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	***Jesus Hernandez, 509-293-7773, jesush@communitychoice.us*** ***Community Choice Health & Education Institute***
Project Title	***Chronic Disease Self-Management Education (CDSME)***

Rationale for the Project

Include:

- *Problem statement – why this project is needed.*
  In State of Washington only, financial and human costs associated with 70,009 diabetes-related hospitalizations surpassed $1.2 billion dollars.
- *Supporting research (evidence-based and promising practices) for the value of the proposed project.*[i]

According to the Washington State Department of Health, the complications resulting from the progressive and irreversible disease of diabetes range from blindness and organ failure to foot amputations and stroke. In 2013, for the State of Washington only, financial and human costs associated with 70,009 diabetes-related hospitalizations surpassed $1.2 billion dollars. The majority of diabetics that year, were older people and individuals from racial and economic minorities. This research based program developed by Stanford University is free and easily applicable education to prevent the deterioration of diabetes is in both the consumer's and health provider's interest.

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

Low income populations and Latinos on Medicaid as well as older Americans on Medicare are affected by diabetes at a higher rate than the average population in the state. In terms of achieving the Triple Aim overarching goals these populations are ideal for a targeted intervention on chronic diseases like diabetes.

Project Description

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

- ☐ **X** Reduce avoidable use of intensive services
- ☐ **X** Improve population health, focused on prevention
- ☐ (potentially) Accelerate transition to value-based payment
- ☐ **X** Ensure Medicaid per-capita growth is below national trends

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

- ☐ **X** 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 initial target population and geographic region is the four North Central Washington counties of Okanogan, Chelan, Douglas and Grant. This includes a total population of just over 250,000 and we estimate that there are upwards of 14000 individuals just in Chelan and Douglas counties that would qualify and benefit from this proposed interventions/services. Additionally, the capacity to serve Latinos with the Spanish version of this research based curriculum would significantly address the disparities that exist in diabetes and similar chronic health problems in that population.

- *Relationship to Washington's Medicaid Transformation goals.*

Diabetes and related chronic diseases is already approved by our NCW ACH as the initial focus on healthcare transformation efforts for the foreseeable future. This aligns very well with Washington's Medicaid transformation goals and the state's prevention plans.

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

Project goals include serving 500 individuals in the first year within Chelan and Douglas counties. Year two would expand to Okanogan and Grant counties with 1000 additional individuals being served. Gradual expansion of the program would focus on high need communities and populations targeting Latinos. This would go a long ways to addressing health equity and disparities in this region.

- *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 proposal basically borrows from the Health Homes Care Coordination program and applies those lessons learned and program design to affect individuals with emerging chronic conditions before they reach a critical stage and becoming much more expensive for Medicaid as the payer. However, the more meaningful impact is in the many individuals whose lives we can improve by empowering them with the inspiration, knowledge and tools to take charge of their health not just manage their chronic health problems and live a miserable life. We truly believe we are learning how to do this effectively and have been gradually building capacity to do it with measurable outcomes.

- *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.*

This project aligns perfectly with the initial goals voted on and approved by our NCW ACH. It would be a relatively easy focus area to engage multi-sector partners in the region with minimal resistance to change. However, the easy wins that would result from this project would compel more difficult system change that our region is envisioning. More specifically, this would engage primary care providers, social support agencies, families and general support systems of the beneficiaries as well as system thinkers interested in learning from the data that would be generated from this project.

Core Investment Components

Describe:

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

Borrowing from the Health Homes program model, we propose Medicaid/Medicare agrees to promote the CDSMP and DSMP services that Community Choice offers to identified Medicaid members as an "additional and optional" benefit of their coverage. Medicaid/Medicare would identify and assign (as an example) 150 members per quarter until a threshold level of program engaged members is reached to insure program feasibility.

This can be an assignment for services/benefits similar to the Health Homes model for care coordination. Medicaid/Medicare would support Community Choice's efforts by sending a letter introducing Community Choice to the members. Medicaid/Medicare would pay Community Choice for engaged clients attending CDSME workshop sessions (6 sessions, 1 session each week) and maintenance programming.

Payment details:

- Engagement: $150 one time initial payment for assigned members that are actually reached/engaged and complete a Health Action Plan focused on addressing their diabetes or other chronic disease.

- Tuition for workshops: $60 per member per session/week* (six initial CDSME sessions). * Based on current rates paid by the state COPES program. Also includes cost of the Living Well with Chronic Conditions book.

- Ongoing support group and maintenance: $60 per member for each follow up maintenance

sessions/meeting/workshop. These would occur monthly, then quarterly for minimum of 24 months. Content for the follow up maintenance programming will focus on nutrition, active lifestyles, overall culture of health and gaining resolve from supportive interaction with cohort members and expert speakers on relevant topics.

- *Best estimate (or ballpark if unknown) for:*
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented.
    In the range of 500 to 1000 individuals in four NCW counties.
  - How much you expect the program to cost per person served, on a monthly or annual basis.
    $60 per month after the initial course of six classes at $60/class plus books.
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.*

Full implementation will take three to six months.

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

This is a research based program developed by Stanford University. Stanford estimates a healthcare cost to savings ratio of approximately 1:4 per individual.

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*[iv]*.*

We have the opportunity to leverage some of the same program indicators we are utilizing in the Health Homes program. Some of the assessments we can readily leverage include:

- Patient Activation Measurement (PAM) which measures the level of "engagement" in the participant indicating their level of resolve to take greater control of their health.

- Hemoglobin A1C test and tracking to help the client see their improvement and areas of focus.

- Eye exams and foot exams in collaboration with their primary care provider.

- Additional measureable success indicators may include: quality of life questionnaires and surveys on desired behavior changes; BMI; self-reported general health; other indicators relevant to specific health problems. Cumulative reports on cohorts of members served will be submitted to Molina before taking the workshop (establishing baseline data), at the end of the CDSME class and quarterly after the initial course.

- *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?

The capacity to track and report on the key measures above is already in place using the platform developed and customized for care coordination. It is currently being use by seven different Care Coordination organizations in Eastern Washington.

[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] 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.

[iii] 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.

[iv] 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.