

Overview: How Culturally Appropriate Models Could Become DSRIP Program Tribal Projects

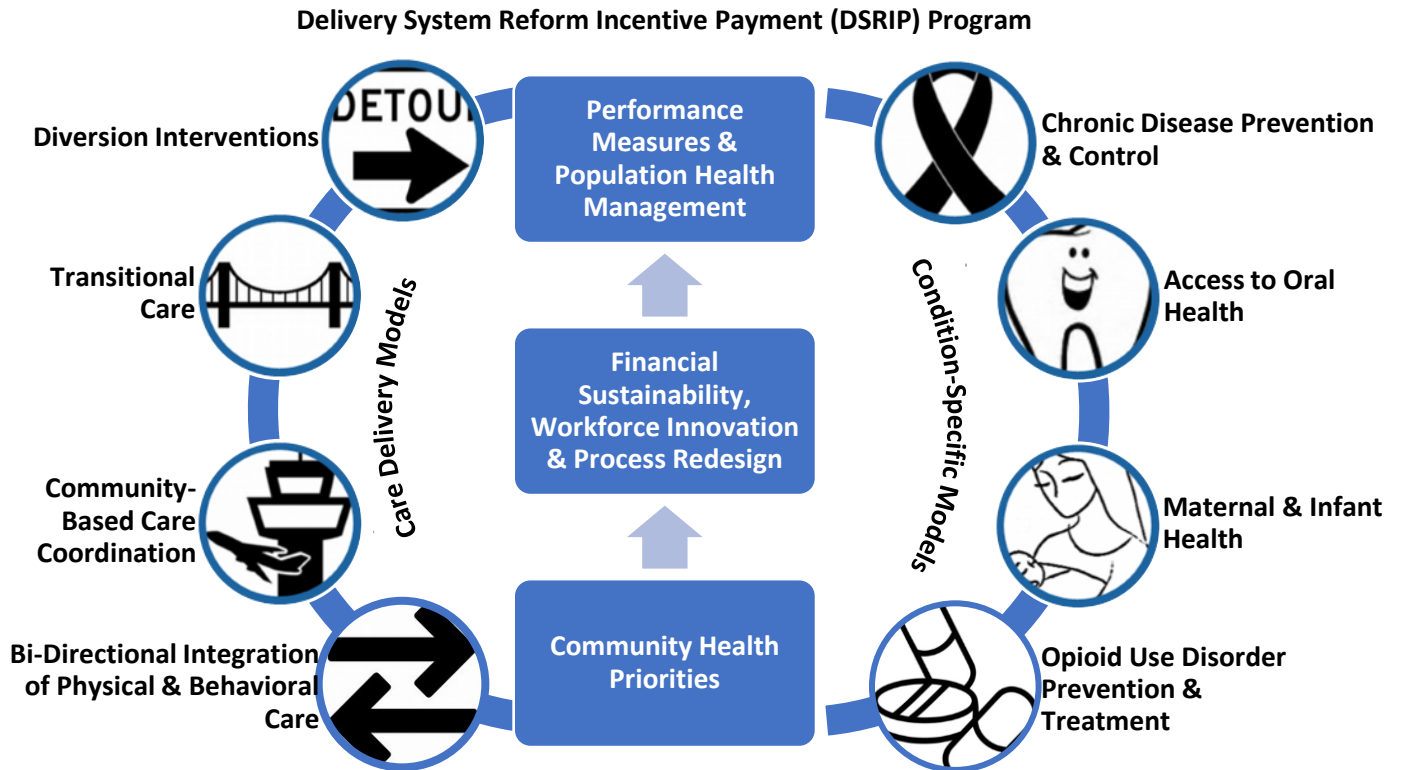
Introduction

The Centers for Medicare and Medicaid Services (CMS) approved Washington State’s request for a Section 1115 Medicaid demonstration entitled *Medicaid Transformation Project*. Under this demonstration, the state will make performance-based funding available to regionally-based Accountable Communities of Health (ACH), tribes, and their partnering providers with the goal of transforming the delivery system for Medicaid beneficiaries. This transformation will be supported by payment reform efforts to move Medicaid payment from primarily volume-based to primarily value-based payment over the course of the demonstration period.

The delivery system reform program will support the state’s continuing efforts to transform health care to achieve better health and to provide better health care at lower costs. Statewide goals for the DSRIP program are to:

- (a) integrate physical and behavioral health purchasing and service delivery;
- (b) convert 90% of Medicaid provider payments to reward value over volume;
- (c) support provider capacity to adopt new payment and care models;
- (d) implement population health strategies that improve health outcomes and reduce health disparities.

Activities under the delivery system reform program will be driven in each region by the Accountable Community of Health (ACH), where participation by tribes, IHS facilities, and Urban Indian Health Programs (together, Indian Health Care Providers or IHCPs) is encouraged. In addition, tribes and IHCPs may work directly with the state on targeted reform projects.



The DSRIP program is based on the achievement of defined milestones and metrics, and payment is earned once achievement is demonstrated or measured. The allocation of potential incentive payments to each project will vary over time to reflect the relative intensity of effort and benefit of each project over the life of the five-year demonstration. Incentive payments cannot be used to pay for existing services, and are intended as investments in the system to improve how care is delivered.

With respect to tribes and IHCPs, the goals of the program are:

1. Support tribes and IHCPs in their work with ACHs to improve regional health and health-related systems; and
2. Support tribes and IHCPs to improve IHCP-specific health and health-related systems.

The State will work with each tribe and IHCP to develop a milestone and incentive plan.

System Redesign

To achieve better health care and better health outcomes at lower cost, the State has identified the following system components that are foundational to DSRIP success:

Community Health Priorities. When designing tribal transformation projects, tribes and IHCPs may draw upon existing data resources such as the Resource Patient Management System, National Indian Health Board reports describing AIAN health disparities, Medicaid claims data and other State data resources, as well as data they may compile from any population health management tool. Tribes also have existing mechanisms as sovereign nations for identifying and prioritizing their communities' health needs.

Financial Sustainability: Transition from Payment for Service to Payment for Patient Outcomes. The State and CMS have made the DSRIP program a key driver for transforming the state's health care system from rewarding more and unnecessary services to rewarding patient-centered, high quality care.

By 2021, the State aims to achieve:

1. Ninety percent of state-financed health care will be in value based payment arrangements measured at the provider/practice level.
2. Washington's annual health care cost growth will be below the national health expenditure trend.

A statewide value-based payment transition taskforce will be created and will include state, regional, local and tribal representation to serve in an advisory capacity to inform the State's efforts to expand value-based payment for health care services. This includes development of survey/attestation assessments to facilitate the reporting of value-based payment levels and to validate current value-based payment baseline.

While tribes are invited to participate in this effort, it's important to note that during the 2012 fiscal year, Congress appropriated approximately \$4.3 billion to support Indian Health Service programs, Tribal health programs and Urban Indian Health programs, which the National Indian Health Board has estimated to meet approximately 56 percent of the level of need. As a result, the State understands the challenge that tribes and IHCPs may face in deciding whether to participate in Medicaid transformation-related activities in general and in value-based payment arrangements in particular.

Workforce Innovation and Process Redesign. Another key aspect of the DSRIP program is support for workforce innovation, including improving and sustaining alignment between health services workforce capacity and

community health needs. The state is working with ACHs to build upon existing statewide work in this area. The state appreciates tribal government and IHCP input to ensure the needs of tribes and IHCPs are considered in designing transformation efforts to meet the growing demand for health care within tribal communities.

In order to maximize the benefit of workforce innovation, the state is also supporting efforts to redesign health care delivery processes in order to take advantage of health care providers and support staff with different licensing levels and skill sets.

Population Health Management. The DSRIP program is also intended to support the transition to the regional management of population health. As sovereign nations responsible for the health of their people, tribal governments will be supported as well in this transition to population health management. The American Indian Health Commission for Washington State (the Commission) has identified the need for a standard population health management tool for all tribes and IHCPs. Key requirements for a standard population health management tool are: (a) ability to use data from different electronic health records systems, including the Indian Health Service's Resource Patient Management System (RPMS), which is the patient electronic health record used by a majority of tribal health programs and urban Indian health programs in the state; (b) flexibility to develop different reports to support tribal sovereignty in how each tribal government wishes to manage its population health; and (c) ease of use and training. Core functions may include the ability to extract and aggregate clinical and financial data, identify at-risk populations, assign personalized actionable care pathways and engage patients in evidence-based interventions across specific care teams. A better population health management tool offers analytics to maximize reimbursement, and to provide solutions for grant requirements and quality tracking. The tool will provide full support for Federally Qualified Health Centers (FQHCs) with Uniform Data System (UDS) reporting requirements; full HEDIS measure support; Patient Centered Medical Home (PCMH) tracking of 37 quality measures; and meaningful use certification. This type of population health management functionality is not available within the RPMS software system.

Performance Measures. During the demonstration years 3, 4 and 5, Transformation Project milestones will transition from actions completed to health outcomes achieved through performance measures. The state prioritized measures from the Statewide Common Measures Set (SCMS) to link to project activities where appropriate, in order to ensure alignment with existing state and agency initiatives. The set of measures in the Transformation Toolkit were designed to be of manageable size and to give preference to nationally endorsed measures, though to allow room for innovative, newly developed measures for domains of measurement that were not addressed by existing measure sets (e.g., reproductive health, opioid use and treatment). The State will accept Government Performance and Results Act (GPRA) measures in lieu of comparable statewide common performance measures when such substitution will reduce duplicative reporting and avoid excessive administrative burden on tribes and UIHPs.

Care Delivery Redesign

The DSRIP program is focused on helping providers, either through the ACHs or directly with tribes and IHCPs, to improve the quality, efficiency and effectiveness of their care delivery processes. Providers can qualify for incentive payments for participating in transformation activities that transform care delivery processes that implement person-centered care. Efforts related to the following areas of care delivery redesign are eligible for incentive payments: bi-directional integration of physical and behavioral health care, community-based care coordination, transitional care, and diversion interventions.



Bidirectional Integration of Physical and Behavioral Care

Bidirectional integration of physical and behavioral care involves a whole-person approach to care resulting in physical and behavioral care provided within one system of care.

The following tribal project example explains how the Indian Health Service (IHS) Improving Patient Care (IPC) Model achieves the requirements for the bidirectional integration project (see “Feature Example: IHS IPC Model” below for more detailed information on how the IHS IPC Model can be applied to more than one of models targeted by the State). The IHS IPC Model is a Patient Centered Medical Home model of care that is culturally based to serve the needs of American Indian and Alaska Native patients.

Another potential tribal project could involve the integration of an Advanced Registered Nurse Practitioner (ARNP) with training in psychiatric care in a medical clinic to provide behavioral health screening, assessment, and care for patients. The planning could involve:

- ***Workforce Innovation:***
 - Train ARNP or other clinic staff in behavioral health screening.
- ***Process Redesign and Sustainability:***
 - Integrate the behavioral health screening (including entry of information into clinic’s EHR) into the clinic’s client service flow.
 - If a referral is needed:
 - Ensure that there is a contract between the tribe/IHCP and the “referred-to” provider to share clinical records.
 - Ensure that the tribe/IHCP has the appropriate interfaces in place to share clinical data with “referred-to” provider EHRs – tribes/IHCPs sometimes experience challenges in sending and receiving client health records, which results in fragmented care.
 - Ensure that client care is coordinated (see Community-Based Care Coordination project area below).
- ***Performance Measures:***
 - Identify key milestones in workforce innovation and process redesign for incentive payments.
 - Identify claims data (diagnosis codes and/or procedure codes) milestones as indicators for care performance measures for incentive payments.
 - Identify appropriate clinical data metrics (either statewide common performance measures or GPRA measures) for incentive payments.
- ***Population Health Management:***
 - Develop a system for the tribe/IHCP to manage the health of its population.

For more information on tribal-specific care models for bidirectional integration of physical and behavioral health care, see the IHS IPC objectives of “Anytime Access to the Care Team” and “Coordinated Team-Based Care” and the National Tribal Behavioral Health Agenda’s foundational element of “Behavioral Health Systems and Support”.



Community-Based Care Coordination

Community-based care coordination involves ensuring coordination of all of the care that patients receive. The project could start by focusing on patients with one or more chronic diseases or conditions, such as a serious mental illness, moderate to severe substance use disorder, Human Immunodeficiency Virus (HIV), birth defects, cancer, diabetes, depression, heart disease or stroke. Patients could also have at least one of the following risk factors: obesity, unstable housing, food insecurity or high Emergency Medical Services (EMS) use. This project could benefit the American Indian and Alaska Native (AIAN) population greatly, with their higher levels of chronic diseases—thereby reducing health disparities.

One potential tribal project could involve providing care coordination through a transitional housing facility. While the DSRIP program incentive payments could not be used for the facility itself, the program could ensure that children and adults with complex health needs are connected to culturally relevant, evidence-based interventions and services that will improve their outcomes. The target population could be tribal patients with a moderate to severe substance use disorder who have successfully completed a residential treatment program and face unstable housing and/or food insecurity. The planning could involve:

- **Workforce Innovation:**
 - Train tribal/IHCP transitional housing staff in care coordination or locate care coordination staff on a part-time basis in transitional housing facility.
- **Process Redesign and Sustainability:**
 - Redesign how clients in transitional housing receive care coordination services to reduce barriers and maximize likelihood of client success with primary, behavioral, and specialty care providers.
 - Redesign EHR interfaces to link various EHR systems and social service case management systems.
 - Develop a single point of access for a client’s information, even if the information is in different systems, a primary care provider and a behavioral health care provider could monitor all of the care the patient receives – enabling more effective care.
- **Performance Measures:**
 - Identify key milestones in workforce innovation and process redesign for incentive payments.
 - Identify claims data (diagnosis codes and/or procedure codes) milestones as indicators for care performance measures for incentive payments.
 - Identify appropriate clinical data metrics (either statewide common performance measures or GPRA measures) for incentive payments.
- **Population Health Management:**
 - Develop a system for the tribe/IHCP to manage the health of its population.

For more information on tribal-specific care models for community-based care coordination, see the IHS IPC objectives of “Anytime Access to the Care Team” and “Coordinated Team-Based Care” and the “Pathways Community HUB”. In addition, a California tribal health organization has opened a transitional housing facility with support from a grant awarded by the Coordinated Tribal Assistance Solicitation Grant distributed by the Department of Justice.



Transitional Care

Transitional care involves patients transitioning from intensive settings of care or institutional settings to outpatient or less intensive settings of care, including returning home. This includes patients discharged from inpatient care (whether medical or psychiatric) or residential substance use treatment to home or supportive housing or clients returning to the community from prison or jail.

One potential tribal project could involve creating culturally relevant community and home-based support services for patients with acute mental illness transitioning home from inpatient care. Supportive services include behavioral health systems and support such as developing an intensive outpatient program (sometimes called an IOP). An intensive outpatient program provides less intensive treatment than an inpatient facility, but provides an appropriate level of care that readies the patient to transition home. A pilot project can be done with a small quantity of patients to test the readiness to launch the program. After a specified period of time has passed, the pilot project is evaluated to determine its effectiveness and financial sustainability. If the project is successful, it may be extended to other high risk populations such as patients transitioning home from other institutional settings. The planning could involve:

- **Workforce Innovation:**
 - Train tribal/IHCP transitional housing staff in support service skills.
- **Process Redesign and Sustainability:**
 - Create additional tools for transitional housing support service providers, such as purchasing additional software licenses to enable providers at the IOP to use the same EHR as the tribal health clinic – this enables better continuity of care to occur.
 - Redesign EHR interfaces to link various EHR systems and social service case management systems.
 - Develop a single point of access for a client’s information, even if the information is in different systems, a primary care provider and a behavioral health care provider could monitor all of the care the patient receives – enabling more effective care.
- **Performance Measures:**
 - Identify key milestones in workforce innovation and process redesign for incentive payments.
 - Identify claims data (diagnosis codes and/or procedure codes) milestones as indicators for care performance measures for incentive payments.
 - Identify appropriate clinical data metrics (either statewide common performance measures or GPRA measures) for incentive payments.
- **Population Health Management:**
 - Develop a system for the tribe/IHCP to manage the health of its population.

For more information on tribal-specific models for transitional care, see the IHS IPC objectives of “Anytime Access to the Care Team” and “Coordinated Team-Based Care” and the National Tribal Behavioral Health Agenda’s foundational element of “Behavioral Health Systems and Support”



Diversion Intervention

Diversion intervention involves patients presenting at the Emergency Department for non-acute conditions; who access the Emergency Medical Services (EMS) system for a non-emergent condition; or those with mental health and/or substance use conditions coming into contact with law enforcement.

The tribal project example involves creating a support system for patients that receive care at the Emergency Department (ED) or EMS. The tribe could convene a meeting with tribal health staff and hospital staff to discuss how to increase the coordination of services provided to ensure that patients receive care in an appropriate setting. The planning could involve:

- **Workforce Innovation:**
 - Train Purchased and Referred Care (PRC) staff in strategies to divert clients from less appropriate places for care, such as better care coordination or more clinical care coordination (see Community-Based Care Coordination above).
- **Process Redesign and Sustainability:**
 - Redesign the use and process for PRC staff to intervene when the patient receives care at the emergency department or from emergency medical services providers.
 - Redesign EHR interfaces to link various EHR systems and social service case management systems.
 - Develop a single point of access for a client’s information, even if the information is in different systems, a primary care provider and a behavioral health care provider could monitor all of the care the patient receives – enabling more effective care.
- **Performance Measures:**
 - Identify key milestones in workforce innovation and process redesign for incentive payments.
 - Identify claims data (diagnosis codes and/or procedure codes) milestones as indicators for care performance measures for incentive payments.
 - Identify appropriate clinical data metrics (either statewide common performance measures or GPRA measures) for incentive payments.
- **Population Health Management:**
 - Develop a system for the tribe/IHCP to manage the health of its population.

For more information on tribal specific models for diversion intervention, see the IHS IPC objectives of “Anytime Access to the Care Team” and “Coordinated Team-Based Care” and the National Tribal Behavioral Health Agenda’s foundational element of Prevention and Recovery Support.

Condition-Specific Care Delivery Redesign

The following section describes how tribes and IHCPs can focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations, while using integrated models of care illustrated with tribal project examples.



Opioid Use Disorder Prevention and Treatment

Opioid use disorder prevention and treatment involves both medication-assisted treatments and non-medication-assisted treatment for prescription opioid and/or heroin use disorder.

One tribal project could involve Medication Assisted Therapy (MAT) for opioid use disorder, such as the SAMHSA “Opioid Overdose Prevention Toolkit” using naloxone injections or nasal spray to prevent overdose. The opportunity for process redesign exists when using naloxone to treat opioid overdoses. Naloxone may be

administered in the clinic by health care providers or in the community by police or and emergency medical service staff. The planning could involve:

- **Workforce Innovation:**
 - Train clinic staff or community staff in the administration of naloxone.
- **Process Redesign and Sustainability:**
 - Redesign police and community staff service processes to include naloxone administration.
 - Expand public education in how to identify signs of opioid overdose and administer naloxone when necessary.
 - Incorporate Prescription Drug Monitoring Program data in tribal/IHCP processes.
- **Performance Measures:**
 - Identify key milestones in workforce innovation and process redesign for incentive payments.
 - Identify claims data (diagnosis codes and/or procedure codes) milestones as indicators for care performance measures for incentive payments.
 - Identify appropriate clinical data metrics (either statewide common performance measures or GPRA measures) for incentive payments.
- **Population Health Management:**
 - Develop a system for the tribe/IHCP to manage the health of its population.

Another tribal project could involve a traditional, culturally-based program for treating opioid use disorder prevention and treatment, such as the White Bison Wellbriety program, created by Don Coyhis, whose philosophy is that wellbriety offers sobriety, recovery, addictions prevention and wellness, while following Native traditional health practices.

- **Workforce Innovation:**
 - Train and certify treatment staff to become a counselor and/or facilitator; certification requires the tribe/IHCP to employ at least one Native American National/State certified alcohol counselor; have a relationship and ready access to at least one Native American elder; tribe must also ensure that Native traditional healing practices are incorporated into treatment programs and that any staff working with Native American clients have continuous sobriety. The initial certification and annual fee is \$5,000, and the two on-site assessment visits done during the first twelve months cost \$2,000. After one year, the annual fee for certification is \$5,000 and one on-site inspection is required at no additional expense.
- **Process Redesign and Sustainability:**
 - Redesign treatment processes to incorporate the White Bison protocols.
- **Performance Measures:**
 - Identify key milestones in workforce innovation and process redesign for incentive payments.
 - Identify claims data (diagnosis codes and/or procedure codes) milestones as indicators for care performance measures for incentive payments.
 - Identify appropriate clinical data metrics (either statewide common performance measures or GPRA measures) for incentive payments.
- **Population Health Management:**
 - Develop a system for the tribe/IHCP to manage the health of its population.

For more information on opioid use disorder prevention and treatment, see <http://www.OpioidPrescribing.com>.



Maternal and Infant Health

Maternal and infant health involves home based support for women of preconception age, pregnant women, and mothers of children ages 0-17 to improve maternal and child health.

There are several strategies listed in the American Indian Health Commission’s “Healthy Communities: A Tribal Maternal-Infant Health Strategic Plan” relevant to maternal and infant health. Key sections identify Youth and Preconception Health, Access to Medical Care, Breastfeeding, and Social Support as health promotion areas to improve. Federal and State care models suggested for tribal use are Preconception Counseling, Nurse Family Partnership (NFP), the Washington State WIC Nutrition Program’s Breastfeeding Peer Counseling Program, Honoring Our Children, and the Native American Women’s Dialogue on Infant Mortality Cradleboard Project.

One tribal project could involve improving maternal and infant health through the implementation of the “Native American Women’s Dialogue on Infant Mortality (NAWDIM) Cradleboard Project”. The dialogue began in Seattle in 2000 to address issues related to infant mortality, particularly Sudden Infant Death Syndrome, also known as SIDS. A unique approach identified to address the issue was offering cradleboard making classes for pregnant and parenting women, as well as their families. The traditional cradleboard provides a safe place for a baby to lay on their back while securely placed in the cradleboard. Cradleboards are thought to encourage bonding between the mom and baby, and enables the mom to work while the baby is safe and nearby. The planning could involve:

- **Workforce Innovation:**
 - Train staff to train pregnant and parenting women to create cradleboards.
- **Process Redesign and Sustainability:**
 - Redesign treatment processes to incorporate cradleboard making and use into maternal care processes, with culturally appropriate counseling.
- **Performance Measures:**
 - Identify key milestones in workforce innovation and process redesign for incentive payments.
 - Identify claims data (diagnosis codes and/or procedure codes) milestones as indicators for care performance measures for incentive payments.
 - Identify appropriate clinical data metrics (either statewide common performance measures or GPRA measures) for incentive payments.
- **Population Health Management:**
 - Develop a system for the tribe/IHCP to manage the health of its population.

For more information on opioid use disorder prevention and treatment, see <http://www.aihc-wa.com>.



Access to Oral Health

Access to oral health involves improving the access to oral health care for the adult population.

One tribal project could involve integrating oral health screening, assessment, intervention and referral for adult patients in the primary care setting. Strategies include improving care team skills such as cross training medical

aides to conduct dental screening and risk assessment, and training mid-level providers to provide dental care. The planning could involve:

- **Workforce Innovation:**
 - Train tribal/IHCP clinic staff to perform oral health screening.
- **Process Redesign and Sustainability:**
 - Redesign primary care treatment processes to include oral health screening.
- **Performance Measures:**
 - Identify key milestones in workforce innovation and process redesign for incentive payments.
 - Identify claims data (diagnosis codes and/or procedure codes) milestones as indicators for care performance measures for incentive payments.
 - Identify appropriate clinical data metrics (either statewide common performance measures or GPRA measures) for incentive payments.
- **Population Health Management:**
 - Develop a system for the tribe/IHCP to manage the health of its population.

Another tribal project could involve the implementation of the Dental Health Aide Therapist (DHAT) program developed by the Alaska Native Tribal Health Consortium and recently implemented at the Swinomish Tribe. DHATs are formally trained to perform a number of routine and preventive dental services, including fillings and simple extractions at a much lower cost to the tribe. The opportunity for workforce development exists when DHAT staff are provided formal dental training that enables improved access to dental care, while maintaining a high quality of care and efficient utilization of resources. An added bonus of the DHAT program is that the DHATs provide routine dental care, freeing up dentists' time to focus on providing a higher level of dental care. The planning could involve:

- **Workforce Innovation:**
 - Train individuals to become DHATs.
- **Process Redesign and Sustainability:**
 - Redesign dental care processes to incorporate DHATs.
 - Redesign EHR systems to improve interoperability between medical and dental clinics. It's not uncommon for a medical clinic to use one type of EHR and a dental clinic to use another. In order to improve the coordination of care, an EHR interface may need to be purchased and implemented to improve the system of care. This enables the record of care to be accessible to medical and dental providers, improving the continuity of care.
- **Performance Measures:**
 - Identify key milestones in workforce innovation and process redesign for incentive payments.
 - Identify claims data (diagnosis codes and/or procedure codes) milestones as indicators for care performance measures for incentive payments.
 - Identify appropriate clinical data metrics (either statewide common performance measures or GPRA measures) for incentive payments.
- **Population Health Management:**
 - Develop a system for the tribe/IHCP to manage the health of its population.

Another tribal project could involve setting up a mobile dental van with assistance from the Washington Dental Association. The planning could involve:

- **Workforce Innovation:**
 - Train staff to provide dental services in a mobile dental van.
- **Process Redesign and Sustainability:**
 - Redesign dental care processes to be performed in a mobile dental van.
- **Performance Measures:**
 - Identify key milestones in workforce innovation and process redesign for incentive payments.
 - Identify claims data (diagnosis codes and/or procedure codes) milestones as indicators for care performance measures for incentive payments.
 - Identify appropriate clinical data metrics (either statewide common performance measures or GPRA measures) for incentive payments.
- **Population Health Management:**
 - Develop a system for the tribe/IHCP to manage the health of its population.

For more information on dental care models, see “Oral Health: An Essential Component of Primary Care, Implementation Guide” by Safety Net Medical Home, and the IHS IPC, specifically the objectives of “Anytime Access to the Care Team”, “High-Quality, Reliable Care” and “Coordinated Team-Based Care”.



Chronic Disease Prevention and Control

Chronic disease prevention and control involves integrating health system and community approaches to improve chronic disease prevention and control for patients that have been diagnosed with or are at risk for asthma, diabetes, heart disease and obesity, with a focus on those populations experiencing the greatest burden of chronic diseases in the region. It’s noteworthy to mention that the chronic diseases mentioned exist in disproportionately high levels within the AI/AN population. Any improvements in chronic disease prevention and control would go far towards improving overall population health.

One tribal project could involve reviewing and implementing training for the “Wisdom Warriors” program used by a number of Washington tribal health organizations. The planning could involve:

- **Workforce Innovation:**
 - Train staff for certification in the Wisdom Warriors training.
- **Process Redesign and Sustainability:**
 - Redesign physical health care processes to support patient care self-management through the Wisdom Warriors program.
 - Redesign EHR systems to enable recording of progress in Wisdom Warrior practices and support cross-disciplinary coordination of care.
- **Performance Measures:**
 - Identify key milestones in workforce innovation and process redesign for incentive payments.
 - Identify claims data (diagnosis codes and/or procedure codes) milestones as indicators for care performance measures for incentive payments.
 - Identify appropriate clinical data metrics (either statewide common performance measures or GPRA measures) for incentive payments.
- **Population Health Management:**
 - Develop a system for the tribe/IHCP to manage the health of its population.

For more information on chronic care management, see “Stanford Chronic Disease Self-Management Program”, including the “Wisdom Warriors” program and the IHS IPC objectives of “Anytime Access to the Care Team” and “Well Care and Sick Care”.

Summary Project Table

Transformation Projects	IHS IPC Care Model (PCMH)	AIHC Care Model (NFP)	SAMSHA Care Model	Wisdom Warriors Care Model (Stanford)	Safety Net Medical Home	AIHC Cradleboard Project	White Bison Wellbriety Program	Family Spirit	National Tribal Behavioral Health Agenda
Integration of Primary and Behavioral Care	✓		✓						✓
Community-Based Care Coordination	✓								
Transitional Care	✓								✓
Diversion Interventions	✓								✓
Opioid Use Prevention & Treatment	✓		✓				✓		
Maternal & Infant Health	✓	✓				✓		✓	
Access to Oral Health	✓				✓				
Chronic Disease Prevention & Control	✓	✓		✓					

Feature Example: IHS IPC Model Touches Multiple Transformation Project Categories

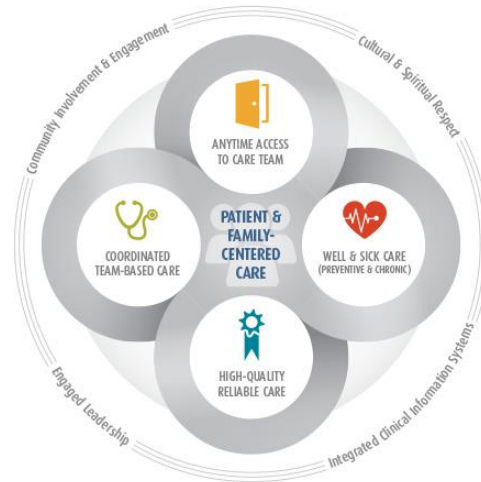
Tribes and Indian Health Care Providers (IHCPs) focus on patient quality care initiatives established by the Indian Health Service, such as the Improving Patient Care (IPC) model. The IPC model of care is based on the National Committee for Quality Assurance model of care known as the Patient Center Medical Home (PCMH). The purpose of the IPC is to assist outpatient primary care teams in their efforts to achieve the PCMH standard of care and to support the pursuit of formal PCMH recognition. Tribes and IHCPs using the IPC model engage patients more fully in decision-making, emphasizing prevention and wellness; use evidence-based medicine principles and point-of-care decision support; and integrate/coordinate care across the medical neighborhood. This requires the efforts of the entire care team and facility management to be successful.

IPC sites focus on:

- Providing consistent, high-quality patient- and family-centered care.
- Ensuring access to primary care for all American Indians and Alaska Natives.
- Delivering care in concert with community and Tribal leadership aims.
- Making positive, sustainable and measurable improvements in care.

The IPC Model depicted in the graphic incorporates the following key elements:

- Anytime Access to the Care Team — Every patient has a relationship with their provider and care team that offers them consistent and reliable access to care when they need it, whether in-person, via phone or by secure messaging through a patient portal.
- Well Care and Sick Care (Preventive and Chronic care) — Patients become partners in their health by utilizing various methods of preventive care (screenings, check-ups, nutritional and behavioral counseling) so they remain healthy, which reduces occurrence of sickness and disease. Working with their provider, patients will learn how to self-manage chronic disease by engaging in goal setting, problem-solving and action planning.
- High-quality, Reliable Care — All Indian health care providers have the skills and training for delivering high-quality, reliable care for patients. System improvements will be made to fully enable providers to use those skills and to remain current as the science changes over time. Measurable outcomes and data are used to make improvements and build better systems of care.
- Coordinated Team-Based Care — The “care team” approach applies to creating highly functioning teams who are able to coordinate care that meets the needs of every patient.



Supporting the above elements to the IPC care model are the following underlying foundational layers.

- Community Involvement and Engagement — Health care quality improves when the entire community is engaged and working together to improve overall health.
- Cultural and Spiritual Respect — IHS recognizes cultural and spiritual respect as crucial components of healing.
- Integrated Clinical Information Systems — Integrated medical record systems, which combine multiple information sources used by the care team, ensure both holistic patient care and information security. Health care quality improves with the combined use of the electronic health records and patient management systems.
- Engaged Leadership — Health care quality improves as facility leaders embrace improving patient care and focus staff energy on improvement work.

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