



**MEDICAID TRANSFORMATION
PROJECT TOOLKIT**

Revised June-October 2017

Table of Contents

USING THE PROJECT TOOLKIT	5
DOMAIN 1: HEALTH AND COMMUNITY SYSTEMS CAPACITY BUILDING.....	7
FINANCIAL SUSTAINABILITY THROUGH VALUE-BASED PAYMENT	7
WORKFORCE.....	11
SYSTEMS FOR POPULATION HEALTH MANAGEMENT	13
DOMAIN 2: CARE DELIVERY REDESIGN	16
PROJECT 2A: BI-DIRECTIONAL INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH THROUGH CARE TRANSFORMATION	16
Project Stages	17
Project Metrics	20
Project Implementation Guidelines.	23
PROJECT 2B: COMMUNITY-BASED CARE COORDINATION.....	28
Project Stages	28
Project Metrics	30
Project Implementation Guidelines.	32

PROJECT 2C: TRANSITIONAL CARE	34
Project Stages	35
Project Metrics	37
Project Implementation Guidelines.	39
PROJECT 2D: DIVERSION INTERVENTIONS.....	44
Project Stages	44
Project Metrics	47
Project Implementation Guidelines	48
DOMAIN 3: PREVENTION AND HEALTH PROMOTION	52
PROJECT 3A: ADDRESSING THE OPIOID USE PUBLIC HEALTH CRISIS (REQUIRED).....	52
Project Stages	53
Project Metrics	56
Project Implementation Guidelines	59
PROJECT 3B: REPRODUCTIVE AND MATERNAL/CHILD HEALTH	64
Project Stages	65
Project Metrics	67
Project Implementation Guidelines	69

PROJECT 3C: ACCESS TO ORAL HEALTH SERVICES	72
Project Stages	72
Project Metrics	75
Project Implementation Guidelines	76
PROJECT 3D: CHRONIC DISEASE PREVENTION AND CONTROL	80
Project Stages	80
Project Metrics	83
Project Implementation Guidelines	86

Using the Project Toolkit

Project Objective: Aim the project is intended to achieve.

Target Population: Population the project is intended to address. For each project selected, the ACH must define the target population, informed by regional needs, based on the target population defined in the toolkit. ACHs may choose one or more target populations.

Evidence-based Approach: Menu of interventions available for the project. One or more evidence-based approaches are identified to serve as a menu of interventions for each project. ACHs have multiple pathways they may pursue, which include:

- Selecting one evidence-based approach for the entire project;
- Combining evidence-based approaches for the entire project; and
- Applying different evidence-based approaches for different target populations/geographies for the project.

ACHs are required to implement one of the evidence-based approaches identified under the selected project. If an ACH declines to implement the evidence-based approach identified, 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.

Project Stages: Progression of project planning, implementation and sustainability. Each project is divided into three stages with defined milestones, timelines, and proof of completion that must be submitted. To the extent possible, milestones, timeline and proof of completion are standardized across projects. The ACH will be held accountable and awarded incentive funds based on completion of milestones and attesting to completion accompanied by the proof of completion within the prescribed timeline from DY 2 through DY 4.

Project Stage	Milestone	Proof of Completion	Timeline (completion no later than)
Stage 1: Planning	<ul style="list-style-type: none">• Assess current state capacity• Identify strategies for Domain 1• Select target population and evidence-based approach• Identify project lead• Identify and engage project partners• Develop project implementation plan	<ul style="list-style-type: none">• Completed current state assessment• Identified strategies• Definition of target population and evidence-based approach• Identified lead and binding letter of intent• Identified implementation partners and binding letters of intent	End of DY 2

		<ul style="list-style-type: none"> Completed implementation plan 	
Stage 2: Implementation	<ul style="list-style-type: none"> Develop guidelines, policies, procedures and protocols Develop Quality Improvement Plan (QIP) Operationalize guidelines, policies, procedures and protocols Implement project 	<ul style="list-style-type: none"> Adopted guidelines, policies and/or procedures Completed QIP Completed operations manual Planned number of partners participating and if applicable, the number implementing each selected pathway. 	End of DY 3
Stage 3: Scale and Sustain	<ul style="list-style-type: none"> Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required Provide ongoing supports to support continuation and expansion Develop payment models to support model Implement VBP strategies to support model 		End of DY 4

Project Metrics: Outcome metrics for the project. The ACH will be held accountable and awarded incentive funds based on performance on a P4R or P4P basis in the region from DY 3 through DY 5. The majority of the P4R reporting metrics will be provided by the ACH and its partnering provider organizations. ACH reported metrics will be provided as part of their semi-annual report submissions. The majority of P4P targets will be provided by the State and are compiled on an annual basis.

Project Implementation Guidelines: Additional details on the project's core components, including Domain 1 strategies and evidence-based approaches that help guide the ACH's development of project implementation plans and quality improvement plans.

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.

Financial Sustainability through Value-based Payment

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

Value-based payment (VBP) categories as defined by the Health Care Payment Learning Action Network (HCP-LAN) framework will be used for the purposes of calculating the annual targets below. Targets will be calculated by dividing the total Medicaid dollars spent in HCP-LAN categories 2C and higher by total Medicaid dollars spent.

Annual Targets:

Percentage of Provider Payments in HCP-LAN APM Categories at or Above which Incentives are Provided to Providers and MCOs

VBP Targets	DY 1	DY 2	DY 3	DY 4	DY 5
HCP-LAN Category 2C-4B	30%	50%	75%	85%	90%
Subset of goal above: HCP-LAN Category 3A-3B	-	10%	20%	30%	50%
Payment in Advanced APMs	-	-	TBD	TBD	TBD

Governance

The HCA will create and facilitate a statewide Medicaid Value-based Payment (MVP) Action Team. The MVP Action Team will serve as a learning collaborative to support Accountable Communities of Health (ACHs) and Medicaid Managed Care Organizations (MCOs) in attainment of Medicaid VBP targets. It will serve as a forum to help prepare providers for value-based contract arrangements and to provide guidance on HCA's VBP definition (based on the HCP-LAN framework). Representatives may include state, regional and local leaders and stakeholders.

Stages

Stage 1 – Planning

Responsibility (Regional/ Statewide)	Activity	Timeline (complete no later than)
Statewide	<p>The MVP Action Team will assist HCA in performing an assessment to capture or validate a baseline of the current VBP levels. To the extent assessments have already been conducted, the MVP Action Team will build from those assessments.</p> <p>Building from existing work when applicable, the MVP Action Team will:</p> <ul style="list-style-type: none"> • Assist HCA in deploying survey/attestation assessments to facilitate the reporting of VBP levels to understand the current types of VBP arrangements across the provider spectrum. • Validate the level of VBP arrangements as a percentage of total payments across the region to determine current VBP baseline. • Perform assessments of VBP readiness across regional provider systems. • Develop recommendations to improve VBP readiness across regional provider systems. 	DY2, Q4
Regional	<p>To support the MVP Action Team, the ACHs will:</p> <ul style="list-style-type: none"> • Inform providers of various VBP readiness tools and resources. Some viable tools may include: <ul style="list-style-type: none"> ○ JSI/ NACHC Payment Reform Readiness Toolkit ○ AMA Steps Forward – Preparing your practice for value-based care: https://www.stepsforward.org/modules/value-based-care#section-references ○ Rural Health Value Team’s comprehensive Value-Based Care Strategic Planning Tool: http://cph.uiowa.edu/ruralhealthvalue/TnR/VBC/VBCTool.php ○ <u>Assessments deployed by the Practice Transformation Support Hub and the Transforming Clinical Practice Initiative (TCPI)</u> ○ <u>Adoption of diagnostic coding in dental for bi-directional medical/dental data sharing and population health.</u> • Connect providers to training and technical assistance developed and made available by the HCA and the statewide MVP Action Team. 	DY 2, Q4

	<ul style="list-style-type: none"> • Support initial survey/attestation assessments of VBP levels to help the MVP Action Team substantiate reporting accuracy. • Disseminate learnings from the MVP Action Team and other state and regional VBP implementation efforts to providers. <p>Using the recommendations of the MVP Action Team, the ACHs will:</p> <ul style="list-style-type: none"> • Develop a Regional VBP Transition Plan that: <ul style="list-style-type: none"> ○ Identifies strategies to be implemented in the region to support attainment of statewide VBP targets. ○ Defines a path toward VBP adoption that is reflective of current state of readiness and the implementation strategies within the Transformation Project Toolkit (Domain 2 and Domain 3). ○ Defines a plan for encouraging participation in annual statewide VBP surveys. 	
Stage 2 – Implementation		
Responsibility (Regional/ Statewide)		Timeline (complete no later than)
Statewide	<ul style="list-style-type: none"> • Implement strategies to support VBP transitions in alignment with Medicaid transformation activities. <ul style="list-style-type: none"> ○ By the End of Calendar Year 2017, achieve 30% VBP target at a regional and MCO level ○ By the End of Calendar Year 2018, achieve 50% VBP target at a regional and MCO level ○ By the End of Calendar Year 2019, achieve 75% VBP target at a regional and MCO level ○ By the End of Calendar Year 2020, achieve 85% VBP target at a regional and MCO level ○ By the End of Calendar Year 2021, achieve 90% VBP target at a regional and MCO level • Perform ongoing monitoring to inform the annual update of the Value-based Roadmap. 	DY 5, Q4
Regional	<ul style="list-style-type: none"> • Implement strategies to support VBP transitions in alignment with Medicaid transformation activities. <ul style="list-style-type: none"> ○ By the End of Calendar Year 2017, achieve 30% VBP target at a regional level ○ By the End of Calendar Year 2018, achieve 50% VBP target at a regional level ○ By the End of Calendar Year 2019, achieve 75% VBP target at a regional level. ○ By the End of Calendar Year 2020, achieve 85% VBP target at a regional level. 	DY 5, Q4

	<ul style="list-style-type: none"> ○ By the End of Calendar Year 2021, achieve 90% VBP target at a regional level. • Continue to engage in and contribute to the MVP Action Team, to include ongoing refinement of the VBP Transition Plan as needed. • Achieve progress toward VBP adoption that is reflective of current state of readiness and the implementation strategies within the Transformation Project Toolkit (Domain 2 and Domain 3). 	
--	---	--

Workforce

Overarching Goal: Promote a health workforce that supports comprehensive, coordinated, and timely access to care.

Governance	Throughout the design and implementation of transformation efforts, ACHs and partnering providers must consider workforce needs pertaining to selected projects and the broader objectives of the Medicaid Transformation demonstration. There are several statewide taskforces and groups with expertise in identifying emerging health workforce needs and providing actionable information to inform the evolving workforce demands of a redesigned system of care. ACHs should leverage existing resources available to inform workforce strategies for the projects their region is implementing.
-------------------	--

Stages

Stage 1 – Planning

Responsibility (Regional/ Statewide)	Activity	Timeline <i>(complete no later than)</i>
Statewide	<ul style="list-style-type: none"> Based on identified regional workforce gaps and needs, provide recommendations and guidance to support and evolve the health care workforce consistent with Medicaid Transformation goals and objectives. Identify existing educational and other resources available to educate, train, and re-train individuals to promote a workforce that supports and promotes evolving care models. 	DY2, Q4
Regional	<ul style="list-style-type: none"> Consider workforce implications as part of project implementation plans and identify strategies to prepare and support the state's health workforce for emerging models of care under Medicaid Transformation. Develop workforce strategies to address gaps and training needs, and to make overall progress toward the envisioned future state for Medicaid transformation: 	DY2, Q4

	<ul style="list-style-type: none"> ○ Identify regulatory barriers to effective team-based care ○ Incorporate strategies and approaches to cultural competency and health literacy trainings ○ Incorporate strategies to mitigate impact of health care redesign on workforce delivering services for which there is a decrease in demand 	
Stage 2 – Implementation		
Responsibility (Regional/ Statewide)		Timeline (complete no later than)
Statewide	<ul style="list-style-type: none"> ● Implement workforce strategies. ● Administer necessary resources to support all efforts. 	DY4, Q4
Regional	<ul style="list-style-type: none"> ● Implement workforce strategies. ● Administer necessary resources to support all efforts. 	DY4, Q4

Systems for Population Health Management

Overarching Goal: Leverage and expand interoperable health information technology (HIT) and health information exchange (HIE) infrastructure and tools to capture, analyze, and share relevant data, including combining clinical and claims data to advance VBP models.

For purposes of this demonstration, population health management is defined as:

- *Data aggregation*
- *Data analysis*
- *Data-informed care delivery*
- *Data-enabled financial models*

Governance	<p>Governance for developing Systems for Population Health Management is envisioned as a multi-tiered approach. Data and measurement activity in service of Medicaid transformation will be facilitated by the HCA, in coordination with Department of Social and Health Services and the Department of Health.</p> <ul style="list-style-type: none"> • The Office of the National Coordinator develops policy and system standards for interoperability which govern Certified Electronic Health Record Technology (CEHRT), and sets the national standards for how health information systems can collect, share, and use information. The use of interoperable Health Information Technology and Health Information Exchange is expected to support care coordination and integration, quality improvement and value-based payment. • The HCA will coordinate efforts among multiple state government agencies to link Medicaid claims, social services data, population health information, and social determinants of health data, as well as direct efforts to increase accessibility of data in line with current legislation. • HCA will work with ACHs to ensure that data products are developed that meet ACH project need; that data are combined in ways that meet local needs; and that access to data accommodates different levels of IT sophistication, local use, and supports improved care.
-------------------	---

Stages		
Stage 1 – Planning & Implementation		
Responsibility (Regional/ Statewide)	Activity	Timeline (complete no later than)

Statewide	<ul style="list-style-type: none"> • HCA will provide guidance to ACHs in assessing current population health management capacity in service of Domain 2 and Domain 3 projects. • HCA will Identify tools available for population health management which may include: <ul style="list-style-type: none"> ○ 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. • The HCA will promote on-demand access to standard care summaries and medical records within the Link4Health CDR through the HIE and claims through the development of an integrated health information system. • To support the work, HCA will coordinate with the state designated entity for HIE, OneHealthPort, which is responsible for building and implementing the infrastructure used for HIE and developing tools and services which support broader access and utilization of both HIE and clinical data. In addition, OneHealthPort works for and with the provider community to help develop community best practices for data exchange and use. 	DY 4 Q2
Regional	<p>To support projects within Domain 2 and Domain 3, ACHs will convene key providers and health system alliances to share information with the state on:</p> <ul style="list-style-type: none"> • Provider requirements to effectively access and use population health data necessary to advance VBP and new care models. • Local health system stakeholder needs for population health, social service, and social determinants of health data. <p>ACHs must address Systems for Population Health Management within their project implementation plans. This must include:</p>	DY 4 Q2

	<ul style="list-style-type: none"> • Define a path toward 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. Include plan for development or enhancement of patient registries, which will allow for the ability to track and follow up on patients with target conditions. • Respond to needs and gaps identified in the current infrastructure. 	
--	--	--

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.

Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation

Project Objective: Through a whole-person approach to care, address physical and behavioral health needs 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 support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through MCOs, for people enrolled in Medicaid.

Target Population: All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).

ACHs must implement a project that includes:

- **At least one approach from integrating behavioral health into primary care settings, and**
- **At least one approach from integrating primary care into the behavioral health setting.**

Evidence-based Approaches for Integrating Behavioral Health into Primary Care Setting:

1. Bree Collaborative's Behavioral Health Integration Report and Recommendations: <http://www.breecollaborative.org/topic-areas/behavioral-health/>.
2. Collaborative Care Model: <http://aims.uw.edu/collaborative-care>
 - The Collaborative Care Model is a team-based model that adds a behavioral health care manager and a psychiatric consultant to support the primary care provider's management of individual patients' behavioral health needs.
 - The model can be either practice-based or telehealth-based, so it can be used in both rural and urban areas.
 - The model can be used to treat a wide range of behavioral health conditions, including depression, substance use disorders, bipolar disorder, PTSD, and other conditions.

Approaches based on Emerging Evidence for Integrating Primary Care into Behavioral Health Setting:

These approaches are 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>.
For any approach, apply core principles of the Collaborative Care Model (see above) to integration into the behavioral health setting.

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

Reference the “Project Implementation Guidelines” for additional details on the project’s core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

Project Stages

Stage 1 – Planning

Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> Assess current state capacity of Integrated Care Model Adoption: Describe the level of integrated care model adoption among the target providers/organizations serving Medicaid beneficiaries. 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). 	Completed current state assessment	DY 2, Q2
<ul style="list-style-type: none"> Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project 	Completed Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2A efforts	DY 2, Q2
<ul style="list-style-type: none"> Select target population(s) and evidence-based approach (es) informed by regional health needs 	Definition of target population and evidence based approach	DY 2, Q2

<ul style="list-style-type: none"> Identify and engage project implementation partnering provider organizations, including: behavioral and physical health providers, organizations, and relevant committees or councils <ul style="list-style-type: none"> 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. 	Identified implementation partners and binding letters of intent	DY 2, Q2
<ul style="list-style-type: none"> Develop project implementation plan, which must include: <ul style="list-style-type: none"> Implementation timeline Selected evidence-based approaches to integration and partners/providers for implementation to ensure the inclusion of strategies that address all Medicaid beneficiaries (children and adults) particularly those with/or at-risk for behavioral health conditions 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 Description of how project aligns with related initiatives and avoids duplication of efforts Roles and responsibilities of implementation partners: should include key organizational and provider participants that promote partnerships across the care continuum, including payer organizations, social services organizations, and across health service settings. Describe strategies for ensuring long-term project sustainability 	Completed implementation plan	DY 2, Q3
<ul style="list-style-type: none"> Engage and convene County Commissioners, Tribal Governments, Managed Care Organizations, Behavioral Health and Primary Care providers, and other critical partners to develop a plan and description of a process and timeline to transition to fully integrated managed care <ul style="list-style-type: none"> Plan should reflect how the region will enact fully integrated managed care by or before January 2020 	Completed plan describing regional transition to fully integrated managed care	DY 2, Q4

<ul style="list-style-type: none"> ○ For regions that have already implemented fully integrated managed care, implementation plans should incorporate strategies to continue to support the transition 		
Stage 2 – Implementation		
Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> • Develop guidelines, policies, procedures and protocols 	Adopted guidelines, policies, procedures and/or procedures	DY 3, Q1
<ul style="list-style-type: none"> • Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected approaches. 	Completed and approved QIP, reporting on QIP measures	DY 3, Q2
<ul style="list-style-type: none"> • Implement project, including the following core components across the approaches selected: <ul style="list-style-type: none"> ○ Ensure implementation addresses the core components of each 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. 	<p>Identify number of practices and providers implementing integrated evidence-based approach(es)</p> <p>Identify number of practices and providers trained on evidence-based practices; projected vs. actual and cumulative</p>	DY 3, Q4
<ul style="list-style-type: none"> • Implementation of fully integrated managed care (applicable to mid-adopter regions) 	Attestation from Managed Care Organizations that the MCOs have entered into a contractual relationship with HCA to cover	DY3, Q1

		Medicaid behavioral health services.	
Stage 3 – Scale & Sustain			
Milestone		Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none">• Increase adoption of the integrated evidence-based approach by additional providers/organizations		Document Stage 3 activities in Semi-Annual Reports.	DY 4, Q4
<ul style="list-style-type: none">• Identify new, additional target providers/organizations.			DY 4, Q4
<ul style="list-style-type: none">• Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required			DY 4, Q4
<ul style="list-style-type: none">• Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion<ul style="list-style-type: none">○ Leverage regional champions and implement a train-the-trainer approach to support the spread of best practices.			DY 4, Q4
<ul style="list-style-type: none">• Identify and document the adoption by partnering providers of payment models that support integrated care approaches and the transition to value based payment for services			DY 4, Q4
<ul style="list-style-type: none">• Implementation of fully integrated managed care (applicable to regions that did not pursue early or mid-adopter status)		Attestation from Managed Care Organizations that the MCOs have entered into a contractual relationship with HCA to cover Medicaid behavioral health services.	DY 4, Q1
Project Metrics			
Year	Metric Type	Metric	Report Timing
	P4R – ACH Reported	<ul style="list-style-type: none">• Report against QIP metrics	Semi-Annual

DY 3 – 2019		<ul style="list-style-type: none"> 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 % PCP in partnering provider organizations meeting PCMH requirement Number of partnering primary care providers who achieve special recognitions/certifications/licensure (for medication-assisted treatment, such as buprenorphine administration, for example). 	
	P4P – State Reported	<ul style="list-style-type: none"> Antidepressant Medication Management Child and Adolescents' Access to Primary Care Practitioners Comprehensive Diabetes Care: Hemoglobin A1c Testing Comprehensive Diabetes Care: Medical Attention for Nephropathy Medication Management for People with Asthma (5 – 64 Years) Mental Health Treatment Penetration (Broad Version) Outpatient Emergency Department Visits per 1000 Member Months Plan All-Cause Readmission Rate (30 Days) Substance Use Disorder Treatment Penetration 	Annual
DY 4 – 2020	P4R – ACH Reported	<ul style="list-style-type: none"> Report against QIP metrics 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 % PCP in partnering provider organizations meeting PCMH requirement Number of partnering primary care providers who achieve special recognitions/certifications/licensure (for medication-assisted treatment, such as buprenorphine administration, for example) 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> Antidepressant Medication Management Child and Adolescents' Access to Primary Care Practitioners Comprehensive Diabetes Care: Eye Exam (retinal) performed Comprehensive Diabetes Care: Hemoglobin A1c Testing Comprehensive Diabetes Care: Medical Attention for Nephropathy <u>Follow-up After Discharge from ED for Mental Health;</u> <u>Follow-up After Discharge from ED for Alcohol or Other Drug Dependence</u> 	Annual

		<ul style="list-style-type: none"> • Follow-up After Hospitalization for Mental Illness • Inpatient Hospital Utilization • Medication Management for People with Asthma (5 – 64 Years) • Mental Health Treatment Penetration (Broad Version) • Outpatient Emergency Department Visits per 1000 Member Months • Plan All-Cause Readmission Rate (30 Days) • Substance Use Disorder Treatment Penetration 	
DY 5 – 2021	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • 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 • % PCP in partnering provider organizations meeting PCMH requirement • Number of partnering primary care providers who achieve special recognitions/certifications/licensure (for medication-assisted treatment, such as buprenorphine administration, for example). 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> • Antidepressant Medication Management • Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • <u>Follow-up After Discharge from ED for Mental Health;</u> • <u>Follow-up After Discharge from ED for</u> Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Inpatient Hospital Utilization • Medication Management for People with Asthma (5 – 64 Years) • Mental Health Treatment Penetration (Broad Version) • Outpatient Emergency Department Visits per 1000 Member Months • Plan All-Cause Readmission Rate (30 Days) • Substance Use Disorder Treatment Penetration 	Annual

Project Implementation Guidelines: This section provides additional details on the project’s core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

Guidance for Project-Specific Domain 1 Strategies

- **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.
- **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 Use Disorder Providers, Social Workers, Nurse Practitioners, Primary Care Providers, Care Coordinators and Care Managers
 - Opportunities for use of telehealth and integration into work streams
 - Workflow changes to support integration of new screening and care processes, care integration, communication
 - Cultural and linguistic competency, health literacy deficiencies
- **Financial Sustainability:** Alignment between current payment structures and guideline-concordant physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for Evidence-Based Approaches

Integrating Behavioral Health into Primary Care Setting

Standards adopted by the Bree Collaborative in the Behavioral Health Integration Report and Recommendations. As part of this option, regions will implement the core components that are consistent with the standards adopted by the Bree Collaborative.

Summary of Core Elements and Minimum Standards for Integrated Care Element Specifications under consideration by the Bree Collaborative:

- **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.

Collaborative Care Model. As part of this option, regions can choose to focus initially on depression screening and treatment program (such as tested in the IMPACT model). Many successful Collaborative Care pilot programs begin with an initial focus on depression and later expand to treat other behavioral health conditions, including substance use disorders.

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.
 - 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 psychiatric consultation and treatment adjustment.
 - Create and support relapse prevention plan when patients are substantially improved.
- 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 (in-person or via telemedicine) :
 - Conduct regular (e.g., weekly) psychiatric caseload review on patients who are not improving.
 - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
 - Provide psychiatric assessments for challenging patients, either in-person or via telemedicine.
- 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.

Integrating Primary Care into Behavioral Health Setting

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 communication systems, but may or may not have periodic non-face-to-face communication including sending reports), to enhanced collaboration that includes tracking physical health outcomes, with the following core components:

- Providers have regular contact and view each other as an interdisciplinary team, working together in a client-centered model of care.
- A process for bi-directional information sharing, including shared treatment planning, is in place and is used consistently.
- Providers may maintain separate care plans and information systems, but regular communication and systematic information sharing results in alignment of treatment plans, and effective medication adjustments and reconciliation to effectively treat beneficiaries to achieve improved outcomes.
- Care managers and/or coordinators are in place to facilitate effective and efficient collaboration across settings ensuring that beneficiaries do not experience poorly coordinated services or fall through the cracks between providers.
- Care managers and/or coordinators track and monitor physical health outcomes over time using registry tools, facilitate communication across settings, and follow up with patients and care team members across sites.

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 integration of physical health care into the behavioral health setting.

- Patient Identification & Diagnosis:
 - Screen for and document chronic diseases and conditions, such as obesity, diabetes, heart disease 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.

- Provide routine immunizations according to ACIP recommendations as needed.
- Provide the U.S. Preventive Services Task Force screenings graded A & B as 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 identified patients.
 - Proactively reach out to patients who experience difficulty following 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 Case Review & Consultation (in person or via telemedicine):
 - 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 to support an integrated team.
 - Provide clinical support and supervision for care team members that are co-located.
 - Routinely examine provider-level and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use to inform quality improvement processes and activities.

Project 2B: Community-Based Care Coordination

Project Objective: Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.

Target Population: Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as, arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke), or mental illness/depressive disorders, or moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization).

Evidence-based Approach:

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

Reference the “Project Implementation Guidelines” for additional details on the project’s core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

Project Stages

Stage 1 – Planning

Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> Assess current state capacity to effectively focus on the need for regional community-based care coordination 	Completed current state assessment	DY 2, Q2
<ul style="list-style-type: none"> Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project 	Completed Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2B efforts	DY 2, Q2
<ul style="list-style-type: none"> Select target population and evidence-based approach informed by regional health needs 	Definition of target population and evidence based approach	DY 2, Q2

<ul style="list-style-type: none"> Identify project lead entity, including: <ul style="list-style-type: none"> Establish HUB planning group, including payers. Designate an entity to serve as the HUB lead. 	Identified lead and binding letter of intent from HUB/lead entity	DY 2, Q2
<ul style="list-style-type: none"> Identify and engage project implementation partnering provider organizations, including: <ul style="list-style-type: none"> Review national HUB standards and provide training on the HUB model to stakeholders 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 lead entity 	Identified implementation partners and binding letters of intent	DY 2, Q2
<ul style="list-style-type: none"> Develop project implementation plan, which must include: <ul style="list-style-type: none"> Description of pathways, focus areas, and care coordination service delivery models, Implementation timeline Roles and responsibilities of implementation partners Describe strategies for ensuring long-term project sustainability 	Completed implementation plan	DY 2, Q3
Stage 2 – Implementation		
Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> Develop guidelines, policies, procedures and protocols 	Adopted guidelines, policies, procedures and/or procedures	DY 3, Q1
<ul style="list-style-type: none"> Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / pathways 	Completed and approved QIP, reporting on QIP measures	DY 3, Q2
<ul style="list-style-type: none"> Implement project, which includes the Phase 2 (Creating tools and resources) and 3 (Launching the HUB) elements specified by AHRQ: <ul style="list-style-type: none"> Create and implement checklists and related documents for care coordinators. 	Estimated number of partners participating and if applicable,	DY 3, Q4

<ul style="list-style-type: none">○ Implement selected pathways from the Pathways Community HUB Certification Program or implement care coordination evidence-based protocols adopted as standard under a similar approach.○ Develop systems to track and evaluate performance.○ Hire and train staff.○ Train care coordinator and other staff at participating partner agencies.○ Conduct a community awareness campaign.		the number implementing each selected pathway.	
Stage 3 – Scale & Sustain			
Milestone		Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none">• Increase scope and scale, such as adding partners, focus areas or pathways		Document Stage 3 activities in Semi-Annual Reports.	DY 4, Q4
<ul style="list-style-type: none">• Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required			DY 4, Q4
<ul style="list-style-type: none">• Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion			DY 4, Q4
<ul style="list-style-type: none">• Identify and document the adoption by partnering providers of payment models that support the HUB care coordination model and the transition to value based payment for services.			DY 4, Q4
Project Metrics			
Year	Metric Type	Metric	Report Timing
DY 3 – 2019	P4R – ACH Reported	<ul style="list-style-type: none">• Report against QIP metrics• Number of partners trained by focus area or pathway: projected vs. actual and cumulative• Number of partners participating and number implementing each selected pathway• % PCP in partnering provider organizations meeting PCMH requirement• % partnering provider organizations using selected care management technology platform• % partnering provider organizations sharing information (via HIE) to better coordinate care• % of partnering provider organizations with staffing ratios equal or better than recommended	Semi-Annual

		<ul style="list-style-type: none"> • Number of new patients with a care plan • Total number of patients with an active care plan 	
	P4P – State Reported	<ul style="list-style-type: none"> • Mental Health Treatment Penetration (Broad Version) • Outpatient Emergency Department Visits per 1000 member months • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • Substance Use Disorder Treatment Penetration 	Annual
DY 4 – 2020	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • Number of partners trained by focus area or pathway: projected vs. actual and cumulative • Number of partners participating and number implementing each selected pathway • % PCP in partnering provider organizations meeting PCMH requirement • % partnering provider organizations using selected care management technology platform • % partnering provider organizations sharing information (via HIE) to better coordinate care • % of partnering provider organizations with staffing ratios equal or better than recommended • Number of new patients with a care plan • Total number of patients with an active care plan 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> • <u>Follow-up After Discharge from ED for Mental Health</u>; • <u>Follow-up After Discharge from ED for</u> Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Inpatient Hospital Utilization • Mental Health Treatment Penetration (Broad Version) • Outpatient Emergency Department Visits per 1000 member months • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • Substance Use Disorder Treatment Penetration 	Annual
DY 5 – 2021	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • Number of partners trained by focus area or pathway: projected vs. actual and cumulative • Number of partners participating and number implementing each selected pathway • % PCP in partnering provider organizations meeting PCMH requirement • % partnering provider organizations using selected care management technology platform • % partnering provider organizations sharing information (via HIE) to better coordinate care 	Semi-Annual

		<ul style="list-style-type: none"> • % of partnering provider organizations with staffing ratios equal or better than recommended • Number of new patients with a care plan • Total number of patients with an active care plan • VBP arrangement with payments / metrics to support adopted model 	
	P4P – State Reported	<ul style="list-style-type: none"> • <u>Follow-up After Discharge from ED for Mental Health</u> • <u>Follow-up After Discharge from ED for</u> Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Inpatient Hospital Utilization • Mental Health Treatment Penetration (Broad Version) • Outpatient Emergency Department Visits per 1000 member months • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • Substance Use Disorder Treatment Penetration 	Annual

Project Implementation Guidelines: This section provides additional details on the project’s core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

Guidance for Project-Specific Domain 1 Strategies

- **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.
- **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 Use Disorder Providers, Social Workers, Nurse Practitioners, Primary Care Providers, Care Coordinators and Care Managers
 - Opportunities for use of telehealth and integration into work streams

- Workflow changes to support integration of new screening and care processes, care integration, communication
- Cultural and linguistic competency, health literacy deficiencies
- **Financial Sustainability:** Alignment between current payment structures and guideline-concordant physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Project 2C: Transitional Care

Project Objective: Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.

Target Population: Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with SMI discharged from inpatient care, or client returning to the community from prison or jail.

Evidence-based Approaches for Care Management and Transitional Care:

1. Interventions to Reduce Acute Care Transfers, INTERACT™4.0, <https://interact.fau.edu/> - a quality improvement program that focuses on the management of acute change in resident condition.
2. Transitional Care Model (TCM), <http://www.nursing.upenn.edu/ncth/transitional-care-model/> - 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-focused 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 of 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>.

Reference the “Project Implementation Guidelines” for additional details on the project’s core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

Project Stages

Stage 1 – Planning

Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> • Assess current state capacity to effectively deliver care transition services 	Completed current state assessment	DY 2, Q2
<ul style="list-style-type: none"> • Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project 	Completed Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2C efforts	DY 2, Q2
<ul style="list-style-type: none"> • Select target population and evidence-based approach informed by regional health needs 	Definition of target population and evidence based approach(s)	DY 2, Q2
<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ○ 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), 	Identified implementation partners and binding letters of intent	DY 2, Q2

health care and behavioral health care service providers, and reentry-involved community-based organizations, including state and local reentry councils.		
<ul style="list-style-type: none"> Develop project implementation plan, which must include: <ul style="list-style-type: none"> Implementation timeline Description of selected evidence-based approach, target population, justification for how approach is responsive to specific needs in the region If applicable, explanation of how the standard pathways selected in Project 2B align with the target population and evidence-based approach selected in this project; 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 Roles and responsibilities of implementation partners Description of service delivery mode, which may include home-based and/or telehealth options Describe strategies for ensuring long-term project sustainability 	Completed implementation plan	DY 2, Q3
Stage 2 – Implementation		
Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> Develop guidelines, policies, procedures and protocols as necessary to support consistent implementation of the model / approach 	Adopted guidelines, policies, procedures and/or procedures	DY 3, Q1
<ul style="list-style-type: none"> Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / approach 	Completed and approved QIP, reporting on QIP measures	DY 3, Q2
<ul style="list-style-type: none"> Implement project, including the following core components across each approach selected: <ul style="list-style-type: none"> Ensure implementation addresses the core components of each selected approach 	Estimated number of partners implementing each selected model / approach	DY 3, Q4

<ul style="list-style-type: none">○ Establish guidelines, policies, protocols and/or procedures as necessary to support consistent implementation of the model○ Incorporate activities that increase the availability of POLST forms across communities/agencies (http://polst.org/), where appropriate.○ 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.○ Develop systems to monitor and track performance○ Establish a performance-based payment model to incentivize progress and improvement.		
Stage 3 – Scale & Sustain		
Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none">• Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities	Document Stage 3 activities in Semi-Annual Reports.	DY 4, Q4
<ul style="list-style-type: none">• Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required		DY 4, Q4
<ul style="list-style-type: none">• Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion		DY 4, Q4
<ul style="list-style-type: none">• Identify and document the adoption by partnering providers of payment models that support transitional care and the transition to value based payment for services.		DY 4, Q4
Project Metrics		

Year	Metric Type	Metric	Report Timing
DY 3 – 2019	P4R – ACH Reported	<ul style="list-style-type: none"> Report against QIP metrics Number of partners trained by selected model / approach: projected vs. actual and cumulative Number of partners participating and number implementing each selected model / approach % partnering provider organizations sharing information (via HIE) to better coordinate care 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> Outpatient Emergency Department Visits per 1000 member months Percent Homeless (Narrow definition) Plan All-Cause Readmission Rate (30 Days) 	Annual
DY 4 – 2020	P4R – ACH Reported	<ul style="list-style-type: none"> Report against QIP metrics Number of partners trained by selected model / approach: projected vs. actual and cumulative Number of partners participating and number implementing each selected model / approach % partnering provider organizations sharing information (via HIE) to better coordinate care 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> Follow-up After Discharge from ED for Mental Health₇ Follow-up After Discharge from ED for Alcohol or Other Drug Dependence Follow-up After Hospitalization for Mental Illness Inpatient Hospital Utilization Outpatient Emergency Department Visits per 1000 member months Percent Homeless (Narrow Definition) Plan All-Cause Readmission Rate (30 Days) 	Annual
DY 5 – 2021	P4R – ACH Reported	<ul style="list-style-type: none"> Report against QIP metrics Number of partners trained by selected model / approach: projected vs. actual and cumulative Number of partners participating and number implementing each selected model / approach 	Semi-Annual

		<ul style="list-style-type: none"> • % partnering provider organizations sharing information (via HIE) to better coordinate care • VBP arrangement with payments / metrics to support adopted model 	
	P4P – State Reported	<ul style="list-style-type: none"> • <u>Follow-up After Discharge from ED for Mental Health</u>, • <u>Follow-up After Discharge from ED for</u> Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Inpatient Hospital Utilization • Outpatient Emergency Department Visits per 1000 member months • Percent Homeless (Narrow Definition) • Plan All-Cause Readmission Rate (30 Days) 	Annual

Project Implementation Guidelines: This section provides additional details on the project’s core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

Guidance for Project-Specific Domain 1 Strategies

- **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.
- **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 Use Disorder Providers, Social Workers, Nurse Practitioners, Primary Care Providers, Care Coordinators and Care Managers
 - Opportunities for use of telehealth and integration into work streams
 - Workflow changes to support integration of new screening and care processes, care integration, communication
 - Cultural and linguistic competency, health literacy deficiencies
- **Financial Sustainability:** Alignment between current payment structures and guideline-concordant physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated

care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for Evidence-Based Approaches

Evidence-based Approaches for Care Management and Transitional Care

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 health care 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 health care 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, re-hospitalizations);
- 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®

Implementation guidance:

- A meeting with a Transitions Coach® in the hospital (where possible, as 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

Set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness:

- 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.
- 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.

Evidence-informed Approaches to Transitional Care for People with Health and Behavioral Health Needs Leaving Incarceration

For projects targeting people transitioning from incarceration, include in the implementation plan at a minimum:

- Strategy to increase Medicaid enrollment, including:
 - 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; and
 - Agreements in place with relevant criminal justice agencies to ensure individuals (1) above receive community-based, Medicaid-reimbursable care in a timely matter when clinically appropriate (with particular consideration of populations “at risk,” such as the elderly, LGBTQ, chronically ill, those with serious mental illness and/or substance use disorders, and more).
- Strategy for beginning care planning and transition planning prior to release, including:

- A process for conducting in-reach to prison/jails and correctional facilities, which leverages and contemplates resources, strengths, and relationships of all partners;
- A strategy for engaging individuals in transitional care planning as a one component to a larger reentry transition plan; and
- A strategy for ensuring care planning is conducted in a culturally competent manner and contemplates social determinants of health, barriers to accessing services or staying healthy, as well as barriers to meeting conditions of release or staying crime-free.

Project 2D: Diversion Interventions

Project Objective: Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.

Target Population: Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

Evidence-supported Diversion Strategies:

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 persons who present at the ED for non-emergency conditions, which may be oral health, general physical health, and/or behavioral health conditions.
2. **Community Paramedicine Model**, <http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf> - an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations. Additional resources include: <http://communityparamedic.org/>, <http://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf>, and <https://www.ruralhealthinfo.org/topics/community-paramedicine>.
3. **Law Enforcement Assisted Diversion, LEAD®** <http://www.leadbureau.org/> - 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.

Reference the “Project Implementation Guidelines” for additional details on the project’s core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

Project Stages

Stage 1 – Planning

Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> Assess current state capacity to effectively deliver diversion interventions 	Completed current state assessment	DY 2, Q2
<ul style="list-style-type: none"> Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project 	Completed Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2C efforts	DY 2, Q2
<ul style="list-style-type: none"> Select target population and evidence-supported approach informed by regional health needs <ul style="list-style-type: none"> If applicable: Determine which non-emergent condition(s) should be the focus of ED Diversion and/or Community Paramedicine (oral health, general physical health, and/or behavioral health conditions). 	Definition of target population(s) and evidence-supported strategy/strategies	DY 2, Q2
<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> For LEAD: Establish a community advisory group that includes representation from community members, health care and social services, law enforcement and community public safety leaders 	Identified implementation partners and binding letters of intent; If LEAD is selected: identify participants of community advisory group	DY 2, Q2
<ul style="list-style-type: none"> Develop project implementation plan, which must include: <ul style="list-style-type: none"> Implementation timeline A description of the target communities and populations, including the rationale for selecting them based on regional health needs In applicable, explanation of how the standard pathways selected in Project 2B align with the target population and evidence-based approach selected in this project. 	Completed implementation plan	DY 2, Q3

<ul style="list-style-type: none"> ○ List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely manner. ○ 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. ○ Description of the service delivery mode, which may include home-based and/or telehealth options ○ Roles and responsibilities of partners ○ Describe strategies for ensuring long-term project sustainability 		
Stage 2 – Implementation		
Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> • Develop guidelines, policies, procedures and protocols as necessary to support consistent implementation for each selected strategy 	Adopted guidelines, policies, procedures and/or procedures	DY 3, Q1
<ul style="list-style-type: none"> • Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support each selected strategy 	Completed and approved QIP, reporting on QIP measures	DY 3, Q2
<ul style="list-style-type: none"> • Implement project, including the following core components across each approach selected: <ul style="list-style-type: none"> ○ Ensure implementation addresses the core components of each selected approach ○ Ensure 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. 	Estimated number of partners implementing each selected strategy	DY 3, Q4

<ul style="list-style-type: none">○ Establish mechanisms for coordinating care management plans with related community-based services and supports such as those provided through supported housing programs.○ Establish a performance-based payment model to incentivize progress and improvement.			
Stage 3 – Scale & Sustain			
Milestone		Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none">• Expand the model to additional communities and/or partner organizations.		Document Stage 3 activities in Semi-Annual Reports.	DY 4, Q4
<ul style="list-style-type: none">• Employ continuous quality improvement methods to refine the approach, updating the approach and adopted guidelines, policies and procedures as required			DY 4, Q4
<ul style="list-style-type: none">• Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion			DY 4, Q4
<ul style="list-style-type: none">• Identify and document the adoption by partnering providers of payment models that support diversion activities and the transition to value based payment for services.			DY 4, Q4
Project Metrics			
Year	Metric Type	Metric	Report Timing
DY 3 – 2019	P4R – ACH Reported	<ul style="list-style-type: none">• Report against QIP metrics• Number of partners trained by selected approach / strategy: projected vs. actual and cumulative• Number of partners participating and number implementing each selected approach / strategy• % partnering provider organizations sharing information (via HIE) to better coordinate care• % of partnering provider organizations with staffing ratios equal or better than recommended	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none">• Outpatient Emergency Department Visits per 1000 member months• Percent Homeless (Narrow Definition)	Annual

DY 4 – 2020	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • Number of partners trained by selected approach / strategy: projected vs. actual and cumulative • Number of partners participating and number implementing each selected approach / strategy • % partnering provider organizations sharing information (via HIE) to better coordinate care • % of partnering provider organizations with staffing ratios equal or better than recommended 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> • Outpatient Emergency Department Visits per 1000 member months • Percent Arrested • Percent Homeless (Narrow Definition) 	Annual
DY 5 – 2021	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • Number of partners trained by selected approach / strategy: projected vs. actual and cumulative • Number of partners participating and number implementing each selected approach / strategy • % partnering provider organizations sharing information (via HIE) to better coordinate care • % of partnering provider organizations with staffing ratios equal or better than recommended • VBP arrangement with payments / metrics to support adopted model 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> • Outpatient Emergency Department Visits per 1000 member months • Percent Arrested • Percent Homeless (Narrow Definition) 	Annual

Project Implementation Guidelines: This section provides additional details on the project’s core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

Guidance for Project-Specific Domain 1 Strategies

- **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.
- **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 Use Disorder Providers, Social Workers, Nurse Practitioners, Primary Care Providers, Care Coordinators and Care Managers
 - Opportunities for use of telehealth and integration into work streams
 - Workflow changes to support integration of new screening and care processes, care integration, communication
 - Cultural and linguistic competency, health literacy deficiencies
- **Financial Sustainability:** Alignment between current payment structures and guideline-concordant physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for Evidence-Based Approaches

Emergency Department (ED) Diversion, a systematic approach to re-directing and managing persons who present at the ED for non-emergency conditions, which may be oral health, general physical health, and/or behavioral health conditions.

While 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 beneficiaries 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 beneficiaries with minor illnesses who do not have a primary care provider. After completing appropriate screenings validating a non-emergency need, will assist the patient in receiving a timely appointment with a primary care provider.

Community Paramedicine Model, an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations.

Approved Medical Program Directors (MPDs), working with first responders, ED practitioners, and primary care providers to develop protocols, which may include transporting beneficiaries with non-emergency needs to alternate (non-ED) care sites, such as urgent care centers and/or patient-centered medical homes. Providers may collaborate to develop Community Paramedicine programs. Core issues to be addressed in the design of a community paramedicine program should include:

- A detailed explanation about how the community paramedics would be trained and would maintain their skills.
- A description of how appropriate medical supervision would be ensured.
- A description of how data to evaluate quality assurance and quality improvement activities would be obtained and monitored.
- An evaluation plan for assessing the impacts on quality and cost of care, and how the local EMS agency will ensure that all patients are treated equally regardless of insurance status and health condition, among other factors.
- A plan for integrating the CP program with other community-based health care and social service programs and for analyzing the potential impacts of the CP program on these providers, including safety-net providers.
- How to leverage the potential of electronic health records (EHRs) and Health Information Exchange (HIE) to facilitate communication between community paramedics and other health care providers.

Law Enforcement Assisted Diversion, LEAD®, 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.

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.

- Apply a harm reduction/housing first approach – develop individual plans that address the problematic behavior as well as the factors driving that behavior.
- Consider the use of peer supports.
- Provide training in the areas of trauma-informed care and cultural competencies.
- Prepare an evaluation plan.

Domain 3: 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 one required project and three optional projects.

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

Project Objective: Support the achievement of the state’s goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.

Target Population: Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.

Recommended Resources for Identifying Promising Practices / Evidence-Supported Strategies:

Clinical Guidelines

1. AMDG’s Interagency Guideline on Prescribing Opioids for Pain, <http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>
2. CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016 <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>
3. 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

1. 2016 Washington State Interagency Opioid Working Plan, http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf.
2. Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan, http://www.theathenaforum.org/prevention_priorities.

Implementation Plans must demonstrate a multi-pronged approach that includes strategies targeting the following essential components:

1. Prevention: Prevent Opioid Use and Misuse
2. Treatment: Link Individuals with OUD with Treatment Services
3. Overdose Prevention: Intervene in Opioid Overdoses to Prevent Death
4. Recovery: Promote Long-Term Stabilization and Whole-Person Care

Reference the “Project Implementation Guidelines” for additional details on the project’s core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

Project Stages

Stage 1 – Planning

Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> Assess the current regional capacity to effectively impact the opioid crisis and include strategies to leverage current capacity and address identified gaps. 	Completed current state assessment	DY 2, Q2
<ul style="list-style-type: none"> Identify how strategies for Domain I focus areas – Systems for Population Health Management/HIT, Workforce, Value-based Payment – will support project 	Completed Workforce, Technology and Financial Sustainability plans as defined in Domain 1, reflective of support for Project 3A efforts	DY 2, Q2
<ul style="list-style-type: none"> Select target population and evidence-based approach informed by regional health needs. (Consider areas with limited access to treatment for opioid disorder, and rates of opioid use, misuse and abuse.) 	Definition of target population and evidence based approach	DY 2, Q2
<ul style="list-style-type: none"> Identify and engage project implementation partnering provider organizations, including: <ul style="list-style-type: none"> 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, physical, mental health and substance use disorder, (SUD) providers and teaching institutions. 	List of implementation partners, must include physical health, mental health and SUD providers with formal written commitment to participate	DY 2, Q2
<ul style="list-style-type: none"> Develop project implementation plan, which must include, at a minimum: <ul style="list-style-type: none"> Implementation timelines for each strategy 	Completed Implementation plan	DY 2, Q3

<ul style="list-style-type: none"> ○ A detailed description of how the ACH will implement selected strategies and activities that together create a comprehensive strategy addressing prevention, treatment, overdose prevention, and recovery supports aimed at supporting whole-person health. ○ Identify the system supports that need to be activated to support an increase in the number of 1) providers prescribing buprenorphine; 2) patients receiving medications approved for treatment of OUD;; 3) the different settings in which buprenorphine is or should be prescribed and 4) the development of shared care plans/communications between the treatment team of physical/mental health and SUD providers. ○ Roles and responsibilities of key organizational and physical, mental health and substance use disorder (SUD) provider participants, including community-based service organizations, along with justification on how the partners are culturally relevant and responsive to the specific population in the region. ○ 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. ○ Specific strategies and actions to be implemented in alignment with the 2016 Washington State Interagency Opioid Working Plan. ○ Describe strategies for ensuring long-term project sustainability 		
Stage 2 – Implementation		
Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> • Develop guidelines, policies, procedures and protocols as necessary to support consistent implementation of the strategy / approach 	Adopted guidelines, policies, procedures and/or procedures	DY 3, Q1
<ul style="list-style-type: none"> • Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / approach 	Completed and approved QIP, reporting on QIP measures	DY 3, Q2

<ul style="list-style-type: none"> • Convene or leverage existing local partnerships to implement project, one or more such partnerships may be convened. <ul style="list-style-type: none"> ○ Each partnership should include health care service, including mental health and SUD providers, community-based service providers, executive and clinical leadership, consumer representatives, law enforcement, criminal justice, emergency medical services, 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 project 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. 	Number and list of community partnerships; for each include list of members and roles.	DY 3, Q2
<ul style="list-style-type: none"> • Implement selected strategies/approaches across the core components: <ol style="list-style-type: none"> 1) Prevention 2) Treatment 3) Overdose Prevention 4) Recovery Supports • Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into project implementation plan. 	Identify number of providers and community partners implementing strategies	DY 3, Q4
<ul style="list-style-type: none"> • Develop a plan to address gaps in the number or locations of providers offering recovery support services, (this may include the use of peer support workers). 	Completed plan to address gaps in number or location of providers offering recovery support services.	DY 3, Q4
Stage 3 – Scale & Sustain		
Milestone	Proof of Completion	Timeline

			<i>(complete no later than)</i>	
<ul style="list-style-type: none">• Increase scale of activities by adding partners and/or reaching new communities under the current initiative (e.g. to cover additional high needs geographic areas), 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			Document Stage 3 activities in Semi-Annual Reports.	DY 4, Q4
<ul style="list-style-type: none">• Review and apply data to inform decisions regarding specific strategies and action to be spread to additional settings or geographical areas.				
<ul style="list-style-type: none">• Convene and support platforms to facilitate shared learning and exchange of best practices and results to date.				
<ul style="list-style-type: none">• Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the selected strategies/approaches.				
<ul style="list-style-type: none">• Engage and encourage Managed Care Organizations to develop/refine model benefits aligned with evidence-based clinical guideline-concordant care and best practice recommendations.<ul style="list-style-type: none">○ Encourage payment models that support non-opioid pain therapies and approach to addressing OUD prevention and management in the transition to VBP for services.○ Encourage payment models that support practices that have implemented a Hub and Spoke, or Nurse Care Manager Model○ Encourage payment models that support the care of persons across the continuum of care from diagnosis, through treatment and for ongoing recovery support.				
<ul style="list-style-type: none">• Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion				
Project Metrics				
Year	Metric Type	Metric	Report Timing	
DY 3 – 2019	P4R – ACH Reported	<ul style="list-style-type: none">• Report against QIP metrics• Number and locations of MDs, ARNPs, and PAs who are approved to prescribe buprenorphine.	Semi-Annual	

		<ul style="list-style-type: none"> • Number and locations of mental health and SUD providers delivering acute care and recovery services to people with OUDs. • Number and list of community partnerships. For each include list of members and roles, including the identification of partners through which MAT is accessible. • 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 or linking to the PDMP. • 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. • Number and types of access points in which persons can receive medication assisted therapy, such as EDs, SUD and mental health settings, correctional settings or other non-traditional community based access points. 	
	P4P – State Reported	<ul style="list-style-type: none"> • Medication Assisted Therapy (MAT): With Buprenorphine or Methadone • Outpatient Emergency Department Visits per 1000 Member Months • Patients on high-dose chronic opioid therapy by varying thresholds • Patients with concurrent sedatives prescriptions 	Annual
DY 4 – 2020	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • Number and locations of MDs, ARNPs, and PAs who are approved to prescribe buprenorphine. • Number and locations of mental health and SUD providers delivering acute care and recovery services to people with OUDs. • 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. 	Semi-Annual

		<ul style="list-style-type: none"> • 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 or linking to the PDMP. • 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. • Number and types of access points in which persons can receive medication assisted therapy, such as EDs, SUD and mental health settings, correctional settings or other non-traditional community based access points. 	
	P4P – State Reported	<ul style="list-style-type: none"> • Inpatient Hospital Utilization • Medication Assisted Therapy (MAT): With Buprenorphine or Methadone • Outpatient Emergency Department Visits per 1000 Member Months • Patients on high-dose chronic opioid therapy by varying thresholds • Patients with concurrent sedatives prescriptions • Substance Use Disorder Treatment Penetration (Opioid) 	Annual
DY 5 – 2021	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • Number and locations of MDs, ARNPs, and PAs who are approved to prescribe buprenorphine. • Number and locations of mental health and SUD providers delivering acute care and recovery services to people with OUDs. • 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 or linking to the PDMP. • Number of local health jurisdictions and community-based service organizations that received technical assistance to organize or expand syringe exchange programs. 	Semi-Annual

		<ul style="list-style-type: none"> • Number of emergency department with protocols in place for providing overdose education and take home naloxone to individuals seen for opioid overdose. • Number and types of access points in which persons can receive medication assisted therapy, such as EDs, SUD and mental health settings, correctional settings or other non-traditional community based access points. 	
	P4P – State Reported	<ul style="list-style-type: none"> • Inpatient Hospital Utilization • Medication Assisted Therapy (MAT): With Buprenorphine or Methadone • Outpatient Emergency Department Visits per 1000 Member Months • Patients on high-dose chronic opioid therapy by varying thresholds • Patients with concurrent sedatives prescriptions • Substance Use Disorder Treatment Penetration (Opioid) 	Annual

Project Implementation Guidelines: This section provides additional details on the project’s core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

Guidance for Project-Specific Domain 1 Strategies

- **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 (PDMP) and the Emergency Department Information Exchange; and strategies to increase use of PDMP 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.
- **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 PDMP, and recognition and treatment of opioid use disorder (OUD).
 - 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 OUD.
- Identifying critical workforce gaps in the substance use treatment system and develop initiatives to attract and retain skilled professionals in the field.
- **Financial Sustainability:** Alignment between current payment structures and guideline-concordant care with regard to opioid prescribing; and evidence-supported treatments and recovery supports for OUDs that incorporate current state and anticipated future state of VBP arrangements to support opioid abuse prevention and control efforts into the regional VBP transition plan.

Guidance for Evidence-Based Approaches

Implementation Plan: *Each region will develop a plan that provides a detailed description of how the ACH will implement selected strategies and activities that together create a comprehensive strategy addressing prevention, treatment, overdose prevention, and recovery supports aimed at supporting whole-person health.*

Prevention: Prevent opioid misuse and abuse

- **Promote use of best practices among health care providers for prescribing opioids for acute and chronic pain:**
 - Promote the use of the PDMP and its linkage into electronic health record systems in an effort to increase the number of providers regularly using the PDMP and the timely input of prescription medication data into the PDMP.
 - Train, coach and offer consultation with providers on opioid prescribing and pain management.
 - Promote the integration of telehealth and telephonic approaches.
 - Support innovative telehealth in rural and underserved areas to increase capacity of communities to support OUD prevention and treatment.
- **Together with the Center for Opioid Safety Education and other partners, such as statewide associations, raise awareness and knowledge of the possible adverse effects of opioid use, including overdose, among opioid users:**
 - Promote accurate and consistent messaging about opioid safety and to address the stigma of addiction by public health, health care providers, law enforcement, community coalitions, and others specific to the region and local communities.
- **Prevent opioid initiation and misuse in communities, particularly among youth:**

- Build awareness and identify gaps as they relate to ongoing prevention efforts (e.g. school-based programs); connect with local health jurisdictions and Washington State Department of Health and Department of Behavioral Health and Recovery to understand the efforts currently underway in the region.
- **Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse:**
 - Identify and map Drug Take Back programs to highlight where additional programs could be implemented or expanded to meet community need.
 - Promote the use of home lock boxes to prevent unintended access to medication.

Treatment: Link individuals with OUD to treatment services

- **Build capacity of health care providers to recognize signs of possible opioid misuse, effectively identify OUD, and link patients to appropriate treatment resources:**
 - Effective treatment of OUD includes medication and psychosocial supports. Conduct inventory of existing treatment resources in the community (e.g. formal treatment programs and practices/providers providing Medication Assisted Treatment, [methadone, buprenorphine, naltrexone]).
 - Educate providers across all health professions on how to recognize signs of opioid misuse and OUD among patients and how to use appropriate tools to identify OUD.
 - Offer patients brief interventions and referrals to medication assisted treatment and psychosocial support services, if needed.
 - 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.
- **Expand access to, and utilization of, clinically-appropriate evidence-based practices for OUD treatment in communities, particularly MAT:**
 - Increase the number of providers certified to prescribe OUD medications in the region; promote the application and receipt of physician, ARNP and Physician Assistant waivers for providers in a variety of settings for example: hospitals, primary care clinics, correctional facilities, mental health and SUD treatment agencies, methadone clinics and other community based sites.
 - 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.
 - Build structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers and staff to implement and sustain medication assisted treatment, such as methadone and buprenorphine; examples of evidence-based models include the hub and spoke and nurse care manager models.

- Promote and support pilot projects that offer low barrier access to buprenorphine in efforts to reach persons at high risk of overdose; for example in emergency departments, correctional facilities, syringe exchange programs, SUD and mental health programs.
- Build linkages/communication pathways between those providers providing medication and those providing psychosocial therapies.
- **Expand access to, and utilization of, OUD medications in the criminal justice system:**
 - 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 correctional facilities into the community and for offenders living in the community under correctional supervision, through effective care coordination and engagement in transitional services.
 - Ensure continuity of treatment for persons with an identified OUD need upon exiting correctional facilities by providing direct linkage to community providers for ongoing care.
- **Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage beneficiaries in support services, including housing:**
 - Provide technical assistance to local health jurisdictions and community-based service organizations to organize or expand syringe exchange and drug user health services.
 - Develop/support linkages between syringe exchange programs and physical health providers to treat any medical needs that require referral.
- **Identify and treat OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns:**
 - Disseminate the guideline Substance Abuse during Pregnancy: Guidelines for Screening and Management.
 - Disseminate the Washington State Hospital Association Safe Deliveries Roadmap standards to health care providers.
 - Educate pediatric and family medicine providers to recognize and appropriately manage newborns with NAS.
 - Increase the number of obstetric and maternal health care providers permitted to dispense and prescribe MAT through the application and receipt of DEA approved waivers.
 - Establish or enhance community pathways to support PPW with connecting to care services that address whole-person health, including physical, mental and substance use disorder treatment needs during, through and after pregnancy.

Overdose Prevention: Intervene in opioid overdoses to prevent death

- **Educate 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**
 - Provide technical assistance to first responders, chemical dependency counselors, and 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.
- **Make system-level improvements to increase availability and use of naloxone**
 - Establish standing orders in all counties and all opioid treatment programs to authorize community-based naloxone distribution and lay administration.
 - Promote co-prescribing of naloxone for pain patients as best practice per AMDG guidelines.
- **Together with the Center for Opioid Safety Education, promote awareness and understanding of Washington State's Good Samaritan Law**
 - Educate law enforcement, prosecutors and the public about the Good Samaritan Response Law.

Recovery: Promote long-term stabilization and whole-person care

- Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.
- Establish or enhance community-based recovery support systems, networks, and organizations to develop capacity at the local level to design and implement peer and other recovery support services as vital components of recovery-oriented continuum of care.
- Support whole person health in recovery:
Connect Substance Use Disorder providers with primary care, behavioral health, social service and peer recovery support providers to address access, referral and follow up for services.

Project 3B: Reproductive and Maternal/Child Health

Project Objective: Ensure that women have access to high quality reproductive health care throughout their lives and promote the health safety of Washington's children.

Target Population: Medicaid beneficiaries who are women of reproductive age, pregnant women, mothers of children ages 0 – 3, and children ages 0 – 17.

Evidence-based Approach:

1. Strategies to improve women's and men's health to ensure families have intended and healthy pregnancies that lead to healthy children. The CDC has provided 10 recommendations that aim to improve a woman's health before conception, whether before a first or a subsequent pregnancy: <https://www.cdc.gov/preconception/hcp/recommendations.html>.
2. Evidence-based home visiting model for pregnant high risk mothers, including high risk first time mothers. Potential approaches can include Nurse Family Partnership (NFP) **or other federally recognized evidence-based home visiting model currently operating in Washington State.** The following federally recognized evidence-based home visiting models are currently operating in Washington State:
 - a. Nurse Family Partnership (NFP), <http://www.nursefamilypartnership.org/communities/model-elements>
NFP provides first-time, low income mothers and their children with nurse-led home-based support and care.
 - b. Early Head Start Home-Based Model (EHS), <https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/poi/miechv-ehs/miechv.html>. EHS works with parents to improve child health, prevent child abuse and neglect, encourage positive parenting and promote child development and school readiness.
 - c. Parents as Teachers (PAT), <http://parentsasteachers.org/evidence-based-model/PAT>, promotes optimal early development, learning and health of children by supporting and engaging their parents and caregivers.
 - d. Family Spirit, <http://www.jhsph.edu/research/affiliated-programs/family-spirit/>, offers culturally tailored home-visiting to promote the optimal health and wellbeing of American Indian parents and their children.
3. Evidence-based model or promising practice to improve regional well-child visit rates and childhood immunization rates. Possible approaches include:
 - a. Bright Futures. <https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx>.
 - b. Stony Brook Children's Hospital Enriched Medical Home Intervention (EMHI).

<http://sb.cc.stonybrook.edu/news/children/homeintervention-improves-child-vaccination-rates-among-children-living-in-poverty.php>.

Reference the “Project Implementation Guidelines” for additional details on the project’s core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

Project Stages

Stage 1 – Planning

Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> Assess current state capacity to effectively focus on the need for high-quality reproductive and maternal and child health care 	Completed current state assessment	DY 2, Q2
<ul style="list-style-type: none"> Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project 	Completed Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 3B efforts	DY 2, Q2
<ul style="list-style-type: none"> Select evidence-based approach(es) and specific target population(s) informed by regional health needs 	Definition of target population and evidence based approach	DY 2, Q2
<ul style="list-style-type: none"> 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. 	Identified implementation partners and binding letters of intent	DY 2, Q2
<ul style="list-style-type: none"> For each selected approach, develop a project implementation plan that includes at minimum: <ul style="list-style-type: none"> Implementation timeline. 	Completed implementation plan	DY 2, Q3

<ul style="list-style-type: none"> ○ 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. ○ Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts and/or duplication of federal funds. Project plans must consider current implementation of all Home Visiting Models and how they might be strengthened or expanded. ○ Description of the mode of service delivery, which may include home-based and/or telehealth options. ○ Roles and responsibilities of partners. ○ Describe strategies for ensuring long-term project sustainability. 		
Stage 2 – Implementation		
Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> • Develop guidelines, policies, procedures and protocols 	Adopted guidelines, policies, procedures and/or procedures	DY 3, Q1
<ul style="list-style-type: none"> • Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected evidence-based approach(es) 	Completed and approved QIP, reporting on QIP measures	DY 3, Q2
<ul style="list-style-type: none"> • Implement project, including the following core components across each approach selected: <ul style="list-style-type: none"> ○ Ensure implementation addresses the core components of each selected approach ○ 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. 	<p>Identified number of partners and providers implementing evidence-based approach (es).</p> <p>Identify number of partners and providers trained on the evidence-based approach: projected vs. actual and cumulative.</p>	DY 3, Q4

<ul style="list-style-type: none">○ 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 3 – Scale & Sustain			
Milestone		Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none">• Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities.		Document Stage 3 activities in Semi-Annual Reports.	DY 4, Q4
<ul style="list-style-type: none">• Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required.			DY 4, Q4
<ul style="list-style-type: none">• Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.			DY 4, Q4
<ul style="list-style-type: none">• Identify and document the adoption by partnering providers of payment models that support selected strategies and the transition to value based payment for services.			DY 4, Q4
Project Metrics			
Year	Metric Type	Metric	Report Timing
DY 3 – 2019	P4R – ACH Reported	<ul style="list-style-type: none">• Report against QIP metrics• Number of partners trained by selected model / approach: projected vs. actual and cumulative• Number of partners participating and number implementing each selected model / approach	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none">• Chlamydia Screening in Women Ages 16 to 24• Mental Health Treatment Penetration (Broad Version) (Women/children)	Annual

		<ul style="list-style-type: none"> • Outpatient Emergency Department Visits per 1000 Member Months • Substance Use Disorder Treatment Penetration (Women/children) • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life 	
DY 4 – 2020	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • Number of partners trained by selected model / approach: projected vs. actual and cumulative • Number of partners participating and number implementing each selected model / approach 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> • Childhood Immunization Status <u>(Combo 10)</u> • Chlamydia Screening in Women Ages 16 to 24 • Contraceptive Care – Access Measures (NQF# 2903, 2904, 2902) <ul style="list-style-type: none"> ○ Performance assessed by annual improvement on at least one of the Contraceptive Care Access measures. • Mental Health Treatment Penetration (Broad Version) (Women/children) • Outpatient Emergency Department Visits per 1000 Member Months • <u>Timeliness of Prenatal Care:</u> Prenatal care in the first trimester of pregnancy • Substance Use Disorder Treatment Penetration (Women/children) • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life • Well-Child Visits in the First 15 Months of Life 	Annual
DY 5 – 2021	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • Number of partners trained by selected model / approach: projected vs. actual and cumulative • Number of partners participating and number implementing each selected model / approach 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> • Childhood Immunization Status <u>(Combo 10)</u> • Chlamydia Screening in Women Ages 16 to 24 • Contraceptive Care – Access Measures (NQF# 2903, 2904, 2902) <ul style="list-style-type: none"> ○ Performance assessed by annual improvement on at least one of the Contraceptive Care Access measures. 	Annual

		<ul style="list-style-type: none"> • Mental Health Treatment Penetration (Broad Version) (Women/children) • Outpatient Emergency Department Visits per 1000 Member Months • Prenatal care in the first trimester of pregnancy • Substance Use Disorder Treatment Penetration (Women/children) • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life • Well-Child Visits in the First 15 Months of Life 	
--	--	--	--

Project Implementation Guidelines: This section provides additional details on the project’s core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

Guidance for Project-Specific Domain 1 Strategies

- **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.
- **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 Use Disorder Providers, Social Workers, Nurse Practitioners, Primary Care Providers, Care Coordinators and Care Managers
 - Opportunities for use of telehealth and integration into work streams
 - Workflow changes to support integration of new screening and care processes, care integration, communication
 - Cultural and linguistic competency, health literacy deficiencies
- **Financial Sustainability:** Alignment between current payment structures and guideline-concordant reproductive, maternal and child health care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support improvement of reproductive, maternal and child health efforts into the regional VBP transition plan. Development of model benefit(s) to cover reproductive, maternal and child health services.

Guidance for Evidence-Based Approaches

Approaches to Improve Reproductive, Maternal and Children's Health

Implementation of evidence-based and emerging strategies to improve reproductive health. *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. More information can be found at: <https://www.cdc.gov/preconception/hcp/recommendations.html>*

Strategies to improve women's and men's health to ensure families have intended and healthy pregnancies that lead to healthy children. In particular, ACHs should consider evidence-based models to improve utilization of effective reproductive health strategies, including pregnancy intention counseling, healthy behaviors and risk reduction, effective contraceptive use, safe and quality perinatal care, interconception care, and general preventive care.

- Washington has acted on these recommendations by providing a program for uninsured people to obtain basic family planning services (Take Charge, <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/apple-health-take-charge-family-planning>) and working with providers to improve obstetric outcomes (<http://www.hca.wa.gov/about-hca/clinical-collaboration-and-initiatives/ob-outcomes>) 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.

Implementation for a home visiting model should follow evidence-based practice standards.

Evidence-based home visiting model for pregnant high risk mothers, including high risk first time mothers. Potential approaches can include Nurse Family Partnership (NFP) **or other federally recognized evidence-based home visiting model currently operating in Washington State.** If chosen, implementing agencies must meet all fidelity, essential requirements and/or program standard requirements as defined by the model developer. The project must demonstrate a valid need for home visiting service expansion and that services will be coordinated. The following federally recognized evidence-based home visiting models are currently operating in Washington State:

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

- b. Early Head Start Home-Based Model (EHS), <https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/poi/miechv-ehs/miechv.html>. EHS works with parents to improve child health, prevent child abuse and neglect, encourage positive parenting and promote child development and school readiness.
- c. Parents as Teachers (PAT), <http://parentsasteachers.org/evidence-based-model/> PAT, promotes optimal early development, learning and health of children by supporting and engaging their parents and caregivers.
- d. Family Spirit, <http://www.jhsph.edu/research/affiliated-programs/family-spirit/>, offers culturally tailored home-visiting to promote the optimal health and wellbeing of American Indian parents and their children.

Implementation of an evidence-based model or promising practice to improve regional well-child visit rates (for ages 3-6) and childhood immunization rates.

If chosen, implementing agencies must meet all fidelity, essential requirements and/or program standard requirements as defined by the model developer.

- a. Bright Futures. <https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx>.
- b. Stony Brook Children's Hospital Enriched Medical Home Intervention (EMHI). <http://sb.cc.stonybrook.edu/news/children/home-intervention-improves-child-vaccination-rates-among-children-living-in-poverty.php>.

Project 3C: Access to Oral Health Services

Project Objective: Increase access oral health services to prevent or control the progression of oral disease and ensure that oral health is recognized as a fundamental component of whole-person care.

Target Population: All Medicaid beneficiaries, especially adults.

Evidence-based Approach:

- 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.
- [Mobile/Portable Dental Care, http://www.mobile-portabledentalmanual.com/](http://www.mobile-portabledentalmanual.com/) - 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.

Reference the “Project Implementation Guidelines” for additional details on the project’s core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

Project Stages

Stage 1 – Planning

Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> • Assess current state capacity to effectively impact access to oral health services 	Completed current state assessment	DY 2, Q2
<ul style="list-style-type: none"> • Identify how strategies for Domain 1 focus areas – Systems for Population Health Management/HIT, Workforce, Value-based Payment – will support project 	Completed Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective	DY 2, Q2

	of support for Project 3C efforts	
<ul style="list-style-type: none"> • Select target population and evidence-based approach informed by regional health needs <ul style="list-style-type: none"> ○ Identify communities or sub-regions with demonstrated shortages of dental providers or otherwise limited access to oral health services. 	Definition of target population and evidence based approach Identified communities or sub-regions	DY 2, Q2
<ul style="list-style-type: none"> • Identify, recruit, and secure formal commitments for participation from implementation partners, to include, at minimum, primary care providers and dentists, via a written agreement. <ul style="list-style-type: none"> ○ Must demonstrate sufficient initial engagement to implement the approach in a timely manner. (Include dentists/dental practices and periodontists that will serve as referral sources.) 	Identified and create list of partners including primary care providers and dentists and executed written agreement	DY 2, Q2
<ul style="list-style-type: none"> • Develop project implementation plan including: <ul style="list-style-type: none"> ○ Implementation timeline ○ Evidence-based approach, justification for how the approach is responsive to the specific needs in the region. ○ Explanation of 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. ○ Partner roles and responsibilities ○ Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts. ○ Description of the mode of service delivery, which may include home-based and/or telehealth options. ○ Describe strategies for ensuring long-term project sustainability 	Completed implementation plan and timeline	DY 2, Q3
Stage 2 – Implementation		
Milestone	Proof of Completion	Timeline (complete no later than)

<ul style="list-style-type: none"> Develop guidelines, policies, procedures and protocols in Oral Health in Primary Care using the five elements of the Oral Health Delivery Framework and Mobile and/or Portable Dental Care. 	Adopted guidelines, policies, procedures and/or procedures	DY 3, Q1
<ul style="list-style-type: none"> Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support each selected strategy 	Completed and approved QIP, reporting on QIP measures	DY 3, Q2
<ul style="list-style-type: none"> Implement project, including the following core components across each approach selected: <ul style="list-style-type: none"> Ensure implementation addresses the core components of each selected approach Implement robust bi-directional communications strategies, to support the care model. Establish mechanisms for coordinating care with related community-based services and supports. Develop workflows to operationalize the protocol, specifying which member of the care performs each function, inclusive of when referral to dentist or periodontist is needed. Establish referral relationships with dentists and other specialists, such as ENTs and periodontists 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 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; may include adoption of dental diagnostic coding to assess and document severity level for both care and periodontal disease. Engage with payers in discussion of payment approaches to support access to oral health services. 	Estimated number of partners implementing each selected strategy	DY 3, Q4
Stage 3 – Scale & Sustain		

Milestone		Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> • 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, updating model and adopted guidelines, policies and procedures as required. • Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion • Identify and document the adoption by partnering providers of payment models that support access to oral health services and the transition to value based payment for services. 		Document Stage 3 activities in Semi-Annual Reports.	DY 4, Q4
			DY 4, Q4
			DY 4, Q4
			DY 4, Q4
Project Metrics			
Year	Metric Type	Metric	Report Timing
DY 3 – 2019	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • Number of Medicaid beneficiaries served: projected vs. actual and cumulative • Number of partners and providers trained on the evidence-based approach: projected vs. actual and cumulative • Number of partners and providers implementing the evidence-based approach(es) 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> • Outpatient Emergency Department Visits per 1000 member months • Primary Caries Prevention Intervention as Part of Well/III Child Care as Offered by Primary Care Medical Providers • Utilization of Dental Services by Medicaid Beneficiaries 	Annual
DY 4 – 2020	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • Number of Medicaid beneficiaries served: projected vs. actual and cumulative • Number of partners and providers trained on the evidence-based approach: projected vs. actual and cumulative • Number of partners and providers implementing the evidence-based approach(es) 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> • Dental Sealants for Children at Elevated Caries Risk • Ongoing Care in Adults with Chronic Periodontitis • Outpatient Emergency Department Visits per 1000 member months 	Annual

		<ul style="list-style-type: none"> Periodontal Evaluation in Adults with Chronic Periodontitis Primary Caries Prevention Intervention as Part of Well/III Child Care as Offered by Primary Care Medical Providers Utilization of Dental Services by Medicaid Beneficiaries 	
DY 5 – 2021	P4R – ACH Reported	<ul style="list-style-type: none"> Report against QIP metrics Number of Medicaid beneficiaries served: projected vs. actual and cumulative Number of partners and providers trained on the evidence-based approach: projected vs. actual and cumulative Number of partners and providers implementing the evidence-based approach(es) 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> Dental Sealants for Children at Elevated Caries Risk Ongoing Care in Adults with Chronic Periodontitis Outpatient Emergency Department Visits per 1000 member months Periodontal Evaluation in Adults with Chronic Periodontitis Primary Caries Prevention Intervention as Part of Well/III Child Care as Offered by Primary Care Medical Providers Utilization of Dental Services by Medicaid Beneficiaries 	Annual

Project Implementation Guidelines: This section provides additional details on the project’s core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

Guidance for Project-Specific Domain 1 Strategies

- **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.
- **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

- **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; promote VBP readiness tools and resources, such as [the adoption of diagnostic coding in dental for bi-directional medical/dental data sharing and population health](#).

Guidance for Evidence-Based Approaches

Oral Health in Primary Care - integrating oral health screening, assessment, intervention, and referral, into the primary care setting.

Planning:

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.
- Articulate the activities in each phase, and the associated timeline.

Implementation:

- Establish and implement clinical guideline or protocol that incorporates the following five elements of the Oral Health Delivery Framework:
 - 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.
 - 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 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.

- 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.
- 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 substance use disorders; 6) referrals to dental.
- 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.
- 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/Portable Dental Care - 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.

Planning:

- 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.
- Include the timeline for educating providers, beneficiaries, and communities about the new service.

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.
- Implement the provider, client, and community education campaign to raise awareness of the new service.

Project 3D: Chronic Disease Prevention and Control

Project Objective: Integrate health system and community approaches to improve chronic disease management and control.

Target Population: Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.

Evidence-based Approach:

1. Chronic Care Model (www.improvingchroniccare.org)

Regions are encouraged to focus on more than one chronic condition under the Chronic Care Model approach.

Examples of Specific Strategies to Consider within Chronic Care Model Approach:

- 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>)
- Community Paramedicine models, (<http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf> and <https://www.ruralhealthinfo.org/topics/community-paramedicine>), locally designed, community-based, collaborative model of care that leverages the skills of paramedics and EMS systems to address care gaps identified through a community specific health care needs assessment.

Reference the “Project Implementation Guidelines” for additional details on the project’s core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

Project Stages

Stage 1 – Planning

Milestone	Proof of Completion	Timeline (complete no later than)

<ul style="list-style-type: none"> Assess current state capacity to effectively impact chronic disease 	Completed current state assessment	DY 2, Q2
<ul style="list-style-type: none"> Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project 	Completed Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2C efforts	DY 2, Q2
<ul style="list-style-type: none"> Select specific target population(s), guided by disease burden and overall community needs, ACH will identify the population demographic and disease area(s) of focus, ensuring focus on population(s) experiencing the highest level of disease burden. Select 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. <ul style="list-style-type: none"> Region may pursue multiple target chronic conditions and/or population-specific strategies in their overall approach. 	Definition of target population(s) and evidence based approach (es)	DY 2, Q2
<ul style="list-style-type: none"> Identify, recruit, and secure formal commitments for participation from all implementation partners, including health care 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). 	List of implementation partners, inclusive of primary care providers and community-based service providers, with formal written commitment to participate.	DY 2, Q2
<ul style="list-style-type: none"> Develop Implementation Plan that includes, at minimum: <ul style="list-style-type: none"> Implementation timelines. Description of the mode of service delivery, which may include home-based and/or telehealth options. Roles and responsibilities of key organizational and provider participants, including community-based organizations. 	Completed Chronic Care implementation plan, including identification of specific change strategies.	DY 2, Q3

<ul style="list-style-type: none"> ○ Description of how project aligns with related initiatives and avoids duplication of efforts. ○ Specific change strategies to be implemented across elements of the Chronic Care Model: <ul style="list-style-type: none"> ▪ Self-Management Support ▪ Delivery System Design ▪ Decision Support ▪ Clinical Information Systems ▪ Community-based Resources and Policy ▪ Health Care Organization ○ 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. ○ Strategies to identify and focus efforts in high risk neighborhoods or geographic locations within the region, with attention to addressing health care disparities related to selected diseases. ○ Describe strategies for ensuring long-term project sustainability 		
Stage 2 – Implementation		
Milestone	Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none"> • Develop guidelines, policies, procedures and protocols 	Adopted guidelines, policies, procedures and/or procedures	DY 3, Q1
<ul style="list-style-type: none"> • Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / approach 	Completed and approved QIP, reporting on QIP measures	DY 3, Q2
<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ Self-Management Support ○ Delivery System Design ○ Decision Support 	Number and list engaged Implementation Team sites, members, and roles.	DY 3, Q4

<ul style="list-style-type: none">○ Clinical Information Systems○ Community-based Resources and Policy○ Health Care Organization <ul style="list-style-type: none">● Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data sharing strategies.			
Stage 3 – Scale & Sustain			
Milestone		Proof of Completion	Timeline (complete no later than)
<ul style="list-style-type: none">● Increase scale of approach, expand to serve additional high-risk populations, include additional providers and/or cover additional high needs geographic areas, to disseminate and increase adoption of change strategies that result in improved care processes and health outcomes		Document Stage 3 activities in Semi-Annual Reports.	DY 4, Q4
<ul style="list-style-type: none">● Continue to employ continuous rapid cycle improvement processes/continuous quality improvement methods to refine change strategies and scale up implementation.			DY 4, Q4
<ul style="list-style-type: none">● Provide or support ongoing training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies.			DY 4, Q4
<ul style="list-style-type: none">● Engage and encourage Managed Care Plans to develop/refine model benefits aligned with evidence-based clinical guideline-concordant care and best practice recommendations.			DY 4, Q4
<ul style="list-style-type: none">● Identify and document the adoption by partnering providers of payment models that support Chronic Care Model approach and the transition to value based payment for services.			DY 4, Q4
Project Metrics			
Year	Metric Type	Metric	Report Timing
DY 3 – 2019	P4R – ACH Reported	<ul style="list-style-type: none">● Report against QIP metrics● Number of partners trained by selected model / approach: projected vs. actual and cumulative	Semi-Annual

		<ul style="list-style-type: none"> • Number of partners participating and number implementing each selected model / approach • 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. 	
	P4P – State Reported	<ul style="list-style-type: none"> • Child and Adolescents’ Access to Primary Care Practitioners • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 – 64 Years) • Outpatient Emergency Department Visits per 1000 Member Months 	Annual
DY 4 – 2020	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • Number of partners trained by selected model / approach: projected vs. actual and cumulative • Number of partners participating and number implementing each selected model / approach • 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 	Semi-Annual

	P4P – State Reported	<ul style="list-style-type: none"> • Child and Adolescents’ Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Inpatient Hospital Utilization • Medication Management for People with Asthma (5 – 64 Years) • Outpatient Emergency Department Visits per 1000 Member Months • Statin Therapy for Patients with Cardiovascular Disease (Prescribed) 	Annual
DY 5 – 2021	P4R – ACH Reported	<ul style="list-style-type: none"> • Report against QIP metrics • Number of partners trained by selected model / approach: projected vs. actual and cumulative • Number of partners participating and number implementing each selected model / approach • 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. 	Semi-Annual
	P4P – State Reported	<ul style="list-style-type: none"> • Child and Adolescents’ Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Inpatient Hospital Utilization • Medication Management for People with Asthma (5 – 64 Years) • Outpatient Emergency Department Visits per 1000 Member Months • Statin Therapy for Patients with Cardiovascular Disease (Prescribed) 	Annual

Project Implementation Guidelines: This section provides additional details on the project’s core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

Guidance for Project-Specific Domain 1 Strategies

- **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.
- **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 Health care 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;” (www.improvingchroniccare.org)
 - Cultural and linguistic competency, health literacy needs
- **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 VBP 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.

Guidance for Evidence-Based Approaches

Chronic Care Model

Regions are encouraged to focus on more than one chronic condition under the Chronic Care Model approach.

Examples of Specific Strategies to Consider within Chronic Care Model Approach:

- *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>)

- *Community Paramedicine models*, (<http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf> and <https://www.ruralhealthinfo.org/topics/community-paramedicine>), locally designed, community-based, collaborative model of care that leverages the skills of paramedics and EMS systems to address care gaps identified through a community specific health care needs assessment.

Specific change strategies to be implemented across elements of the Chronic Care Model: *Self-management support, delivery system design, decision support, clinical information systems, community-based resources and policy, and health care organization.*

- **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; provide motivational interviewing; 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, 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, increase community-based supports for disease management and prevention, and development of local collaborations to address structural barriers to care such as: Community Paramedicine, 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.
- **Health Care 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.

Appendix II: Toolkit ProjectProject Toolkit Metrics							Assessment of ACH Performance, by Demonstration Year			
Name	NQF#	Measure Steward	Measure Description	Statewide Demonstration DSRIP Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associated Project Areas
Antidepressant Medication Management	0105	NCQA	The percentage of Medicaid enrollees 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment.	Y	Gap to Goal	State (HCA)	P4P	P4P	P4P	2.a
Child and Adolescents' Access to Primary Care Practitioners		NCQA	Percent of children enrolled in Medicaid who had a visit with a primary care provider. Reported separately for the following age groups: 12-24 months, 2-6 years, 7-11 years, and 12-19 years.	N	Gap to Goal	State (HCA)	P4P	P4P	P4P	2.a, 3.d
Childhood Immunization Status (Combo 10)	0038	DOH	Percentage of children 2 years of age who received the combo 10 HEDIS vaccine series (4DTaP/DT/Td, 3 Hib, 3 polio, 3 Hep B, 1 MMR, 1 Varicella, 2 Hep A, 2 flu, 4 PCV, 2 rotavirus) during the measurement period.	N	Gap to goal	State (DOH DSHS-RDA)	Inactive	P4P	P4P	3.b
Chlamydia Screening in Women Ages 16 to 24	0033	NCQA	The percentage of female Medicaid enrollees 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	N	Gap to Goal	State (HCA)	P4P	P4P	P4P	3.b

<div>Appendix II: Toolkit</div> <div>Project Toolkit Metrics</div>							Assessment of ACH Performance, by Demonstration Year			
Name	NQF#	Measure Steward	Measure Description	Statewide Demonstration DSRIP Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associated Project Areas
Comprehensive Diabetes Care: Eye Exam (retinal) performed	0055	NCQA	Percentage of Medicaid enrollees 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	N	Gap to Goal	State (HCA)	Inactive	P4P	P4P	2.a, 3.d
Comprehensive Diabetes Care: Hemoglobin A1c Testing	0057	NCQA	The percentage of Medicaid enrollees 18–75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	N	Gap to Goal	State (HCA)	P4P	P4P	P4P	2.a, 3.d
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	NCQA	The percentage of Medicaid enrollees 18–75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	N	Gap to Goal	State (HCA)	P4P	P4P	P4P	2.a, 3.d
Contraceptive Care—Access to LARC	2904	US Office of Population Affairs	Percentage of female Medicaid enrollees aged 15–44 years at risk of unintended pregnancy that is provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems (IUD/IUS).	N	Improvement over self	State (DSHS-RDA)	Inactive	P4P	P4P	3.b

Appendix II: Toolkit Project Toolkit Metrics							Assessment of ACH Performance, by Demonstration Year			
Name	NQF#	Measure Steward	Measure Description	Statewide Demonstration DSRIP Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associated Project Areas
Contraceptive Care – Most & Moderately Effective Methods	2903	US Office of Population Affairs	Percentage of female Medicaid enrollees aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception.	N	Improvement over self	State (HCA)	Inactive	P4P	P4P	3.b
Contraceptive Care – Postpartum	2902	US Office of Population Affairs	Among female Medicaid enrollees ages 15 through 44 who had a live birth, the percentage that is provided 1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery. 2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.	N	Improvement over self	State (HCA)	Inactive	P4P	P4P	3.b

Appendix II: Toolkit Project Toolkit Metrics							Assessment of ACH Performance, by Demonstration Year			
Name	NQF#	Measure Steward	Measure Description	Statewide Demonstration DSRIP Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associated Project Areas
Dental Sealants for Children at Elevated Caries Risk	2508, 2509	DQA	Percentage of children enrolled in Medicaid in at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth within the reporting year. Reported separately by age category: 6-9 years, 10-14 years.	N	Improvement over self	State (HCA)	Inactive	P4P	P4P	3.c
Depression Screening and Follow-up for Adolescents and Adults	-	HEDIS NCQA	The percentage of Medicaid enrollees age ≥12 who were screened for clinical depression using a standardized tool and, if screened positive, who received appropriate follow-up care. This measure is adapted from a provider-level measure stewarded by CMS (NQF 0418). Planned for HEDIS implementation in 2018.	N	Improvement over self	ACH	Inactive	P4R	P4R	2.a

Appendix II: Toolkit Project Toolkit Metrics							Assessment of ACH Performance, by Demonstration Year			
Name	NQF#	Measure Steward	Measure Description	Statewide Demonstration DSRIP Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associate d Project Areas
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence	2605	NCQA	The percentage of emergency department (ED) visits for beneficiaries with a principal diagnosis of mental illness, who had a follow up visit for mental illness within 30 days of discharge. Two rates are reported: (1) The percentage of discharges for beneficiaries who received follow-up within 30 days of discharge; (2) The percentage of discharges for beneficiaries who received follow-up within 7 days of discharge. The percentage of discharges for Medicaid enrollees 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow up visit within 30 days of discharge with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence. Two rates are reported: (1) The percentage of discharges for enrollees who received follow-up within 30 days of discharge; (2) The percentage of discharges for enrollees who received follow up within 7 days of discharge.	N	Gap to goal Improvement over self	State (DSHS-RDA)	Inactive	P4P	P4P	2.a, 2.b, 2.c

Appendix II: Toolkit Project Project Toolkit Metrics							Assessment of ACH Performance, by Demonstration Year			
Name	NQF#	Measure Steward	Measure Description	Statewide Demonstration DSRIP Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associate d Project Areas
Follow-up After Discharge from ED for Alcohol or Other Drug Dependence	2605	NCQA	<p><u>The percentage of emergency department (ED) visits for beneficiaries with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow up visit for AOD within 30 days of the ED visit. Two rates are reported:</u></p> <p><u>(1) The percentage of discharges for beneficiaries who received follow-up within 30 days of discharge;</u></p> <p><u>(2) The percentage of discharges for beneficiaries who received follow-up within 7 days of discharge.</u></p>	N	<u>Improvement over self</u>	State (DSHS-RDA)	<u>Inactive</u>	<u>P4P</u>	<u>P4P</u>	<u>2.a, 2.b, 2.c</u>
Follow-up After Hospitalization for Mental Illness	0576	NCQA	<p>The percentage of discharges for Medicaid enrollees 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:</p> <p>(1) The percentage of discharges for enrollees who received follow-up within 30 days of discharge;</p> <p>(2) The percentage of discharges the enrollees who received follow-up within 7 days of discharge.</p>	N	Gap to goal <u>Improvement over self</u>	State (DSHS-RDA)	Inactive	P4P	P4P	2.a, 2.b, 2.c

Appendix II: Toolkit Project Project Toolkit Metrics							Assessment of ACH Performance, by Demonstration Year			
Name	NQF#	Measure Steward	Measure Description	Statewide Demonstration DSRIP Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associate d Project Areas
Inpatient Hospital Utilization		NCQA	For members 18 years of age and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year reported by Surgery, Medicine and Total.	N	Improvement over self	State (HCA)	Inactive	P4P	P4P	2.a, 2.b, 2.c, 3.a, 3.d
Medication Assisted Therapy (MAT): With Buprenorphine or Methadone	-	Bree Collaborative	The count and percentage of Medicaid members with a documented diagnosis of opioid abuse/dependence who are engaged in Medication Assisted Treatment (MAT): Buprenorphine or Methadone.	N	Improvement over self	State (HCA)	P4P	P4P	P4P	3.a
Medication Management for People with Asthma (5 – 64 Years)	1799	NCQA	The percentage of Medicaid enrollees 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.	Y	Gap to Goal	State (HCA)	P4P	P4P	P4P	2.a, 3.d
Mental Health Treatment Penetration (Broad Version)		RDA	Percent of Medicaid enrollees with a mental health service need who received at least one qualifying service during the measurement year. Separate reporting by age groups: 12-17 years and ; 18-64 years; <u>65+ years</u> .	Y	Improvement over self	State (DSHS-RDA)	P4P	P4P	P4P	2.a, 2.b, 3.b

Appendix II: Toolkit Project Project Toolkit Metrics							Assessment of ACH Performance, by Demonstration Year			
Name	NQF#	Measure Steward	Measure Description	Statewide Demonstration DSRIP Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associated Project Areas
Ongoing Care in Adults with Chronic Periodontitis	-	Dental Quality Alliance (DQA)	Percentage of Medicaid enrollees age 35 years and older with chronic periodontitis who received ongoing periodontal care at least 2 times within the reporting year.	N	Improvement over self	State (HCA)	Inactive	P4P	P4P	3.c
Outpatient Emergency Department Visits per 1000 Member Months		NCQA/RDA	The rate of Medicaid enrollee visits to emergency department per 1000 member months, including visits related to mental health and chemical dependency. Separate reporting for age groups 10-17, 18-64, and 65+.	Y	Improvement over self	State (HCA)	P4P	P4P	P4P	2.a, 2.b, 2.c, 2.d, 3.a, 3.b, 3.c, 3.d
Patients on high-dose chronic opioid therapy by varying thresholds		Bree Collaborative	Measure specification in development. Among Medicaid enrollees, the percentage of chronic opioid therapy patients receiving doses: >50 mg. MED in a quarter, doses >90 mg. MED in a quarter.	N	Improvement over self	State (HCA)	P4P	P4P	P4P	3.a
Patients with concurrent sedatives prescriptions		Bree Collaborative	Measure specification in development. Among Medicaid enrollees receiving chronic opioid therapy, the percentage that had more than 45 days of Sedative Hypnotics/ Benzodiazepines/ carisoprodol/ barbiturates dispensed in the quarter.	N	Improvement over self	State (HCA)	P4P	P4P	P4P	3.a

<div>Appendix II: Toolkit</div> <div>Project Toolkit Metrics</div>							Assessment of ACH Performance, by Demonstration Year			
Name	NQF#	Measure Steward	Measure Description	Statewide Demonstration DSRIP Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associated Project Areas
Percent Arrested		RDA	Percent of Medicaid enrollees who were arrested at least once during the measurement year.	N	Improvement over self	State (DSHS-RDA)	Inactive	P4P	P4P	2.d
Percent Homeless (Narrow Definition)		RDA	Percent of Medicaid enrollees who were homeless in at least one month in the measurement year. Excludes "homeless with housing" ACES living arrangement code	N	Improvement over self	State (DSHS-RDA)	P4P	P4P	P4P	2.b, 2.c, 2.d
Periodontal Evaluation in Adults with Chronic Periodontitis		Dental Quality Alliance (DQA)	Percentage of Medicaid enrollees age 30 5 years and older with chronic periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year.	N	Improvement over self	State (HCA)	Inactive	P4P	P4P	3.c
Plan All-Cause Readmission Rate (30 Days)	1768	NCQA	The proportion of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days among Medicaid enrollees ages 18-64 years old.	Y	Gap to Goal Improvement over self	State (DSHS-RDA)	P4P	P4P	P4P	2.a, 2.b, 2.c

Appendix II: Toolkit Project Toolkit Metrics							Assessment of ACH Performance, by Demonstration Year			
Name	NQF#	Measure Steward	Measure Description	Statewide Demonstration DSRIP Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associated Project Areas
<u>Timeliness of Prenatal Care:</u> <u>Prenatal care in the first trimester of pregnancy</u> Prenatal care in the first trimester of pregnancy		HEDIS NCQA	Percentage of pregnant women enrolled in Medicaid who began -prenatal care in the first trimester of pregnancy during the measurement period.	N	Gap to Goal	State (DSHS-RDA)	Inactive	P4P	P4P	3.b
Primary Caries Prevention Intervention as Part of Well/III Child Care as Offered by Primary Care Medical Providers	1419	DQA	Among eligible Medicaid enrollees, the measure quantifies a) -the application of fluoride varnish (FV) as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) examination by the PCMP or clinic and b) each billing entity's use of the EPSDT with FV codes increases from year to year.	N	Improvement over self	State (HCA)	P4P	P4P	P4P	3.c
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)		NCQA	Percentage of male Medicaid enrollees 21 to 75 years of age and female Medicaid enrollees 40 to 75 years of age during the measurement year who were identified as having clinical ASCVD who were dispensed at least one high- or moderate-intensity statin medication.	N	Improvement over self	State (HCA)	Inactive	P4P	P4P	3.d

Appendix II: Toolkit Project Project Toolkit Metrics							Assessment of ACH Performance, by Demonstration Year			
Name	NQF#	Measure Steward	Measure Description	Statewide Demonstration DSRIP Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associate d Project Areas
Substance Use Disorder Treatment Penetration		RDA	The percentage of Medicaid enrollees with a substance use disorder treatment need who received substance use disorder treatment in the measurement year Separate reporting by age groups: 12-17 years; 18-64 years; 65+ years.- Separate reporting by age groups: 12-17 years and 18-64 years.	Y	Improvement over self	State (DSHS-RDA)	P4P	P4P	P4P	2.a, 2.b, 3.b
Substance Use Disorder Treatment Penetration (Opioid)		RDA	Measure specification in development. Percent of Medicaid enrollees with a diagnosis of opioid use disorder who have a substance use service need who received at least one qualifying service during the measurement year. Reported separately for adults and for children.	N	Improvement over self	State (DSHS-RDA)	Inactive	P4P	P4P	3.a
Utilization of Dental Services by Medicaid Beneficiaries			Dental service utilization among eligible members; reported separately: overall services and preventative services , by age.	N	Improvement over self	State (HCA)	P4P	P4P	P4P	3.c

Appendix II: Toolkit ProjectProject Toolkit Metrics							Assessment of ACH Performance, by Demonstration Year			
Name	NQF#	Measure Steward	Measure Description	Statewide Demonstration DSRIP Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associate d Project Areas
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	1516	NCQA	The percentage of Medicaid-covered children 3-6 years of age who had one or more well-child visits with a primary care provider during the measurement year.	Y	Gap to Goal	State (HCA)	P4P	P4P	P4P	3.b
Well-Child Visits in the First 15 Months of Life	1392	NCQA	The percentage of Medicaid-covered children 15 months old enrolled in Medicaid -who had the recommended number of well-child visits with a primary care provider during their first 15 months of life.	N	Gap to Goal	State (HCA)	Inactive	P4P	P4P	3.b

Statewide Performance: Accountability Metrics (Refer to Attachment D, Funding and Mechanics, Section VI)				
Name	NQF#	Measure Steward	Measure Description	Associated Project Areas
Antidepressant Medication Management	0105	NCQA	The percentage of Medicaid enrollees 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment.	2.a
Comprehensive Diabetes Care: Blood Pressure Control	0061	HEDIS NCQA	The percentage of Medicaid enrollees 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading is <140/90 mm Hg.	Statewide DSRIP Accountability Measure
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	0059	NCQA	The percentage of Medicaid enrollees 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control)	Statewide DSRIP Accountability Measure
Controlling High Blood Pressure	0018	NCQA	The percentage of Medicaid enrollees 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	Statewide DSRIP Accountability Measure
Medication Management for People with Asthma (5 – 64 Years)	1799	NCQA	The percentage of Medicaid enrollees 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.	2.a, 3.d
Mental Health Treatment Penetration (Broad Version)		RDA	Percent of Medicaid enrollees with a mental health service need who received at least one qualifying service during the measurement year. Separate reporting by age groups: 12-17 years and 18-64 years.	2.a, 2.b, 3.b
Outpatient Emergency Department Visits per 1000 Member Months		NCQA/ RDA	The rate of Medicaid enrollee visits to emergency department per 1000 member months, including visits related to mental health and chemical dependency. Separate reporting for age groups 10-17, 18-64, and 65+.	2.a, 2.b, 2.c, 2.d, 3.a, 3.c, 3.d
Plan All-Cause Readmission Rate (30 Days)	1768	NCQA	The proportion of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days among Medicaid enrollees ages 18-64 years old.	2.a, 2.b, 2.c
Substance Use Disorder Treatment Penetration		RDA	The percentage of Medicaid enrollees with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting by age groups: 12-17 years and 18-64 years.	2.a, 2.b, 3.a, 3.b
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	1516	NCQA	The percentage of Medicaid-covered children 3-6 years of age who had one or more well-child visits with a primary care provider during the measurement year.	3.b