

Initiative 1: Transformation through ACHs

Project Planning & Implementation

Transformation Project Planning

What is the Project Toolkit?

The [Project Toolkit](#)¹ provides details about projects eligible for funding under Initiative 1: Transformation through Accountable Communities of Health. Initiative 1 focuses on health improvement projects that change the Medicaid delivery system to serve the whole-person and use resources more wisely. The Project Toolkit is a CMS-approved document that was developed with state and regional health priorities in mind. It includes input from cross-sector experts and stakeholders. The Project Toolkit outlines evidence-based approaches, milestones, progress measures, timelines, and outcome metrics for each project.

What is the Project Plan?

The Project Plan details each ACH's plan to pursue specific projects in their region from the Medicaid Transformation Project Toolkit. ACHs submitted their Project Plans in November of 2017. Each Project Plan contains two key components: 1) ACH-level information, building on Phase I and II certification, and 2) project-level information, including project selection and expected outcomes. ACHs were expected to develop Project Plans in collaboration with community stakeholders and partnering providers to address regional health needs, and support Medicaid transformation objectives. More information about ACH Project Plans, scoring criteria, assessment, and earned incentives can be found on the Medicaid Transformation [webpage](#)².

Are there any required projects?

ACHs are required to select and implement Project 2A: Bi-directional Integration of Physical and Behavioral Health, and Project 3A: Addressing the Opioid Use Public Health Crisis. ACHs were also required to select at least two additional projects.

What opportunities will ACHs have after Demonstration Year (DY) 1 to adjust projects, and what are the implications for future funding?

In accordance with Section V of the DSRIP Planning Protocol, HCA will consider modifications to an ACH's Project Plan on a case-by-case basis no more than twice a year. These project modifications may include eliminating and/or replacing selected evidence-based approaches or promising practices, or dropping a selected project. Modifications to decrease the scope of a project may result in a reduction in earnable funds.

¹ <https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf>

² <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources>

HCA will not permit modifications that lower expectations for project milestones or Pay-for-Performance results because of difficulty in meeting a milestone or metric. In the case that removal of a planned project intervention is required, such modification may result in forfeiture of funding for that project, at HCA discretion. Project modifications that do not require authorization from the state include routine adjustments, such as: the ACH's project management, monitoring and continuous improvement, revising or scaling target populations, or partnering provider management approach(es).

Are the evidence-based approaches or promising practices identified for each project required or recommended?

One or more evidence-based approaches or promising practices are identified to serve as a menu of interventions for each project in the Project Toolkit. ACHs may pursue one of the following options for each project:

- Select one evidence-based approach or promising practice for the entire project.
- Combine evidence-based approaches or promising practices for the entire project.
- Apply different evidence-based approaches or promising practices from the Toolkit for different target populations/geographies for the project.
- If an ACH declines to implement one of the evidence-based approaches from the menu of options within a given project area in the Toolkit, it must identify another, similar evidence-based approach and demonstrate convincingly its equivalency, including ability to attain achievement of performance on required project metrics. The Independent Assessor will determine whether the ACH has sufficiently satisfied the equivalency requirement.

ACHs must implement two approaches to accomplish Project 2A. To achieve bi-directional integration, an ACH must implement at least one approach integrating behavioral health into primary care settings, and at least one approach integrating primary care into behavioral health settings.

Is there a required approach for Project 2B: Care Coordination?

Pathways HUB was selected as the designated model under Project 2B: Care Coordination. The selection was based on feedback from the original project idea solicitation. It was recommended as a promising practice that had shown success in other states. If appropriate, alternative approaches to care coordination may be undertaken by ACHs as a component of other projects in their portfolios.

Is the community paramedicine model required for Projects 2D and 3D?

Community paramedicine is one of the diversion frameworks highlighted in Projects 2D and 3D. While ACHs are not required to implement a specific community paramedicine framework, HCA has provided resources on existing frameworks, models, evidence-based approaches, and promising practices from the [University of California, Davis](#)³, the [Community Paramedic Program](#)⁴, [Health Resources and Services Administration](#)⁵, and the [Rural Health Information Hub](#)⁶.

³ <https://emsa.ca.gov/wp-content/uploads/sites/47/2017/07/CPReport.pdf>

⁴ <http://communityparamedic.org/>

⁵ <https://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf>

⁶ <https://www.ruralhealthinfo.org/topics/community-paramedicine>

Can ACHs change their intended evidence-based approaches or promising practices from what was submitted in Project Plans?

Yes, ACHs may adjust selected, or choose different, evidence-based approaches or promising practices as put forth in Project Plans. ACHs may make these changes as part of the first Semi-Annual Report, due July 31, 2018. ACHs will be expected to provide the reasoning for any changes.

Project 2A: Bi-directional Integration of Physical & Behavioral Health

What is bi-directional integration?

“Bi-directional integration” means integrating behavioral health services into primary care settings and integrating primary care services into behavioral health settings. This change supports, in part, the state’s commitment to whole-person care - the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improving health.

Is there a required approach to accomplishing Project 2A?

ACHs must implement two approaches to accomplish Project 2A. To achieve bi-directional integration, an ACH must implement at least one approach integrating behavioral health into primary care settings, and at least one approach integrating primary care into behavioral health settings. Although there is no required model, the core principles adopted by the Bree Collaborative ([Behavioral Health Integration Report](#)⁷), and the [Collaborative Care model](#)⁸ should be applied to integration in a behavioral health setting.

Why are ACHs required to propose a project that integrates primary care into a behavioral health setting?

People with serious mental illness and/or substance use disorders often experience multiple chronic health conditions. These conditions can dramatically reduce life expectancy. This population constitutes one of the highest cost, highest risk groups among Medicaid enrollees. There is emerging evidence supporting the value of providing whole-person care in behavioral health settings where these patients already receive care.

People who have complex behavioral health disorders and co-occurring chronic physical health conditions often face barriers to accessing effective primary care. In addition, they often need services not available in most primary care facilities. Licensed behavioral health providers are equipped to manage whole-person integrated care for people whose mental health and/or substance use disorder cannot be stabilized in a primary care setting. The Bree Collaborative recommendations set forth in the [Behavioral Health Integration Report](#)⁹ presents a continuum of behavioral health system integration which includes behavioral health homes. These are defined by SAMHSA as “a behavioral health agency that serves as a health home for people with mental health and substance use disorders.”

What is considered a behavioral health setting under Project 2A?

Substitute senate bill, [SSB 5779](#)¹⁰, provides guidance on what is considered a behavioral health setting. To facilitate bi-directional integration, the legislation directs HCA to 1) complete a review of payment codes available to health plans and providers that relate to primary care and behavioral health services, and 2) create

⁷ <http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Draft-Recommendations-2017-01.pdf>

⁸ <https://aims.uw.edu/collaborative-care>

⁹ <http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Draft-Recommendations-2017-01.pdf>

¹⁰ <http://app.leg.wa.gov/billssummary?BillNumber=5779&Year=2017>

a matrix listing “all physical health-related codes available for payment when provided in licensed behavioral health agencies.”

To comply with this legislation, Project 2A proposals must include at least one licensed behavioral health agency as a partner. Licensed behavioral health agencies may be certified to provide mental health and/or Substance Use Disorder treatment services.

Is bringing a primary care physician into a behavioral health setting the only approach for integrating primary care services into behavioral health settings?

No, there are different levels of integration in behavioral health settings. For example, [SSB 5779](#)¹¹ defines “whole-person care in behavioral health” as a health care integration model in which primary care services are integrated into a behavioral health setting either through co-location or community-based care management.

The project toolkit describes three different approaches; each approach reflects different levels of integration in behavioral health settings:

- *Off-site enhanced collaboration* moves beyond simply making referrals to primary care. Instead, providers have regular contact with each other, an agreement for bi-directional information sharing, and use care managers to track physical health outcomes and facilitate provider communication across treatment settings.
- *Co-located enhanced collaboration* where primary care providers and behavioral health providers work in the same location, rely on care managers to facilitate communications, but they use separate treatment planning and records.
- *Co-located integrated* refers to integrated team-based care and provides routine physical health screenings and diagnosis (e.g., blood pressure, weight, BMI) in a behavioral health agency. It includes on-site primary care, either limited or full-scope. Multiple levels of health practitioners (e.g., RN, ARNP, PA, MD) may provide physical health services within their scope of practice.

In addition to following the recommendations set forth by the [Bree Collaborative](#)¹², the core principles of the Collaborative Care model must be applied and implemented in both of the co-location approaches.

Approaches based on emerging evidence for integrating primary care into behavioral health settings are further described here:

- [SAMHSA-HRSA Center for Integrated Health Solutions](#)¹³
- [Approaches to Integrating Physical Health Services into Behavioral Health Organizations](#)¹⁴
- [U.S. Preventive Services Task Force](#)¹⁵

¹¹ <http://apps2.leg.wa.gov/billsummary?BillNumber=5779&Year=2017&BillNumber=5779&Year=2017>

¹² <http://www.breecollaborative.org/>

¹³ <https://www.integration.samhsa.gov/integrated-care-models>

¹⁴ http://www.integration.samhsa.gov/Approaches_to_Integrating_Physical_Health_Services_into_BH_Organizations_RIC.pdf

¹⁵ <https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>

How does the Collaborative Care model (CoCM) compare to the recommended principles in the Bree Collaborative Behavioral Health Integration Report? Are there particular similarities or differences?

The Bree Collaborative Behavioral Health Integration Report and Recommendations focuses on integrating behavioral health care services into primary care. The goal is that the eight Bree Collaborative elements will allow providers and practices to learn about and adopt core principles and proven practices that will help them to deliver effective integrated care. Their patients will also know when they are receiving integrated care and purchasers and health plans will know when they are buying integrated care that can be expected to improve patient outcomes and lower costs.

When developing the recommendations for a framework of standard elements to adopt in moving to integrated of care, the Bree Collaborative workgroup looked to existing work in the field but did not define or mandate a single model of care. The workgroup adopted a framework that includes the core principles of the evidence-based CoCM, which was developed by the University of Washington AIMS Center. The workgroup also allowed for promising strategies such as the Primary Care Behavioral Health model as long as the model of care incorporates the same CoCM principles.

The core principles of the CoCM, as included in the Bree Collaborative can be summarized by the following:

- Team-based and person-centered: primary care and behavioral health providers collaborate effectively, using shared care plans.
- Population-based and data-driven: a defined group of patients or clients is tracked in a registry so that no one “falls through the cracks.”
- Measurement-based treatment to target: treatment goals clearly defined and tracked for every patient. Treatments actively changed until clinical goals are achieved.

In the summary below of the minimum standards for Integrated Care Element Specifications recommended by the Bree Collaborative, the ways in which practices operationalize the core principles of CoCM are in **boldface**:

- Integrated care team: Each member of the integrated care team has clearly defined roles for both physical and behavioral health services. Team members, including clinicians and non-licensed staff, may participate in team activities either in person or virtually.
- Routine access to integrated services: Access to behavioral health and primary care services are available routinely, as part of the care team’s daily work flow and on the same day as patient needs are identified as much as feasible. Patients can be engaged and receive treatment in person or by phone or videoconferencing, as convenient for the patient.
- Accessibility and sharing of patient information: **The integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care. All clinicians work together to jointly support their roles in the patient’s shared care plan.**
- Access to psychiatry services: Access to psychiatry consultation services is available in a systematic manner to assist the care team in developing a treatment plan and to advise the team on adjusting treatments for patients who are not improving as expected.

- Operational systems and workflows support population-based care: **A structured method is in place for proactive identification and stratification of patients for behavioral health conditions. The care team tracks patients to make sure each patient is engaged and treated-to-target (i.e., to remission or other appropriate individual improvement goals).**
- Evidence-based treatments: **Age-appropriate, measurement-based interventions for physical and behavioral health interventions are adapted to the specific needs of the practice setting. Integrated practice teams use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether their patients are improving.**
- Patient involvement in care: The patient's goals are incorporated into the care plan. The team communicates effectively with the patient about their treatment options and asks for patient input and feedback into care planning.

The recommendations by the Bree Collaborative align with the core principles intrinsic to the management strategy under the CoCM. The CoCM is one approach to moving to an integrated care model in the primary care setting that meets the standards put forth by the Bree Collaborative. However, the Collaborative Care Model is not the only path to effective integrated services in a primary care setting. Practices are expected to refine and improve their model over time so as to meet the minimum elements necessary for comprehensive, measurement-based integrated care that drives patient improvement.

Transformation Partnering Providers

The Project Plan requires a list of partnering providers. If additional partners are identified after the Project Plan submission, how is this list updated?

ACHs have the opportunity to identify additional partnering providers through registration in the Financial Executor Portal, and in further reporting in Semi-Annual Reports. Partnering providers may be registered in the Financial Executor Portal at any time during the Transformation. Semi-Annual Reports will be submitted by ACHs on a twice-yearly cadence starting in July 2018.

How will the Practice Transformation Support Hub support partnering providers involved in Transformation projects?

The Practice Transformation Support Hub (Hub) is a program of Healthier Washington. It is managed by the Washington State Department of Health. The Hub delivers tools, technical assistance, training and on-site coaching and support to providers in small to medium-sized physical and behavioral health practices. The Hub's goals are to help physical and behavioral health practices 1) focus on whole-person care by achieving bi-directional physical and behavioral health integration, 2) move from volume-based payments to value-based care, and 3) improve population health by building connections to community resources. The Hub provides tools, training, and hands-on technical assistance to support providers in coordinating care, promoting community linkages, and transitioning to value-based payment models.

What are HCA's expectations as it relates to clinical provider and community-based organization engagement? What types of providers should ACHs target with their engagement efforts?

Engagement of both clinical and social service providers is critical to the success of Medicaid transformation. Effective project planning and implementation will be informed by clinical expertise and an understanding of

clinical provider resource needs and capacity. At a minimum, primary care, behavioral health, and hospital/health system providers, and community-based organizations must be represented on the ACH decision-making body. On a regular and ongoing basis, HCA also expects ACHs to engage with providers who represent a broad spectrum of care and regional areas. ACHs may engage providers in a variety of forums, including committees, workgroups, and open meetings. ACHs described their current provider engagement and future strategies in their Project Plans, and will continue to report on provider engagement in Semi-Annual Reports.

How do you become an ACH partnering provider?

The best way to become a partnering provider is to stay connected to the ACH in your region. Your ACH will explain the additional steps to become involved in transformation activities, and discuss specific needs and opportunities for partnering providers to participate.

How many providers should be involved in project implementation?

During the project selection and planning phase, ACHs determined how many and what types of providers and other stakeholders are needed for successful project implementation. ACHs considered the size of their target population, evidence-based approaches or promising practices, the type of clinical models of care, and provider capacity. At a minimum, ACHs should include providers that serve a significant portion of the Medicaid population, and represent a broad spectrum of services critical to improving how care is delivered and paid for.

What are the expectations and/or requirements for how ACHs and MCOs should work together?

ACHs should engage Managed Care Organizations (MCOs) in the design and implementation of Transformation projects, and to work together to support provider needs as they transition from Fee-For-Service to Value-based Payment (VBP) arrangements. Preparations include developing workforce capacity, clinical infrastructure, and evidence-based care models. MCOs are expected to serve in a leadership supportive capacity in every ACH. In addition, MCOs should:

- Implement VBP arrangements with network providers, in alignment with the state's VBP targets, and report on those VBP arrangements in HCA's annual VBP survey of MCOs.
- Ensure payment models evolve and sustain new models of care delivery and population health management, during and beyond the five-year Transformation.