

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	<p>Winfried Danke, Executive Director CHOICE Regional Health Network, (360) 539-7576; dankew@crhn.org</p> <p>Organizations associated with project development: <i>Cascade Pacific Action Alliance, CHOICE Regional Health Network, Life Long, Child and Adolescent Clinic of Longview WA, Community Health Plan of Washington, Coordinated Care, ESD 112, ESD 113, Cowlitz County Public Health, Grays Harbor Public Health and Social Services, Lewis County Public Health, Mason County Public Health, Mason General Hospital, Mason-Thurston RSN, Molina Healthcare of WA, Summit Pacific Medical Center, Ocean Beach Hospital, OSPI, Pacific County Public Health, Providence, SeaMar, Thurston County Public Health and Social Services, TOGETHER!, United Healthcare, Wahkiakum County Public Health, Washington Chapter American Academy of Pediatrics (WCAAP)</i></p>
Project Title	<i>Collaborative Care Teams for Youth Behavioral Health Improvement</i>
Rationale for the Project	
<p>Problem Statement. Mental health and chemical dependency issues are closely linked to Adverse Childhood Experiences (ACEs). There is a vast body of research detailing the enormous costs associated with individuals who experience ACEs. In several foundational studies conducted by the CDC, the lifetime economic burden for each ACEs impacted individual is \$210,012 (in 2010 dollars). The average lifetime cost per death is \$1,272,900, including medical costs and productivity losses. Children with undiagnosed or untreated mental health and chemical dependency issues (hereafter referred to as <i>behavioral health</i>) have a significantly lower rate of success in school than healthy students resulting in severe lifelong negative impacts. School attendance and academic achievement rates are reduced leading to lower school graduation rates, correspondingly lower economic achievement, and long-term productivity losses. Moreover, untreated behavioral health issues correlate closely with poor physical health and substantially reduced life expectancy. This places enormous costs on both affected individuals and our society, not to mention, raises serious health equity concerns.</p> <p>Supporting research (evidence-based and promising practices) for the value of the proposed project.ⁱ There is an abundance of scientific evidence showing that positive intervention mitigates the impacts of ACEs on individuals and reduces future societal costs as children grow into adulthood (see Foundation for Healthy Generations, www.healthygen.org). In particular, identifying children with behavioral health challenges as early as possible and connecting at risk children with community-based interventions and treatment services will pay huge dividends over time.</p> <p>Relationship to federal objectives for Medicaidⁱⁱ with particular attention to how this project benefits Medicaid beneficiaries. This project is closely aligned with federal Medicaid objectives. In particular, the project increases and strengthens coverages of low-income populations and improves health outcomes for Medicaid and low-income populations. Regrettably, low-income pediatric populations receiving Medicaid suffer disproportionately from poor physical and behavioral health; they are eight times more likely to have fair or poor health than children with commercial insurance (<i>Reducing Health Disparities Among Children: Strategies and Programs for Health Plans</i>. National Institute for Health Care Management (NIHCM) Foundation. Issue Paper. Feb. 2007).</p>	

Project Description
<p><i>Which Medicaid Transformation Goalsⁱⁱⁱ are supported by this project/intervention? Check box(es)</i></p> <p><input checked="" type="checkbox"/> Reduce avoidable use of intensive services <input checked="" type="checkbox"/> Improve population health, focused on prevention <input type="checkbox"/> Accelerate transition to value-based payment <input checked="" type="checkbox"/> Ensure Medicaid per-capita growth is below national trends</p> <p><i>Which Transformation Project Domain(s) are involved? Check box(es)</i></p> <p><input checked="" type="checkbox"/> Health Systems Capacity Building <input checked="" type="checkbox"/> Care Delivery Redesign <input checked="" type="checkbox"/> Population Health Improvement – prevention activities</p> <p><i>Describe:</i></p> <p>Region(s) and sub-population(s) impacted by the project. This project targets school-aged youth (K-12) who suffer from mental health and chemical dependency issues, which are closely linked to ACEs. A pilot project is underway in four counties (Cowlitz, Mason, Thurston, and Wahkiakum) within the Cascade Pacific Action Alliance (CPAA) Accountable Community of Health (ACH). The project can be scaled up across the CPAA region and Washington State.</p> <p>Relationship to Washington’s Medicaid Transformation goals. The project is squarely aligned with the Triple Aim goals of improved health and better care at less cost. It combines a cross-sector approach bringing together the clinical, educational, and community-based services sectors.</p> <p>Project goals, interventions and outcomes. The project seeks to decrease the number of school-aged youth with unmet behavioral health and physical health needs through improved care coordination between schools, primary care physicians and pediatricians, behavioral health providers, and social support services. In turn, this will lead to improved school attendance and academic achievement, higher graduation rates, higher economic success and better lifelong health. By identifying school-aged youth with behavioral health challenges as early as possible in both education and health care settings through screening for behavioral health conditions, at risk children can be effectively connected with school-based and community-based interventions and treatment services. As a starting point, the project aims to connect the 10% of students with the highest needs to school-based and community-based services, thus, reducing some of the greatest health disparities. A key strategy is the establishment of collaborative care teams for youth with behavioral health issues spanning educational, clinical and community settings. This includes making a mental health trained registered nurse (RN) available to schools to augment existing school nursing capacity which is often very limited, especially in rural areas. The RN is a critical link to coordinating care across fragmented service sectors and will play a hands-on role in ensuring that at-risk youth receive needed medications, have transport to and from appointments, and are connected with MCO case managers.</p> <p>Links to complementary transformation initiatives. The project has strong links to complementary transformation initiatives, including:</p> <ul style="list-style-type: none"> • CMS Transforming Clinical Practice Initiative – WA Department of Health, Molina, and WCAAP leads https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-29.html • Washington State’s Health Home Care Coordination program - http://www.hca.wa.gov/medicaid/health_homes/Pages/index.aspx <p>Potential partners, systems, and organizations needed to be engaged. This project requires partnerships between schools, healthcare (primary care and pediatricians), and social service providers, including behavioral health providers, public health, and MCOs.</p>

Core Investment Components
<p>Proposed activities and cost estimates (“order of magnitude”) for the project. The project can be scaled beyond the pilot communities to the entire 7-county CPAA region and beyond (statewide). Project activities include: (1) partnership development with Educational Service Districts, schools, clinical healthcare providers (primary care providers and pediatricians), behavioral health providers, social service providers, public health, and MCOs; (2) developing an inventory of existing school-based and community-based intervention and treatment services; (3) developing customized workflows for participating sub-regions; (4) recruiting, hiring and deploying mental health trained RNs co-located at participating schools; (5) screening youth for behavioral health risks; (6) coordinating care for at risk youth through collaborative care teams; (7) evaluating progress and making course corrections as necessary; (8) measure outcomes, including measuring youth population health outcomes based on specific youth behavioral health trends noted on the every two year Healthy Youth Surveys.</p> <p>Best estimate (or ballpark if unknown) for number of beneficiaries and per person cost. The average cost per collaborative care team RN (1.0 FTE) is \$90,000 per 12 months, each serving an average caseload of 60 students. For the seven-county CPAA region, the estimated highest-spending 5% of pediatric Medicaid enrollees that account for 54% of total expenditures are 3,789 children. Including other project costs and project coordination, the total estimated project cost is \$6.5 million per annum. This excludes substantial in-kind contributions from project partners (e.g., existing staff time and program funding).</p> <p>How long it will take to fully implement the project within a region where you expect it will have to be phased in. In the four pilot counties, this project is already underway and can be implemented without delay. Scaling up the project across the seven-county CPAA ACH region and beyond is estimated to take approximately 12 months.</p> <p>The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline. There are substantial ROI opportunities that increase over time, given the lifelong positive impacts of this project as youth with appropriately managed behavioral health conditions grow into adulthood. Short-term ROI opportunities exist through the decrease of medical/medication costs in ED use and prescribing and efficiencies gained through the better coordination of existing care resources across fragmented healthcare, educational and community-based services systems. Mid to long-term ROI opportunities include medical cost savings and decreased societal costs, and long-term decreased intergenerational ACEs/poverty/unemployment. A recent study (<i>Comparison of Health Care Spending and Utilization Among Children With Medicaid Insurance</i>, Kuo DZ, et al. Pediatrics. Nov. 16, 2015) found that Medicaid spent \$80,856 on the top 1% of pediatric high resource users and \$14,400 on the next 4%. The study also found that the sickest, most expensive kids are not getting any more primary care than those who are healthy. By better coordinating care for the sickest children, this project could reduce healthcare spending for the top 5% of children on Medicaid. With 5% of Medicaid enrollees – most of whom suffer from chronic conditions – accounting for 48% of its costs (<i>Access to Primary Care Improves Health Outcomes for Children – and Reduces Cost of Care</i>, Cryts. http://www.fiercepracticemanagement.com. Dec. 16, 2015), the cost savings potential is substantial. Another study looking at the impact of improved care coordination through pediatric ACOs documents an overall cost reduction of 15.7% through changes in the use of healthcare resources focused on providing consistent primary care among the pediatric Medicaid population (<i>Effect of Attribution Length on the Use and Cost of Health Care for a Pediatric Medicaid Accountable Care Organization</i>, Christensen and Payne. JAMA Pediatr. Dec. 14, 2015).</p>
Project Metrics

Key process and outcome measures against which the performance of the project would be measured. There are a number of key process and outcome measures for this project, including: Number of children connected to pediatric primary care, receiving annual well child examination, and behavioral health screening; number of children connected to and engaged in behavioral health care; number of children per 1,000 that are homeless; number of children per 1,000 with suicidal ideation, attempts, and suicide; number of days of incarceration in juvenile justice; potentially avoidable ED visits, in particular ED utilization for mental health; hospital days for mental health diagnoses; reduction in use of inappropriate psychiatric medications; improvement in school attendance (number of days attended) and math/reading scores as a proxy for high school graduation.

ⁱThe 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.