimum of 4 out of 6 sessions attended). Historical data can guide estimates at the regional level of appropriate targets for the ACH populations.
- A variety of measures in the Measures set may be used depending upon the Chronic Disease(s) addressed, but for Diabetes Specifically, improvements would be expected among program completers in Effective Management of Chronic Illness in the Outpatient Setting. These measures expected to be impacted include:
  - Diabetes: Blood Sugar (HbA1c) Testing
  - Diabetes: Blood Sugar (HbA1c) Poor Control (>9.0%)
  - Diabetes: Eye Exam
  - Diabetes: Kidney Disease Screening
  - Diabetes: Blood Pressure Control (<140/90 mm Hg)
  - Cardiovascular Disease: Blood Pressure Control
  - Cardiovascular Disease: Use of Statin Medications
  - Patient Experience with Primary Care: Provider Communication

  For clients with diabetes and other conditions the measures have included:
  - Reduction in emergency room usage

- Reductions in hospitalizations

---

[i] 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

[ii] 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.