MEDICAID TRANSFORMATION PROJECT TOOLKIT

DRAFT FOR PUBLIC COMMENT

January 3, 2017 – February 2, 2017

Context for Understanding this Document

The Role of the Accountable Communities of Health – Through this demonstration, each ACH will serve as the administrative lead for its region to coordinate and oversee regional projects identified in this toolkit. ACHs are regionally situated, multi-sector organizations and, as such, are the vehicle to foster relationships between providers that are necessary to achieve the envisioned Medicaid system transformation. It is critical to understand that ACHs are comprised of groups of leaders from a variety of sectors. Together, these sectors will partner to design and implement the transformation projects within this toolkit. References throughout this document to expectations of the ACHs are meant to include the broad partnerships of the ACHs. In other words, the expectation is that providers, both traditional Medicaid and non-traditional providers, will collaborate on the implementation of projects and be responsible for committing to and carrying out the project objectives. These participating providers will be eligible for incentive payments for their role in Medicaid transformation.

ACHs are not service delivery organizations nor do they replace Medicaid managed care organizations (MCOs). This demonstration does not interrupt the relationship that Medicaid beneficiaries currently have with their MCO, which remains the central delivery mechanism for services. Additionally, projects are intended to be implemented in a manner that uses and builds on existing capacity and infrastructure and are not to duplicate systems that are already in place.

Incentive Payments – While the ACH as an entity will have an opportunity to access funding for administrative responsibilities, the majority of the DSRIP funding will be distributed to providers participating in the transformation projects upon completion of milestones. 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 5-year demonstration. Additional information for how incentive payments are calculated and earned will be forthcoming but is not reflected in this toolkit.

Value-based Payments – At no point will ACHs be expected, or permitted, to engage in contract negotiations between MCOs and providers around value-based payment arrangements. ACHs, through their represented sectors and participating partners, will be eligible to receive funds for exceptional performance and attainment of quality within that region. Incentivizing ACHs reinforces the expectation that the project toolkit activities should align with quality attainment goals and the value-based payment arrangements between MCOs and providers.

Regional Health Needs Inventory – The Regional Health Needs Inventory (RHNI) is not an exclusive Domain 1 activity and is foundational to the entire toolkit. There will be a standard RHNI deliverable that will inform project selection and design, with an emphasis on understanding health disparities across various dimensions of the population and to identify opportunities for improved health equity. We recognize that much of the RHNI, including the description of the health care and community-based service systems, will be a formative process. The state is responsible for providing initial data to populate the inventory.

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ACH Certification Process – Prior to submission of a Project Plan, ACHs must fulfill certification criteria which will ensure that ACHs are prepared to coordinate and oversee project activities. The state will provide more information on the certification process over the coming weeks.

Transformation Project Plans – Over the coming months the state will develop and release a Project Plan template. The template will be developed by the state and posted for public comment. This template will outline the information required to be submitted by each ACH as part of its Medicaid Transformation Project Plan. It will require ACHs to provide information about how the region is implementing projects and how project selection is based on community needs and will address health disparities and improve health equity. It will also require information related to the ACH composition, governance structure, and community engagement strategies. In developing its Project Plan, each ACH must solicit and incorporate community input to ensure it reflects the specific needs of its region.

What happens next? Once the public comment period concludes, we will work on revisions based on the feedback received to finalize toolkit. The final version will be submitted to CMS no later than 60-days after we reach approval on the Medicaid Transformation demonstration. This toolkit is ultimately subject to CMS approval.

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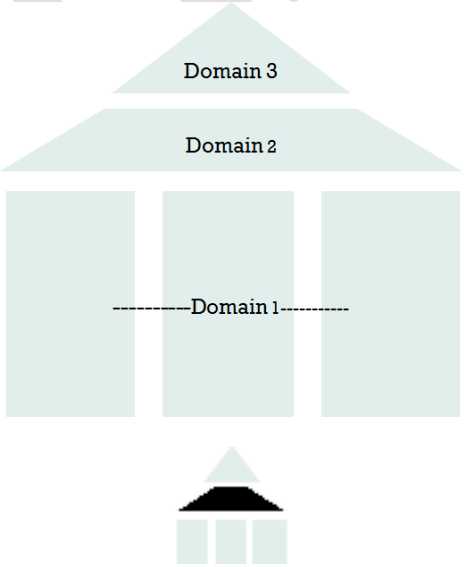
Introduction to the Transformation Project Toolkit

Accountable Communities of Health (ACH) and the transformation efforts they undertake are a key component of Washington's Medicaid Transformation demonstration and critical levers to help the state achieve Medicaid transformation goals. Through Initiative 1 of the demonstration, communities will be provided with financial resources to improve health system performance for Medicaid beneficiaries at the local level. Each region, through its ACH, will pursue projects aimed at transforming the Medicaid delivery system to serve the whole person and to use resources more wisely. Efforts will focus on improving population health and reducing disparities to achieve health equity across populations.

The Transformation Project Toolkit reflects the evidence-based strategies and promising practices the ACHs will use to develop Medicaid transformation project plans for implementation across regions. Evidence-based transformation strategies are included within several project options and organized within a framework of three domains:

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

The Domains, and the strategies defined within each Domain, are interdependent. Domain 1 is focused on systemwide planning and capacity-building to reinforce transformation projects. Domain 1 strategies are to be tailored to support efforts in Domain 2 and Domain 3; projects in Domain 2 and Domain 3 integrate and apply Domain 1 strategies to the specified topics and approaches. Projects will be interrelated and interdependent. ACHs must evaluate priorities and implement projects concurrently across all domains, as opposed to approaching the domains as sequential undertakings.



Importantly, projects within this toolkit are not a replacement for existing services provided under the Medicaid State Plan and cannot duplicate services provided through Initiative 2 and Initiative 3 of this demonstration.

Domain 1 does not represent individual projects, but three required focus areas (Financial Sustainability through Value Based Payment, Workforce, and Systems for Population Health Management) to be implemented and expanded across the delivery system, inclusive of all provider types, to benefit the entire Medicaid population.

Domain 2 includes one required project (Project 2A-Bi-Directional Integration of Care and Primary Care Transformation) and three optional projects (Project 2B-Community-based Care Coordination, Project 2C-Transitional Care and Project 2D-Diversion Interventions). ACHs must select at least one of the optional projects in Domain 2.

Domain 3 includes one required project (Project 3A-Addressing the Opioid Use Public Health Crisis) and three optional projects (Project 3B-Maternal and Child Health, Project 3C-Access to Oral Health Services, and Project 3D-Chronic Disease Prevention and Control). ACHs must select at least one of the optional projects in Domain 3.

In summary, ACHs (through their partners and participating providers) will implement:

- The strategies across all three Domain 1 focus areas;
- At least two Domain 2 projects; and
- At least two Domain 3 projects.

Performance Measurement

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

Project-level measures will be included for each project. These measures serve to track performance at a level more directly tied to project deliverables. For example, an increase in mental health treatment penetration at the regional level should be reflected in an improvement in reported adult mental health status at the systemwide, state-level. The project-specific measures should be reported at the ACH level and, if possible and applicable, at the practice level. They should be reported as frequently as feasible and relevant; frequency may vary by measure.

A list of performance measures is included in Appendix I. Depending on the design of regional project plans, measures will be selected that best relate to the project activities and intended outcomes. Additional guidance and measurement details will be forthcoming; this is not intended to be an exhaustive list of outcome measures. Measures from the Washington State Common Measure Set and the Cross-Agency HB 1519/SB 5732 are prioritized to ensure alignment. However, particular project areas may require measures not currently available in existing state measures lists to appropriately monitor and measure project performance.

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Project Planning Activities and Resources

Regional Health Needs Inventory

To ensure a strategic approach, ACHs will use population health and health service capacity information to guide the selection, planning, targeting, and implementation of transformation projects. Each ACH will be required to complete a comprehensive Regional Health Needs Inventory (RHNI) ahead of finalizing project implementation plans. The Washington Health Care Authority (HCA) will package and provide relevant information to the ACH from various statewide data sets, to the fullest extent possible, to populate the RHNI. ACHs will need to fill gaps in data using local data sources and will need to complete an environmental scan of current service delivery and partner organization capacity. Information gathered and included in the RHNI should be sufficient to justify the selection of specific projects and strategies and to guide project implementation plan development. Efforts should be explicitly targeted to address identified disparities in health service access, health service quality, and health outcomes across populations.

The ACH may rely on previously completed inventories or assessments to meet the requirements of the RHNI. The RHNI is a vital component of the planning process, as it provides the information necessary to design the initiatives to maximum benefit by tailoring them to the unique needs and circumstances of the communities in which the projects will be implemented. For a description of what should be included in the RHNI, see Appendix II.

Statewide Value Based Payment Transition Taskforce and Workforce Development Taskforce

The HCA, in partnership with ACHs, will create and facilitate a Statewide Value-based Payment Transition Taskforce and a Statewide Workforce Development Taskforce to support Medicaid transformation. ACHs will engage in these statewide taskforces through commitment to ongoing participation, contribution to outputs and recommendations, and incorporation of taskforce recommendations at the regional level. To the extent that regional and local-level needs are not fulfilled through the statewide taskforce structures, ACHs should convene regional or local-level sub-taskforces to provide input to and guide efforts around regional value based payment transition and workforce development efforts needed for successful implementation.

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

- Serving in an advisory capacity to the further development and implementation of the HCA Value-based Roadmap and alignment to federal VBP/APM efforts.

- Recommending a process for conducting a statewide assessment of value-based payment transition and readiness:
  - Unless otherwise available, develop survey/attestation assessments to facilitate the reporting of value-based payment levels to understand the current types of value-based payment arrangements across the provider spectrum; and
  - Validate current value-based payment baseline, the level of value-based payment arrangements as a percentage of total payments across the state.
- Identifying and recommending strategies to address stakeholder needs for education, training, and technical assistance to shift to value-based payment models and providing stakeholder training around value-based payment methodologies.

The Statewide Workforce Development Taskforce will include state, regional and local-level stakeholders and tribal government partners representing: physical health care providers, behavioral health care providers, Indian health care providers, community-based organizations, government entities (such as elected officials, education authorities, law enforcement, housing authorities, workforce authorities, Department of Health and Department of Social and Health Services), union and employee advocacy organizations, institutions of higher learning, consumer advocates and community representatives, and others. Representation will appropriately reflect Domain 2 and Domain 3 recommended partners and required strategies.

Practice Transformation Support Hub

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

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

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

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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. Domain 1 does not outline individual projects, but rather three required focus areas to be implemented and expanded across the delivery system, inclusive of all provider types, to benefit the entire Medicaid population. The three areas of focus are: financial sustainability through value based payment, workforce, and systems for population health management. Each of these areas will need to be addressed progressively throughout the five-year timeline to directly support Domain 2 and Domain 3 transformation project success.

Financial Sustainability through Value Based Payment

Rationale: Medicaid transformation efforts must contribute meaningfully to moving Washington forward on value-based payment (VBP). Paying for value across the continuum of care is necessary to ensure the sustainability of the transformation projects undertaken through the Medicaid Transformation demonstration. A transition away from paying for volume may be challenging to some providers, both financially and administratively. As not all provider organizations are equipped at present to successfully operate in these payment models, providers may need assistance to develop additional capabilities and infrastructure. It will be imperative that providers within a specific ACH take responsibility to support and embrace VBP. If VBP benchmarks for statewide VBP attainment are not met, a percentage of Delivery System Reform Incentive Payment (DSRIP) funding will be at risk. Financial incentives will support provider and plan capacity in achieving systemic change in how services are reimbursed. Funds will further incent providers already participating in Healthier Washington Payment Test models.

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

Annual Benchmarks:

- By the End of Calendar Year 2017, achieve 30% VBP benchmark.
- By the End of Calendar Year 2018, achieve 50% VBP benchmark.
- By the End of Calendar Year 2019, achieve 75% VBP benchmark.
- By the End of Calendar Year 2020, achieve 85% VBP benchmark.
- By the End of Calendar Year 2021, achieve 90% VBP benchmark.

Stage 1 - Governance	• The HCA, in partnership with ACHs, will facilitate the establishment of the Statewide Value-based Payment Transition Taskforce. Representatives may include: ○ Physical health care providers; ○ Behavioral health care providers; ○ Hospitals and clinics; ○ Tribal governments and Indian health care providers;

	○ Local health jurisdictions; ○ Community-based organizations; ○ Managed Care Organizations (MCO); and ○ Behavioral Health Organizations (BHO).	
Stage 2 - Planning	**Statewide Planning Activities:** In collaboration with the HCA, the Statewide Value-based Payment Transition Taskforce will perform an assessment to capture or validate a baseline of the current VBP levels. To the extent assessments have already been conducted, the taskforce will build from those assessments. Building from existing work when applicable, the taskforce will: • Deploy 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.	**Regional Planning Activities:** To support the Statewide Value-based Payment Transition Taskforce, the ACHs will: • Inform providers of various VBP readiness tools and resources. Some viable tools may include: ○ JSI/ NACHC Payment Reform Readiness Toolkit ○ https://www.stepsforward.org/modules/value-based-care#section-references ○ http://cph.uiowa.edu/ruralhealthvalue/TnR/VBC/VBCTool.php ○ Assessments deployed by the Practice Transformation Hub and the Transforming Clinical Practice Initiative (TCPI) • Connect providers to training and technical assistance developed and made available by the HCA and the statewide taskforce. • Support initial survey/attestation assessments of VBP levels to help the taskforce substantiate reporting accuracy. Using the recommendations of the taskforce, the ACHs will: • Develop a Regional VBP Transition Plan that: ○ Identifies strategies to be implemented in the region to support attainment of statewide VBP targets.

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		○ 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 3 - Implementation	**Statewide Implementation Activities:** • Implement strategies to support VBP transitions in alignment with Medicaid transformation activities. ○ By the End of Calendar Year 2017, achieve 30% VBP benchmark at a regional level ○ By the End of Calendar Year 2018, achieve 50% VBP benchmark at a regional level ○ By the End of Calendar Year 2019, achieve 75% VBP benchmark at a regional level. ○ By the End of Calendar Year 2020, achieve 85% VBP benchmark at a regional level. ○ By the End of Calendar Year 2021, achieve 90% VBP benchmark at a regional level. • Perform ongoing monitoring to inform the annual update of the Value-based Roadmap.	**Regional Implementation Activities**: • Implement strategies to support VBP transitions in alignment with Medicaid transformation activities. ○ By the End of Calendar Year 2017, achieve 30% VBP benchmark at a regional level ○ By the End of Calendar Year 2018, achieve 50% VBP benchmark at a regional level ○ By the End of Calendar Year 2019, achieve 75% VBP benchmark at a regional level. ○ By the End of Calendar Year 2020, achieve 85% VBP benchmark at a regional level. ○ By the End of Calendar Year 2021, achieve 90% VBP benchmark at a regional level. • Continue to engage in and contribute to the Statewide VBP Transition Taskforce, 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).

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Workforce		
Rationale: The health services workforce will need to evolve to meet the demands of the redesigned system of care. Workforce transformation will be supported through the provision of training and education services, hiring and deployment processes, and integration of new positions and titles to support transition to team-based, patient-centered care and ensure the equity of care delivery across populations. This taskforce will build on the work that has been done by other health workforce committees.		
Overarching Goal: Improve and sustain alignment between health services workforce capacity and community health needs.		
Stage 1 - Governance	The HCA, in partnership with ACHs, will facilitate the establishment of the Statewide Workforce Development Taskforce to build on existing statewide work. Representatives may include: ○ Health care providers; ○ Community-based organizations; ○ Managed care organizations; ○ Behavioral health organizations; ○ State government entities (such as elected officials, education authorities, law enforcement, housing authorities, workforce authorities, Department of Health, and Department of Social and Health Services); ○ Tribal governments and Indian health care providers; ○ Public health providers; ○ Education institutions; ○ Union and employee advocacy organizations; and ○ Consumer advocates and community representatives.	
Stage 2 - Planning	**Statewide Planning Activities:** • Support identification of workforce required to meet the objectives of the Medicaid Transformation demonstration. • Identify gaps in current workforce initiatives/activities as it pertains to Domain 2 and Domain 3 activities. • Develop a specific action plan to address gaps and training needs, and to make overall progress toward the	**Regional Planning Activities:** • Training of existing workforce (utilizing the Practice Transformation Support Hub as appropriate); • Development and deployment efforts; and • Recruitment and retention incentives and efforts to address workforce shortages (e.g., family practitioners, behavioral health providers, community health workers, dentists, others).

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	envisioned future state for Medicaid transformation. The action plan should include: ○ Activities/strategies to respond to gap analysis, including objectives, actions to be taken, and target dates, that tie directly to Domain 2 and Domain 3 projects. ○ Strategies may include: ○ The approach to cultural competency and health literacy trainings (particularly for clinical staff, service providers, and other patient-facing staff); ○ A plan for continuation of activities and expectation for reaching goals beyond the demonstration timeline; ○ Strategies to mitigate impact of health care redesign on workforce delivering services for which there is a decrease in demand.	
Stage 3 – Implementation	• Implement the Workforce Action Plan. • Administer necessary resources to support all efforts.	

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Systems for Population Health Management		
Rationale: The expansion, evolution and integration of health information systems and technology will need to be supported to improve the speed, quality, safety, and cost of care. This includes linkages to community-based care models. Health data and analytics capacity will need to be improved to support system transformation efforts, including combining clinical and claims data to advance VBP models and to achieve the triple aim.		
Overarching Goal: 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.		
Stage 1 - Governance	*For purposes of this demonstration, population health management is defined as:* • *Data aggregation* • *Data analysis* • *Data-informed care delivery* • *Data-enabled financial models* 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 other state agencies and partner organizations. • The Office of the National Coordinator develops policy and system standards 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 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. • HCA will work with ACHs to ensure that data products are developed that meet ACH project needs, 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.	
Stage 2 - Planning	**Statewide Planning Activities:** • Assess current population health management capacity in service of Domain 2 and Domain 3 projects.	**Regional Planning Activities:** 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:

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	• Identify tools available for population health management which may include:
	  ○ 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.
		• 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.
		ACHs will create Population Health Management Transformation Plans that:
		• 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.
		• Responds to needs and gaps identified in the current infrastructure.

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Domain 2: Care Delivery Redesign

Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes. Person-centered approaches and integrated models are emphasized. Domain 2 includes one required project and three optional projects. ACHs will be required to select at least one of the optional projects for a minimum of two Domain 2 projects in total.

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

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

The state is changing how it pays for delivery of physical health services, mental health services and substance use disorder (SUD) services in the Medicaid (Apple Health) program. By combining the financing for all services and holding one organization (the managed care plan) accountable for delivering high-quality whole-person care, incentives are better aligned to allow for expanded prevention, improved health outcomes, and flexible models of care that can support interdisciplinary care teams. To support the movement to fully integrated managed care, increased financial resources under Project 2A will be available for those regions that commit to and implement integrated financing of physical and behavioral health services for people enrolled in Medicaid, through managed care prior to 2020.

Primary care and behavioral health providers are undergoing substantial changes in order to deliver whole-person care efficiently and effectively, and to transition to value-based payment models. High-quality, comprehensive primary and behavioral health care are cornerstones of any high-performing health system. All providers will need support to implement advanced team-based models that are person-centered, rely on evidence-based guidelines, and use health information technology meaningfully to support care integration and coordination. This project offers a variety of implementation options in an effort to be sensitive to the unique circumstances of a given practice or community, and still provide an avenue for increasing the level of integration. The evidence-based approaches provided are consistent with the 7 elements identified by the Bree Collaborative:

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team-based care, access to psychiatry for medication management, access to routine behavioral health and physical health care, population-based care, accessibility/sharing of information, evidence-based prescribing, and use of data for quality improvement.

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

Recommended Implementation Partners: Behavioral Health Providers, Primary Care Providers, County Government, Local Public Health Agencies, Tribal Governments, Indian Health Care Providers, Managed Care Organizations, Criminal Justice, Department of Social and Health Services. Partners for Primary Care Transformation should include: Primary Care Providers (including independent practices), hospital-affiliated health centers, and Federally Qualified Health Centers and Rural Health Clinics serving Medicaid beneficiaries.

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

1. Patient-Centered Medical Home (PCMH) http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh
2. Collaborative Care Model 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 telemedicine-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: (MUST SELECT AT LEAST ONE)
Select at least one of the three approaches described in the report "*Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness"* http://www.milbank.org/wp-content/files/documents/papers/Integrating-Primary-Care-Report.pdf.

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

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

Additional Resources

- *Bree Collaborative*, http://www.breecollaborative.org/
- *SAMHSA-HRSA Center for Integrated Health Solutions http://www.integration.samhsa.gov/integrated-care-models*

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- *Evolving Models of Behavioral Health Integration in Primary Care* http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf
- *Approaches to Integrating Physical Health Services into Behavioral Health Organizations* http://www.integration.samhsa.gov/Approaches_to_Integrating_Physical_Health_Services_into_BH_Organizations_RIC.pdf
- HCA Advancing Integrated Care: The Road to 2020: Joe Parks, MD - *Best Practices in Integrated Care – A Full Continuum of Integrated Care, Part II*
- *U.S. Preventive Services Task Force* https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Project Implementation Stages

Stage 1 – Planning

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

- 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; and
  - 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.

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

Engage and convene County Commissioners, Tribal Governments, Managed Care Organizations, Behavioral Health providers and other critical partners to develop a plan and description of a process and timeline to transition to fully integrated managed care. This plan should reflect how in the region will enact fully integrated managed care by or before January 2020; include an explanation of the process for obtaining county commitment to pursue full integration. This requirement does not apply to regions that have already implemented or are implementing fully integrated managed care.

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

- Selected evidence-based approaches to integration and partner/providers for implementation;
- Implementation timeline;
- Description of the service delivery mode, which may include home-based and/or telehealth options;
- Roles and responsibilities of key organizational and provider participants, including payer organizations;
- Description of how project aligns with related initiatives and avoids duplication of efforts; and
- Justification demonstrating that the selected evidence-based approaches and the committed partner/providers are culturally relevant and responsive to the specific population health needs in the region.

Stage 1 – Planning: Progress Measures

- Complete assessment for the current state of integrated care
- List of target providers and organizations with formal commitment to participate in the project
- Complete plan for pursuing fully integrated managed care
- Binding letters of intent from all counties within the regional service area to implement full integration by 2020. Regions that achieve fully integrated managed care along an accelerated timeline may be eligible for increased incentive payments
- Complete Project Implementation Plan

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- Complete Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, explicitly reflective of support for Project 2A

Stage 2 – Implementation

Implementation of Stage 2 activities can move forward prior or in parallel to completion of stage 1 planning activities.

Implementation of plan for pursuing fully integrated managed care.

Integrating Behavioral Health into Primary Care Setting:

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

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

- Identification of a physician champion with knowledge of PCMH implementation.
- Gap analysis of practice sites within the regional service area.
- Identification of care coordinators at each primary care site who are responsible for care connectivity and engagement of other staff in PCMH process as well connectivity to other care managers who provide services for higher risk patients (e.g., health home care managers).
- Implementation of necessary HIT functionality including EHRs that meet meaningful use standards (MU), health information exchange (HIE) connectivity, e-prescribing, instant messaging, ER alerts.
- Staff training on care model including evidence-based prevention and chronic disease management.
- Preventive care screenings including behavioral health screenings (PHQ-9, SBIRT) will be implemented for all patients to identify unmet needs.
- A process must be developed for ensuring referral to appropriate care, if not provided in the practice, in a timely manner, including a "warm hand-off" where possible.
- Implementation of open access scheduling.
- Development of quality management program to monitor process and outcome metrics and to implement improvement strategies including rapid cycle improvements to ensure fidelity with PCMH standards and practice quality improvement. The program should include reporting to staff and patients.
- Demonstration of cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation, including addressing health disparities.

Option 2: Develop policies and procedures and implement the core principles of the selected evidence-based approach: **Collaborative Care Model**. As part of this option, regions can choose to focus initially on depression screening and treatment program. 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.

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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.

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- Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
- Provide psychiatric assessments for challenging patients 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

Option 1: Off-site, Enhanced Collaboration

- Primary Care and Behavioral Health providers located at a distance from one another will move beyond basic collaboration (in which providers make referrals, do not share any communication systems, but may or may not have periodic non-face-to-face communication including sending reports), to enhanced collaboration, 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; and
  - 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.

Option 2: 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, asthma, and others.
    - Diagnose chronic diseases and conditions.
    - Assess chronic disease management practices and control status.
  - Engagement in Integrated Care Program:

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- 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, needed.
  - Prescribe and manage medications as clinically indicated.
  - Change or adjust treatments if patients do not meet treatment targets, refer to specialists as needed.
- Systematic Follow-up, Treatment Adjustment:
  - Use population-based registry to systematically follow all patients.
  - Proactively reach out to patients who do not follow up.
  - Monitor treatment response at each contact with valid outcome metrics.
  - Monitor treatment side effects and complications.
  - Identify patients who are not improving to target them for specialist evaluation or connection to increased primary care access/utilization.
- Communication & Care Coordination:
  - Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
  - Engage and support family and significant others as clinically appropriate.
  - Facilitate and track referrals to specialty care, social services, and community-based resources.
- Systematic Psychiatric Case Review & Consultation:
  - Conduct regular (e.g., weekly) chronic disease and condition caseload review on patients who are not improving.
  - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
- Program Oversight and Quality Improvement:
  - Provide administrative support and supervision for program.
  - Provide clinical support and supervision for program.
  - Routinely examine provider-level and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use to inform quality improvement.

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

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

Stage 2 – Implementation: Progress Measures

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

Stage 3 – Scale & Sustain

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

Stage 3 – Scale & Sustain: Progress Measures

- Identify number of practices trained on selected evidence-based practices: projected vs. actual
- Identify number of practices implementing evidence-based practices
- Begin pay for ***performance*** of select outcome metrics
- Complete implementation of fully integrated managed care purchasing

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Project 2B: Community-Based Care Coordination *(Optional)*

Rationale: Care coordination is essential for ensuring that children and adults with complex health service needs are connected to the evidence-based interventions and services that will improve their outcomes. Appropriately coordinated care is especially important for high-risk populations, such as those living with chronic conditions, those impacted by the social determinants of health such as unstable housing and/or food insecurity, the aging community, and those dependent on institutionalized settings. Communities are challenged to leverage and coordinate existing services, as well as establish new services to fill gaps. Without a centralized approach to "coordinating the coordinators," a single person might be assigned multiple care coordinators who are unaware of one another, potentially provide redundant services, and risk creating confusion for the individual. **Importantly, activities are not a replacement for existing care coordination services provided under the Medicaid State Plan nor is this intended to produce an additional service array beyond what is already established in contracts and in the Medicaid State Plan.**

A hub-based (or similar) model provides a platform for communication among multiple care coordination resources, so that each is able to work to the maximum benefit of the individual in a more coordinated fashion. For example, in a hub-based model, a care coordinator who is embedded in a patient-centered medical home would know if the individual is receiving assistance with housing resources from a community-based organization, and thus, would not need to directly coordinate housing, but might instead focus on other needs. In addition to improving communication across multiple care coordination resources, a centralized approach allows for standardization of evidence-based care coordination protocols across various providers of care coordination services, better positioning regions and groups of providers and payers to transition to VBP. Under this approach, care coordination resources remain available in multiple organizations and settings, but are working in a more consistent way as a team. This project is built on the elements of an evidence-based model for establishing a model for care coordination that includes adoption of standardized requirements, and establishment of centralized processes, systems, and resources to allow accountable tracking of those being served, and a method to tie care coordination work products or units to payments and to outcomes. The preferred model that includes these elements is Pathways Community HUB. Activities within this project must leverage existing care coordination capacity, reduce duplication of efforts, and increase accountability.

Target Population: Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as, serious mental illness, moderate to severe substance use disorder, HIV, birth defects, cancer, diabetes, depression, heart disease and stroke) and at least one risk factor (e.g., obesity, unstable housing, food insecurity, high EMS utilization).

Recommended Implementation Partners: Behavioral Health Providers, Primary Care Providers, Managed Care Organizations, Department of Social and Health Services, Local Public Health Agencies, Area Agencies on Aging, Tribal Governments, Indian Health Care Providers, Criminal Justice, Law

Enforcement, Hospitals, Long-Term Care, Care Management Agencies, Home Health, Health Home Providers, Housing, Emergency Medical Services, and Community-Based Service Organizations.

Evidence-based Approach:

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

Additional Resources:

- Northwest Ohio Pathways HUB http://www.hcno.org/health-improvement-initiatives/pathways.html
- Pathways Community HUB Certification Program https://pchcp.rockvilleinstitute.org/

Project Implementation Stages

Stage 1 – Planning

Prepare for implementation of a community-based coordination model, such as the Pathways Community HUB model. Rely on the needs identified in the Regional Health Needs Inventory to guide development. Throughout this project description, the term "HUB" is used to refer to both a Pathways Community HUB and a similar HUB-like centralized care coordination system that includes the core elements of the Pathways HUB model. Regardless of whether the ACH intends to establish a HUB that achieves certification under the Pathways Community HUB model, or implement a similar model without certification, the core components of the planning phase are:

Assess the current state of capacity, including existing care coordination activities, to effectively focus on the need for regional community-based care coordination in the following areas; include strategies within the system wide plan completed within Domain 1 for:

- Population Health Management/HIT: Describe the ways in which EHRs and other technologies are currently used in processes for identifying high-risk populations, linking to services, tracking beneficiaries through care coordination processes, and documenting the outcomes of such processes. Include systems that support: bi-directional communication and data sharing, timely communication among care team members, care coordination processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- Workforce: Capacity and shortages for workforce to implement the selected care coordination focus areas; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:
  - Shortage of Community Health Workers, Patient Navigators, other care coordination providers; take into account the full range of care coordination resources in the health care system, including those housed in patient-centered medical homes, health homes, behavioral health organizations, and other community-based service organizations;
  - Access to specialty care, opportunities for telehealth integration;
  - Workflow changes to support integration of care coordination processes and communications; and

  - Training and technical assistance to ensure effective referral structures and prepared, proactive community partners; and to address cultural and linguistic competency, health literacy needs.
- Financial Sustainability: Alignment between current payment structures and guideline-concordant care, inclusive of community-based services; assessment of current payment models for supporting care coordination; incorporate current state and anticipated future state of VBP arrangements to support care coordination efforts into the regional VBP transition plan.

If applicable, determine HUB leadership:
- Establish HUB planning group, including payers.
- Review national HUB standards and provide training on the HUB model to all stakeholders.
- Designate an existing entity to serve as the HUB lead.

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

Develop HUB Implementation Plan:
- The HUB Implementation Plan will include, at minimum:
  - Description of how the pathways will be implemented to leverage or enhance related initiatives, including health homes and Managed Care-led coordination and avoid duplication of efforts or existing Medicaid services;
  - Clear articulation of how existing care coordination capacity will be effectively leveraged;
  - A list of the selected focus areas for the first phase of implementation, and explanation of how they align with the high-priority regional health needs identified in the inventory; examples include Behavioral Health, Medical Home and Family Planning. Explain how the selected focus areas align with other Domain 2 and Domain 3 projects.
  - Description of the care coordination service delivery mode(s), which may include home-based and/or telehealth options;
  - Plan for establishing the HUB Operations Manual, which must include methods for training, case assignment and caseload monitoring, HIPPA compliance plan, and methods for tracking and documenting services provided;
  - Plan for establishing the HUB Quality Improvement Program;

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- Implementation timeline;
- Roles and responsibilities of HUB implementation partners, including payer organizations; and
- HUB sustainability plan, including plan to increase scale and scope and secure financial support from multiple payers.

Stage 1 – Planning: Progress Measures

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

Stage 2 – Implementation

- Complete the HUB Operations Manual and the HUB Quality Improvement Plan.
- Develop and adopt related policies and procedures.
- Implement the Phase 2 (Creating tools and resources) and 3 (Launching the HUB) elements specified by AHRQ:
  - Create and implement checklists and related documents for care coordinators;
  - Implement 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; and
  - Conduct a community awareness campaign.

Stage 2 – Implementation: Progress Measures

- Complete HUB Operations Manual
- Complete HUB Quality Improvement Plan
- List policies and procedures in place
- Identify number of partners participating and if applicable, the number implementing each selected pathway
- Identify number of partners trained: projected vs. actual and cumulative
- Begin pay for ***reporting*** of outcome metrics

Stage 3 – Scale & Sustain

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- Recruit additional community-based service organizations and other partners to participate in the HUB.
- Implement additional focus areas or standardized pathways.
- Employ continuous quality improvement methods to refine pathways.
- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support HUB model and selected pathways.
- Develop payment models to support care coordination pathways.
- Implement VBP strategies to support the HUB care coordination pathways.

Stage 3 – Scale & Sustain: Progress Measures

- Identify number of partners participating in the HUB and number implementing each selected pathway
- Identify number of partners trained on each selected pathway: projected vs. actual and cumulative
- Begin pay for ***performance*** of select outcome metrics

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Project 2C: Transitional Care *(Optional)*

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

Target Population: Medicaid 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.

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

Evidence-based Approaches for Care Management and Transitional Care: (Optional, may select one or more approaches)

1. Interventions to Reduce Acute Care Transfers, INTERACT™4.0, http://www.interactteam.org/interact/ - a quality improvement program that focuses on the management of acute change in resident condition
2. Transitional Care Model (TCM), http://www.transitionalcare.info/about-tcm - a nurse led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up
3. The Care Transitions Intervention® (CTI®), http://caretransitions.org/ - a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives. *Note: The Care Transitions Intervention® is also known as the Skill Transfer Model™, the Coleman Transitions Intervention Model®, and the Coleman Model®.*
4. Care Transitions Interventions in Mental Health, http://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf - provides a set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness (SMI)

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

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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 on critical components of an integrated transitional care approach. Refer to the following:

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

Project Implementation Stages

Stage 1 – Planning

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

- 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 Community Health Workers, Social Workers, Home Health Care Providers, Mental Health Providers, Care Coordinators and Care Managers; Correctional Health Providers; take into account the full range of care coordination resources in the health care system and corrections system (as appropriate), including those housed in patient-centered medical homes, health homes, behavioral health organizations, and other community-based service organizations;
  - Workflow changes to support integration of care transition processes and communications;
  - Training and technical assistance to ensure effective referral structures and prepared, proactive community partners; and to address cultural and linguistic competency, health literacy needs; and
  - Specialized training needs to complete certifications requirements of selected approach (if applicable).

- Financial Sustainability: Alignment between current payment structures and care transition services, inclusive of community-based services; incorporate current state and anticipated future state of VBP arrangements to support new and/or expanded care transition and supportive efforts into the regional VBP transition plan.

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

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

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- 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.

Stage 1 – Planning: Progress Measures

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

Stage 2 – Implementation

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.

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- 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®

- 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

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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.

For projects targeting people returning to the community from incarceration:

- Process for completing and submitting applications for Medicaid eligible or likely-Medicaid eligible, such that status will move from *suspended* to *active* at release *or* so the supervising facility can admit individuals to qualifying entities for Medicaid reimbursable services.
- Process for triaging transitional care and care planning for individuals with the greatest health and behavioral health needs in addition to greatest risk of recidivism, as per criminogenic risk and needs assessments.

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For all approaches, implementation must include the following core components and must leverage existing regional resources:

- 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.
- Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes.
- Establish a performance-based payment model to incentivize progress and improvement.

Stage 2 – Implementation: Progress Measures

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

Stage 3 – Scale & Sustain

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

Stage 3 – Scale & Sustain: Progress Measures

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

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Project 2D: Diversion Interventions *(Optional)*

Rationale: Diversion strategies provide opportunities to re-direct individuals away from high-cost medical and legal avenues and into community-based health care and social services that can offer comprehensive assessment, care/case planning and management to lead to more positive outcomes. The following strategies promote more appropriate use of emergency care services and also support person-centered care through increased access to primary care and social services, especially for medically underserved populations. There are three diversion strategies recommended under this project. The first is diversion at the point of Emergency Department (ED) presentation for a non-acute condition; the second is the use of community paramedicine to divert individuals who access the emergency medical services (EMS) system for non-emergent 911 calls away from the hospital ED to a receive non-emergent medical care or social assistance at a more appropriate destination; and the third is law enforcement assisted diversion (LEAD), a pre-booking approach to redirect low-level offenders engaged in drug or prostitution activity to community-based services, instead of jail and prosecution.

Target Population: Medicaid 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.

Recommended Implementation Partners: Behavioral Health Providers, Managed Care Organizations, Department of Social and Health Services, Local Public Health Agencies, Tribal Governments, Indian Health Care Providers, Housing, Criminal Justice, Law Enforcement, Emergency Departments, Emergency Medical Services and/or Community Paramedicine Services, Dental Providers, Care Coordination, Case Management and other Community-Based Service Organizations.

Evidence-supported Diversion Strategies: (Select at least one approach)

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.

Project Implementation Stages

Stage 1 – Planning

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

- 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 Community Health Workers, Social Workers, Mental Health Providers, Substance Abuse Disorder Providers;
  - Law enforcement willingness and preparedness to engage;
  - Training and technical assistance to ensure effective referral structures and prepared, proactive community partners; and to address Cultural and linguistic competency, health literacy needs; and
  - Specialized training needs to complete certifications requirements of selected approach (if applicable).
- Financial Sustainability: Alignment between current payment structures to support diversion interventions; incorporate current state and anticipated future state of VBP arrangements to support new or expanded services and supportive efforts into the regional VBP transition plan.

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

- Utilize the Regional Health Needs Inventory to guide planning, including identification of priority communities and partners for implementation.
- Utilize the Regional Health Needs Inventory to 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).
- In the case of LEAD®: establish a community advisory group that includes representation from community members, health care and social services, law enforcement and community public safety leaders.
- In the case of ED Diversion/Community Paramedicine: identify, recruit, and secure formal commitments for participation from implementation partners as appropriate to the selected conditions of focus, including hospitals, emergency medical services, dental providers, primary care providers, and/or behavioral health providers, via a written agreement and the specific role the organization and/or provider will perform in the selected approach.
- For each selected approach, develop a project implementation plan that includes, at minimum:

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- A description of the target communities and populations, including the rationale for selecting them based on the Regional Health Needs Inventory;
- 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;
- List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely fashion;
- Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts. 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;
- Implementation timeline;
- Description of the service delivery mode, which may include home-based and/or telehealth options; and
- Roles and responsibilities of partners.

Stage 1 – Planning: Progress Measures

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

Stage 2 – Implementation

ED Diversion

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.

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Community Paramedicine

First responders, ED practitioners, and primary care providers may collaborate 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 HIE to facilitate communication between community paramedics and other health care providers

Law Enforcement Assisted Diversion (LEAD®)

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

- Establish the LEAD® program as a voluntary agreement among independent decision-makers.
- Engage law enforcement and generate buy-in, including obtaining Commander level support.
- Identify a dedicated project manager.
- Tailor the LEAD® intervention to the community.
- Provide intensive case management – to link diverted individuals to housing, vocational and educational opportunities, treatment, and community services. Participants may need access to medication-assisted therapy and other drug treatment options; they may also need access to food, housing, legal advocacy, job training, and other services.
    - 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.

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

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

Stage 2 – Implementation: Progress Measures

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

Stage 3 – Scale & Sustain:

- Expand the model to additional communities and/or partner organizations.
- Employ continuous quality improvement methods to refine the approach.
- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion efforts.
- Develop payment models to support diversion strategies.
- Implement VBP strategies to support the diversion activities.

Stage 3 – Scale & Sustain: Progress Measures

- Identify number of partners trained on selected pathways: projected vs. actual and cumulative
- Begin pay for ***performance*** of select outcome metrics

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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. ACHs will be required to select at least one of the optional projects for a minimum of two Domain 3 projects in total.

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

Rationale: Washington State, along with the nation, is in the midst of a crisis. The opioid epidemic affects communities, families, and overwhelms law enforcement, health care and social service providers. Opioid use disorder is a devastating and life-threatening chronic medical condition and access to treatments that support recovery and access to lifesaving medications to reverse overdose needs to be improved. Through this project, ACH will support achievement of the goals outlined in Executive Order 16-09 and the state interagency opioid working plan. Stakeholders across Washington State have been building capacity to reduce opioid-related morbidity and mortality. State agencies, public health, Tribal governments, and other partners are coming together to focus on strategies for implementing the state opioid response plan. This project aligns with this plan, and focuses on strategies under four of the plan goals: (1) prevent opioid misuse and abuse by improving prescribing practices, (2) expand access to opioid dependence treatment, (3) intervene in opioid overdoses to prevent death, and (4) use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.

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

Recommended Implementation Partners: Mental and Behavioral health providers, Substance Use Disorder providers, Primary Care Providers, including Community Health Centers/FQHCs; Managed Care Organizations, Department of Social and Health Services, Tribal Governments, Indian Health Care Providers, Hospitals, Community-based Service Organizations, Criminal Justice institutions, Local Public Health Agencies, Emergency Medical Services, Law Enforcement, Dental Care Providers, Professional Associations, and Teaching Institutions.

Recommended Approach:

Clinical Guidelines

1. AMDG's Interagency Guideline on Prescribing Opioids for Pain, http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf
2. 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/sites/default/files/SPE%20Strategic%20Plan%20FINAL%20-%20v.%208.10.12.pdf

Other Resources

- CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 (http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm)

Project Implementation Stages

Stage 1 – Planning

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

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

- Population Health Management Systems/HIT: Adoption of technology with the capability to support identification of persons at high-risk for opioid overdose, notifications to health care providers of opioid overdose events, monitoring of prescribing practices, and implementation of quality improvement processes; a plan to build enhancements in EHRs and other systems to support clinical decisions in accordance with guidelines; an assessment of the current level of use of the Prescription Drug Monitoring Program and the Emergency Department Information Exchange; and strategies to increase use of Prescription Drug Monitoring Program and interoperability with EHRs. Overall, in line with Goal 4 of the State Interagency Opioid Working Plan, develop a plan to use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.
- Workforce: Capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:
  - Efforts to enhance medical, nursing, and physician assistant school curricula on pain management, the Prescription Drug Monitoring Program, and recognition and treatment of opioid use disorder;
  - Partnering with professional associations and teaching institutions to educate dentists, osteopaths, nurses, and podiatrists on current opioid prescribing guidelines;
  - Encouraging licensing boards of authorized prescribers to mandate CEUs on opiate prescribing and pain management guidelines;
  - Encouraging family medicine, internal medicine, OB/GYN residency programs to train residents on care standards/medications for opioid use disorder;

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- Identifying critical workforce gaps in the substance use treatment system and develop initiatives to attract and retain skilled professionals in the field; and
- Using the Prescription Monitoring Program.

- Financial Sustainability: Alignment between current payment structures and guideline-concordant care with regards to opioid prescribing; incorporate current state and anticipated future state of VBP arrangements to support opioid abuse prevention and control efforts into the regional VBP transition plan.

Additional planning steps will include:

- Identify communities or sub-regions of focus for this project, based on Regional Health Needs Inventory. Consider areas with limited access to treatment for opioid disorder, areas with limited or no availability of pain management clinics or providers, and rates of opioid use, misuse, and abuse.
- Identify established local partnerships that are addressing the opioid crisis in their communities and establish new partnerships where none exist. Identify, recruit, and secure formal commitments for participation in project implementation, including professional associations and teaching institutions.
- Develop a Regional Opioid Working Plan that provides a detailed description of how the ACH will implement, at minimum, selected strategies and activities outlined in the 2016 Washington State Interagency Opioid Working Plan. The regional plan will include, at minimum:
  - Implementation timelines for each strategy;
  - Roles and responsibilities of key organizational and provider participants, including community-based service organizations, along with justification of how the partners are culturally relevant and responsive to the specific population in the region;
  - 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; and
  - Specific strategies and actions to be implemented, selected from the 2016 Washington State Interagency Opioid Working Plan:

GOAL 1: Prevent opioid misuse and abuse

- **Strategy 1: Promote use of best practices among health care providers for prescribing opioids for acute and chronic pain; explain how ACH will support or take steps to:**
  - Educate health care providers on current and future iterations of the Agency Medical Directors' Group Interagency Guideline for Prescribing Opioids for Pain and the Washington Emergency Department Opioid Prescribing Guidelines and CDC Guideline for Prescribing Opioids for Chronic Pain

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- Promote the use of the Prescription Drug Monitoring Program
- Train, coach and offer consultation with providers on opioid prescribing and pain management, integrate TelePain video conferencing and other tele-medicine approaches
- Work with organizations and associations developing specifications around individual prescribing after individual health services (e.g., C-Sections, routine vaginal births, dental procedures, sports injuries)
- Build enhancements in EHRs and other systems to default to recommended dosages, integrate Prescription Monitoring Program

- **Strategy 2: 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; explain how the ACH will support or take steps to:**
  - Distribute counseling guidelines and other tools to pharmacists, chemical dependency professionals, and health care providers and encourage them to educate patients on prescription opioid safety (storage, disposal, overdose prevention and response)
  - Educate patients on the potential side effects and dangers of opioid use after acute prescribing
  - Provide targeted health education to opioid users and their social networks through print and web-based media
  - Promote accurate and consistent messaging about opioid safety and addiction by public health, law enforcement, community coalitions, and others
  - Conduct an inventory of existing patient materials on medication safety for families and children, develop new materials as needed as tools for health care providers and parents.
- **Strategy 3: Prevent opioid misuse in communities, particularly among youth; explain how ACH will support or take steps to:**
  - Implement strategies from the Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan, http://www.theathenaforum.org/sites/default/files/SPE%20Strategic%20Plan%20FINAL%20-%20v.%208.10.12.pdf
- **Strategy 4: Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse; explain how ACH will support or take steps to:**
  - Educate patients and the public on the importance and ways to properly store and dispose of prescription pain medication
  - Promote the use of home lock boxes to prevent unintended access to medication
  - Explore funding and regulatory enhancements to sustain and evaluate Drug Take Back programs
- **Strategy 5: Decrease the supply of illegal opioids; explain how ACH will support or take steps to:**
  - Educate law enforcement on the Prescription Drug Monitoring Program and how it works

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

- **Strategy 1: Build capacity of health care providers to recognize signs of possible opioid misuse, effectively screen for opioid use disorder (OUD), and link patients to appropriate treatment resources; explain how ACH will support or take steps to:**
  - Educate providers across all health professions on how to recognize signs of opioid misuse among patients and how to use appropriate tools to screen for OUD
  - Universally screen all patients for drug misuse with validated tools; provide preventive care screenings and SBIRT for all patients to identify unmet needs
  - Offer patients brief interventions and supported referrals to treatment, 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
- **Strategy 2: Expand access to, and utilization of, opioid use disorder medications in communities; explain how ACH will support or take steps to:**
  - Together with the Health Care Authority, identify policy gaps and barriers that limit availability and utilization of buprenorphine, methadone, and naltrexone and contribute to the development of policy solutions to expand capacity
  - Together with the Center for Opioid Safety Education, provide technical assistance and resources to county health officers to advocate for expanded local access to OUD medications
  - Build structural supports (e.g. case management capacity) to support medical providers and staff to implement and sustain buprenorphine treatment
- **Strategy 3: Expand access to, and utilization of, opioid use disorder medications in the criminal justice system; explain how ACH will support or take steps to:**
  - Train and provide technical assistance to criminal justice professionals to endorse and promote agonist therapies for people under criminal sanctions
  - Optimize access to chemical dependency treatment services for offenders who have been released from prison into the community and for offenders living in the community under correctional supervision
- **Strategy 4: Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage beneficiaries in support services, including housing; explain how ACH will support or take steps to:**
  - Provide technical assistance to local health jurisdictions and community-based service organizations to organize or expand syringe exchange and drug user health services

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- **Strategy 5: Identify and treat opioid use disorder among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns; explain how ACH will support or take steps to:**
  - Disseminate the guideline Substance Abuse during Pregnancy: Guidelines for Screening and Management
  - Disseminate the WA State Hospital Association Safe Deliveries Roadmap standards to health care providers
  - Educate pediatric and family medicine providers to recognize and appropriately refer newborns with NAS
- **Strategy 6: Support whole person in recovery; explain how ACH will support or take steps to:**
  - 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

GOAL 3: Intervene in opioid overdoses to prevent death

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

GOAL 4: Use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions

Explain how ACH will support or take steps to:

- **Strategy 1: Improve PMP functionality to document and summarize patient and prescriber patterns to inform clinical decision making.**
- **Strategy 2: Utilize the PMP for public health surveillance and evaluation.**
- **Strategy 3: Continue and enhance efforts to monitor opioid use and opioid-related morbidity and mortality.**
- **Strategy 4: Monitor progress toward goals and strategies and evaluate the effectiveness of our interventions.**

Stage 1 – Planning: Progress Measures

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- Completed Workforce, Technology, and Financial Sustainability plans, as defined in Domain 1, reflective of support for Project 3A efforts
- List of implementation partners with formal written commitment to participate
- Number and list of MDs, ARNPs, and PAs who are approved to prescribe buprenorphine
- Completion of Regional Opioid Working Plan

Stage 2 – Implementation

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

Convene or leverage existing local partnerships to implement the ACH Regional Opioid Working Plan; one or more such partnerships may be convened. Each partnership will include health care service 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 ACH Regional Opioid Working Plan and provides mechanisms for any workgroups or subgroups to share across teams, including implementation successes, challenges and overall progress. Continue to convene the partnership(s) and any necessary workgroups on a regular basis throughout implementation phase.

Implement the ACH Regional Opioid Working Plan. Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into the Regional Working Plan.
Develop a plan to Scale and Sustain that includes adding partners and/or reaching new communities under the current initiative, as well as defining a path forward to deploy the partnership's expertise, structures, and capabilities to address other yet-to-emerge public health challenges.

Stage 2 – Implementation: Progress Measures

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

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Stage 3 – Scale & Sustain

• Implement Scale and Sustain Plan to increase scale, include additional partners, and/or cover additional high needs geographic areas.
  ○ Review and apply data to inform decisions regarding specific strategies and action to be spread to additional settings or geographical areas
  ○ Convene and support platforms to facilitate shared learning and exchange of best practices and results to date
  ○ Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the ACH Region Opioid Working Plan
• Engage and encourage Managed Care Organizations to develop/refine model benefits aligned with evidence-based clinical guideline-concordant care and best practice recommendations.
  ○ Encourage payment models that support non-opioid pain therapies and approach to addressing opioid use disorder 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.

Stage 3 – Scale & Sustain: Progress Measures
• Number and list of community partnerships. For each include list of members and roles • Number of health care providers, by type, trained on AMDG's Interagency Guideline on Prescribing Opioids for Pain • Number of health care organizations with EHRs or other systems newly put in place that provide clinical decision support for the opioid prescribing guideline, such as defaulting to recommended dosages • Number of local health jurisdictions and community-based service organizations that received technical assistance to organize or expand syringe exchange programs • Number of emergency department with protocols in place for providing overdose education and take home naloxone to individuals seen for opioid overdose • Begin pay for ***performance*** of select outcome metrics

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

Rationale: Maternal and child health is a primary focus for the Medicaid program as Medicaid funds more than half of the births in the state and provides coverage to more than half of Washington's children. Providing mothers and their children with home visits has been demonstrated to improve maternal and child health. Home visitors work with the expectant or new mother in supporting a healthy pregnancy, by recognizing and reducing risk factors, promoting prenatal health care through healthy diet, exercise, stress management, ongoing well-woman care, and by supporting positive parenting practices that facilitate the infant and young child's safe and healthy development. Child health promotion is a state priority to keep children as healthy and safe as possible, which includes parents accessing timely and routine preventative care for children, especially well-child screenings and assessments. A third focus is to ensure beneficiaries access ongoing well women care and improve utilization of effective family planning strategies through implementation of the CDC's recommendations to improve women's health before a first, or subsequent, pregnancy.

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

Recommended Implementation Partners: Primary Care Providers, Home Health, Pediatricians, Obstetricians and Gynecologists, Department of Social and Health Services, Department of Early Learning, Local Public Health Agencies, Tribal Governments, Indian Health Care Providers, Family Planning providers and Community-Based Service Organizations.

Evidence-based Approaches for Maternal and Child Health: (May select one or more approaches)

1. Implementation of an evidence-based home visiting model for pregnant high risk mothers, including high risk first time mothers. Potential programs can include Nurse Family Partnership (NFP) or other federally recognized evidence-based home visiting model currently operating in Washington State. If a program currently exists in the ACH region, it can only be selected for this project if there is a valid justification for an expansion of the program and a demonstration that duplication of effort will not occur. ACHs must also demonstrate how they are coordinating across existing services.
    a. Nurse Family Partnership (NFP), http://www.nursefamilypartnership.org/communities/model-elements - provides first-time, low-income mothers and their children with nurse-led home-based support and care.
    b. Early Head Start Home-Based Model (EHS), https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/poi/miechv-ehs/miechv.html which works with parents to improve child health; prevent child abuse and neglect; encourage positive parenting; and promote child development and school readiness.
2. Implementation of an evidence-based model or promising practice to improve regional well-child visit rates (for ages 3-6) and childhood immunization rates.
    a. Bright Futures. https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx

3. Implementation of recommendations to Improve Preconception Health and Health Care, http://www.cdc.gov/MMWR/PDF/rr/rr5506.pdf. In particular, ACHs should consider evidence-based models to improve utilization of effective family planning strategies.
   a. If applicable, ACHs could leverage the Family Planning Pathway to align with Project 2B.

Additional Resources:

- *Long Acting Reversible Contraception: http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception*

Project Implementation Stages

Stage 1 – Planning

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

- Utilize the Regional Health Needs Inventory to guide selection of evidence-based approach(es) and specific target population(s).
- Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.
- For each selected approach, develop a project implementation plan that includes, at minimum:
  - The selected evidence-based approach(es) and description of the target population, including justification for how the approach is responsive to the specific needs in the region as documented in the Regional Health Needs Inventory;
  - List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely fashion;
  - Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts. Project plans must consider current implementation of all Home Visiting Models and how they might be strengthened or expanded;
  - Implementation timeline;
  - Description of the mode of service delivery, which may include home-based and/or telehealth options; and
  - Roles and responsibilities of partners.

Stage 1 – Planning: Progress Measures

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

Stage 2 – Implementation

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- **Implementation for a home visiting model should follow evidence-based practice standards.** For example, if Nurse Family Partnership® (NFP) were chosen then implementation must include the elements specified by the NFP model developer:
    - Nurse Family Partnership Model Elements: http://www.nursefamilypartnership.org/Communities/Model-elements

- **Implementation of an evidence-based model or promising practice to improve regional well-child visit rates (for ages 3-6) and childhood immunization rates**. For example, Bright Futures is intended to support primary care practices in providing well-child and adolescent care. If chosen, implementing agencies must meet all fidelity, essential requirements and/or program standard requirements as defined by the model developer.
    - https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx

- **Recommendations to Improve Preconception Health and Health Care**. The CDC has provided 10 recommendations that aim to improve a woman's health before conception, whether before a first or a subsequent pregnancy. The recommendations fall into 10 areas listed below.

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

  The recommendations to be implemented as part of this project, at the regional level, and CDC's identified action steps, are shown below. Activities should be designed to improve utilization of effective family planning strategies, including long-acting reversible contraception methods (LARCs), where applicable, and in consumer awareness campaigns and professional curricula.

1) Individual responsibility across the lifespan:
    - Develop, evaluate, and disseminate reproductive life planning tools for women and men in their childbearing years, respecting variations in age; literacy, including health literacy; and cultural/linguistic contexts.
2) Consumer awareness:
    - Develop, evaluate, and disseminate age-appropriate educational curricula and modules for use in school health education programs. Integrate reproductive health messages into existing health promotion campaigns (e.g., campaigns to reduce obesity and smoking).

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- Conduct consumer-focused research to identify terms that the public understands and to develop messages for promoting preconception health and reproductive awareness.
- Design and conduct social marketing campaigns necessary to develop messages for promoting preconception health knowledge and attitudes, and behaviors among men and women of childbearing age.

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

4) Interventions for identified risks:
   - Increase health provider awareness concerning the importance of ongoing care for chronic conditions and intervention for identified risk factors.
   - Develop and implement modules on preconception care for specific clinical conditions for use in clinical education at graduate, postgraduate, and continuing education levels.
   - Consolidate and disseminate existing guidelines related to evidence-based interventions for conditions and risk factors. Disseminate existing evidence-based interventions that address risk factors that can be used in primary care settings (i.e., isotretinoin, alcohol misuse, antiepileptic drugs, diabetes [preconception], folic acid deficiency, hepatitis B, HIV/AIDS, hypothyroidism, maternal phenylketonuria [PKU], rubella seronegativity, obesity, oral anticoagulant, STD, and smoking).
   - Develop fiscal incentives (e.g., pay for performance) for risk management, particularly in managed care settings.

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- Apply quality improvement techniques and tools (e.g., conduct rapid improvement cycles, establish benchmarks, use practice self-audits, and participate in quality improvement collaborative groups).

5) Inter-conception care:
   - Monitor the percentage of women who complete postpartum visits (e.g. using the Health Employer Data and Information Set measures for managed care plans and Title V Maternal Child Health Block Grant state measures), and use these data to identify communities of women at risk and opportunities to improve provider follow-up.
   - Develop, evaluate, and replicate intensive evidence-based inter-conception care and care coordination models for women at high social and medical risk. Enhance the content of postpartum visits to promote inter-conception health.
   - Use existing public health programs serving women in the postpartum period to provide or link to interventions (e.g., family planning, home visiting, and the Special Supplemental Nutrition Program for Women, Infants, and Children).
6) Pre-pregnancy checkup:
   - Consolidate existing professional guidelines to develop the recommended content and approach for such a visit. Modify third party payer rules to permit payment for one pre-pregnancy visit per pregnancy, including development of billing and payment mechanisms.
   - Educate women and couples regarding the value and availability of pre-pregnancy planning visits.

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

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

Stage 2 – Implementation: Progress Measures

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

Stage 3 – Scale & Sustain

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

Stage 3 – Scale & Sustain: Progress Measures

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

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Project 3C: Access to Oral Health Services *(Optional)*

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

Target Population: All Medicaid beneficiaries, especially adults.

Recommended Implementation Partners: Primary Care Providers, Dental Care Providers, Hospitals, Tribal Governments, Indian Health Care Providers, and Community-based Service Organizations.

Evidence-based Approaches for Access to Oral Health Services: (Optional, may select one or both approaches)

1. Oral Health in Primary Care, http://www.safetynetmedicalhome.org/sites/default/files/White-Paper-Oral-Health-Primary-Care.pdf - integrating oral health screening, assessment, intervention, and referral, into the primary care setting
2. Mobile/Portable Dental Care, http://www.mobile-portabledentalmanual.com/ – the national maternal and child health resource center provides a manual to guide planning and implementation of mobile dental units and portable dental care equipment for school-age children, which could be adapted for adults

Additional Resources:

- https://www.ncbi.nlm.nih.gov/pubmed/11760318
- http://www.nationaloralhealthconference.com/docs/presentations/2005/0501/mobiledentalclinics.PDF

Project Implementation Stages

Stage 1 – Planning:

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

- 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; and
  - 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.

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

- Utilize the Regional Health Needs Inventory to identify communities or sub-regions with demonstrated shortages of dental providers or otherwise limited access to oral health services.
- Identify, recruit, and secure formal commitments for participation from implementation partners, to include, at minimum, primary care providers and dentists, via a written agreement.
- For each selected approach, develop a project implementation plan that includes, at minimum:
  - The selected evidence-based approach and description of the target population, including justification for how the approach is responsive to the specific needs in the region as documented in the Regional Health Needs Inventory. Explain the combination of oral health services to meet the needs of the target population and how the approach addresses barriers to accessing oral health services. Consider a phased approach, for example, by beginning to focus on adults with diabetes, or other chronic conditions, before expanding to additional populations.
  - List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely fashion; partner roles and responsibilities. Include dentists/dental practices and periodontists that will serve as referrals resources.
  - Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts. Consider current efforts to broaden oral health service delivery sites, and how they might be strengthened or expanded.

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- Implementation timeline.
- Description of the mode of service delivery, which may include home-based and/or telehealth options.
- For Oral Health in Primary Care, consider a phased approach to implementation, as follows:
  - Begin with screening patients for signs and symptoms of early disease and develop a structured referral process for dentistry;
  - Offer fluoride varnish for pediatric patients per the USPSTF61 and AAP guidelines; consider indications for fluoride varnish for high-risk adults;
  - Focus on patient/caregiver risk assessment and risk reduction through patient education, dietary counseling, and oral hygiene training;
  - Identify a particular high-risk patient population (e.g., adult patients with diabetes, pregnant women) and begin with a pilot before expanding population/practice wide; and
  - Articulate the activities in each phase, and the associated timeline.
- For Mobile/Portable Dental Care:
  - Specify where the mobile units and/or portable equipment will be deployed. Consider locations where Medicaid beneficiaries access housing, transportation, or other community-based supports, as well as rural communities, migrant worker locations, and Native American reservations;
  - Secure commitments from potential sites and develop a list of potential future sites;
  - Specify the scope of services to be provided, hours of operation, and staffing plan;
  - Include steps to show how ACH will research, and comply with, laws, regulations, and codes that may impact the design or implementation of the mobile unit and/or portable equipment; and

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

Stage 1 – Planning: Progress Measures

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

Stage 2 – Implementation

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Oral Health in Primary Care

- 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.
  - 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 and/or Portable Dental Care

Implementation will include the following core components:

- Establish guidelines, policies, protocols, and/or procedures as necessary to support the full scope of services being provided;
- Secure necessary permits and licenses required by the state or locality;

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- Establish referral relationships with primary care providers, dental providers, and other specialists, e.g. ENTs and periodontists, as needed;
- Acquire mobile unit and/or portable equipment and other supplies;
- Recruit, hire, and train staff; and
- Implement the provider, client, and community education campaign to raise awareness of the new service.

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

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

Stage 2 – Implementation: Progress Measures

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

Stage 3 – Scale & Sustain

- Increase scope and scale, expand to serve additional high-risk populations, and add partners or service sites to spread approach to additional communities
- Employ continuous quality improvement methods to refine the model
- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion
- Develop payment models to support provision of oral services in primary care and/or via mobile clinics
- Implement VBP strategies to support access to oral health services

Stage 3 – Scale & Sustain: Progress Measures

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

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Project 3D: Chronic Disease Prevention and Control (*Optional)*

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

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

Recommended Implementation Partners: Behavioral Health Providers, Primary Care Providers, Managed Care Organizations, Department of Social and Health Services, Local Public Health Agencies, Tribal Governments, Indian Health Care Providers, Hospitals, Long-Term Care, Community Based Organizations, Home Health, School Health Services and Human Service Agencies, and Emergency Medical Services.

Evidence-based Approach:

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

Specific Strategies to Consider Including 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.

Additional Resources:

- *Guidelines for the Diagnosis and Management of Asthma (EPR-3) (http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines)*
- *JNC 8 Guidelines for the Management of Hypertension in Adults (http://www.aafp.org/afp/2014/1001/p503.html)*
- *American Diabetes Association Standards of Medical Care in Diabetes – 2016 (http://professional.diabetes.org/CONTENT/CLINICAL-PRACTICE-RECOMMENDATIONS%20)*

Project Implementation Stages

Stage 1 – Planning

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

Planning steps will include:

- Select specific target population(s), guided by disease burden and overall Regional Health Needs Inventory findings, ACH will identify the population demographic and disease area(s) of focus (for example: children age 0-17 with asthma, adults ages 18-64 with or at risk for diabetes), ensuring focus on population(s) experiencing the highest level of disease burden.
- Identify, recruit, and secure formal commitments for participation from all implementation partners, including 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).
- Assess the current state of capacity to effectively impact chronic disease control in the following areas; include strategies within the system wide plan completed within Domain 1 for:
  - 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; and Training and technical assistance to ensure a "prepared, proactive practice team" and "prepared, proactive community partners;" (www.improvingchroniccare.org), and
- 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.

- Develop a disease/population-specific Chronic Care Implementation Plan that includes, at minimum:
  - 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;
  - 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:
    - **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.

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- **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.

- Justification demonstrating that the selected strategies and the committed partner/providers are culturally relevant and responsive to the specific population health needs in the region; and
- Strategies to identify and focus efforts in high risk neighborhoods or geographic locations within the region, with attention to addressing health care disparities related to selected diseases.

Stage 1 – Planning: Progress Measures

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

Stage 2 – Implementation

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

Convene partner-level, site-specific implementation teams, inclusive of: health care service providers, community-based service providers, executive and clinical leadership, consumer representatives; identify team leads and clinical champions. Continue to convene teams on a regular basis throughout implementation phase to review and share across teams: change strategy implementation progress, progress and performance data, challenges, and successes.

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

Implement disease/population-specific Chronic Care Implementation Plan for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/or improve:

- Self-Management Support;
- Delivery System Design;
- Decision Support;
- Clinical Information Systems;
- Community-based Resources and Policy; and
- Health Care Organization.

Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data sharing strategies. Employ rapid cycle improvement processes to refine changes strategies.

Develop a Scale and Spread Plan to disseminate and increase adoption of change strategies that result in improved care processes and health outcomes:

- Identify additional partner organizations and implementation sites.
- Define communication and learning processes; identify ACH and implementation team roles in these efforts.

Stage 2 – Implementation: Progress Measures

- Number and list engaged Implementation Team sites, members, and roles
- Identify number of new or expanded nationally recognized self-managed support programs, such as CDSMP and NDPP
- Identify number of home visits for asthma services, hypertension
- Identify percent of documented, up to date Asthma Action Plans
- Identify number of health care providers trained in appropriate blood pressure assessment practices
- Identify percent of patients provided with automated blood pressure monitoring equipment
- Begin pay for ***reporting*** of outcome metrics

Stage 3 – Scale & Sustain

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

Stage 3 – Scale & Sustain: Progress Measures

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

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APPENDIX I: Performance Measures

The following is a list of potential measures that have been identified based on the evidence-based and promising practice models outlined in the toolkit.

Measure Name	NQF#	Measure Description	Measure Steward	WA State Common Measure Set (Y/N)	HB1519/ SB 5732 Measure (Y/N)	Level of monitoring (dependent on project design)	Associated Project Areas
Adult Mental Health Status		Percentage of respondents who reported having poor mental health for 14 or more days in the past 30 days during the measurement period.	DOH	Y	Y	Systemwide	2.a
Potentially Avoidable ED Visits		Percentage of potentially avoidable emergency room (ER) visits using the definition of potentially avoidable ER visits originally developed by the Medicaid program for the state of California.	MediCal/ Group Health	Y	N	Systemwide	2.a, 2.b, 2.c, 2.d, 3.a, 3.c
Ambulatory Care - Emergency Department Visits per 1000 MM		Ambulatory Care – Emergency Department Visits/1000 population (member months for Medicaid, member years for commercial)	NCQA	Y	Y	Systemwide	2.a, 2.b, 2.c, 2.d, 3.a, 3.d
Inpatient utilization per 1000 MM		Inpatient utilization—general hospital/acute care: summary of utilization of acute inpatient care and services in the following categories: Total Inpatient, Maternity, Surgery, and Medicine.	NCQA	N	N	Systemwide	2.a, 2.b, 2.c, 3.a
Psychiatric Hospital Readmission Rate		Percentage of Medicaid enrollees, ages 18 to 64, who had an acute readmission for a psychiatric diagnosis within 30 days of initial psychiatric acute admission during the measurement year.	RDA	Y	Y	Systemwide	2.a, 2.c

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Measure Name	NQF#	Measure Description	Measure Steward	WA State Common Measure Set (Y/N)	HB1519/ SB 5732 Measure (Y/N)	Level of monitoring (dependent on project design)	Associated Project Areas
Plan All-Cause Readmission Rate (30 Days)	1768	The proportion of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days	NCQA	Y	Y	Systemwide	2.a, 2.c
Percent Employed (Medicaid)		Percent of Medicaid enrollees with any earnings reported in the Employment Security Department (ESD) employment data in the measurement year.	RDA	N	Y	Systemwide	2.b
Home and Community Based Long Term Services and Supports Use		Proportion of months receiving long-term services and supports (LTSS) associated with receipt of services in home and community-based settings during the measurement year.	RDA	N	Y	Systemwide	2.b
Opioid Related Deaths (Medicaid Enrollees and Statewide) per 100,000		Rate of opioid related deaths per 100,000 population (calculated separately for Medicaid Enrollees and Statewide)	DSHS	N	N	Systemwide	3.a
Opioid Related Overdoses for Medicaid Enrollees per 100,000		Rate of opioid related overdoses for Medicaid enrollees per 100,000 population	DSHS	N	N	Systemwide	3.a
CAHPS Clinical & Group Survey (C&G CAHPS)	5	Standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 12 months.	AHRQ	Y	N	Systemwide	3.d
Percent Homeless (Broad Definition)		Percent of Medicaid enrollees who were homeless in at least one month in the measurement year. Includes “homeless with housing” ACES living arrangement code.	RDA	N	Y	Systemwide, project-level	2.b, 2.c, 2.d

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Measure Name	NQF#	Measure Description	Measure Steward	WA State Common Measure Set (Y/N)	HB1519/ SB 5732 Measure (Y/N)	Level of monitoring (dependent on project design)	Associated Project Areas
Percent Homeless (Narrow Definition)		Percent of Medicaid enrollees who were homeless in at least one month in the measurement year. Excludes "homeless with housing" ACES living arrangement code.	RDA	N	Y	Systemwide, project-level	2.b, 2.c, 2.d
Unintended Pregnancies		Estimated proportion of pregnancies that are unintended (derived from Pregnancy Risk Assessment Monitoring Survey, birth data, and abortion data).	DOH	Y	N	Systemwide, project-level	2.b, 3.b
Rate of Teen Pregnancy (15 – 19)		Teenagers 15 through 19 years of age who were pregnant, regardless of marital status.	DOH	N	N	Systemwide, project-level	2.b, 3.b
Antidepressant Medication Management	105	The percentage of patients 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.	NCQA	Y	N	Project-level	2.a, 2.b
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence	2605	The percentage of discharges for patients 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 with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.	NCQA	Y	N	Project-level	2.a, 2.b, 2.c

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Measure Name	NQF#	Measure Description	Measure Steward	WA State Common Measure Set (Y/N)	HB1519/ SB 5732 Measure (Y/N)	Level of monitoring (dependent on project design)	Associated Project Areas
Follow-up After Hospitalization for Mental Illness	576	The percentage of discharges for patients 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: The percentage of discharges for which the patient received follow-up within 30 days of discharge; The percentage of discharges for which the patient received follow-up within 7 days of discharge.	NCQA	Y	N	Project-level	2.a, 2.b, 2.c
Adult Access to Preventive/Ambulatory Care		Percent of adults who had a visit with a PCP (3 age ranges)	NCQA	Y	Y	Project-level	2.a, 2.b, 2.d, 3.d
Mental Health Treatment Penetration (Broad Version)		Percent of individuals (separate measures for adults and for children) with a mental health service need who received at least one qualifying service during the measurement year.	RDA	Y	Y	Project-level	2.a, 2.b, 3.b
Substance Use Disorder Treatment Penetration		Percent of individuals (separate measures for adults and for children) with a substance use service need who received at least one qualifying service during the measurement year.	RDA	Y	Y	Project-level	2.a, 2.b, 3.b
Influenza Immunizations 6 months of age and older	41	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	AMA-PCPI	Y	N	Project-level	2.a, 2.b, 3.d
Child and Adolescents' Access to Primary Care Practitioners		Percent of children who had a visit with a PCP (4 age ranges).	NCQA	Y	N	Project-level	2.a, 2.b, 3.d

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Measure Name	NQF#	Measure Description	Measure Steward	WA State Common Measure Set (Y/N)	HB1519/ SB 5732 Measure (Y/N)	Level of monitoring (dependent on project design)	Associated Project Areas
Adolescent Well-Care Visits		The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	NCQA	N	N	Project-level	2.b
Childhood Immunization Status	38	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	NCQA	Y	N	Project-level	2.b
Immunization Status for Adolescents	1407	The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday.	NCQA	Y	N	Project-level	2.b
Medication Safety: Proportion of Days Covered - Adherence to Prescribed Medications (3 types)		Percent of patients with proportion of days covered >=80%. One rate for each medication: A.) Cholesterol lowering medications; B.) Diabetes medications; C.) Hypertension medications	PQA	Y	N	Project-level	2.b

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Measure Name	NQF#	Measure Description	Measure Steward	WA State Common Measure Set (Y/N)	HB1519/ SB 5732 Measure (Y/N)	Level of monitoring (dependent on project design)	Associated Project Areas
Annual Monitoring for Patients Persistent Medications (Hypertension Medications)	2371	Percent of patients 18 years and older who received at least 180 treatment days of ACE inhibitors or ARBs (drugs to help lower blood pressure) during the measurement year and who had at least one monitoring event (serum potassium and serum creatinine) in the measurement year.	NCQA	Y	N	Project-level	2.b
Pneumonia Vaccination Status for Older Adults	43	Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination.	NCQA	Y	N	Project-level	2.b
Adult Tobacco Use		Percent of adults ages 18 and older who answer “every day” or “some days” in response to the question, “Do you now smoke cigarettes every day, some days or not at all?” on the Washington State Behavioral Risk Factor Surveillance System	DOH	Y	N	Project-level	2.b
HPV Vaccines – Adolescents (male and female)		Adolescents 13 years of age as of December 31 of the measurement year who had three doses of the HPV vaccine that was reported to the Washington State Immunization Information System (IIS).	HEDIS	Y	N	Project-level	2.b
Contraceptive Care – Access to LARC	2904	Percentage of women 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).	US Office of Population Affairs	N	N	Project-level	2.b, 3.b
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	1516	The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	NCQA	Y	Y	Project-level	2.b, 3.b, 3.d

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Measure Name	NQF#	Measure Description	Measure Steward	WA State Common Measure Set (Y/N)	HB1519/ SB 5732 Measure (Y/N)	Level of monitoring (dependent on project design)	Associated Project Areas
Well-Child Visits in the First 15 Months of Life	1392	The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life.	NCQA	Y	Y	Project-level	2.b, 3.b, 3.d
Medication Management for People with Asthma (5 – 64 Years) – 75% of Treatment Days Covered	1799	The percentage of patients 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.	NCQA	Y	N	Project-level	2.b, 3.d
Comprehensive Diabetes screening – All Three Tests (a composite of 3 measures on the Common Measure Set: HbA1c, dilated eye exam, and medical attention for nephropathy)		The percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing (NQF#0057); - Eye exam (retinal) performed (NQF#0055); - Medical attention for nephropathy (NQF#0062).	NCQA (for the individual measures)	Y	Y	Project-level	2.b, 3.d
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)		Percentage of males 21 to 75 years of age and females 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.	NCQA	Y	N	Project-level	2.b, 3.d
Percent Arrested		Percent of Medicaid enrollees who were arrested at least once during the measurement year.	RDA	N	Y	Project-level	2.d

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Measure Name	NQF#	Measure Description	Measure Steward	WA State Common Measure Set (Y/N)	HB1519/ SB 5732 Measure (Y/N)	Level of monitoring (dependent on project design)	Associated Project Areas
Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer		The proportion of individuals without cancer receiving prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.	Pharmacy Quality Alliance (PQA)	N	N	Project-level	3.a
Use of Opioids at High Dosage in Persons Without Cancer		The proportion of individuals without cancer receiving a daily dosage of opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.	Pharmacy Quality Alliance (PQA)	N	N	Project-level	3.a
Use of Opioids from Multiple Providers in Persons Without Cancer		The proportion of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.	Pharmacy Quality Alliance	N	N	Project-level	3.a
Chlamydia Screening in Women Ages 16 to 24	33	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	NCQA	Y	N	Project-level	3.b

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Measure Name	NQF#	Measure Description	Measure Steward	WA State Common Measure Set (Y/N)	HB1519/ SB 5732 Measure (Y/N)	Level of monitoring (dependent on project design)	Associated Project Areas
Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers	1419	The measure will a) track the extent to which the PCMP or clinic (determined by the provider number used for billing) applies FV as part of the EPSDT examination and b) track the degree to which each billing entity's use of the EPSDT with FV codes increases from year to year (more children varnished and more children receiving FV four times a year according to ADA recommendations for high-risk children).	DQA	Y	N	Project-level	3.c
Ongoing Care in Adults with Chronic Periodontitis		Percentage of enrolled adults age 35 years and older with chronic periodontitis who received ongoing periodontal care at least 2 times within the reporting year.	Dental Quality Alliance (DQA)	N	N	Project-level	3.c
Periodontal Evaluation in Adults with Chronic Periodontitis		Percentage of enrolled adults age 35 years and older with chronic periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year.	Dental Quality Alliance (DQA)	N	N	Project-level	3.c
Topical Fluoride Application for Adults at Elevated Caries Risk		Percentage of enrolled adults over age 18 years who are at "elevated" caries risk (i.e., "moderate" or "high") who received at least two topical fluoride applications within the reporting year.	Dental Quality Alliance (DQA)	N	N	Project-level	3.c

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APPENDIX II: Regional Health Needs Inventory

The RHNI will include a description of the region's population health (Section I) and a description of the current health care and community service system capacities (Section II).

The minimum essential components of the RHNI include:

I. Description of the Community

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

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

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

C. Health Status and Health Disparities: Describe the health of the population. Provide data segmented by demographic factors (defined in Section B above) and identify existing health disparities. Include a similar description of the population in prison or under community supervision returning to, or living in, the region. At minimum, include the following with a focus on identifying key target populations for addressing health disparities:

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

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- Consider other key population health and clinical outcome metrics (both systemwide and project-level) from projects under Domain 2 and 3 as seen in the Appendix (see Measures Appendix document)

D. Tribal Statement(s): Include the opportunity for tribal government(s) within the region to describe their community, including their geography, infrastructure, demographics, and health status. Tribal government(s) have the right to decline to provide such a statement or such information.

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

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

- Hospitals, including general medical/surgical, and specialty facilities (psychiatric, children's, etc.)
- Long-term Services and Supports, including Skilled Nursing Facilities and Home and Community-Based Services
- Rehabilitative Services
- Specialty Medical Providers
- Urgent Care Centers
- Indian Health Care Providers
- Dental Providers
- Community-Based Care Coordination and Management, including Health Homes
- Home Health Care, including visiting nurses and other skilled supports
- Primary Care Providers, including Federally Qualified Health Centers, private practices, family planning clinics, and hospital-based or affiliated clinics or centers
- Behavioral Health Providers, including mental health and substance use disorder service providers, in both public and private settings
- Other community-based services that support the social determinants of health, including, but not limited to social and human services, food security, housing, transportation, faith-based organizations and employment
- Tribal government services that support the social determinants of health, including, but not limited to, social and human services, food security, housing, transportation, and employment
- Local health departments and governmental units, correctional health, school nurses, school-based health centers

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- Managed Care Organizations
- Behavioral Health Organizations
- Other workers (medical or otherwise) needed to address health needs associated with systemwide and project-level outcome metrics for projects under Domain 2 and 3 (See Appendix)

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