

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>Identify point person, telephone number, e-mail address:</p> <p>Jennifer Sewitsky, 541-858-8170, jsewitsky@columbiacare.org</p> <p>Which organizations were involved in developing this project suggestion?</p> <p>ColumbiaCare Services, Inc.</p>
Project Title	<p>Title of the project/intervention:</p> <p>Intensive Case Management – Post-Hospitalization Follow-up Team</p>
Rationale for the Project	
<p>Include:</p> <ul style="list-style-type: none"> • Problem statement – why this project is needed: A lack of proper and timely follow-up after discharge from a psychiatric hospitalization causes individuals to be 30% more likely to be readmitted or visit the local emergency departments than those who receive a follow-up contact/appointment, resulting in unnecessarily and avoidable high healthcare costs. • Supporting research (evidence-based and promising practices) for the value of the proposed project: SAMHSA's National Behavioral Health Quality Framework (SNBHQF) recommends post-hospital follow up as a measure to address identified gaps in the behavioral healthcare system. It is listed as an Evidence Based Practice that ultimately reduces cost of behavioral healthcare, promotes effective care coordination, makes behavioral healthcare safer by reducing adverse events (harm caused in the delivery of care), and promotes affordable and accessible care. Medicaid Health Plans of America endorses 7-day post-hospitalization follow up as a Best Practice, and shows a correlation between a decrease in follow-up with an increase in hospital readmissions, which reduces avoidable use of intensive services. PHFU is a simple yet innovative way to help regional behavioral health organizations meet performance metrics, while helping people avoid unnecessary, traumatic, and costly re-admits to hospital settings. National studies show that a person who receives a follow-up contact from a mental health representative within 7 days of a hospital discharge are significantly less likely to be decompensate and be readmitted to the hospital, as well as identify individuals in need of additional interventions before they reach a crisis point. ColumbiaCare proposes that a team of Qualified Mental Health Associates and Qualified Mental Health Professionals can ensure those contacts are made, and that the Member is either connected to their own service provider (a follow up appointment made), or are seen by one of the PHFU treatment professionals. • Relationship to federal objectives for Medicaid¹ with particular attention to how this project benefits Medicaid beneficiaries: ColumbiaCare's PHFU programs will increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations; and increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform the service delivery networks. These objectives will be met by making timely (within 7 days) contact with individuals stepping out of a higher level care and providing support, informing them of community services, and assisting them with accessing those services through follow up appointments. This may include checking appointment availability, transportation to those appointments, providing appointment reminders, etc. By establishing and maintaining community services and supports, they will experience more efficient and higher quality of lower levels of care vs. experiencing decompensation that could potentially lead to psychiatric crisis, and ultimately hospital readmission. 	

Project Description

Which Medicaid Transformation Goalsⁱⁱ are supported by this project/intervention? Check box(es)

- Reduce avoidable use of intensive services
- 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
- 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):**
Regions: ColumbiaCare believes that all of Washington State’s Regional Support Networks would benefit from implementing PHFU teams. For this project, we suggest starting with SWBH, Optum, King, and North Sound Regional Support Networks—specifically in Seattle, Vancouver, Snohomish and Tacoma. **Subpopulations** would include all Medicaid-covered adults in these catchment areas who have experienced a psychiatric hospital admission and subsequent discharge.
- **Relationship to Washington’s Medicaid Transformation goals:** Post Hospital Follow Up programs will reduce avoidable use of intensive services and settings such as acute care hospitals, psychiatric hospitals, traditional long-term services and supports, and jails by reducing hospital readmissions and providing continuity and care coordination at the community service level. In return, the costs related to hospital readmissions will be saved, which will help Washington ensure that Medicaid per-capita cost growth is contained.
- **Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities:**
 Project goals for the waiver period include the following:
 - Developing PHFU teams (QMHA and/or QMHPs);
 - Providing follow-up contact within 7 days following hospital discharge for the target subpopulations in the identified areas, meet or exceed industry benchmarks of 66% for PHFU contact, with a goal of 70% (providing same day contact for those who meet protocol for “high risk for follow up” (HRFU). HRFU include homeless, A&D/SUD/CD, symptomatic, high hospital users and people with history of no-shows.
 - Ensuring continuity of care in order to increase compliance with outpatient follow up services (first priority of continuing services with their current provider, second priority meeting with the PHFU QMHP),
 - Detecting, resolving and documenting potential post hospitalization problems such as lack of transportation, lack of communication tools, etc.
 - Improving and tracking treatment outcomes such as number of contacts, decrease in the number of sub-acute treatment services and hospital readmissions from baseline data
- **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:** PHFU programs are directly linked to Medicaid Transformation Initiative #2 in that it is an added service that enables individuals to stay at home and delay or avoid the need for more intensive care through hospital diversion. The programs are outcome-directed with specific targets for follow-up contact, creating better linkages within the health care system, and ultimately reducing the need for acute care and/or hospital readmissions.
- **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 include hospitals (staff, including peer workers), Outpatient Service Providers, Regional Support Networks, Primary Care providers, and Accountable Communities of Health.

Core Investment Components

Describe:

- **Proposed activities and cost estimates (“order of magnitude”) for the project.** Salary, fringe, transportation, communication, support staff, supervision and administration would be \$345,000 annually for each team of 2.
- **Best estimate (or ballpark if unknown) for:**
 - **How many people you expect to serve, on a monthly or annual basis, when fully implemented.** Each PHFU team/program made up of 2 FTE licensed QMHP’s will serve between 800-850 individuals annually. For this project, we propose a PHFU team for each city: Seattle, Vancouver, Snohomish, and Tacoma, for a total of 3200-3400 individuals. This could easily be scaled up for the need in any or all areas.
 - **How much you expect the program to cost per person served, on a monthly or annual basis.** \$382 per person served.
- **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 this project would include identifying office space, recruiting, hiring, and training of staff, and the execution of a contract for services. As an experienced provider of these services, ColumbiaCare could complete this process in 90 days.
- **The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.** If the only savings is reducing the re-hospitalization rate by 30% and only 1 day was saved per hospitalization (hospital cost @ \$1750 per day) the savings annually per team would still be \$117,000. If the avoided hospital stay was longer than 1 day the savings would be much higher.

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 46-47ⁱⁱⁱ.** PHFU programs will have a significant impact on reducing Psychiatric Hospitalization Readmission rates and associated cost savings, as well as resulting in improved and increased Mental Health Treatment Penetration. As individuals experience a timely follow-up with a mental health professional, and receive the added supports needed to make and keep their next appointment in the community mental health system; we believe that the target population will be able to follow through on less costly and more beneficial outpatient care and avoid psychiatric decompensation and hospitalization (by 30% according to various studies).
- **If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation?** N/A