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	*Increase Dementia-Capability of Providers*

Rationale for the Project

There are many benefits to early detection and diagnosis of Alzheimer's disease and other dementias. It allows families time to adapt to changes, to get legal and financial affairs in order, to participate in research, and gives an opportunity to engage in advance planning. Early detection offers health care providers key information to reduce poor health outcomes and prevent emergencies for both the individual and their family caregivers. Unfortunately, fewer than half of the people who meet diagnostic criteria for dementia have received a diagnosis. (Bradford, Kunik, Shultz, Williams, & Singh, 2009).

Compared to individuals without dementia, people with dementia have as many or more serious co-occurring conditions, take more medication, and are more likely to be hospitalized than individuals of the same age without dementia. Individuals with dementia may also be less able to manage their medical and/or behavioral conditions – which contribute to a decline in the individuals' abilities to carry out daily activities. Medicare data show that people with dementia have more potentially avoidable hospitalizations due to complications of diabetes and hypertension – conditions that could be prevented.

As the number of people with Alzheimer's and other dementias increases, so will their presence in health care systems. People with Alzheimer's and other dementias are more likely to have other chronic conditions than those without the condition. The dementia population has more than triple the number of hospital stays per year as other older people. People with dementia living in the community are more likely than those without dementia to have potentially avoidable emergency department visits or preventable hospitalizations.

As the population of individuals with dementia is projected to increase by 30% as the number of individuals over age 65 doubles. It is imperative that early diagnosis of the disease occurs.

Supporting research (evidence-based and promising practices) for the value of the proposed project.

Many steps toward dementia-capable systems can be implemented now, supported by new national policies favoring early detection, care planning and coordination, support for caregivers, and measurement of care quality. "Dementia-capable" health care systems are those "that provide individualized, coordinated, and integrated medical and psychosocial care for patients and their care partners, delivered by cohesive teams of clinicians, staff, and health care administrators." (Borson & Chodosh, 2014) A recent economic forecasting study modeled the impact of implementing a dementia screening, diagnosis, and management program for AD in primary care, at varying rates of effectiveness and in constant dollars. The model estimates that direct annual savings for Medicare & Medicaid Services of such intervention could be as much as $22 billion in 2025 and $29 billion in 2050 (Boustani MA, Jermoumi R. 2012). In 2014, Minnesota's Act on Alzheimer's developed an economic model of potential cost savings associated with in-person caregiver support for persons with Alzheimer's disease and other dementias. This study concludes that Minnesota could book savings in direct healthcare costs and indirect costs. Their findings suggest that broader access to enhanced caregiver supports is

a promising way to moderate the growing economic burden of dementia.

To improve care quality and prepare for the future growth of this population in our systems, it is critical to integrate dementia-capable best practices in integrated health and long-term care systems to detect cognitive impairment, make and disclose timely diagnosis, coordinate care for wellness and to manage co-occurring conditions, provide early and ongoing education and support of family caregivers, and address the need for advance planning while cognitive capacity exists.

Relationship to federal objectives for Medicaid[i] with particular attention to how this project benefits Medicaid beneficiaries.

The largest component of costs attributable to dementia is the cost for institutional and home-based long-term supports and services. The total per client Medicaid payments for Medicare beneficiaries age 65 and over with Alzheimer's and other dementias were 19 times as great as those for Medicare beneficiaries without the illness. Washington State has developed home and community-based service options that can extend the time people with dementia can stay in the preferred home setting, which costs less than more intensive nursing home care. Due to disconnects between the health and LTSS, though, families are often not made aware of these supports and services early in the course of dementia – and don't learn about LTSS until a crisis has occurred (i.e., ED visit, hospitalization).

This project would benefit Medicaid beneficiaries themselves. This project would offer the workforce, both care coordinators and health care practitioners, additional awareness about the benefits of early diagnosis, and information and resources about cognitive assessment, the impact and management of co-occurring chronic conditions, and a better understanding of dementia behaviors and community resources – all of which are important to individuals with dementia and their families as they attempt to maintain a life in their own home/community.

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**

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

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

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).

Target population are those eligible for Medicaid and/or dually eligible for Medicare-Medicaid with chronic conditions that increase risk for developing dementia (e.g., cardiovascular conditions, high blood pressure, diabetes, etc.), those with cognitive impairment or possible/diagnosed dementia. The project could be done at a local ACH level, multiple ACHs or statewide.

Screening and interventions put in place to benefit the Medicaid population could also be utilized with individuals who have the benefit of private insurance or private pay arrangements.

Relationship to Washington's Medicaid Transformation goals.

X Reduce avoidable use of intensive services

Individuals with dementia are significant users of intensive, costly services (see above sections).

Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.

An increase in the prevalence of Alzheimer's disease will increase the demand for care and Medicare and Medicaid expenditures. People with Alzheimer's disease frequently need care from a wide range of providers, from home care workers to geriatricians and psychiatrists, but care is often provided in a fragmented and uncoordinated fashion (Alzheimer's Association, 2013) and individuals do not receive a timely diagnosis. Early screening and detection as well as development of local protocols to ensure referrals to community resources are made, education and support of the individual and their families is in place and coordination of care will improve health outcomes, patient/family experience of care and reduce the need for individuals to leave their home settings prematurely.

Project goals include promoting early identification, diagnosis and disclosure of cognitive impairment and dementia; reducing unnecessary ED, hospital admissions and readmissions; increasing referrals to and use of community supports and services; and increasing care transition coordination activities between facility staff (hospital, nursing facility and Residential Habilitation Centers)

Interventions include:

- **Building expertise of care coordinators,** related to the recognition and management of dementia, and effective support for individuals with dementia and family caregivers;
- **Advance training for health care providers in dementia capable, evidence based practices in disease management,** management of co-occurring chronic conditions, causes of potentially avoidable causes of ED visits/hospital admissions/readmissions for people with dementia, responding to behavioral symptoms including use of non-pharmacologic approaches and reducing use of potentially harmful psychoactive drugs, importance of partnership/communication between clinician and care partners, facilitation of early enrollment into palliative and hospice care.
- **Dementia-Capable Practice Toolkit** -(information and resources) to support the integration of dementia-capable practices into the Health Home program.

Outcomes expected during the waiver period include :

- Dementia Capable Care Coordination Training for care coordinators,
  - Dementia Capable Practices Training for health care professionals
  - Dementia Capable Practices Toolkit for health care professionals
  - Dementia-capability training for 100-200 care coordinators and 100 health care practitioners each year.
  - Dementia-capable care coordination for 5,000 beneficiaries (1,000 per year).

Health disparities - Available statistics indicate that in the U.S. older African-Americans are twice as likely as older whites to have Alzheimer's disease and other dementias. Hispanic/Latinos are about 1.5 times as likely to have dementia. Medicare data indicate that African-Americans are less likely than whites to be diagnosed. And when diagnosed, African-Americans and Hispanics are generally diagnosed in later stages of the illness – the impact of this is a higher use of health care services and higher costs.37

Links to complementary transformation initiatives - those funded through other local, state or federal authorities and/or Medicaid Transformation initiatives # 2 and 3.

- Washington State Plan to Address Alzheimer's and Other Dementias – This project supports the work of the newly released collaboratively developed state plan to address dementia. Goals of the state plan include "Identifying dementia early and providing dementia-capable, evidence based health care" and "Ensuring dementia-capable LTSS available in the setting of choice".
- This success of Medicaid Transformation Initiative #2 to effectively serve individuals with dementia and their family caregivers and extend their times at home is dependent upon reaching these families early in the disease process when planning, education, support and adaptation can occur. This project would bolster the success of Initiative #2 being successful.
- Washington State Health Homes Program

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.

- *Apple Health contractors*
- *Health Home lead entities and Care Coordination organizations*
- *Alzheimer's Association*
- *AAAs, HCS, ACHs, DOH and Behavioral Health Organizations*

Core Investment Components

Proposed activities and cost estimates ("order of magnitude") for the project.

- **Developing statewide training curricula that impart dementia-capable, evidence-based and promising practices to support effective care coordination and health care.** This will be accomplished through the development of training (in two tiers), and a resource toolkit to support Dementia Capable Practices. Dementia-Capability enhancements would be spear-headed by a subject matter expert (consultant) that would support the collective work of statewide ACHs. **$$ INVESTMENT: Contract 1 FTE = $110,000/year**
- **Local trainings.** Implementation of the second tier training would be accomplished at the regional level by each ACH. ACHs would receive funding to support a .25 FTE ($25,000/year) to receive training in the standardized curriculum, and subsequently provide the training locally/regionally. Participating ACHs would receive an additional $10,000/year to support training costs for local/regional health professionals using the standardized training curriculum. **$$ INVESTMENT: .25 FTE ($25,000) + ($10,000 local training costs) x 9 ACHS = $350,000/year**

  - **Year 1: $110,000 (1 SME FTE)**
  - **Year 2: $110,000 + $225,000 (.25 FTE at each ACH) + $90,000 (Training costs)**
  - **Year 3: $225,000 + $90,000**
  - **Year 4: $225,000 + $90,000**
  - **Year 5: $225,000 + $90,000** *** **TOTAL = $1,480,000**

o *Best estimate (or ballpark if unknown) for:*

Estimate serving around 1,000 clients each year x 5 years = 5,000 clients
Cost of $1,480,000/5,000 client = $296 per client

o *How long it will take to fully implement the project within a region where you expect it will have to be phased in. ESTIMATE:*

- *6 months - 1 year to develop trainings, Tiers 1 & 2; another year to both train the 'ACH trainers' and have regional ACH trainers train providers in respective areas*

o *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*

The ROI of this specific project is difficult to estimate. However, absent intervention, the increasing population of people with dementia and their higher use of intensive services Washington State should expect increasing costs. Given the expected growth of the target population, their use of higher intensity services, and factors known to increase ED visits and hospital use, it is critical to strengthening dementia-specific knowledge, skill and activities of care coordinators and practitioners in order to bend the expected cost curve. Other studies related to increasing dementia-capability reveal such potential. For example, a recent economic forecasting study modeled the impact of implementing a dementia screening, diagnosis, and management program for AD in primary care, at varying rates of effectiveness and in constant dollars. The model estimates that direct annual savings for Medicare & Medicaid Services could be as much as $22 billion in 2025 and $29 billion in 2050. (Boustani MA, Jermoumi R. 2012).

Project Metrics

Potential Metrics might include:

OUTCOMES	***PROCESS****
• Preventable hospitalizations • Hospital readmission • Nursing home placements	• Cognitive assessments performed/documented • Neuropsychiatric symptom assessment • Management of neuropsychiatric symptoms • Screening for depressive symptoms • Counseling re safety concerns • Counseling re risks of driving • Palliative care counseling and advance care planning

***See Quality Improvement in Neurology: Dementia Management Quality Measures** Physician Consortium for Performance Improvement Web site at www.physicianconsortium.org.

[i] 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.

[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.