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	Liz McNamara lmca@uw.edu (206) 744-3943 Brigitte Folz ebgf@uw.edu (206 744-4052 Harborview Medical Center in consultation with Adult Family Home Providers and DSHS.
Project Title	Bringing Integrated Care to Adult Family Homes

Rationale for the Project

Include:

- Problem statement – why this project is needed.
  Medical Care for patients living in adult family homes (AFH) is often fragmented among various specialty clinics and behavioral health care. Often the AFH care provider cannot be involved because they cannot leave the facility due to need to care for other patients. Communication with the care provider is often lacking and fragmented among various specialty services with little opportunity for teaching and comprehensive care planning with the inclusion of the home care provider. This may lead to frequent ER visits and hospitalizations.

- Supporting research (evidence-based and promising practices) for the value of the proposed project.
  Integrated care management improves the utilization of primary care. Timely primary care improves health outcomes, decreased hospitalizations and ED utilization. (Farrell, Tomoaia-Cotisel, & al, 2015)It is anticipated that readmissions and costly office or hospital care could be reduced with comprehensive primary care intervention delivered on site at Adult Family Homes. Studies have shown integrated care with patients going home has had a positive impact on readmission rates, improved health, decreased ED utilization (Tricco, Antony, & al, 2014) but not much has been studied with a patient going to an AFH.

- Relationship to federal objectives for Medicaid[i] with particular attention to how this project benefits Medicaid beneficiaries.
  Reduction of re-admission and utilization of intensive services; this also supports Initiative 2 to develop community based alternatives to institutional use. Many adult family home residents are funded by Medicaid or at risk of becoming Medicaid eligible once resources are spent-down. These beneficiaries are often experiencing multiple co-morbid conditions and evidence has shown that patients from lower socioeconomic status are at highest risk especially in the post hospital period. (Kangovi, Nandita, & al, 2014)Many AFH residents are discharged from an acute care hospital to an AFH.

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
X 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 target population is persons with chronic illnesses requiring assistance with activities of daily living that are living in adult family homes. This could include persons with TBI, dementia, cognitive impairments, and other fragile and chronic medical conditions requiring custodial care and medical treatment such as diabetes, heart failure and chronic infections and behavioral health issues.

- Relationship to Washington's Medicaid Transformation goals.

This program would meet transformation goals of improving health and avoiding preventable escalation of care to the emergency room or inpatient setting. The AFH primary care team would additionally allow for improved continuity of care and education of AFH providers. This would also support post-acute care options being explored in Initiative 2.

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

A primary goal would be the reduction of hospital readmissions both medical surgical and behavioral. Subsequent outcomes would be: decrease ED visits, improved collaboration with health care team and AFH providers and improving health of the AFH population of patients.

- 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.

This specialized team which would focus on outreach and home visits to AFHs would fit well with Health Home initiatives and Regional Support Networks outlined initiatives #2 and #3.

- 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.

Potential Partners would include DSHS, Adult Family Home programs, community service providers, medical centers and the MCOs.

Core Investment Components
Describe: • Proposed activities and cost estimates ("order of magnitude") for the project. As primary care providers in an integrated setting we would be looking at providing ARNP, RN, Behavioral Specialist partnering with the AFH staff and providers to deliver comprehensive health care services. The development of this integrated team approach to both custodial and medical care will allow for reduction of other health care costs. Cost estimates are challenging because of provider travel time for outreach and the challenge of taking this to scale. A demonstration project for the first year would cost $500,000 and could potentially serve 50-100 individuals. For the pilot project there would be designated intervention AFH willing to participate/ This would allow us to show a comparison of outcome measure with intervention AFH and non-intervention AFH. • Best estimate (or ballpark if unknown) for: o How many people you expect to serve, on a monthly or annual basis, when fully implemented. 50-100 for a pilot project o How much you expect the program to cost per person served, on a monthly or annual basis. For the pilot project we would consider developing as above, we would require $5,000-10,000 per person annually. • How long it will take to fully implement the project within a region where you expect it will have to be phased in. 1 year. • The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline. A return on investment over 2 years in decrease costs due to less readmissions and ED visits.
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[iii]. Key outcome measures which relate to waiver priorities would include monitoring and improved outcomes of chronic conditions including diabetes, substance use disorder, mental health treatment and reduced hospitalizations and unnecessary ED visits. • If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation? If this concept were funded as a demonstration project pilot, we would have a comparison group for assessment of outcomes of those Adult Family Homes where the integrated team approach was not available.

[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.

[iii] 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 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.