DRAFT TRANSFORMATION PROJECT TOOLKIT

Contents

Introduction to the Transformation Project Toolkit

Accountable Communities of Health (ACH) and the transformation efforts they undertake are a key component of Initiative 1 of Washington's Medicaid Transformation waiver and critical levers to help the state achieve Medicaid transformation goals. The Transformation Project Toolkit reflects the evidence-based strategies the ACH will use to develop Medicaid transformation project plans for implementation across their regions. Evidence-based transformation strategies are included within several project options and organized within a framework of three domains:

- Domain 1: Health Systems and Community Capacity Building
- Domain 2: Care Delivery Redesign
- Domain 3: Health Equity through Prevention and Health Promotion

The Domains and strategies defined within each are interdependent. Domain 1 strategies are foundational and are to be tailored to support efforts in Domain 2 and Domain 3, and projects in Domain 2 and Domain 3 integrate and apply Domain 1 strategies to the specified topics and approaches. Domain 1 is largely focused on system-wide planning and capacity-building to reinforce transformation projects.

Performance Measurement

System-wide measures are included for each project. These measures reflect the impact of the projects on the larger system. System-wide measures are to be monitored and reported at the state level and, where possible, at the ACH level. These measures should be reported at least annually, but if possible, at the same frequency as the project-level measures.

Project-level measures are included for each project. These measures serve to track performance at a level more directly tied to project deliverables. For example, an increase in appropriate screening for diabetes at the project level should be reflected in decreased inpatient admissions for individuals with diabetes at the health care delivery system-wide level. The project-specific measures should be reported at the ACH level and, if possible and applicable, at the practice level. They should be reported as frequently as feasible and relevant; frequency may vary by measure.

Regional Health Needs Inventory

To ensure a strategic approach, ACH will use population health and health service capacity information to guide the selection, planning, targeting, and implementation of transformation projects. Each ACH will be required to complete a comprehensive Regional Health Needs Inventory (RHNI). The Washington Health Care Authority (HCA) will package and provide relevant information to the ACH from various statewide data sets, to the fullest extent possible, to populate the RHNI. ACH will need to fill gaps in data using local data sources and complete an environmental scan of current service delivery and partner organization capacity. Information gathered and included in the RHNI should be sufficient to justify the selection of specific projects and strategies and to guide project implementation plan development. The ACH may rely on previously completed inventories or assessments to meet the requirements of the RHNI. The RHNI is a vital component of the planning process, as it provides the information necessary to design the initiatives to

their maximum benefit, by tailoring them to the unique needs and circumstances of the communities in which the projects will be implemented. It will include a description of the region's population health (Section I) and a description of the current health care and community service system capacities (Section II).

The minimum essential components of the RHNI include:

I. Description of the Community

Describe the region's geography and infrastructure, demographics, and community health status.

A. Geography and Infrastructure: Describe the geographic region as it impacts access to services and the health of population, including relevant infrastructure, such as the availability (or lack of) of affordable housing, public transportation, education, proximity of industrial zones, and more. Identify the region's assets to leverage to contribute to implementation such as: major employers, employment opportunities and rates, institutions of higher learning, trade schools, and more. Do not include health care and community-based service capacity (covered in Section II).

B. Demographics: Describe the demographics of the population, including data on gender, age, race, ethnicity, housing status, employment status, insurance status, income, educational attainment, language and health literacy, immigration status, and rates of incarceration and 1- and 3-year re-incarceration rates in the region.

C. Health Status: Describe the health of the population. Provide data segmented by demographic factors (age, gender, race/ethnicity, insurance status, etc.) and identify health disparities. Prepare a similar description of the population in prison/jail or under community supervision returning to or living in your region. At minimum, include:

- Leading causes of death and premature death
- Leading causes of hospitalization and preventable hospitalization (including psychiatric inpatient admission and re-admission)
- Leading causes of ED visits
- Rates of chronic disease, including ambulatory care sensitive conditions: hypertension, diabetes, obesity, asthma, cardiovascular disease, depression and substance use disorders, as well as a detailed description of prescription and illegal opioid use, misuse, and abuse
- Rates of risk factors such as tobacco use and dependence, alcohol use and abuse, drug use and abuse, healthy eating habits, physical activity, oral health, etc.
- Maternal and child health indicators, including utilization of pre- and post-natal care, infant mortality and low birth weight, birth rates by age cohorts,
- Child, adolescent, adult, and elderly immunization rates
- Sexually transmitted infections

- Consider other key outcome metrics (both system-wide and project-level) from projects under Domain 2 and 3 as seen in the Appendix (see Measures Appendix document).

II. Description of the Health Care and Community-Based Service Systems

Describe the current capacity of the health care system and related community-based supportive services. Include data on the availability and accessibility of services, as well as utilization of services, and key partner organizations. For each type of service, include data, where available, on overall capacity, service area, Medicaid status, and sub-specialties or areas of expertise that could be leveraged for implementation support. Ensure the assessment includes all types of services necessary for successful project implementation and overall health system transformation. In all areas, include both public and private providers such as:

- Hospitals, including general medical/surgical, and specialty facilities (psychiatric, children's, etc.)
- Long-term Services and Supports, including Skilled Nursing Facilities and Home and Community-Based Services
- Rehabilitative Services
- Specialty Medical Providers
- Urgent Care Centers
- Dental Providers
- Community-Based Care Coordination and Management, including Health Homes
- Home Health Care, including visiting nurses and other skilled supports
- Primary Care Providers, including Federally Qualified Health Centers, private practices, and hospital-based or affiliated clinics or centers
- Behavioral Health Providers, including mental health and substance use disorder service providers, in both public and private settings
- Other community-based services that support the social determinants of health, including, but not limited to social and human services, food security, housing, transportation, and employment
- Local health departments and governmental units, correctional health, school nurses, school-based health centers
- Managed Care Organizations
- Other workers (medical or otherwise) needed to address health needs associated with system-wide and project-level outcome metrics for projects under Domain 2 and 3 (See Appendix) as well as projects outlined in Domain 2 and 3.

Evaluate the extent to which the health care, social services, corrections and criminal justice, and community service systems are capable of meeting the needs of the community, now and in the near future. Identify priority focus areas and sub-populations that will be the target for health system expansion and transformation initiatives in the region. Identify gaps in services that will need to be addressed in implementation plans.

Statewide Value Based Payment Transition Taskforce and Workforce Development Taskforce

The Washington HCA will convene a Statewide Taskforce for Value-Based Payment Transition and a Statewide Taskforce for Workforce Development to support Medicaid Transformation. ACH will be required to engage in these statewide taskforces through identification of regional representatives for each taskforce, commitment to ongoing participation, and contribution to and incorporation of taskforce recommendations. To the extent that regional and local level needs are not fulfilled through the statewide taskforce structures, ACH should convene regional or local-level taskforce bodies to provide input to and guide efforts around regional value based payment transition and workforce development efforts needed for successful implementation.

The Statewide Taskforce for Value-Based Payment Transition will include state, regional and local level stakeholders representing: physical health care providers, behavioral health care providers, hospitals, clinics, community-based organizations, Managed Care Organizations (MCO), and others. Representation will appropriately reflect Domain 2 and Domain 3 recommended partners and required strategies. This taskforce will be responsible for:

- Serving in an advisory capacity to the further development and implementation of the HCA VBP Roadmap
- Designing a statewide assessment of VBP transition and readiness:
  o Develop inventory and tracking tools to be implemented by the ACH to facilitate the reporting of VBP payment levels to understand the current levels and types of VBP arrangements across the provider spectrum.
  o Calculating current VBP baseline, the level of VBP payment arrangements as a percentage of total payments across the state
- Identifying and responding to stakeholder needs for education, training, and technical assistance to shift to VBP models and providing stakeholder training around VBP methodologies.
- Develop a VBP payment provisions template to be used by providers to enter VBP arrangements with MCOs. Template should:
  o Define VBP payment methodologies;
  o Define service and population exceptions for specific methodologies;
  o Provide recommendations for quality metrics for each VBP initiative in accordance with the adopted common measures used in HCA purchasing efforts; and
  o Provide recommendations for methodologies surrounding fund flow strategies on shared savings.

The Statewide Taskforce for Workforce Development will include state, regional and local level stakeholders representing: health care providers, community-based organizations, government entities (such as elected officials, education authorities, law enforcement, housing authorities, workforce authorities, and departments of social and health services), union and employee advocacy organizations, consumer advocates and community representatives, and others. Representation will appropriately reflect Domain 2 and Domain 3 recommended partners and required strategies.

Practice Transformation Support Hub

Healthier Washington will support transformation of the health delivery system through investment in knowledge, training, and tools, that effectively coordinate care, promote clinical-community linkages, and transition to value-based payment models. The Hub will convene, coordinate and develop resources to give practices the training, coaching and tools they need to:

- Stimulate and accelerate the uptake of integrated and bi-directional behavioral health (mental health and substance use disorder) and primary care.
- Support progress toward value-based payment systems.
- Improve population health by strengthening clinical practice alignment with community-based services for whole person care.

The Hub will assist providers in the ACH region to improve clinic site data management capacity by providing training and tools that strengthen practices' use of data to drive decision-making, contract negotiations, demonstrate health improvement/outcomes, and connect care delivery transformation success with cost reduction (performance, outcome, value-based approaches). ACH will connect with and depend upon the Hub to support transformation project implementation efforts.

Domain 1: Health and Community Systems Capacity Building

This domain addresses the core health system capacities to be developed or enhanced to transition the delivery system according to Washington's Medicaid Transformation Demonstration. There are three areas of focus: financial sustainability through value based payment, workforce, and systems for population health management. Each of these areas will need to be addressed progressively throughout the five-year timeline to directly support Domain 2 and Domain 3 transformation project success. Domain 1 does not outline individual projects, but three required focus areas to be implemented and expanded across the delivery system, inclusive of all provider types, to address the entire Medicaid population of service.

Financial Sustainability through Value Based Payment

Rationale: Medicaid transformation efforts must contribute meaningfully to moving Washington forward on value-based payment (VBP). Paying for value across the continuum of Medicaid services is necessary to assure the sustainability of the transformation projects undertaken through the Medicaid Transformation Demonstration. A transition away from paying for volume may be challenging to some providers, both financially and administratively. Because not all provider organizations are equipped at present to successfully operate in these payment models, providers may need assistance to develop additional capabilities and infrastructure. Financial incentives will support provider and plan capacity in achieving systemic change in how services are reimbursed. Funds will further incentive providers participating in Healthier Washington Transitional Payment models.

Overarching Goal: Achieve the Healthier Washington goal of having 90% of state payments tied to value by 2021.

Annual Benchmarks:
- By the End of Calendar Year 2017, achieve 30% VBP payment benchmark.
- By the End of Calendar Year 2018, achieve 50% VBP payment benchmark.
- By the End of Calendar Year 2019, achieve 80% VBP payment benchmark.
- By the End of Calendar Year 2020, achieve 85% VBP payment benchmark.
- By the End of Calendar Year 2021, achieve 90% VBP payment benchmark.

Stage 1 - Governance: *By 02/28/2017*	- Identify appropriate regional representation and establish commitment to participate in and contribute to the Statewide Value-Based Payment Transition Taskforce. Representatives may include: - Physical health care providers; - Behavioral health care providers; - Hospitals and clinics; - Community-based organizations; - Managed Care Organizations (MCO); and - Behavioral Health Organizations (BHO). - Convene health system alliances and MCO/BHO partnerships.

Stage 2 - Planning:
By 09/30/17
	• In collaboration with the HCA and the Statewide VBP Transition Taskforce, perform an assessment of the current VBP payment levels
	   o Deploy the tracking tool developed and adopted by the statewide taskforce to facilitate the reporting of VBP payment levels to understand the current levels and types of VBP arrangements across the provider spectrum.
	   o Determine the level of VBP payment arrangements as a percentage of total payments across the region to determine current VBP baseline. Assessment should include an attestation by providers to substantiate the accuracy of the reporting process.
	• Perform assessment of VBP readiness across regional provider systems
	   o Inform providers of various VBP readiness tools and resources. Some viable tools may include:
	      ▪ JSI/ NACHC Payment Reform Readiness Toolkit
	      ▪ https://www.stepsforward.org/modules/value-based-care#section-references
	      ▪ http://cph.uiowa.edu/ruralhealthvalue/TnR/VBC/VBCTool.php
	   o Connect providers to training and technical assistance developed and made available by the HCA and the statewide taskforce
	• Develop a Regional VBP Transition Plan:
	   o Define a path towards VBP adoption that is reflective of current state of readiness and the implementation strategies within the Transformation Project Toolkit (Domain 2 and Domain 3)
	   o Defines priority VBP payment methodologies in accordance with the approved VBP categories within the HCA VBP Roadmap
	  o Create a regional Value-Based Payment Transformation Report that:
	   o Identifies VBP payments strategies to be implemented in the region to ensure statewide VBP targets are met
	   o Outlines by provider the "as is" level of VBP payments and the "to be" level of VBP payments.
	   o Differentiates VBP payments by the Category as outlined in the CMS VBP Framework (e.g. Category 2 through Category 4).

Stage 3 - Implementation:
By 03/31/2018 and beyond
	• Implement Value-Based Payment Strategies.
	   o Leverage support, resources, products developed in collaboration with the HCA and Statewide VBP Transition Taskforce
	   o Demonstrate VBP payment contracts have been executed with MCOs
	• Perform on-going monitoring and update the Regional Value-Based Payment Transformation Report annually

	• Continue to engage in and contribute to the Statewide VBP Transition Taskforce, to include on-going refinement of the VBP Transition Plan as needed. • By the End of Calendar Year 2018, achieve 50% VBP payment benchmark. • By the End of Calendar Year 2019, achieve 80% VBP payment benchmark. • By the End of Calendar Year 2020, achieve 85% VBP payment benchmark. • By the End of Calendar Year 2021, achieve 90% VBP payment benchmark.

Workforce
Rationale: The health services workforce will need to evolve to meet the demands of the redesigned system of care. Workforce transformation will be supported through the provision of training and education services, hiring and deployment processes, and integration of new positions and titles to support transition to team-based, patient-centered care and ensure the equity of care delivery across populations.
Overarching Goal: Improve and sustain alignment between health services workforce capacity and community health needs.
System-wide Outcomes: • Expand Community Health Worker and Peer Support integration • Advance clinical and non-clinical staff knowledge and expertise to implement new or re-designed approaches to care delivery, including prevention and health promotion strategies • Develop workforce supply and competencies to meet demands of a fully integrated delivery system • Improve quality, accessibility and cultural competency of care

Stage 1 - Governance:
By 02/28/2017
	• Identify appropriate regional representation and establish commitment to participate in and contribute to the Statewide Workforce Development Taskforce. Representatives may include:
	   o Health care providers;
	   o Community-based organizations;
	   o Government entities (such as elected officials, education authorities, law enforcement, housing authorities, workforce authorities, and departments of social and health services);
	   o Union and employee advocacy organizations; and
	   o Consumer advocates and community representatives.

Stage 2 - Planning:
By 09/30/17
	• Create a Workforce Transformation Plan.
	  ○ Conduct a current state assessment and gap analysis of the existing health workforce in the region.
	  ○ Define and describe the vision for the "future state," to include:
	    ▪ Workforce gaps and training needs, particularly related to Domain 2 and Domain 3 activities;
	    ▪ Characteristics and goals aligned with the overarching goal and outcomes included in the description above; and
	    ▪ Anticipated workforce development needs extending beyond the demonstration timeline.
	  ○ Develop a detailed and specific action plan to address gaps and training needs, and to make overall progress towards the envisioned future state. The Workforce Transformation Plan must include:
	    ▪ Activities/strategies to respond to findings of current state assessment and gap analysis, including objectives, actions to be taken, and target dates, that tie directly to Domain 2 and Domain 3 projects; activities/strategies may include:
	      • Pipeline projects;
	      • Training of existing workforce (utilizing the Practice Transformation Support Hub as appropriate);
	      • Development and deployment efforts; and
	      • Recruitment and retention incentives and efforts to address workforce shortages (e.g., family practitioners, behavioral health providers, community health workers, dentists, others).
	    ▪ The approach to cultural competency and health literacy trainings and trauma-informed care trainings (particularly for clinical staff, service providers, and other patient-facing staff);
	    ▪ A plan for continuation of activities and expectation for reaching goals beyond the demonstration timeline; and
	    ▪ Strategies to mitigate impact of healthcare redesign on workforce delivering services for which demand is decreasing.
	• Design an evaluation plan which proposes how progress will be tracked and measured and the impact of the Workforce Transformation Plan assessed.

Stage 3 – Implementation: *By 03/31/2018*	• Implement the Workforce Transformation Plan. • Implement the Evaluation Plan. • Administer necessary resources to support all efforts.

	• Develop and implement payment and compensation models to sustain the new workforce structure and aligned with VBP arrangements.

Systems for Population Health Management
Rationale: The expansion, evolution and integration of health information systems and technology will need to be supported to improve the speed, quality, safety, and cost of care. This includes linkages to community-based care models. Health data and analytics capacity will need to be improved to support system transformation efforts, including combining clinical and claims data to advance VBP models and to achieve the triple aim.
Overarching Goal: Develop interoperable health information technology (HIT) and exchange (HIE) infrastructure to capture, analyze, and share population health data, including combining clinical and claims data to advance VBP models.
System-wide Outcomes: • Expand integration and evolution of electronic health records (EHRs) • Expand connectivity to and bi-directional functionality of HIEs • Improve the quality and efficiency of care through improved workflow design implementation

Stage 1 – Governance: *by March 2017*	HCA is advancing Washington's capabilities to collect, share, and use integrated physical and behavioral health information from provider's EHRs by implementing the Washington Link4Health Clinical Data Repository (CDR). The CDR aggregates clinical information from disparate EHRs in one easily accessible location. By providing access to clinical information from outside the enterprise, the CDR helps the care team gain a more comprehensive understanding of the patient's medical history. To participate in the CDR, providers need to be contracted with a managed care organization, be utilizing a certified EHR, and a participant in the OneHealthPort HIE. ACH should convene key provider groups and health system alliances to ensure regional participation in the CDR or planning for adequate alternatives for data collection and sharing.

Stage 2 – Planning:
by June 2017
	• Perform current state assessment of technology and analytics infrastructure.
	   o Identify data collection and analytic capacity for:
	      ▪ Patient-level care processes and outcomes of care;
	      ▪ Population-level stratification across systems;
	      ▪ Social determinants of health; and
	      ▪ Per-capita costing.

	- Conduct a gap analysis and needs assessment of HIT and HIE infrastructure across the network of providers and payers, assessing at minimum: - Level electronic health record (EHR) adoption and utilization; - Level of systems interoperability; and - Level of HIE connectivity and utilization. - Inform providers of tools and resources to support population health management readiness, such as the Healthier Washington Dashboard reporting tool (CORE), Predictive Risk Intelligence System (PRISM), and Washington Health Alliance Community Checkup Additional tools may include, but are not limited to: - Agency for Healthcare Research and Quality's (AHRQ) Practice-Based Population Health; - Office of the National Coordinator for Health IT's 2016 Interoperability Standards Advisory; and - SAMHSA-HRSA's Center for Integrated Health Solutions Population Health Management webinars. • Create a Population Health Management Capacity Transformation Plan that: - Defines a path towards information exchange for community-based, integrated care. Transformation plans should be tailored based on regional providers' current state of readiness and the implementation strategies selected within Domain 2 and Domain 3; - Includes an approach to stratification of population registries, patient messaging such as alerts for needed chronic and preventive care appointments, incorporation of patient-reported outcomes, and data sharing and confidentiality in accordance with all Federal and State privacy laws; and - Responds to identified needs and gaps identified in current infrastructure.
Stage 3 – Implementation: *by December 2017*	• Implement the Population Health Management Capacity Transformation Plan. - Ensure ready access to meaningful and actionable data at the point of service, in both clinical and community-based settings. - Create mechanism for refining plan strategies and resources to address unintended changes, needs, barriers, or unfavorable outcomes at any point during implementation and measurement. - Establish monitoring for plan implementation and communicating on progress.

Domain 2: Care Delivery Redesign

Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency and effectiveness of care processes. Person-centered approaches and integrated models are emphasized. Domain 2 includes two required and two optional projects.

Project 2A: Bi-Directional Integration of Care and Primary Care Transformation *(Required)*

Rationale: The Medicaid system aims to support person-centered care that delivers the right services in the right place at the right time. Primary care services are a key gateway to the behavioral health system, and primary care providers need additional support and resources to screen and treat individuals for behavioral health care needs, provide or link with appropriate services, and manage care. Similarly, for persons not engaged in primary care services, behavioral health settings can be equipped to provide essential primary care services. Integrating mental health, substance use disorder, and primary care services has been demonstrated to deliver positive outcomes and is an effective approach to caring for people with multiple healthcare needs. Through a whole-person approach to care, physical and behavioral health needs will be addressed in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will advance Healthier Washington's initiative to bring together the payment and delivery of physical and behavioral health services for people enrolled in Medicaid, through managed care.

The state is changing how it pays for delivery of physical health services, mental health services and substance use disorder (SUD) services in the Medicaid (Apple Health) program. By transitioning to combining the funding sources for all services and holding one organization (the managed care plan) accountable for delivering high-quality whole-person care, incentives are better aligned to allow for expanded prevention, improved health outcomes, and flexible models of care that can support interdisciplinary care teams. To support the movement to fully integrated managed care, increased financial resources will be available for those regions that commit to and implement the payment and delivery of physical and behavioral health services for people enrolled in Medicaid, through managed care prior to 2020. Fully integrated managed care will be implemented in a person-centered manner with respect for patient choice.

Primary care and behavioral health providers are undergoing substantial changes in order to deliver whole-person care efficiently and effectively, and to transition to value-based payment models. High-quality, comprehensive primary and behavioral health care are cornerstones of any high-performing health system. All providers will need support to implement advanced collaborative models, that are person-centered, rely on evidence-based guidelines, and use health information technology meaningfully to support care integration and coordination.

Target Populations: Medicaid clients (children and adults) with, or at-risk for, behavioral health conditions, including mental illness and/or substance use disorder.

Recommended Implementation Partners: Behavioral Health Providers, Primary Care Providers, County Government Units, Managed Care Organizations, Criminal Justice, Department of Social and Health Services. Partners for Primary Care Transformation should include: Primary Care

Providers (including independent practices), hospital-affiliated health centers, and Federally Qualified Health Centers and Rural Health Clinics serving Medicaid clients.

System-wide Outcome Metrics:

- Behavioral Health Measures
  - Adult Mental Health Status*
  - Psychiatric Hospital Readmission Rate*
- Overuse Measures
  - Potentially Avoidable Emergency Department(ED) Visits*
  - Prevention Quality Indicator #90 Overall Composite
  - Pediatric Quality Indicator #90 Overall Composite
  - Plan All-Cause Readmission Rate (NQF#1768)*
  - Potentially Avoidable Emergency Medical Services (EMS) Use**

Project Outcome Metrics:

- Physical Health Measures
  - Adult Access to Preventive/Ambulatory Care*
  - Child and Adolescents' Access to Primary Care Practitioners *
  - Influenza Immunizations 6 months of age and older (NQF#0041)*
- Behavioral Health Measures
  - Follow-up After Hospitalization for Mental Illness (NQF#0576)*
  - Follow-up After Discharge from ER for Mental Health, Alcohol or Other Drug Dependence at 30 days (NQF#2605)*
  - Mental Health Treatment Penetration (Broad Version)*
  - Substance Use Disorder Treatment Prevention*
  - Antidepressant Medication Management (NQF#0105)*
- Patient Experience: Clinician & Group CAHPS V 3.0 Measures (NQF#0005)* Questions
  - Primary Care: Usual Source of Care (Q2)
  - Primary Care: Length of Relationship (Q3)
  - Getting Timely Appointments, Care and Information (Q6, 8, 10)

Evidence-based Approach(es) for Integrating Behavioral Health into Primary Care Setting: (MUST SELECT AT LEAST ONE)

1. Patient-Centered Medical Home (PCMH) http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh

2. Collaborative Care Model https://aims.uw.edu/sites/default/files/CollaborativeCarePrinciplesAndComponents_2014-12-23.pdf

3. Improving Mood – Providing Access to Collaborative Treatment (IMPACT) Model
http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/

Approach(es) based on Emerging Evidence for Integrating Primary Care into Behavioral Health Setting: (MUST SELECT AT LEAST ONE)

Select at least one of the three approaches described in the report "*Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness*" http://www.milbank.org/wp-content/files/documents/papers/Integrating-Primary-Care-Report.pdf.

1. Off-site, Enhanced Collaboration
2. Co-located, Enhanced Collaboration
3. Co-located, Integrated

And apply core principles of the Collaborative Care Model (see above) to integration into the Behavioral Health setting.

Additional Resources

SAMHSA-HRSA Center for Integrated Health Solutions http://www.integration.samhsa.gov/integrated-care-models

Evolving Models of Behavioral Health Integration in Primary Care http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf

Approaches to Integrating Physical Health Services into Behavioral Health Organizations

http://www.integration.samhsa.gov/Approaches_to_Integrating_Physical_Health_Services_into_BH_Organizations_RIC.pdf

U.S. Preventive Services Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Project Implementation Stages

Stage 1 – Planning: *insert dates*

Rely on the Regional Health Needs Inventory to identify target population and providers serving Medicaid clients. Assess the target providers' current capacity to effectively deliver integrated care in the following areas; include strategies within the system wide plan completed within Domain 1 for:

o Population Health Management/HIT: current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.

o Workforce: capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:

- - Shortage of Mental Health Providers, Substance Abuse Disorder Providers, Social Workers, Nurse Practitioners, Primary Care Providers, Care Coordinators and Care Managers;
    - Opportunities for telehealth integration;
    - Workflow changes to support integration of new screening and care processes, care integration, communication
    - Cultural and linguistic competency, health literacy deficiencies.
  - o <u>Financial Sustainability</u>: alignment between current payment structures and guideline-concordant physical and behavioral care, inclusive of clinical and community-based; incorporate current state and anticipated future state of Value Based Payment arrangements to support integrated care efforts into the regional VBP transition plan. Assess current level of adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Assess the current state of Integrated Care Model Adoption: Describe the level of integrated care model adoption among the target providers/organizations serving Medicaid clients. Explain which integrated models or practices are currently in place and describe where each target provider/organization currently falls in the five levels of collaboration as outlined in the Standard Framework for Integrated Care. (http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf)

Engage and obtain formal agreements from participating behavioral and physical health providers, organizations, and relevant committees or councils – Identify, recruit, and secure formal commitments for participation from all target providers/organizations via a written agreement specific to the role each will perform in the project.

Engage and convene County Commissioners, Managed Care Organizations, Behavioral Health providers and other critical partners to develop a plan and description of a process and timeline to transition to fully integrated managed care. This plan should reflect how in the region will enact fully integrated managed care by no later than January 2020; include an explanation of the process for obtaining county commitment to pursue full integration.

Select at least one evidence-based approaches (from the two categories of Evidence-Based Approaches section above), and for each one selected, develop a Project Implementation Plan that demonstrates progression from the current state, including:

- Selected evidence-based approaches to integration and partner/providers for implementation;
- Implementation timeline;
- Roles and responsibilities of key organizational and provider participants, including payer organizations;

- Description of how project aligns with related initiatives and avoids duplication of efforts; and
- Justification demonstrating that the selected evidence-based approaches and the committed partner/providers are culturally relevant and responsive to the specific population health needs in the region.

Develop a plan to transition to fully integrated managed care contract(s) in region, including an explanation of the process for obtaining county commitment to pursue full integration.

Stage 1 – Planning: Progress Measures

- Complete assessment for the current state of integrated care
- List target providers and organizations with formal commitment to participate in the project
- Complete plan for pursuing fully integrated managed care
- Binding letters of intent from all counties within the regional service area to implement full integration by 2020. Regions that achieve fully integrated managed care along an accelerated timeline may be eligible for increased incentive payments
- Complete Project Implementation Plan
- Complete Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2A

Stage 2 – Implementation: *insert dates*

Implementation of plan for pursuing fully integrated managed care

Integrating Behavioral Health into Primary Care Setting:

Option 1: Develop policies and procedures and implement the core components of the selected evidence-based approach: **PCMH Model.**

Implement the core components of the NCQA 2017 PCMH Recognition Standards:

- Identification of a physician champion with knowledge of PCMH implementation.
- Gap analysis of practice sites within the regional service area.
- Identification of care coordinators at each primary care site who are responsible for care connectivity and engagement of other staff in PCMH process as well connectivity to other care managers who provide services for higher risk patients (e.g., health home care managers).
- Implementation of necessary HIT functionality including EHRs that meets meaningful use standards (MU), health information exchange (HIE) connectivity, e-prescribing, instant messaging, ER alerts.
- Staff training on care model including evidence based preventive and chronic disease management.
- Preventive care screenings including behavioral health screenings (PHQ-9, SBIRT) will be implemented for all patients to identify unmet needs.

- A process must be developed for assuring referral to appropriate care, if not provided in the practice, in a timely manner, including a "warm hand-off" where possible.
- Implementation of open access scheduling.
- Development of quality management program to monitor process and outcome metrics and to implement improvement strategies including rapid cycle improvements to ensure fidelity with PCMH standards and practice quality improvement. The program should include reporting to staff and patients.
- Demonstration of a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation, including addressing issues of health disparities.

Option 2: Develop policies and procedures and implement the core principles of the selected evidence-based approach: **Collaborative Care Model**. Implement the core components and tasks for effective integrated behavioral health care, as defined by the AIMS Center of the University of Washington and shown here:

- Patient Identification & Diagnosis:
  - Screen for behavioral health problems using valid instruments.
  - Diagnose behavioral health problems and related conditions.
  - Use valid measurement tools to assess and document baseline symptom severity.
- Engagement in Integrated Care Program:
  - Introduce collaborative care team and engage patient in integrated care program.
  - Initiate patient tracking in population-based registry.
- Evidence-based Treatment:
  - Develop and regularly update a biopsychosocial treatment plan.
  - Provide patient and family education about symptoms, treatments, and self-management skills.
  - Provide evidence-based counseling (e.g., Motivational Interviewing, Behavioral Activation).
  - Provide evidence-based psychotherapy (e.g., Problem Solving Treatment, Cognitive Behavioral Therapy, Interpersonal Therapy).
  - Prescribe and manage psychotropic medications as clinically indicated.
  - Change or adjust treatments if patients do not meet treatment targets.
- Systematic Follow-up, Treatment Adjustment, and Relapse Prevention:
  - Use population-based registry to systematically follow all patients.
  - Proactively reach out to patients who do not follow-up.

- o Monitor treatment response at each contact with valid outcome metrics.
- o Monitor treatment side effects and complications.
- o Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment.
- o Create and support relapse prevention plan when patients are substantially improved.
- Communication & Care Coordination:
  - o Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
  - o Engage and support family and significant others as clinically appropriate.
  - o Facilitate and track referrals to specialty care, social services, and community-based resources.
- Systematic Psychiatric Case Review & Consultation:
  - o Conduct regular (e.g., weekly) psychiatric caseload review on patients who are not improving.
  - o Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
  - o Provide psychiatric assessments for challenging patients in-person or via telemedicine.
- Program Oversight and Quality Improvement:
  - o Provide administrative support and supervision for program.
  - o Provide clinical support and supervision for program.
  - o Routinely examine provider- and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use this information for quality improvement.

Option 3: Develop policies and procedures and implement the core components of the selected evidence-based approach: **IMPACT Model**

- Collaborative Care:
  - o The patient's primary care physician works with a care manager to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy).
  - o Care manager and primary care provider consult with psychiatrist to change treatment plans if patients do not improve.
- Depression Care Manager (nurse, social worker, or psychologist, may be supported by a medical assistant or other paraprofessional):
  - o Educates patient about depression.
  - o Supports antidepressant therapy prescribed by the patient's primary care provider if appropriate.
  - o Coaches patients in behavioral activation and pleasant events scheduling.
  - o Offers a brief (six-eight session) course of counseling, such as Problem-Solving Treatment in Primary Care.
  - o Monitors depression symptoms for treatment response.

- o   Completes a relapse prevention plan with each patient who has improved.
- Designated Psychiatrist:
  - o   Consults to the care manager and primary care physician on the care of patients who do not respond to treatments as expected
- Outcome Measurement:
  - o   IMPACT care managers measure depressive symptoms at the start of a patient's treatment and regularly thereafter, using the PHQ-9 or other effective tools.
- Stepped Care:
  - o   Treatment is adjusted based on clinical outcomes and according to an evidence-based algorithm; aim is for a 50 percent reduction in symptoms within 10-12 weeks. If patient is not significantly improved at 10-12 weeks after the start of a treatment plan, the treatment plan is modified.
- Quality Process and Outcome Program is implemented.

Integrating Primary Care into Behavioral Health Setting

Option 1: Off-site, Enhanced Collaboration

- Primary Care and Behavioral Health providers located at a distance from one another will move beyond basic collaboration (in which providers make referrals, do not share any systems, but may have periodic non-face to face communication including sending reports), to enhanced collaboration, with the following core components:
  - o   Providers have regular contact and view each other as resources;
  - o   A process for bi-directional information sharing is in place;
  - o   Providers may maintain separate care plans and information systems, but regular communication and information sharing results in alignment of plans and effective medication reconciliation; and
  - o   Care managers and/or coordinators are in place and facilitate collaboration across settings.

Option 2 or Option 3: Co-located, Enhanced Collaboration or Co-located, Integrated

- Apply and implement the core principles of the **Collaborative Care Model** to integration of primary care, implement the core components and tasks for effective integrated of physical health care into the behavioral health setting.
  - o   Patient Identification & Diagnosis:
    - ▪   Screen for and document chronic diseases and conditions, such as obesity, diabetes, heart disease, asthma, and others.
    - ▪   Diagnose chronic diseases and conditions.

- Assess chronic disease management practices and control status.
  - Engagement in Integrated Care Program:
    - Introduce collaborative care team and engage patient in integrated care program.
    - Initiate patient tracking in population-based registry.
  - Evidence-based Treatment:
    - Develop and regularly update a biopsychosocial treatment plan.
    - Provide patient and family education about symptoms, treatments, and self-management skills.
    - Provide evidence-based self-management education (ASMT, DSME).
    - Provide routine immunizations according to ACIP recommendations, as needed.
    - Provide the U.S. Preventive Services Task Force screenings graded A & B, needed.
    - Prescribe and manage medications as clinically indicated.
    - Change or adjust treatments if patients do not meet treatment targets, refer to specialists as needed.
  - Systematic Follow-up, Treatment Adjustment:
    - Use population-based registry to systematically follow all patients.
    - Proactively reach out to patients who do not follow-up.
    - Monitor treatment response at each contact with valid outcome metrics.
    - Monitor treatment side effects and complications.
    - Identify patients who are not improving to target them for specialist evaluation or connection to increased primary care access/utilization.
  - Communication & Care Coordination:
    - Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
    - Engage and support family and significant others as clinically appropriate.
    - Facilitate and track referrals to specialty care, social services, and community-based resources.
  - Systematic Psychiatric Case Review & Consultation:
    - Conduct regular (e.g., weekly) chronic disease and condition caseload review on patients who are not improving.
    - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
  - Program Oversight and Quality Improvement:
    - Provide administrative support and supervision for program.
    - Provide clinical support and supervision for program.

- Routinely examine provider- and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use this information for quality improvement.

In addition to implementing the core components for the selected evidence-based approach:

- Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to perform their role in the integrated model.
- Implement shared care plans, shared EHRs and other technology to support integrated care.
- Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care models.
- Establish a performance-based payment model to incentivize progress and improvement.

Stage 2 – Implementation: Progress Measures

- Identify number of practices and providers implementing integrated evidence based approach(es)
- Identify number of practices and providers trained on evidence based practices: projected vs. actual and cumulative
- Begin pay for ***reporting*** of outcome metrics
- Primary care practices/providers achieve PCMH recognition
- Primary care providers achieve special recognitions/certifications/licensure (for medication-assisted treatment, such as buprenorphine administration, for example)

Stage 3 – Scale & Sustain: insert dates

- Increase adoption of the integrated evidence-based approach by additional providers/organizations.
- Identify new, additional target providers/organizations.
- Leverage regional champions and implement a train-the-trainer approach to support the spread of best practices.
- Maintain progress and improvements demonstrated in Stage 2, implement quality improvement processes to address areas where progress has not been demonstrated.
- Implement VBP strategies to support new integrated system of care.
- Complete contracting for fully integrated managed care.
- Fully implement payment mechanisms for integrated models across regional service area and phase introduction of new, advanced models following initial transition to integration.

Stage 3 – Scale & Sustain: Progress Measures

- Identify number of practices trained on selected evidence based practices: projected vs. actual

- Identify number of practices implementing evidence based practices
- Begin pay for *performance* of select outcome metrics
- Fully Implement fully integrated managed care

Project 2B: Community-Based Care Coordination *(Required)*
Rationale: Care coordination is essential for ensuring that children and adults with complex health service needs are connected to the evidence-based interventions and services that will improve their outcomes. Appropriately coordinated care is especially important for high-risk populations, such as those living with chronic conditions, persons facing unstable housing and/or food insecurity, the aging community, and those dependent on institutionalized housing. Communities are challenged to leverage and coordinate existing services, as well as establish new services to fill gaps. Without a centralized approach to "coordinating the coordinators", a single person might be assigned multiple care coordinators based on the specific needs that each care coordinator is addressing. A centralized approach also allows for standardization of evidence-based care coordination protocols across various providers of care coordination services, better positioning regions and groups of providers and payers to transition to value-based payment. This required project is an evidence-based model for establishing a Pathways Community HUB, a model for care coordination that includes adoption of standardized pathways, and establishment of centralized processes, systems, and resources to allow accountable tracking of those being served, and a method to tie care coordination work products or units to payments and to outcomes. The HUB leverages existing care coordination capacity, reduces the potential for duplication of efforts, and increases accountability. Alternatively, the ACH may establish a "HUB-like" centralized care coordination system that includes the core elements of the Pathways HUB model.
Target Population: Medicaid clients with one or more chronic disease or condition (such as, serious mental illness, moderate to severe substance use disorder, HIV, birth defects, cancer, diabetes, depression, heart disease and stroke) and at least one risk factor (i.e.: obesity, unstable housing, food insecurity, high EMS utilization).
Recommended Implementation Partners: Behavioral Health Providers, Primary Care Providers, Managed Care Organizations, Behavioral Health Organizations, Department of Social and Health Services, Criminal Justice, Law Enforcement, Hospitals, Long-Term Care, Care Management Agencies, Home Health, Housing, Emergency Medical Services, and other Community-Based Service Organizations.

System-wide Outcome Metrics
• Overuse Measures
    ○ Potentially Avoidable Emergency Department Visits*
    ○ Percent Homeless (Broad)
    ○ Percent Homeless (Narrow)

- o   Percent Employed (Medicaid)
- o   Home and Community Based Long Term Services and Supports Use

Project Outcome Metrics

In Stage 1 Planning, standardized pathways will be selected that meet the needs of the identified high-risk target populations, as identified in the Regional Health Needs Inventory. Measures, primarily drawn from the Common Measures Set, that tie to selected pathways are shown below. The actual pathways, and thus the outcome metrics, are dependent on the regional health needs inventory, but are likely to include those shown here.

Behavioral Health Pathway:

- Adult Mental Health Status*
- Follow-up After Hospitalization for Mental Illness (NQF#0576)*
- Follow-up After Discharge from ER for Mental Health, Alcohol or Other Drug Dependence (NQF#2605)*
- Mental Health Treatment Penetration (Broad Version)*
- Substance Use Disorder Treatment Prevention*
- Psychiatric Hospital Readmission Rate*
- Antidepressant Medication Management (NQF#0105)*

Immunization Pathways:

- Influenza Immunizations 6 months of age or older (NQF#0041)*
- Childhood Immunization Status (NQF#0038)*
- Immunization Status for Adolescents (NQF#1407)*
- Pneumonia Vaccination Status for Older Adults (NQF#0043)*
- HPV Immunizations – Adolescents (male and female)*

Medical Home Pathway:

- Physical Health Measures
  - o   Adult Access to Preventive/Ambulatory Care*
  - o   Child and Adolescents' Access to Primary Care Practitioners*
  - o   Well-Child Visits in the first 15 months of life (NQF#1392)**
  - o   Well-Child Visits 3 – 6 years of life (NQF#1516) *
  - o   Adolescent Well-Care Visits

- Patient Experience: C&G CAHPS V 3.0 (NQF#0005)* Questions:
  - Primary Care: Usual Source of Care (Q2)
  - Primary Care: Length of Relationship (Q3)
  - Getting Timely Appointments, Care and Information (Q6, 8, 10)

Medication Assessment & Management Pathways:
- Antidepressant Medication Management (NQF#0105)*
- Medication Management for People with Asthma (NQF#1799)*
- Medication Safety: Proportion of Days Covered Adherence to Prescribed Medications (3 types)*
  - Annual Monitoring for Patients Persistent Medications (Hypertension Medications) (NQF#2371)*

Smoking Cessation Pathway:
- Adult Tobacco Use*
- Medical Assistance with Smoking and Tobacco Use Cessation (NQF#0027)*

Evidence-based Approach:

Pathways Community HUB https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf

Additional Resources:

Northwest Ohio Pathways HUB http://www.hcno.org/health-improvement-initiatives/pathways.html

Pathways Community HUB Certification Program https://pchcp.rockvilleinstitute.org/

Project Implementation Stages

Stage 1 – Planning: *insert dates*

Prepare for implementation of the Pathways Community HUB model, or similar approach. Each region may establish a HUB. Planning steps include the Phase 1 "Planning a HUB" elements specified by AHRQ. Rely on the needs identified in the Regional Health Needs Inventory to guide HUB development. Throughout this document, the term "HUB" is used to refer to both a Pathways Community HUB or a similar approach. Regardless of whether the ACH intends to establish HUBs that achieve certification under the Pathways Community Hub model, or implement a similar model without certification, the core components of the planning phase are:

Assess the current state of capacity to effectively deliver community-based care coordination in the following areas; include strategies within the system wide plan completed within Domain 1 for:

- o Population Health Management/HIT: Describe the ways in which EHRs and other technologies are currently used in processes for identifying high-risk populations, linking to services, tracking clients through care coordination processes, and documenting the outcomes of such processes. Include systems that support: bi-directional communication and data sharing, timely communication among care team members, care coordination processes, and information to enable population health management and quality improvement processes.; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- o Workforce: capacity and shortages for workforce to implement the HUB and the selected care coordination pathways; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:
  - Shortage of Community Health Workers, Patient Navigators, other care coordination providers; take into account the full range of care coordination resources in the health care system, including those housed in patient-centered medical homes, health homes, behavioral health organizations, and other community-based service organizations
  - Access to specialty care, opportunities for telehealth integration;
  - Workflow changes to support integration of care coordination processes and communications
  - Training and technical assistance to ensure effective referral structures and prepared, proactive community partners; and to address cultural and linguistic competency, health literacy needs.
- o Financial Sustainability: alignment between current payment structures and guideline-concordant care, inclusive of community-based services; assessment of current payment models for supporting care coordination; incorporate current state and anticipated future state of Value Based Payment arrangements to support care coordination efforts into the regional VBP transition plan.

Determine legal structure and HUB leadership:
- Establish HUB planning group, including payers.
- Review national HUB standards and provide training on the HUB model to all stakeholders.
- Designate an existing agency (a legal entity) or create a new umbrella organization to serve as the HUB lead.

Engage Partners / Fill Gaps:
- Identify, recruit, and secure formal commitments for participation from all implementation partners, including patient-centered medical homes, health homes, care coordination service providers and other community-based service organizations, with a written agreement specific to the role each will perform in the HUB.
- Determine how to fill gaps in resources, including augmenting resources within existing organizations and/or hiring at the HUB centralized level.

Develop HUB Implementation Plan:

- The HUB Implementation Plan will include, at minimum:
  - A list of the selected standardized pathways for the first phase of implementation, and explanation of how they align with the high-priority regional health needs identified in the inventory; examples include Behavioral Health Pathway, Medical Home Pathway, Social Services Referral Pathway, Housing Pathway, etc. If implementing a HUB-like approach, provide a description of the evidence-based care coordination approach that will be adopted as standard care coordination practice for specific risk factors;
  - Description of how the pathways will be implemented to leverage or enhance related initiatives, and avoid duplication of efforts;
  - Plan for establishing the HUB Operations Manual, which must include methods for training, case assignment and caseload monitoring, HIPPA compliance plan, and methods for tracking and documenting services provided;
  - Plan for establishing the HUB Quality Improvement Program;
  - Implementation Timeline; Roles and responsibilities of HUB implementation partners, including payer organizations; and
  - HUB Sustainability plan, including plan to increase scale and scope (adding new pathways), and secure financial support from multiple payers.

Stage 1 – Planning: Progress Measures

- Obtain binding letter of intent from HUB lead entity
- List implementation partners with formal written commitment to participate
- Complete Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2B efforts
- Complete HUB Implementation Plan

Stage 2 – Implementation: *insert dates*

- Complete the HUB Operations Manual and the HUB Quality Improvement Plan.
- Develop and adopt related policies and procedures.
- Implement the Phase 2 (Creating tools and resources) and 3 (Launching the HUB) elements specified by AHRQ:
  - Create and implement checklists and related documents for care coordinators;
  - Implement the selected standardized pathways from the Pathways Community HUB Certification Program or implement care coordination evidence-based protocols adopted as standard under a HUB-like approach;
  - Develop systems to track and evaluate performance;
  - Hire and train HUB staff;
  - Train care coordinator and other staff at participating partner agencies; and
  - Conduct a community awareness campaign.

Stage 2 – Implementation: Progress Measures
• Complete HUB Operations Manual
• Complete HUB Quality Improvement Plan
• List policies and procedures in place
• Identify number of partners participating in the HUB and number implementing each selected pathway
• Identify number of partners trained on each selected pathway: projected vs. actual and cumulative
• Begin pay for *reporting* of outcome metrics

Stage 3 – Scale & Sustain: insert dates
• Recruit additional community-based service organizations and other partners to participate in the HUB.
• Implement additional standardized pathways.
• Employ continuous quality improvement methods to refine pathways.
• Provide on-going supports (e.g., training, technical assistance, learning collaboratives) to support HUB model and selected pathways.
• Develop payment models to support care coordination pathways.
• Implement Value-based Payment strategies to support the HUB care coordination pathways.

Stage 3 – Scale & Sustain: Progress Measures
• Identify number of partners participating in the HUB and number implementing each selected pathway
• Identify number of partners trained on each selected pathway: projected vs. actual and cumulative
• Begin pay for *performance* of select outcome metrics

Project 2C: Transitional Care *(Optional)*
Rationale: Transitional care services provide opportunities to eliminate avoidable admissions and readmissions. Points of transition out of intensive services/settings and into the community are critical intervention points in the care continuum. While some readmissions are appropriate, many are due to potentially avoidable events. Individuals discharged from intensive settings may not have a stable environment to return to or may lack access to reliable care. Transitions can be especially difficult on clients and caregivers when there are substantial changes in medications or routines or an increase in care tasks. One population particularly at-risk for disruptions in care and barriers to (re)engaging with care are people incarcerated in prison or jail. This project includes multiple care management and transitional care approaches from which the ACH will select at least one.
Target Population: Medicaid clients in transition from intensive settings of care or institutional settings, including clients discharged from acute care to home or to supportive housing, and clients with SMI discharged from inpatient care, or client returning to the community from prison or jail.

Recommended Implementation Partners: Behavioral Health Providers, Primary Care Providers, Managed Care Organizations, Behavioral Health Organizations, Department of Social and Health Services, Hospitals, Long-Term Care, Care Management Agencies, Home Health, Housing, Emergency Medical Services, and other Community-Based Service Organizations (particularly those working in prison and jail reentry both independent of or in coordination with local reentry councils and committees).

System-wide Outcome Metrics:
- Behavioral Health Measures
  - Psychiatric Hospital Readmission Rate*
  - Potentially Avoidable ED Visits*
  - Plan All-Cause Readmission Rate (NQF#1768)*
- Housing Measures
  - Percent Homeless (Broad Definition)
  - Percent Homeless (Narrow Definition)

Project Outcome Metrics:
- Behavioral Health Measures
  - Follow-up After Hospitalization for Mental Illness (NQF#0576)*
  - Follow-up After Discharge from ER for Mental Health, Alcohol or other Drug Dependence (NQF#2605)*
- Patient Experience: HCAHPS Questions (NQF#0166*):
  - Communication about Medicines Composite (Q16, Q17)
  - Discharge Information Composite (Q19, Q20)
  - Care Transitions Measure (Q23, Q24, Q25)

Evidence-based Approaches for Care Management and Transitional Care: (MUST SELECT AT LEAST ONE OF THE FOLLOWING)

1. Interventions to Reduce Acute Care Transfers, INTERACT™4.0, http://www.interactteam.org/interact/ - a quality improvement program that focuses on the management of acute change in resident condition

2. Transitional Care Model (TCM), http://www.transitionalcare.info/about-tcm - a nurse led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up

3. The Care Transitions Intervention® (CTI®), http://caretransitions.org/ - a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives. *Note: The Care Transitions Intervention® is also known as the Skill Transfer Model™, the Coleman Transitions Intervention Model®, and the Coleman Model®.*

4. Care Transitions Interventions in Mental Health, http://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf - provides a set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness (SMI)

Evidence-informed Approaches to transitional care for people with health and behavioral health needs leaving incarceration

Despite the relative dearth of specific, outcomes-focus research on effective integrated health and behavioral health programs for people leaving incarceration, considerable evidence on effective integrated care models, prison/jail reentry, and transitional programming has paved the way for increased understanding on critical components of an integrated transitional care approach. Refer to the following:

- *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison*, https://csgjusticecenter.org/wp-content/uploads/2013/12/Guidelines-for-Successful-Transition.pdf
- *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model*, http://www.prainc.com/wp-content/uploads/2015/10/best-practice-approach-community-re-entry-inmates-co-occurring-disorders.pdf
- *American Association of Community Psychiatrists' Principles for Managing Transitions in Behavioral Health Services*, http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.55.11.1271

Project Implementation Stages

Stage 1 – Planning: *insert dates*

Assess the current state of capacity to effectively deliver care transition services in the following areas; include strategies within the system wide plan completed within Domain 1 for:

o Population Health Management/HIT: current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.

o Workforce: capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:

- Shortage of Community Health Workers, Social Workers, Home Healthcare Providers, Mental Health Providers, Care Coordinators and Care Managers; take into account the full range of care coordination resources in the health care system, including those housed in patient-centered medical homes, health homes, behavioral health organizations, and other community-based service organizations

- Workflow changes to support integration of care transition processes and communications

- ▪ Training and technical assistance to ensure effective referral structures and prepared, proactive community partners; and to address cultural and linguistic competency, health literacy needs.
  - ▪ Specialized training needs to complete certifications requirements of selected approach (if applicable)
- o <u>Financial Sustainability</u>: alignment between current payment structures and care transition services, inclusive of community-based services; incorporate current state and anticipated future state of Value Based Payment arrangements to support new and/or expanded care transition and supportive efforts into the regional VBP transition plan

Plan for implementation of the selected evidence-based approach(es).

- Utilize the Regional Health Needs Inventory to guide selection of target population and evidence-based approach(es).
  - o For projects targeting people transitioning from incarceration: work with criminal justice partners to use health and behavioral health screening and assessments, as well as risk of recidivism assessments to further identify appropriate target population.
- Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.
  - o For projects targeting people transitioning from incarceration: identify and secure formal partnerships with relevant criminal justice agencies (including but not limited to correctional health, local releasing and community supervision authorities), health care and behavioral health care service providers, and reentry-involved community-based organizations.
- For each selected approach, develop a project implementation plan that includes, at minimum:
  - o The selected evidence-based approach and description of the target population, including justification for how the approach is responsive to the specific needs in the region as documented in the regional health needs inventory performed under Project 2B;
  - o List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely fashion;
  - o Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts, consider Health Home and other care management or case management services, including those provided through the Department of Corrections;
  - o Implementation timeline;
  - o Roles and responsibilities of partners; and
  - o For projects targeting people transitioning from incarceration, include in the plan at a minimum:

- - Process for identifying (1) individuals who are covered under Medicaid *and* whose benefits will not be terminated as a result of incarceration; (2) individuals whose Medicaid eligibility will terminate as a result of incarceration; (3) individuals who will likely be Medicaid eligible at release regardless of current or prior beneficiary status;
  - Process for completing and submitting Medicaid applications for individuals (2) and (3) above, timed appropriately such that their status moves from *suspended* to *active* at release;
  - Processes for beginning care planning and transition planning prior to release.

Stage 1 – Planning: Progress Measures

- Select evidence-based approach(es), and for each:
  - Complete Project Implementation Plan
  - List implementation partners with formal written commitment to participate in the project
  - List committed Managed Care Organization(s) and Behavioral Health Organization(s) as appropriate to selected approach(es)
- Complete Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2B efforts.

Stage 2 – Implementation: *insert dates*

Interventions to Reduce Acute Care Transfers, INTERACT™4.0

The skilled nursing facility (SNF) and the project implementation team will utilize INTERACT 4.0 toolkit and resources and implement the following core components:

- Educate leadership in the INTERACT principles.
- Identify a facility champion who can engage other staff and serve as a coach.
- Develop care pathways and other clinical tools for monitoring patients that lead to early identification of potential instability and allow intervention to avoid hospital transfer.
- Provide all staff with education and training to fill their role in the INTERACT model.
- Educate patients and families and provide support that facilitates their active participation in care planning.
- Establish enhanced communication with acute care hospitals, relying on technology where appropriate.
- Establish quality improvement process, including root cause analysis of transfers and identification and testing of interventions.
- Demonstrate cultural competence and client engagement in the design and implementation of the project.

Transitional Care Model (TCM)

Implement the essential elements of the TCM model:

- Use of advanced knowledge and skills by a transitional care nurse (TCN) to deliver and coordinate care of high risk older adults *within* and *across* all healthcare settings. The TCN is primary coordinator of care throughout potential or actual episodes of acute illness;
- Comprehensive, holistic assessment of each older adult's priority needs, goals and preferences;
- Collaboration with older adults, family caregivers and team members in implementation of a streamlined, evidenced-based plan of care designed to promote positive health and cost outcomes;
- Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months;
- Continuity of healthcare between hospital, post-acute and primary care clinicians facilitated by the TCN accompanying patients to visits to prevent or follow-up on an acute illness care management;
- Active engagement of patients and family caregivers with a focus on meeting their goals;
- Emphasis on patients' early identification and response to health care risks and symptoms to achieve *longer term* positive outcomes and avoid adverse and untoward events that lead to acute care service use (e.g., emergency department visits, rehospitalizations);
- Multidisciplinary approach that includes the patient, family caregivers and health care providers as members of a team;
- Strong collaboration and communication between older adults, family caregivers and health care team members across episodes of acute care and in planning for future transitions (e.g., palliative care); and
- Ongoing investment in optimizing transitional care via performance monitoring and improvement.

Care Transitions Intervention®
- A meeting with a Transitions Coach® in the hospital (where possible—this is desirable but not essential) to discuss concerns and to engage patients and their family caregivers.
- Set up the Transitions Coach® in home follow-up visit and accompanying phone calls designed to increase self-management skills, personal goal attainment and provide continuity across the transition.

Care Transitions Interventions in Mental Health
Adapt the following components, as proposed by Viggiano et al., of care transitions interventions to focus on points of transition for the SMI population, including discharge from intensive behavioral health care, and discharge from ER for mental health, alcohol, or other drug dependence. (http://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf)
- Prospective modeling: employ prospective modeling to identify who is at greatest risk. Consider different patterns of morbid conditions within and among mental illnesses, substance abuse disorders and general medical/surgical conditions that might require modifications.

- Patient and family engagement: create culturally competent engagement strategies to drive authentic inclusion of patient and/or family in treatment/transitional care plan. Adapt engagement strategies for individuals with SMI.
- Transition planning: establish an appropriate client specific plan for transition to the next point of care. Consider how to utilize step-down mental health services, such as day treatment and intensive outpatient care. Consider trade-offs between length of stay for stabilization and risk of re-hospitalization. Include assessment of need of primary care planning as well as substance abuse and dual disorders. An assessment and specific plan for housing and other social services should be included.
- Care pathways: establish specific clinical/procedural guidelines and instructions; link with national guidelines. Consider predeveloped pathways for certain categories of patients and clinical pathways customized to the local environment.
- Information transfer/personal health record: ensure all information is communicated, understood, and managed, and links patients, caregivers, and providers. Establish protocols to ensure privacy and other regulations are followed. Establish pathways for information flow among providers and clinics.
- Transition coaches/agents: define transition coach role, tasks, competencies, training and supervision requirements. Consider the need for mental health providers, such as social workers, to serve as transition agents or to train other personnel in mental health tools and techniques. Consider use of health information technology to augment/assist coaches.
- Provider engagement: providers at each level of care should have clear responsibility and plan for implementing all transition procedures/interventions. Communication and hand-off arrangements should be pre-specified in a formal way.
- Quality metrics and feedback: gather metrics on follow-up post-hospitalization, re-hospitalization and other feedback on process and outcomes and consumer/family perspective. Utilize metrics in quality improvement and accountability.
- Shared accountability: all providers share in expectations for quality as well as rewards/penalties. Accountability mechanisms may include financial mechanisms and public reporting with regard to quality and value. Consumers/families share in accountability as well.

For projects targeting people returning to the community from incarceration:
- Process for completing and submitting applications for Medicaid eligible or likely-Medicaid eligible, such that status will move from *suspended* to *active* at release *or* so the supervising facility can admit individuals non-public care entities for 24 hours or more for Medicaid reimbursable services.
- Process for triaging transitional care and care planning for individuals with the greatest health and behavioral health need in addition to greatest risk of recidivism

For all approaches, implementation must include the following core components:

- Establish guidelines, policies, protocols, and/or procedures as necessary to support consistent implementation of the model.
- Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.
- Implement robust bi-directional communication strategies, ensure care team members, including client and family/caregivers, have access to the care plan.
- Establish mechanisms for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs.
- Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes.
- Establish a performance-based payment model to incentivize progress and improvement.

Stage 2 – Implementation: Progress Measures

- Adopt guidelines, policies, protocols, and/or procedures, specific to the selected approach
- Identify number of partners and providers implementing evidence based approach(es)
- Identify number of partners and providers trained on evidence based approach: projected vs. actual and cumulative
- Begin pay for *reporting* of outcome metrics

Stage 3 – Scale & Sustain: insert dates

- Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities.
- Employ continuous quality improvement methods to refine the model.
- Provide on-going supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.
- Develop payment models to support care transitions approaches.
- Implement VBP strategies to support transitional care.

Stage 3 – Scale & Sustain: Progress Measures

- Identify number of partners participating in the care transition program
- Identify number of partners trained on the approach: projected vs. actual and cumulative
- Begin pay for *performance* of select outcome metrics

Project 2D: Diversion Interventions *(Optional)*
Rationale: Diversion strategies provide opportunities to re-direct individuals away from high-cost medical and legal avenues and into community-based health care and social services that can offer comprehensive assessment, care/case planning, and management to lead to more positive outcomes. Two types of diversion are provided under Project 2D: diversion at the point of Emergency Department (ED) presentation for a non-acute condition, and law enforcement assisted diversion (LEAD), a pre-booking approach to redirect low-level offenders engaged in drug or prostitution activity to community-based services, instead of jail and prosecution.
Target Population: Medicaid clients presenting at the ED for non-acute conditions, and Medicaid clients with mental health and/or substance use conditions coming into contact with law enforcement.
Recommended Implementation Partners: Behavioral Health Providers, Managed Care Organizations, Department of Social and Health Services, Housing, Criminal Justice, Law Enforcement, Emergency Departments, Care Coordination, Case Management and other Community-Based Service Organizations.
System-wide Outcome Metrics • Overuse Measures   o Potentially Avoidable ED Use*
Project Outcome Metrics o Adult Access to Preventive/Ambulatory Care* o Percent Homeless (Broad Definition) o Percent Homeless (Narrow Definition) o Percent Arrested
Evidence-based Diversion Approaches: (Optional, may select one or both approaches) 1. Emergency Department (ED) Diversion, http://www.wsha.org/quality-safety/projects/er-is-for-emergencies/, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4038086/ - a systematic approach to re-directing and managing clients who present at the ED for non-emergency conditions. 2. Law Enforcement Assisted Diversion, LEAD http://www.leadbureau.org/ - is a community-based diversion approach with the goals of improving public safety and public order, and reducing the criminal behavior of people who participate in the program.

Project Implementation Stages
Stage 1 – Planning: *insert dates*

Assess the current state of capacity to effectively deliver diversion interventions in the following areas; include strategies within the system wide plan completed within Domain 1 for:

- o Population Health Management/HIT: current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- o Workforce: capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:
  - Shortage of Community Health Workers, Social Workers, Mental Health Providers, Substance Abuse Disorder Providers
  - Law enforcement willingness and preparedness to engage
  - Training and technical assistance to ensure effective referral structures and prepared, proactive community partners; and to address Cultural and linguistic competency, health literacy needs.
  - Specialized training needs to complete certifications requirements of selected approach (if applicable)
- o Financial Sustainability: alignment between current payment structures to support diversion interventions; incorporate current state and anticipated future state of Value Based Payment arrangements to support new or expanded servivers and supportive efforts into the regional VBP transition plan

Plan for implementation of the selected evidence-based approach(es).

- Utilize the Regional Health Needs Inventory to guide planning, including identification of priority communities and partners for implementation.
- In the case of LEAD: establish a community advisory group that includes representation from community members, health care and social services, law enforcement and community public safety leaders.
- In the case of ED Diversion: identify, recruit, and secure formal commitments for participation from implementation partners including hospitals and primary care, via a written agreement and the specific role the organization and/or provider will perform in the selected approach.
- For each selected approach, develop a project implementation plan that includes, at minimum:
  - o A description of the target communities and populations, including the rationale for selecting them based on the regional health needs inventory performed under Project 2B;

- o List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely fashion;
- o Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts. In the case of ED Diversion, explain how the project will build on the Washington State Hospital Association's "ER is for Emergencies" and "Seven Best Practices" initiatives;
- o Implementation timeline; and
- o Roles and responsibilities of partners.

Stage 1 – Planning: Progress Measures

- Select evidence-based approach(es), and for each:
  - o Complete Project Implementation Plan
  - o For LEAD: list Community Advisory Group members
  - o List implementation partners with formal written commitment to participate in the project
  - o List committed Managed Care Organization(s) and as appropriate to selected approach(es)
- Complete Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2D efforts

Stage 2 – Implementation: *insert dates*

Law Enforcement Assisted Diversion (LEAD®)

Review resources and assistance available from the LEAD National Support Bureau. Many components of LEAD® can be adapted to fit local needs and circumstances, however, the following core principles must be built into the implementation:

- Establish the LEAD program as a voluntary agreement among independent decision-makers.
- Engage law enforcement and generate buy-in, including obtaining Commander level support.
- Identify a dedicated project manager.
- Tailor the LEAD intervention to the community.
- Provide intensive case management – to link diverted individuals to housing, vocational and educational opportunities, treatment, and community services. Participants may need access to medication-assisted therapy and other drug treatment options; they may also need access to food, housing, legal advocacy, job training, and other services.
  - o Apply a harm reduction/housing first approach – develop individual plans that address the problematic behavior as well as the factors driving that behavior.
  - o Consider the use of peer supports.
- Provide training in the areas of trauma-informed care and cultural competencies.

- Prepare an evaluation plan.

ED Diversion

There is no single model for effective ED Diversion, a variety of examples can be found that share common elements. The following elements must be reflected in the implementation, unless noted otherwise:

- ED will establish linkages to community primary care provider(s) in order to connect clients without a primary care provider to one, or for the purpose of notifying the current primary care provider of the ED presentation and coordinating a care plan. Where available, care coordinators can facilitate this process.
- ED will establish policies and procedures for identifying clients with minor illnesses who do not have a primary care provider and after completing appropriate screenings validating a non-emergency need, assist the patient in receiving a timely appointment with a primary care provider.
- Optional: first responders, ED, and primary care providers may collaborate to develop protocols that are followed under the supervision of ED practitioners, which may include transporting clients with non-emergency needs to alternate (non-ED) care sites, such a patient-centered medical homes.

For both approaches, implementation must include the following core components:

- Establish guidelines, policies, protocols, and/or procedures as necessary to support consistent implementation of the model.
- Ensure each participating partners are provided with, or have access to, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.
- Implement robust bi-directional communication strategies, ensure team members, including client, have access to the information appropriate to their role in the team.
- Establish mechanisms for coordinating care management plans with related community-based services and supports such as those provided through supported housing programs.
- Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes.
- Establish a performance-based payment model to incentivize progress and improvement.

Stage 2 – Implementation: Progress Measures
• Adopt guidelines, policies, protocols, and/or procedures, specific to the selected approach
• Identify number of partners and providers implementing evidence based approach(es)
• Identify number of partners and providers trained on evidence based approach: projected vs. actual and cumulative
• Begin pay for *reporting* of outcome metrics

Stage 3 – Scale & Sustain: insert dates
• Expand the model to additional communities and/or partner organizations.
• Employ continuous quality improvement methods to refine the approach.
• Provide on-going supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion efforts.
• Develop payment models to support diversion strategies.
• Implement VBP strategies to support the diversion activities.

Stage 3 – Scale & Sustain: Progress Measures
• Identify number of partners participating in the HUB and implementing selected pathways
• Identify number of partners trained on selected pathways: projected vs. actual and cumulative
• Begin pay for *performance* of select outcome metrics

Domain 3: Health Equity through Prevention and Health Promotion

Transformation projects within this domain focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations. Domain 3 includes three optional projects and one required project. ACH will be required to implement at least two Domain 3 projects in total.

Project 3A: Health Equity through Chronic Disease Prevention and Control (*Optional*)

Rationale: Chronic health conditions are prevalent among Washington's Medicaid clients, and the number of individuals with or at risk for chronic disease is increasing. Disease prevention and effective management is critical to individuals' quality of life and longevity. Many individuals face cultural, linguistic and health literacy barriers to accessing quality care, navigating the health care system, and understanding how to take steps to improve their health. Improving health care services and health behaviors is only part of the solution. Washington State recognizes the impact that factors outside the health care system have on health and is committed to a "health in all policies" approach to effective health promotion and improved treatment of disease. The Chronic Disease Prevention and Control Project focuses on integrating health system and community approaches improve chronic disease management and control. The Chronic Care Model is the single evidence-based approach to be tailored by the ACH to address specific populations and disease categories. This single change model is applicable to most preventive and chronic care issues, and once applied to implement system changes, "paves the way for new guidelines or innovation" (www.improvingchroniccare.org).

Target Populations: Medicaid clients (children and adults) with, or at risk for, asthma, diabetes, heart disease, and/or at risk for obesity, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.

Target Participating Providers: Behavioral Health Providers, Primary Care Providers, Managed Care Organizations, Department of Social and Health Services, Hospitals, Long-Term Care, Community Based Organizations, Home Health, School Health Services and Human Service Agencies.

System-wide Outcome Metrics:
- Ambulatory Care - Emergency Department Visits per 1,000 Member Months*
- Potentially Avoidable ED Visits*
- Clinician & Group CAHPS v3.0 (NQF#0005)*
- Prevention Quality Indicator # 1 (Diabetes Short Term Complication Admissions Rate) (NQF#0272)
- Prevention Quality Indicator # 7 (Hypertension) (NQF#0276)
- Prevention Quality Indicator # 8 (Heart Failure Admission Rate) (NQF#0277)
- Pediatric Quality Indicator # 14 Pediatric Asthma (NQF#0728)
- Prevention Quality Indicator # 15 Younger Adult Asthma (NQF#0283)
- Prevention Quality Indicator # 90 Overall Composite
- Pediatric Quality Indicator #90 Overall Composite

Project Outcome Metrics:

• Well Child Visits in the First 15 Months of Life (NQF#1392)*

• Well Child Visits Ages 3-6 (NQF#1516)*

• Controlling High Blood Pressure (NQF#0018)*

• Statin Therapy for Patients with Cardiovascular Conditions*

• Medical Assistance with Smoking and Tobacco Use Cessation (NQF#0027)*

• Influenza Immunizations 6 months of age and older (NQF#0041)*

• Health Literacy (C&G CAHPS Supplement QHL13, 14, and 16) (NQF#1902)

• Comprehensive Diabetes screening – All Three Tests (a composite of 3 measures on the Common Measure Set: HbA1c, dilated eye exam, and medical attention for nephropathy)

• Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (NQF#0059)*

• Asthma Medication Ratio (5 – 64 Years) (NQF#1800)

• Medication Management for People with Asthma (5 – 64 Years) – 75% of Treatment Days Covered (1799)*

• Child and Adolescents' Access to Primary Care Practitioners *Adult Access to Preventive/Ambulatory Car*e Adult Body Mass Index Assessment (NQF#0023)*

• Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (NQF#0024)*

Evidence-based Approach: Chronic Care Model (www.improvingchroniccare.org)

Additional Resources:

Guidelines for the Diagnosis and Management of Asthma (EPR-3) (http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines)

JNC 8 Guidelines for the Management of Hypertension in Adults (http://www.aafp.org/afp/2014/1001/p503.html)

American Diabetes Association Standards of Medical Care in Diabetes – 2016 (http://professional.diabetes.org/CONTENT/CLINICAL-PRACTICE-RECOMMENDATIONS%20)

The Community Guide (https://www.thecommunityguide.org/)

Million Hearts Campaign (http://millionhearts.hhs.gov)

Stanford Chronic Disease Self-Management Program (http://patienteducation.stanford.edu/programs/cdsmp.html)

CDC-recognized National Diabetes Prevention Programs (NDPP) (http://www.cdc.gov/diabetes/prevention/index.html)

Project Implementation Stages
Stage 1 – Planning: *insert dates*

ACH will guide and support implementation of evidence-based guidelines and best practices for chronic disease care and management using the Chronic Care Model approach to improve asthma, diabetes, and/or heart disease control and address obesity in their region.

Planning steps will include:

- Select specific target population(s), guided by disease burden and overall Regional Health Needs Inventory findings, ACH will identify the population demographic and disease area(s) of focus (for example: children age 0-17 with asthma, adults ages 18-64 with or at risk for diabetes), ensuring focus on population(s) experiencing the highest level of disease burden.

- Identify, recruit, and secure formal commitments for participation from all implementation partners, including healthcare providers (must include primary care providers) and relevant community-based service organizations. Form partnerships with community organizations to support and develop interventions that fill gaps in needed services. (www.improvingchroniccare.org).

- Assess the current state of capacity to effectively impact chronic disease control in the following areas; include strategies within the system wide plan completed within Domain 1 for:

  o Population Health Management/HIT: current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable chronic disease population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.

  o Workforce: capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:

    ▪ Shortage of Community Health Workers, Certified Asthma Educators, Certified Diabetes Educators, Home Healthcare Providers;

    ▪ Access to specialty care, opportunities for telehealth integration;

    ▪ Workflow changes to support Registered Nurses and other clinical staff to be working to the top of professional licensure; Training and technical assistance to ensure a "prepared, proactive practice team" and "prepared, proactive community partners;" and

    ▪ Cultural and linguistic competency, health literacy needs.

  o Financial Sustainability: alignment between current payment structures and guideline-concordant care, inclusive of community-based services (such as home-based asthma visits, Diabetes Self-Management Education, and home-based blood pressure monitoring); incorporate current state and anticipated future state of Value Based Payment arrangements to support chronic disease control efforts into the regional VBP

transition plan. Consider inclusion of the following within reimbursement models: bundled services, group visits, once-daily medication regimens, community-based self-management support services.

- Develop a disease/population-specific Chronic Care Implementation Plan that includes, at minimum:
  - o Implementation timelines;
  - o Roles and responsibilities of key organizational and provider participants, including community-based organizations;
  - o Description of how project aligns with related initiatives and avoids duplication of efforts;
  - o Specific change strategies to be implemented across elements of the Chronic Care Model:
    - **Self-Management Support** strategies and resources to "empower and prepare patients to manage their health and health care" (www.improvingchroniccare.org), such as: incorporate the 5As into regular care; complete and update Asthma Action Plans; provide access to Asthma Self-Management Education, Diabetes Self-Management Education, Stanford Chronic Disease Management Program; support home-based blood pressure monitoring; ensure cultural and linguistic appropriateness.
    - **Delivery System Design** strategies to support effective, efficient care, such as: implementing and supporting team-based care strategies, increasing the presence and clinical role of non-physician members of the care team; increasing frequency and improving processes of planned care visits and follow-up; referral processes to care management and specialty care.
    - **Decision Support** strategies to support clinical care that is consistent with scientific evidence and patient preference (www.improvingchroniccare.org), such as: development and/or provision of decision support tools (guideline summaries, flow sheets, etc); embed evidence-based guidelines and prompts into EHRs; provide education as needed on evidence-based guidelines via case-based learning, academic detailing or modeling by expert providers; establish collaborative management practices and communication with specialty providers; incorporate patient education and engagement strategies.
    - **Clinical Information Systems** strategies to organize patient and population data to facilitate efficient and effective care, such as: utilization of patient registries; automated appointment reminder systems; bi-directional data sharing and encounter alert systems; provider performance reporting.
    - **Community-based Resources and Policy** strategies to activate the community and increase community-based supports for disease management and prevention, such as: tobacco free policy expansion; tobacco cessation assistance; nutritional food access policies; National Diabetes Prevention Program, home-based and school-based asthma services, worksite nutritional and physical activity programs; behavioral screen time interventions
    - **Healthcare Organization** strategies that ensure high quality care, such as: engagement of executive and clinical leadership; support for quality improvement processes; shared learning structures; intersection with Care Coordination efforts; financial strategies to align payment with performance.

- Reference the following for disease/condition-specific recommended change strategies to include within Chronic Care Model approach:
  - The Community Guide (https://www.thecommunityguide.org/)
    - Asthma Home-based Multi-Trigger, Multi-Component Environmental interventions
    - Tobacco Use and Secondhand Smoke Exposure: Smoke-free Policies
    - Obesity: Behavioral Interventions that Aim to Reduce Recreational Sedentary Screen Time Among Children
    - Obesity: Technology-Supported Multicomponent Coaching or Counseling Interventions – To Reduce Weight
    - Obesity: Worksite Programs
    - Cardiovascular Disease: Interventions Engaging Community Health Workers
    - Cardiovascular Disease: Self-Measured Blood Pressure Monitoring Interventions for Improved Blood Pressure Control
    - Others
  - Million Hearts Campaign (http://millionhearts.hhs.gov)
  - Stanford Chronic Disease Self-Management Program (http://patienteducation.stanford.edu/programs/cdsmp.html)
  - CDC-recognized National Diabetes Prevention Programs (NDPP) (http://www.cdc.gov/diabetes/prevention/index.html)
  - Justification demonstrating that the selected strategies and the committed partner/providers are culturally relevant and responsive to the specific population health needs in the region; and
  - Strategies to identify and focus efforts in in high risk neighborhoods or geographic locations within the region, with attention to addressing health care disparities related to selected diseases.

Stage 1 – Planning: Progress Measures

- List implementation partners, inclusive of primary care providers and community-based service providers, with formal written commitment to participate
- Complete Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 3A efforts
- Complete Chronic Care Implementation Plan, to include identification of specific change strategies

Stage 2 – Implementation: *insert dates*

Implement Workforce, HIT, and Financial Sustainability strategies in support of this project according to Domain 1 implementation plan.

Convene partner-level, site-specific implementation teams, inclusive of: health care service providers, community-based service providers, executive and clinical leadership, consumer representatives; identify team leads and clinical champions. Continue to convene teams on a regular basis

throughout implementation phase to review and share across teams: change strategy implementation progress, progress and performance data, challenges, and successes.

Collect baseline progress and performance data for target population from participating health care providers. Prioritize Health Information Technology and Clinical Information System strategies to address gaps in available information. Engage and support project teams to collect and review practice/team-level progress and performance data at regular, frequent intervals with their team to assess progress and inform continued implementation and scaling of change strategies.

Implement disease/population-specific Chronic Care Implementation Plan for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/or improve:
- Self-Management Support;
- Delivery System Design;
- Decision Support;
- Clinical Information Systems;
- Community-based Resources and Policy; and
- Healthcare Organization.

Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data sharing strategies.

Employ rapid cycle improvement processes to refine changes strategies.

Develop a Scale and Spread Plan to disseminate and increase adoption of change strategies that result in improved care and health outcomes:
- Identify additional partner organizations and implementation sites.
- Define communication and learning processes; identify ACH and implementation team roles in these efforts.

Stage 2 – Implementation: Progress Measures
- Number and list engaged Implementation Team sites, members, and roles
- Identify number of new or expanded nationally recognized self-managed support programs, such as CDSMP and NDPP
- Identify number of home visits for asthma services, hypertension
- Identify percent of documented, up to date Asthma Action Plans

- Identify number of health care providers trained in appropriate blood pressure assessment practices
- Identify percent of patients provided with automated blood pressure monitoring equipment

Stage 3 – Scale & Sustain: *insert dates*

- Implement Scale and Spread Plan to increase scale, expand to serve additional high-risk populations, include additional providers and/or cover additional high needs geographic areas.
  - o Provide or support on-going training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies.
- Continue to employ continuous rapid cycle improvement processes/continuous quality improvement methods to refine change strategies and scale up implementation.
- Engage Managed Care Plans to develop/refine model benefits aligned with evidence-based clinical guideline-concordant care and best practice recommendations; Develop payment models to support Chronic Care Model approach to addressing disease and transition to Value-based Payment for services.

Stage 3 – Scale & Sustain: Progress Measures

- Identify number of partner organizations and implementation teams implementing the project
- Identify number of new or expanded nationally recognized self-managed support programs, such as CDSMP and NDPP
- Identify number of home visits for asthma services, hypertension
- Identify percent of documented, up to date Asthma Action Plans
- Identify number of health care providers trained in appropriate blood pressure assessment practices
- Identify percent of patients provided with automated blood pressure monitoring equipment
- Begin pay for ***performance*** of select outcome metrics

Project 3B: Maternal and Child Health (*Optional*)

Rationale: Maternal and child health is a primary focus for the Medicaid program since it funds more than half of the births in the state and provides coverage to more than half of Washington's children. Providing first-time low-income mothers and their children with nurse home visits has been demonstrated to improve maternal and child health. Nurse home visitors work with the client in supporting a healthy pregnancy, by recognizing and reducing risk factors and by promoting prenatal health care, healthy diet, exercise, stress management, and ongoing well-woman care. By applying trauma-informed approaches to care and strategies to prevent or mitigate the effects of adverse childhood experiences, communities can build healthier futures. Adverse childhood experiences (ACEs) are stressful or traumatic experiences, including abuse, neglect, and a range of household

dysfunction such as witnessing domestic violence, or growing up with substance abuse, mental illness, parental discord, or crime in the home. Research has shown such experiences are common, tend to occur in clusters, and are associated with numerous health, social, and behavioral problems throughout the lifespan, including substance use and abuse. The Substance Abuse and Mental Health Services Administration (SAMHSA) advises states and communities to implement "programs, policies, and strategies designed to address ACEs; including efforts focusing on reducing intergeneration transmission of ACEs". Two approaches offered under this project provide avenues for early identification of ACEs, and have the potential to reduce intergeneration transmission. First, the Nurse-Family Partnership provides first-time low-income mothers and their children with the support and guidance of a home visit nurse. Second, the Child FIRST program is a national, evidence-based, two-generation model that works with very vulnerable young children and families, providing intensive, home-based psychotherapeutic intervention for children (birth to 6 years) and families, including expectant mothers. The program seeks to prevent or reduce children's emotional, behavioral, developmental, and learning problems, and prevent or reduce abuse and neglect by their caregivers. A third option is to incorporate trauma-informed approaches to care into existing programs or settings of care. A trauma-informed approach is a set of principles, not a service model, that are generalizable across multiple types of settings.

Target Population: Medicaid clients who are Women of preconception age, Pregnant Women, Mothers of children ages 0-2, and children ages 0-17.

Recommended Implementation Partners: Primary Care Providers, Home Health, Pediatricians, Obstetricians and Gynecologists, Department of Social and Health Services, and Community-Based Service Organizations.

System-wide Outcome Metrics
- Unintended Pregnancies*
- Rate of Teen Pregnancy (15 – 19)
- Teen Births to Women Who Were Already Mothers
- Births to Single Teenage Mothers
- Children Who Have Experienced Two or More Adverse Experiences

Project Outcome Metrics
- Well Child Visits in the First 15 Months of Life (NQF#1392)*
- Well Child Visits Ages 3-6 (NQF#1516)*
- Lead Screening in Children*
- Chlamydia Screening in Women Ages 16 – 24 (NQF#0033)*
- Mental Health Service Penetration (for Children)*
- Substance Abuse Disorder Service Penetration (for Children)*
- Prenatal and Postpartum Care (NQF#1517)

- Frequency of Ongoing Prenatal Care (NQF#1391)

Evidence-based Approaches for Maternal and Child Health:

1. Nurse Family Partnership (NFP), http://www.nursefamilypartnership.org/communities/model-elements - provides first-time, low-income mothers and their children with nurse-led home-based support and care, and/or

2. Child FIRST (Child and Family Interagency, Resource, Support, and Training), http://www.childfirst.org/ - a home-based, psychotherapeutic intervention for children (birth to 6 years) and families, including expectant mothers. The program seeks to prevent or reduce children's emotional, behavioral, developmental, and learning problems, and prevent or reduce abuse and neglect by their caregivers, and/or

3. Recommendations to Improve Preconception Health and Health Care – United States, http://www.cdc.gov/MMWR/PDF/rr/rr5506.pdf, AND

4. Trauma-Informed Approaches to Care, http://www.samhsa.gov/nctic/trauma-interventions - a set of principles that can be applied to multiple services and/or settings of care

Additional Resources:

Child FIRST: http://nrepp.samhsa.gov/ProgramProfile.aspx?id=138#hide1

ACE (adverse childhood experiences) Prevention & Mitigation

http://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences

Project Implementation Stages

Stage 1 – Planning: *insert dates*

Plan for implementation of the selected evidence-based approach(es).

- Utilize the Regional Health Needs Inventory to guide selection of evidence-based approach(es) and specific target population(s).
- Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.
- For each selected approach, develop a project implementation plan that includes, at minimum:
  - The selected evidence-based approach(es) and description of the target population, including justification for how the approach is responsive to the specific needs in the region as documented in the Regional Health Needs Inventory;
  - List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely fashion;
  - Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts. Consider current implementation of Nurse Family Partnership Programs, and how they might be strengthened or expanded;
  - Implementation timeline; and

o   Roles and responsibilities of partners.

Child FIRST

If Child FIRST approach is selected, in addition to the planning steps shown above, planning a Child FIRST implementation begins with review of the national model and criteria provided by the Child FIRST National Planning Organization (NPO). The NPO provides all policies, system development, and technical assistance to Child First affiliate agencies to ensure fidelity to the model. Planning will include:

- Identify the State Lead Agency;
- Determine lead affiliate agencies at the local level; and
- Establish local Child FIRST Advisory Boards.

Stage 1 – Planning: Progress Measures

- Selection of evidence-based approach(es), and for each:
  o   Complete Project Implementation Plan
  o   List implementation partners with formal written commitment to participate in the project
  o   List committed Managed Care Organization(s) as appropriate to selected approach(es)
- Complete Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 3B efforts.

Stage 2 – Implementation: *insert dates*

Nurse Family Partnership® (NFP)

Implementation must include the following elements, as specified by the NFP:

- Clients are first-time, low-income mothers who voluntarily participate;
- Enrollment is early in pregnancy, with first home visit no later than the end of week 28 of pregnancy;
- Client is visited one-to-one, one nurse home visitor to one first-time mother or family, in the client's home;
- Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current Nurse-Family Partnership guidelines;
- Nurse home visitors and nurse supervisors are registered professional nurses with a minimum of a baccalaureate degree in nursing;
- Nurse home visitors and nurse supervisors complete core educational sessions required by the Nurse-Family Partnership National Service Office and deliver the intervention with fidelity to the Nurse-Family Partnership model;
- Nurse home visitors, using professional knowledge, judgment, and skill, apply the Nurse-Family Partnership visit guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains;

- Nurse home visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology, and attachment theories, through current clinical methods;
- A full-time nurse home visitor carries a caseload of no more than 25 active clients;
- A full-time nurse supervisor provides supervision to no more than eight individual nurse home visitors;
- Nurse supervisors provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including one-to-one clinical supervision, case conferences, team meetings, and field supervision;
- Nurse home visitors and nurse supervisors collect data as specified by the Nurse-Family Partnership National Service Office and use Nurse-Family Partnership reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality, and demonstrate program fidelity;
- A Nurse-Family Partnership Implementing Agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families;
- A Nurse-Family Partnership Implementing Agency convenes a long-term community advisory board that meets at least quarterly to promote a community support system to the program and to promote program quality and sustainability; and
- Adequate support and structure shall be in place to support nurse home visitors and nurse supervisors to implement the program and to assure that data are accurately entered into the database in a timely manner.

Child FIRST
- Each affiliate designates or recruits a Child First Clinical Director/Supervisor and establishes clinical teams. Teams consist of a licensed, Master's level Mental Health/Developmental Clinician and Bachelor's level Care Coordinator, both with significant expertise with very young children and vulnerable families.
- Each team usually carries between 12 and 16 families, completing 12-14 home visits/week (will vary based on intensity of service need, success of planned visits, and travel time).
- Families receive visits twice per week during the assessment period (first month) and then once a week or more, depending on the needs of the child and family. After assessment, Clinicians and Care Coordinators may visit together or separately, based on the individual family needs. Visits last 1- 1.5 hours.
- Duration of services: Services generally continue for six to twelve months, but may be longer based on individual family needs.

The home-based intervention includes the core components:

- Engagement of the family – the team works to build trust and help the family define their own goals.
- Comprehensive assessment of child and family – team performs an assessment to understand the child's health and development, the child's important relationships with parents as well as other individuals who care for the child (e.g., early care providers), child trauma and other stressors (e.g., violence and separation), and the multiple challenges experienced by the parents that interfere with their ability to protect, nurture, and support their child's development. Assessment should include formal measures, conversations, observations, and records from other providers.
- Development of a child and family plan of care - consisting of comprehensive, well-coordinated, therapeutic intervention goals, supports, and services, developed in partnership with the parents or caregivers. This plan reflects the parents' goals, priorities, strengths, culture, and needs, and serves as the Medicaid-compliant treatment plan.
- Parent-child psychotherapeutic intervention – a highly individualized approach driven by the child and family's unique strengths, needs, and culture. The intervention is an intensive approach that blends parent guidance and dyadic, psychotherapeutic treatment.
- Enhancement of executive functioning – the team promotes self-regulation and executive functioning capacity through both the psychotherapeutic intervention and the development and execution of the service plan. The Team mentors caregivers so that they are able to thoughtfully focus attention, plan, organize, problem solve, and succeed, which in turn enables them to scaffold the development of executive functioning in their own children, which is essential to their children's educational success.
- Mental health consultation in early care and education – the Mental Health Clinician works with the early care and education environment to provide consultation to the teacher or caregiver. This is especially critical when there are challenging behaviors within the classroom. The Clinician conducts observations, discusses past and current behavior with the teacher, and helps the teacher understand the meaning of the child's behavior. Together they develop strategies that can meet the child's individual needs and coordinate efforts between early care and education and the home.
- Care coordination - The Care Coordinator facilitates the coordination of services and the family's access to multiple resources throughout the community, based on the collaborative planning with the parents.

Recommendations to Improve Preconception Health and Health Care

The CDC has provided 10 recommendations that aim to improve a woman's health before conception, whether before a first or a subsequent pregnancy. The recommendations fall into 10 areas 1) individual responsibility across the lifespan, 2) consumer awareness, 3) preventive visits 4) interventions for identified risks, 5) interconception care, 6) prepregnancy checkup, 7) health insurance coverage for women with low incomes, 8) public health programs and strategies, 9) research, and 10) monitoring improvements.

Washington has acted on these recommendations by providing insurance coverage (Take Charge, http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/apple-health-take-charge-family-planning) and grants (Personal Responsibility and Education Plan, http://www.doh.wa.gov/CommunityandEnvironment/Schools/PersonalResponsibilityandEducationPlan), and through other actions. This project builds on current efforts, and provides a mechanism for communities to further the implementation of the recommendations. The recommendations to be implemented as part of this project, at the regional level, and CDC's identified action steps, are:

1) Individual responsibility across the lifespan:
   o Develop, evaluate, and disseminate reproductive life planning tools for women and men in their childbearing years, respecting variations in age; literacy, including health literacy; and cultural/linguistic contexts.

2) Consumer awareness:
   o Develop, evaluate, and disseminate age-appropriate educational curricula and modules for use in school health education programs. Integrate reproductive health messages into existing health promotion campaigns (e.g., campaigns to reduce obesity and smoking).
   o Conduct consumer-focused research to identify terms that the public understands and to develop messages for promoting preconception health and reproductive awareness.
   o Design and conduct social marketing campaigns necessary to develop messages for promoting preconception health knowledge and attitudes, and behaviors among men and women of childbearing age.

3) Preventive visits:
   o Increase health provider awareness regarding the importance of addressing preconception health among all women of childbearing age. Develop and implement curricula on preconception care for use in clinical education at graduate, postgraduate, and continuing education levels.
   o Consolidate and disseminate existing professional guidelines to develop a recommended screening and health promotion package.
   o Develop, evaluate, and disseminate practical screening tools for primary care settings, with emphasis on the 10 areas for preconception risk assessment (e.g., reproductive history, genetic, and environmental risk factors).
   o Develop, evaluate, and disseminate evidence-based models for integrating components of preconception care to facilitate delivery of and demand for prevention and intervention services.
   o Apply quality improvement techniques (e.g., conduct rapid improvement cycles, establish benchmarks and brief provider training, use practice self-audits, and participate in quality improvement collaborative groups) to improve provider knowledge and attitudes, and practices and to reduce missed opportunities for screening and health promotion. Use the federally funded collaborative for community health centers and other Federally Qualified Health Centers to improve the quality of preconception risk assessment, health promotion, and interventions provided through primary care. Develop fiscal incentives for screening and health promotion.

4) Interventions for identified risks:
   o Increase health provider awareness concerning the importance of ongoing care for chronic conditions and intervention for identified risk factors.
   o Develop and implement modules on preconception care for specific clinical conditions for use in clinical education at graduate, postgraduate, and continuing education levels.
   o Consolidate and disseminate existing guidelines related to evidence-based interventions for conditions and risk factors. Disseminate existing evidence-based interventions that address risk factors that can be used in primary care settings (i.e., iotretinoins, alcohol misuse, antiepileptic drugs, diabetes [preconception], folic acid deficiency, hepatitis B, HIV/AIDS, hypothyroidism, maternal phenylketonurea [PKU], rubella seronegativity, obesity, oral anticoagulant, STD, and smoking).
   o Develop fiscal incentives (e.g., pay for performance) for risk management, particularly in managed care settings.
   o Apply quality improvement techniques and tools (e.g., conduct rapid improvement cycles, establish benchmarks, use practice self-audits, and participate in quality improvement collaborative groups).
5) Interconception care:
   o Monitor the percentage of women who complete postpartum visits (e.g. using the Health Employer Data and Information Set measures for managed care plans and Title V Maternal Child Health Block Grant state measures), and use these data to identify communities of women at risk and opportunities to improve provider follow-up.
   o Develop, evaluate, and replicate intensive evidence-based interconception care and care coordination models for women at high social and medical risk. Enhance the content of postpartum visits to promote interconception health.
   o Use existing public health programs serving women in the postpartum period to provide or link to interventions (e.g., family planning, home visiting, and the Special Supplemental Nutrition Program for Women, Infants, and Children).
6) Prepregnancy checkup:
   o Consolidate existing professional guidelines to develop the recommended content and approach for such a visit. Modify third party payer rules to permit payment for one prepregnancy visit per pregnancy, including development of billing and payment mechanisms.
   o Educate women and couples regarding the value and availability of prepregnancy planning visits

Trauma-informed Approaches to Care

A trauma-informed approach can be adopted by any program, organization, or system that:

- Realizes the widespread impact of trauma and understands potential paths for recovery;
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;

- Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively resist re-traumatization; and adheres to six key principles:
  - Safety;
  - Trustworthiness and Transparency;
  - Peer support;
  - Collaboration and mutuality;
  - Empowerment, voice and choice;
  - Cultural, Historical, and Gender Issues;

Implementation steps include:

- Provide training to health care providers, community-based service organizations, and other stakeholders on trauma-informed approaches to care; and
- Provide resources and tools for organizations to adopt a trauma-informed approach in their programs and/or settings of care.

For all approaches, implementation must include the following core components:

- Establish guidelines, policies, protocols, and/or procedures as necessary to support consistent implementation of the model.
- Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.
- Implement robust bi-directional communication strategies, ensure care team members, including client and family/caregivers, have access to the care plan.
- Establish mechanisms for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs.
- Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes.
- Establish a performance-based payment model to incentivize progress and improvement.

Stage 2 – Implementation: Progress Measures
• Adopt guidelines, policies, protocols, and/or procedures, specific to the selected approach
• Identify number of partners and providers implementing evidence based approach(es)
• Identify number of partners and providers trained on the evidence based approach: projected vs. actual and cumulative
• Begin pay for *reporting* of outcome metrics

Stage 3 – Scale & Sustain: *insert dates*
• Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities.
• Employ continuous quality improvement methods to refine the model.
• Provide on-going supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.
• Develop payment models to support care transitions approaches.
• Implement VBP strategies to support the program.

Stage 3 – Scale & Sustain: Progress Measures
• Identify number of partners participating in the care transition program
• Identify number of partners trained on the approach: projected vs. actual and cumulative
• Begin pay for *performance* of select outcome metrics

Project 3C: Access to Oral Health Services *(Optional)*
Rationale: Oral health impacts overall health and quality life, and most oral disease is preventable. Oral disease has been referred to as a "silent epidemic" and has been associated with increased risk for serious adverse health outcomes. Increasing access to oral health services for adults provides an opportunity to prevent or control the progression of oral disease, and to reduce reliance on emergency departments for oral pain and related conditions. While many initiatives have addressed the oral health needs of children, during crucial preventive windows, less attention has been paid to increasing access to oral health services for adults. This project focuses on providing oral health screening and assessment, intervention, and referral, in the primary care setting, or through the deployment of mobile clinics and/or portable equipment. Primary care providers and their teams have the skills, resources, tools, and scope of practice required to understand and intervene in the oral disease process. The project seeks to leverage the primary care workforce, and to strengthen relationships between primary care and dental providers, through stronger referral networks, improved communications, and shared incentives. The project builds on lessons learned from behavioral health and primary care integration, namely, that providers in historically siloed settings, can improve outcomes by relying on a framework that is combined with validated tools, well-designed workflows, and a structured referral process.

Target Population: All Medicaid clients, especially adults.
Recommended Implementation Partners: Primary Care Providers, Dentists, Hospitals, and Community-based Service Organizations.
System-wide Outcome Metrics • Overuse Measures   ○ Potentially Avoidable ED Visits*

Project Outcome Metrics
• Pediatric Measures
   ○ Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers (NQF#1419)*
• Adult Measures[i]
   ○ Periodontal Evaluation in Adults with Chronic Periodontitis
   ○ Ongoing Care in Adults with Chronic Periodontitis
   ○ Topical Fluoride Application for Adults at Elevated Caries Risk

Evidence-based Approaches for Access to Oral Health Services: 1. Oral Health in Primary Care, http://www.safetynetmedicalhome.org/sites/default/files/White-Paper-Oral-Health-Primary-Care.pdf - integrating oral health screening, assessment, intervention, and referral, into the primary care setting 2. Mobile/Portable Dental Care, http://www.mobile-portabledentalmanual.com/ – the national maternal and child health resource center provides a manual to guide planning and implementation of mobile dental units and portable dental care equipment for school-age children, which could be adapted for adults Additional Resources: https://www.ncbi.nlm.nih.gov/pubmed/11760318 http://www.nationaloralhealthconference.com/docs/presentations/2005/0501/mobiledentalclinics.PDF

Project Implementation Stages
Stage 1 – Planning: *insert dates*

Assess the current state of capacity to effectively impact access to oral health services in the following areas; include strategies within the system wide plan completed within Domain 1 for:

o   Population Health Management/HIT: current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.

o   Workforce: capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:

  ▪   Shortage of dentist, hygienist, and other dental care providers, and primary care providers;

  ▪   Access to periodontal services;

  ▪   Training and technical assistance to ensure cultural and linguistic competency, health literacy needs.

o   Financial Sustainability: alignment between current payment structures and integration of oral health services; incorporate current state and anticipated future state of Value Based Payment arrangements to support access to oral health efforts into the regional VBP transition plan.

Plan for implementation of the selected evidence-based approach(es).

•   Utilize the Regional Health Needs Inventory to identify communities or sub-regions with demonstrated shortages of dental providers or otherwise limited access to oral health services.

•   Identify, recruit, and secure formal commitments for participation from implementation partners, to include, at minimum, primary care providers and dentists, via a written agreement.

•   For each selected approach, develop a project implementation plan that includes, at minimum:

  o   The selected evidence-based approach and description of the target population, including justification for how the approach is responsive to the specific needs in the region as documented in the Regional Health Needs Inventory. Explain the combination of oral health services to meet the needs of the target population and how the approach addresses barriers to accessing oral health services Consider a phased approach, for example, by beginning to focus on adults with diabetes, or other chronic conditions, before adding additional populations.

- o List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely fashion; partner roles and responsibilities. Include dentists/dental practices and periodontists that will serve as referrals resources.
- o Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts, consider any current efforts to broaden oral health service delivery sites, and how they might be strengthened or expanded.
- o Implementation timeline.
- o For Oral Health in Primary Care, consider a phased approach to implementation, as follows:
  - ▪ Begin with screening patients for signs and symptoms of early disease and develop a structured referral process for dentistry;
  - ▪ Offer fluoride varnish for pediatric patients per the USPSTF61 and AAP guidelines; consider indications for fluoride varnish for high-risk adults;
  - ▪ Focus on patient/caregiver risk assessment and risk reduction through patient education, dietary counseling, and oral hygiene training;
  - ▪ Identify a particular high-risk patient population (e.g., adult patients with diabetes, pregnant women) and begin with a pilot before expanding population/practice wide; and
  - ▪ Articulate the activities in each phase, and the associated timeline.
- o For mobile/portable Dental Care:
  - ▪ Specify where the mobile units and/or portable equipment will be deployed. Consider locations where Medicaid beneficiaries access housing, transportation, or other community-based supports, as well as rural communities, migrant worker locations, and Native American reservations;
  - ▪ Secure commitments from potential sites and develop a list of potential future sites;
  - ▪ Specify the scope of services to be provided, hours of operation, and staffing plan;
  - ▪ Include steps to show how ACH will research, and comply with, laws, regulations, and codes that may impact the design or implementation of the mobile unit and/or portable equipment; and
- • Include the timeline for educating providers, clients, and communities about the new service.
  - o

Stage 1 – Planning: Progress Measures

- • Select evidence-based approach(es), and for each:
  - o Complete Project Implementation Plan
  - o List implementation partners with formal written commitment to participate in the project
    - ▪ For mobile/portable dental care, "partner" list must include locations/sites that commit to providing access to the mobile unit
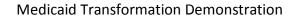
- o List committed Managed Care Organization(s) as appropriate to selected approach(es)
- Complete Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 3C efforts.

Stage 2 – Implementation: *insert dates*

Oral Health in Primary Care

- Establish and implement clinical guideline or protocol that incorporates the following five elements of the Oral Health Delivery Framework:
  - o Ask about symptoms that suggest oral disease and factors that place patients at increased risk for oral disease. Two or three simple questions can be asked to elicit symptoms of oral dryness, pain or bleeding in the mouth, oral hygiene and dietary habits, and length of time since the patient last saw a dentist. These questions can be asked verbally or included in a written health risk assessment.
  - o Look for signs that indicate oral health risk or active oral disease. Assess the adequacy of salivary flow; look for signs of poor oral hygiene, white spots or cavities, gum recession or periodontal inflammation; and conduct examination of the oral mucosa and tongue for signs of disease. During a well-visit or complete physical exam, this activity could be included as a component of the standard Head, Ears, Eyes, Neck, and Throat Exam (HEENT exam) resulting in a comprehensive assessment that includes the oral cavity—a "HEENOT" exam.
  - o Decide on the most appropriate response. Review information gathered and share results with patients and families. Determine a course of action using standardized criteria based on the answers to the screening and risk assessment questions; findings of the oral exam; and the values, preferences, and goals of the patient and family.
  - o Act by delivering preventive interventions and/or placing an order for a referral to a dentist or medical specialist. Preventive interventions delivered in the primary care setting may include: 1) changes in the medication list to protect the saliva, teeth, and gums; 2) fluoride therapy; 3) dietary counseling to protect the teeth and gums, and to promote glycemic control for patients with diabetes; 4) oral hygiene training; and, 5) therapy for tobacco, alcohol, or drug addiction.
  - o Document the findings as structured data to organize information for decision support, measure care processes, and monitor clinical outcomes so that quality of care can be managed. (Follow Up)
- Establish and implement workflows to operationalize the protocol, specifying which member of the care performs each function, inclusive of when referral to dentist or periodontist is needed.
- Ensure each member of the care team receives the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.
- Establish referral relationships with dentists and other specialists, such as ENTs and periodontists.
- Engage with payers in discussion of payment approaches to support the model.

Mobile and/or Portable Dental Care

Implementation will include the following core components:

- Establish guidelines, policies, protocols, and/or procedures as necessary to support the full scope of services being provided;
- Secure necessary permits and licenses required by the state or locality;
- Establish referral relationships with primary care providers, dental providers, and other specialists, e.g. ENTs and periodontists, as needed;
- Acquire mobile unit and/or portable equipment and other supplies;
- Recruit, hire, and train staff; and
- Implement the provider, client, and community education campaign to raise awareness of the new service.

For both approaches, implementation must include the following core components:

- Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner;
- Implement robust bi-directional communication strategies, to support the care model;
- Establish mechanisms for coordinating care with related community-based services and supports;
- Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes; and
- Establish a performance-based payment model to incentivize progress and improvement.

Stage 2 – Implementation: Progress Measures

- Adopt guidelines, policies, protocols, and/or procedures, specific to the selected approach
- Identify number of partners and providers implementing the evidence based approach(es)
- Identify number of partners and providers trained on the evidence based approach: projected vs. actual and cumulative
- Identify number of Medicaid beneficiaries served, projected vs. actual and cumulative
- Begin pay for *reporting* of outcome metrics

Stage 3 – Scale & Sustain: *insert dates*

- Increase scope and scale, expand to serve additional high-risk populations, and add partners or service sites to spread approach to additional communities
- Employ continuous quality improvement methods to refine the model
- Provide on-going supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion

- Develop payment models to support provision of oral services in primary care and/or via mobile clinics
- Implement VBP strategies to support access to oral health services

Stage 3 – Scale & Sustain: Progress Measures

- Identify number of partners participating in the project
- Identify number of partners trained on the approach: projected vs. actual and cumulative
- Begin pay for *performance* of select outcome metrics

Project 3D: Addressing the Opioid Use Public Health Crisis *(Required)*

Rationale: Washington State, along with the nation, is in the midst of a crisis. The opioid epidemic affects communities, families, and overwhelms law enforcement, health care and social service providers. Opioid use disorder is a devastating and life-threatening chronic medical condition and we need to improve access to treatments that support recovery and lifesaving medications to reverse overdoses. ACH will support achievement of the goals outlined in Executive Order 16-09. Stakeholders across Washington State have been building capacity to reduce opioid-related morbidity and mortality. State agencies, public health, Tribal governments, and other partners across the state are coming together to focus on strategies for implementing the state opioid response plan. This project aligns with this plan, and focuses on strategies under three of the plan goals, (1) Prevent opioid misuse and abuse by improving prescribing practices, (2) expand access to opioid dependence treatment, and (3) intervene in opioid overdoses to prevent death

Target Populations: Medicaid clients, including youth, who use prescription opioids and/or heroin at any level.

Target Participating Providers: Mental health providers, substance use disorder providers, Primary Care Providers, Managed Care Organizations, Behavioral Health Organizations, Department of Social and Health Services, Hospitals, Community-based Service Organizations, Criminal Justice institutions. Local Public Health, Professional Associations, and Teaching Institutions.

System-wide Outcome Metrics:
- Substance Use Disorder Treatment Penetration (Opioid)
- Opioid Related Overdoses for Medicaid Enrollees per 100,000
- Opioid Related Deaths (Medicaid Enrollees and Statewide) per 100,000

Additionally, the development and tracking of outcome metrics to determine whether goals of the 2016 Washington State Interagency Opioid Working Plan have been met is included as a 'new action' under Goal 4 Strategy 4.

Project Outcome Metrics:

Three measures are recommended by the Pharmacy Quality Alliance. Additional project metrics may be added as they are developed under the 2016 Washington State Interagency Opioid Working Plan. The recommended measures are:

- Use of Opioids at High Dosage in Persons Without Cancer
- Use of Opioids from Multiple Providers in Persons Without Cancer
- Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer

Recommended Approach:

Clinical Guidelines

AMDG's Interagency Guideline on Prescribing Opioids for Pain, http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

Substance Use during Pregnancy: Guidelines for Screening and Management, http://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy/13_PregSubs_E16L.pdf

Statewide Plans

2016 Washington State Interagency Opioid Working Plan, http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan,

http://www.theathenaforum.org/sites/default/files/SPE%20Strategic%20Plan%20FINAL%20-%20v.%208.10.12.pdf
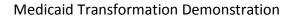
Project Implementation Stages

Stage 1 – Planning: *insert dates*

ACHs will guide and support implementation of current and future iterations of AMDG's Interagency Guideline on Prescribing Opioids for Pain (http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf) and will implement strategies to expand access to opioid dependence treatment in their region.

Assess the current capacity to effectively impact the opioid crisis in the following areas and include strategies to leverage current capacity and address identified gaps. Within the Domain 1, regional, system-wide plan, include:

o Population Health Management Systems/HIT: adoption of technology with the capability to support identification of persons at high-risk for opioid overdose, notifications to health care providers of opioid overdose events, monitoring of prescribing practices, and implementation of quality improvement processes; a plan to build enhancements in EHRs and other systems to support clinical decisions in accordance with guidelines; an assessment of the current level of use of the Prescription Drug Monitoring Program and the Emergency Department Information Exchange; and strategies to increase use of Prescription Drug Monitoring Program and interoperability with EHRs. Overall, in line with Goal 4 of

the State Interagency Opioid Working Plan, develop a plan to use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.
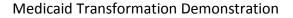
- o Workforce: capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:
  - Efforts to enhance medical, nursing, and physician assistant school curricula on pain management, the Prescription Drug Monitoring Program, and treatment of opioid use disorder
  - Partnering with professional associations and teaching institutions to educate dentists, osteopaths, nurses, and podiatrists on current opioid prescribing guidelines
  - Encouraging licensing boards of authorized prescribers to mandate CEUs on opiate prescribing and pain management guidelines
  - Encouraging family medicine, internal medicine, OB/GYN residency programs to train residents on care standards/medications for opioid use disorder
  - Identifying critical workforce gaps in the substance use treatment system and develop initiatives to attract and retain skilled professionals in the field
- o Financial Sustainability: alignment between current payment structures and guideline-concordant care with regards to opioid prescribing; incorporate current state and anticipated future state of Value Based Payment arrangements to support opioid abuse prevention and control efforts into the regional VBP transition plan. Consider reimbursement of non-opioid pain therapies, separation of buprenorphine from existing daily reimbursement rate for opioid treatment program providers, and creation of a differential reimbursement rate for buprenorphine.

Additional planning steps will include:

- Identify communities or sub-regions of focus for this project, based on Regional Health Needs Inventory. Consider areas with limited access to treatment for opioid dependence, areas with limited or no availability of pain management clinics or providers, and rates of opioid use, misuse, and abuse.
- Identify established local partnerships that are addressing the opioid crisis in their communities and establish new partnerships where none exist. Identify, recruit, and secure formal commitments for participation in project implementation, including professional associations and teaching institutions.
- Develop an ACH Regional Opioid Working Plan that provides a detailed description of how the ACH will implement, at minimum, selected strategies and activities outlined in the 2016 Washington State Interagency Opioid Working Plan. The regional plan will include, at minimum:
  - o Implementation timelines for each strategy

- o Roles and responsibilities of key organizational and provider participants, including community-based service organizations, along with justification of how the partners are culturally relevant and responsive to the specific population in the region
- o Description of how project aligns with related initiatives and avoids duplication of efforts, including established local partnerships that are addressing the opioid crisis in their communities
- o Specific strategies and actions to be implemented, selected from the 2016 Washington State Interagency Opioid Working Plan:

  GOAL 1: Prevent opioid misuse and abuse

  - ▪ **Strategy 1: Promote use of best practices among health care providers for prescribing opioids for acute and chronic pain; explain how ACH will support or take steps to:**
    - Educate health care providers on current and future iterations of the Agency Medical Directors' Group Interagency Guideline for Prescribing Opioids for Pain and the Washington Emergency Department Opioid Prescribing Guidelines
    - Promote of the use of the Prescription Drug Monitoring Program
    - Train, coach and offer consultation on with providers on opioid prescribing and pain management, consider TelePain video conferencing and other tele-medicine approaches
    - Build enhancements in EHRs and other systems to default to recommended dosages, pill counts, etc.
  - ▪ **Strategy 2: Together with the Center for Opioid Safety Education, raise awareness and knowledge of the possible adverse effects of opioid use, including overdose, among opioid users; explain how the ACH will support or take steps to:**
    - Distribute counseling guidelines and other tools to pharmacists, chemical dependency professionals, and health care providers and encourage them to educate patients on prescription opioid safety (storage, disposal, overdose prevention and response)
    - Provide targeted health education to opioid users and their social networks through print and web-based media
    - Promote accurate and consistent messaging about opioid safety and addiction by public health, law enforcement, community coalitions, and others
    - Conduct an inventory of existing patient materials on medication safety for families and children, develop new materials as needed as tools for health care providers and parents
  - ▪ **Strategy 3: Prevent opioid misuse in communities, particularly among youth; explain how ACH will support or take steps to:**
    - Implement strategies from the Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan, http://www.theathenaforum.org/sites/default/files/SPE%20Strategic%20Plan%20FINAL%20-%20v.%208.10.12.pdf
  - ▪ **Strategy 4: Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse; explain how ACH will support or take steps to:**
    - Educate patients and the public on the importance and ways to properly store and dispose of prescription pain medication

- Promote the use of home lock boxes to prevent unintended access to medication
- Explore funding and regulatory enhancements to sustain and evaluate Drug Take Back programs
- **Strategy 5: Decrease the supply of illegal opioids; explain how ACH will support or take steps to:**
  - Educate law enforcement on the Prescription Drug Monitoring Program and how it works

GOAL 2: Link individuals with opioid use disorder to treatment support services

- **Strategy 1: Build capacity of health care providers to recognize signs of possible opioid misuse, effectively screen for opioid use disorder (OUD), and link patients to appropriate treatment resources; explain how ACH will support or take steps to:**
  - Educate providers across all health professions on how to recognize signs of opioid misuse among patients and how to use appropriate tools to screen for OUD
  - Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options
  - Give pharmacists tools on where to refer patients who may be misusing prescription pain medication
- **Strategy 2: Expand access to, and utilization of, opioid use disorder medications in communities; explain how ACH will support or take steps to:**
  - Together with the Health Care Authority, identify policy gaps and barriers that limit availability and utilization of buprenorphine, methadone, and naltrexone and contribute to the development of policy solutions to expand capacity
  - Together with the Center for Opioid Safety Education, provide technical assistance and resources to county health officers to advocate for expanded local access to OUD medications
  - Build structural supports (e.g. case management capacity) to support medical providers and staff to implement and sustain buprenorphine treatment
- **Strategy 3: Expand access to, and utilization of, opioid use disorder medications in the criminal justice system; explain how ACH will support or take steps to:**
  - Train and provide technical assistance to criminal justice professionals to endorse and promote agonist therapies for people under criminal sanctions
  - Optimize access to chemical dependency treatment services for offenders who have been released from prison into the community and for offenders living in the community under correctional supervision
- **Strategy 4: Increase capacity of syringe exchange programs (SEP) to effectively provide overdose prevention and engage clients in support services, including housing; explain how ACH will support or take steps to**

- Provide technical assistance to local health jurisdictions and community-based service organizations to organize or expand syringe exchange and drug user health services
- **Strategy 5: Identify and treat opioid use disorder among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns; explain how ACH will support or take steps to:**
  - Disseminate the guideline Substance Abuse during Pregnancy: Guidelines for Screening and Management
  - Disseminate the WA State Hospital Association Safe Deliveries Roadmap standards to health care providers
  - Educate pediatric and family medicine providers to recognize and appropriate refer newborns with NAS

GOAL 3: Intervene in opioid overdoses to prevent death

- **Strategy 1: Education individuals who use heroin and/or prescription opioids, and those who may witness an overdose, on how to recognize and appropriately respond to an overdose; explain how ACH will support or take steps to:**
  - Provide technical assistance to first responders/law enforcement on opioid overdose response training and naloxone programs
  - Assist emergency department to develop and implement protocols on providing overdose education and take home naloxone to individuals seen for opioid overdose
- **Strategy 2: Make system-level improvements to increase availability and use of naloxone; explain how ACH will support or take steps to:**
  - Establish standing orders in all counties to authorize community-based naloxone distribution and lay administration
  - Promote co-prescribing of naloxone for pain patients as best practice per AMDG guidelines
- **Strategy 3: Together with the Center for Opioid Safety Education, promote awareness and understanding of WA State's Good Samaritan law; explain how ACH will support or take steps to:**
  - Educate law enforcement, prosecutors and the public about the law

Stage 1 – Planning: Progress Measures
• Completed Workforce, Technology, and Financial Sustainability plans, as defined in Domain 1, reflective of support for Project 3D efforts • List of implementation partners with formal written commitment to participate • Completion of ACH Regional Opioid Working Plan

Stage 2 – Implementation: *insert dates*
Implement Workforce, Technology, and Financial Sustainability strategies in support of this project according to Domain 1 implementation plan.

Convene, or leverage existing, local partnerships to implement the ACH Regional Opioid Working Plan. One or more such partnerships may be convened. Each will include health care service providers, community-based service providers, executive and clinical leadership, consumer representatives, law enforcement, criminal justice, and elected officials; identify partnership leaders and champions. Consider identifying a clinical champion and one or more community champions. Establish a structure that allows for efficient implementation of the ACH Regional Opioid Working Plan and provides mechanisms for any workgroups or subgroups to share across teams, including implementation successes, challenges and overall progress. Continue to convene the partnership(s) and any necessary workgroups on a regular basis throughout implementation phase.

Implement the ACH Regional Opioid Working Plan. Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into the Regional Working Plan.

Develop a plan to Scale and Sustain that includes adding partners and/or reaching new communities under the current initiative, as well as defining a path forward to deploy the partnership's expertise, structures, and capabilities to address other yet-to-emerge public health challenges.

Stage 2 – Implementation: Progress Measures

- Number and list of community partnerships. For each include list of members and roles
- Number of health care providers, by type, trained on AMDG's Interagency Guideline on Prescribing Opioids for Pain
- Number of health care organizations with EHRs or other systems newly put in place that provide clinical decision support for the opioid prescribing guideline, such as defaulting to recommended dosages
- Number of local health jurisdictions and community-based service organizations that received technical assistance to organize or expand syringe exchange programs
- Number of emergency department with protocols in place for providing overdose education and take home naloxone to individuals seen for opioid overdose
- Begin pay for reporting of newly developed project outcome metrics

Stage 3 – Scale & Sustain: *insert dates*

- Implement Scale and Sustain Plan to increase scale, include additional partners, and/or cover additional high needs geographic areas.
  - o Review and apply data to inform decisions regarding specific strategies and action to be spread to additional settings or geographical areas
  - o Convene and support platforms to facilitate shared learning and exchange of best practices and results to date
  - o Provide or support on-going training, technical assistance, and community partnerships to support spread and continuation of the ACH Region Opioid Working Plan

- Engage Managed Care Organizations to develop/refine model benefits aligned with evidence-based clinical guideline-concordant care and best practice recommendations. Develop payment models to support non-opioid pain therapies and approach to addressing opioid use disorder prevention and management in the transition to Value-Based Payment for services.

Stage 3 – Scale & Sustain: Progress Measures

- Number and list of community partnerships. For each include list of members and roles
- Number of health care providers, by type, trained on AMDG's Interagency Guideline on Prescribing Opioids for Pain
- Number of health care organizations with EHRs or other systems newly put in place that provide clinical decision support for the opioid prescribing guideline, such as defaulting to recommended dosages
- Number of local health jurisdictions and community-based service organizations that received technical assistance to organize or expand syringe exchange programs
- Number of emergency department with protocols in place for providing overdose education and take home naloxone to individuals seen for opioid overdose
- Begin pay for performance of select outcome metrics

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[i] These measures were put out to public comment by the Dental Quality Alliance (DQA) and will be put forward for approval in December 2016.

* These measures are from the Statewide Common Measure Set or in the process of being considered for inclusion in the 2017 measure set.

** There is not a widely adopted measure available that addresses this topic, however there have been studies that look at how people were transported to the ED for potentially avoidable visits, this approach could be used to develop a measure for this area.