**DRAFT DEMONSTRATION PROJECTS AND REQUIREMENTS SUMMARY**

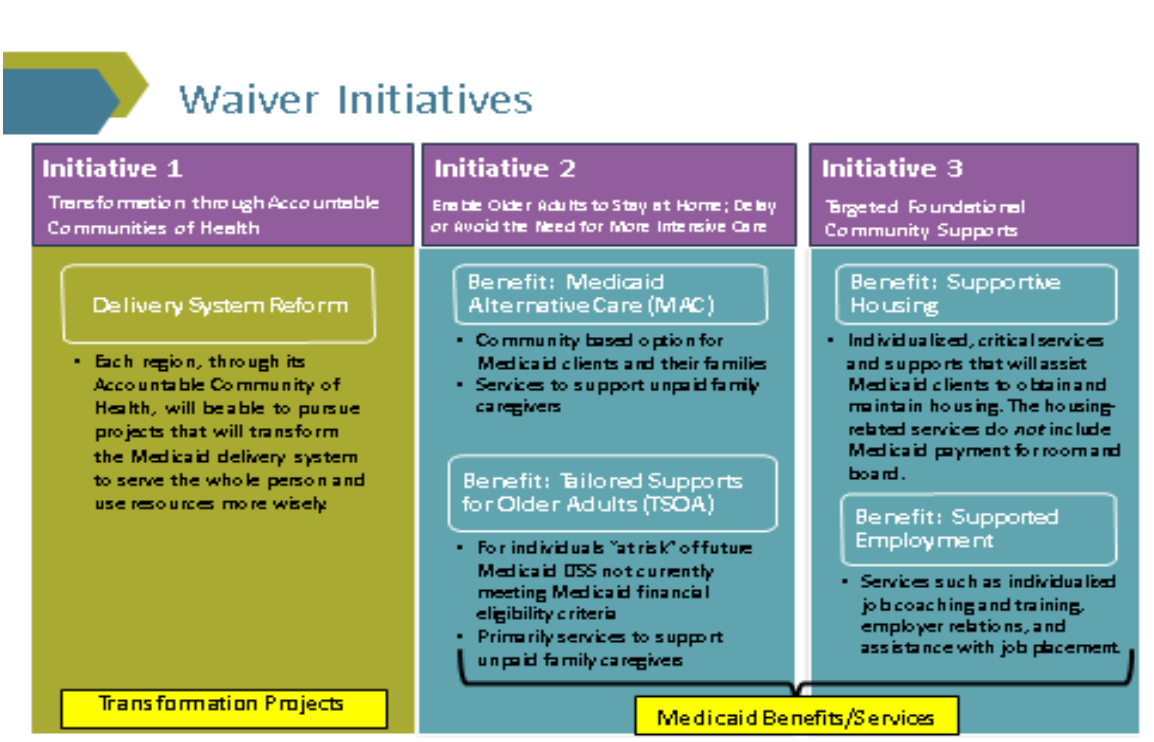
**North Central Accountable Community of Health – February 1, 2017**

Based on Toolkit Public Comment Draft of 12/30/2016

The Federal Government (CMS) and the State of Washington have signed a contract for implementation of a 5-year Medicaid Demonstration (formerly known as the Waiver). The current Demonstration Projects Toolkit draft will be revised on the basis of comments received through February 3, 2017, and must be submitted in final form to CMS for their approval by March 9, 2017. The toolkit draft is over 70 pages long; this document attempts to highlight the key points but those interested in complete information should read the Toolkit. It includes detailed recommendations (not included here) for a staged planning, implementation and sustainability effort. Intervention resources and Progress Measures for each project are included here to provide an overview. Quoted text in this summary is from the Toolkit draft. Passages that address major ACH activities and responsibilities are highlighted in green. The draft Toolkit is available at:

http://www.hca.wa.gov/sites/default/files/program/medicaid-transformation-toolkit.pdf

The Medicaid Demonstration includes three major initiatives. This document summarizes the Draft Toolkit **for projects under Initiative #1**, which will be supported by about $1.125B of the Demonstration's total $1.5B in funding over 5 years. Most of 2017 will be used for planning, with implementation beginning in 2018.




## CONTEXT FOR UNDERSTANDING THE TOOLKIT

"Throughout this demonstration, each ACH will serve as the administrative lead for its region to coordinate and oversee regional projects identified in this toolkit....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 will be provided mainly to providers in the form of DSRIP (Delivery System Reform Incentive Payments), but ACHs will be eligible for some incentive payments based on milestones achieved by regional projects.

A "Regional Health Inventory" will be a foundational element of the Demonstration in each region and must include specific elements to be defined by the state. The state expects to provide basic data sets, though regional efforts will be needed to produce locally appropriate RHIs.

ACHs must fulfill certification criteria (not yet provided) to assure they are prepared for their responsibilities under the Demonstration.

The state will soon release a Project Template that ACHs will use to submit basic information on 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."

## TOOLKIT INTRODUCTION

### Domains and Projects

"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."

"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"

Domain 1 does not involve separate projects but includes three focus areas that must be addressed on a regional basis:

1. Financial Sustainability Through Value Based Payment
2. Workforce
3. Systems for Population Health Management

Domain 2 includes one required project (Bi-Directional Integration of Care and Primary Care Transformation) and three optional projects, at least one of which must be implemented by each ACH:

1. Community-based Care Coordination
2. Transitional Care
3. Diversion Interventions

Domain 3 includes one required project (Addressing the Opioid Use Public Health Crisis) and three optional projects, at least one of which must be implemented by each ACH:

1. Maternal and Child Health
2. Access to Oral Health Services
3. Chronic Disease Prevention and Control

**Performance Measurement**

Performance measures at the state, regional and project level are required for each project and are specified to some extent in the Toolkit in Appendix I, though additional measures may be developed to meet the needs of specific projects or regions.

## PROJECT PLANNING ACTIVITIES AND RESOURCES

**Regional Health Needs Inventory (RHNI)**

Population health and service delivery capacity information will be used to support selection, planning, targeting and implementation of Demonstration projects. Each ACH will complete an RHNI using existing needs assessments and additional information as needed, using the list of minimum required components provided by HCA in Appendix II of the Toolkit.

**Statewide Value Based Payment (VBP) Transition Taskforce and Workforce Development Taskforce**

ACHs will participate in statewide taskforces on these topics, and will develop regional taskforces to the extent the state groups do not fully meet regional needs. The task force(s) on Value Based Payment will advise the state on implementation, coordination with Federal VBP efforts, and assessment of the state VBP Roadmap. The Workforce taskforce(s) will address workforce issues with emphasis on those related to Demonstration projects.

**Practice Transformation Support Hub**
*(Not to be confused with the Pathways Community Care Coordination HUB Model, described separately below.)*

ACHs will connect with and depend upon the Hub to support transformation project implementation. The Hub will convene, coordinate and develop resources to give practices the training, coaching and tools they need to make an effective transition to whole person care, value based payment systems, and the integration of behavioral and physical health care. Hub activities under the SIM grant were delegated to the State Department of Health, which selected Qualis Health as its contractor for Hub services.

## DOMAIN 1 – HEALTH SYSTEMS AND COMMUNITY CAPACITY BUILDING

"This domain addresses the core health system capacities to be developed or enhanced.... Domain 1 does not outline individual projects, but rather three required focus areas to be implemented and expanded across the delivery system....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**

"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....Financial incentives will support provider and plan capacity in achieving systemic change in how services are reimbursed."

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

Stage 1 – Governance HCA creates Statewide Value-Based Payment Transition Taskforce including representatives from all affected partners.

Stage 2 – Planning The Taskforce and HCA will assess readiness and capacity for VBP among providers and establish VBP adoption benchmarks. ACHs will support this assessment (including assessments by the Transformation Hub) and work with providers to use various VBP adoption readiness tools and resources. Each ACH will develop a Regional VBP Transition Plan.

Stage 3 – Implementation – HCA will achieve annual VBP implementation goals at the regional level (30% in 2017, 50% in 2018, 75% in 2019, 85% in 2020, 90% in 2020), updating the VBP Roadmap as needed. ACHs will implement strategies to support these levels of VBP adoption.

**Workforce**

"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...[building] 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 – HCA will establish the Statewide Workforce Development Taskforce with broad stakeholder representation.

Stage 2 – Planning – HCA and the Statewide Taskforce will assess workforce needs and gaps, and develop a specific action plan to address them. ACHs will develop plans for training of existing workforce (with the Transformation Hub as a resource) and plan other measures such as recruitment and retention activities to address workforce shortages such as those among family practitioners, behavioral health providers, community health workers, dentists and others.

Stage 3 – Implementation – State and regional workforce development plans will be implemented.

**Systems for Population Health Management**

"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....including combining clinician and claims data to advance VBP models and achieve the triple aim."

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

Stage 1 – Governance -- "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 – HCA will assess current IT capacity in service of Domain 2 and 3 projects, identify population health management IT tools (state and national), promote on-demand access to standard care summaries and med records via

the Link4Health CDR, and to claims through development of an integrated health information system. HCA will coordinate with the designated HIE entity, OneHealthPort to enable effective access to and utilization of HIE and clinical data. ACHs will convene key providers to share data needs with the state, and will create Population Health Management plans defining a path toward information exchange for community-based integrated care, and addressing needs and gaps identified in the current regional infrastructure.

(Note that there is no Stage 3 Implementation section in the toolkit for this category.)

## 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 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 (Required): **Bi-Directional Integration of Care and Primary Care Transformation**

**Overview:** This project will advance Healthier Washington's initiative to bring together the payment and delivery of physical and behavioral health services for people enrolled in Medicaid, through managed care. Metrics to be applied are summarized in the Toolkit. Planning and implementation guidelines are provided for each option outlined below.

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

**Evidence Based Approaches for Integrating BH into Primary Care (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

**Approaches Based on Emerging Evidence for Integrating Primary Care into BH (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*

- 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/*

**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.

Financial Sustainability: Alignment between current payment structures and guideline-concordant physical and behavioral care...and anticipated future state of VBP arrangements....

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.

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.

Planning Progress Measures require plans addressing all major topics above, see pp. 18-19 of toolkit.

**Stage 2 – Implementation** may move forward prior to or in parallel to planning activities above.

For integration of BH into Primary care, specific steps are identified depending on whether the PCMH or Collaborative Care model is selected, though both models address similar issues.

For integration of Primary Care into BH, options listed include:

1. Off-site, Enhanced Collaboration
2. Co-Located, Enhanced Collaboration; or Co-Located, Integrated

Specific issues and milestones are shown for each option. In addition, all providers will address:

- Training and technical assistance resources necessary to perform their role in the model.
- 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.

(Note the attention to financial resources and payment models above. The extent to which Demonstration funds can be used so support the cost of care and payment transitions is not addressed in the Toolkit.)

Implementation Progress Measures include:

- Number of practices and providers implementing integrated evidence-based approach(es)
- Number of practices and providers trained on evidence-based practices: projected vs. actual
- 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 and Sustain** describe further measures to implement above changes, including adoption of evidence-based integration approaches by more provider organizations including adaptation to VBP..
Scale and Sustain Progress Measures include:

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

## PROJECT 2B (Optional): **Community-Based Care Coordination: Pathways Community Care Coordination HUB**

**Rationale: ....**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...creating confusion for the individual. **Importantly, [Pathways HUB] 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.... This project is built on...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).

Details on HUB material in the Tookit are best summarized by the Progress Measures listed for Planning, Implementation and Scale/Sustain phases:

**Progress Measures** for each stage include the following:

Planning 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

Implementation Measures

- Complete HUB Operations Manual
- Complete HUB Quality Improvement Plan
- List policies and procedures in place
- 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

Scale/Sustain Measures

- 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.

Workforce issues, especially those involving Community Health Workers, are also relevant to this project.

## PROJECT 2C (Optional): **Transitional Care**

**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. This project includes multiple care management and transitional care approaches from which the ACH will select at least one [if the ACH chooses to implement this optional project].

**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.

**Approaches** The Toolkit lists several approaches from which the ACH may choose one or more, if the ACH chooses to implement this project.

Evidence-based Approaches:

1. Interventions to Reduce Acute Care Transfers, INTERACT™4.0, http://www.interactteam.org/interact/
2. Transitional Care Model (TCM), http://www.transitionalcare.info/about-tcm
3. The Care Transitions Intervention® (CTI®), http://caretransitions.org/ *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

Evidence-informed Approaches:

1. 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
2. *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
3. 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*

**Progress Measures** for each stage include the following:

Planning 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

Implementation 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

Scale/Sustain Measures

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

PROJECT 2D (Optional): **Diversion Interventions**

**Rationale:** This project "provides opportunities to re-direct individuals away from high-cost medical and legal avenues and into community-based health care and social services....There are three diversion strategies recommended under this project."

1. Diversion at the point of Emergency Department (ED) presentation for a non-acute condition
2. Use of community paramedicine to divert individuals who access the emergency medical services (EMS) system for non-emergent 911 calls [to] a more appropriate destination.
3. 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.

**Approaches (Select at least one):**

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/
2. Community Paramedicine Model, http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf 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/

**Progress Measures** for each stage include the following:

Planning 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

Implementation 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

Scale/Sustain Measures

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

## DOMAIN 3 – HEALTH EQUITY THROUGH PREVENTION AND HEALTH PROMOTION

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

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

**Rationale: ....**The opioid epidemic affects communities, families, and overwhelms law enforcement, health care and social service providers....Through this project, ACH will support achievement of the goals outlined in Executive Order 16-09 and the state interagency opioid working plan....This project...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.

**Approaches:**

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 )

**Progress Measures** for each stage include the following:

Planning Measures

- 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

Implementation 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

Scale/Sustain 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

## PROJECT 3B (Optional): **Maternal and Child Health**

**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.... 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.

**Approaches** (may select one or more):

1. Implementation of an evidence-based home visiting model for pregnant high risk mothers, including high risk first time mothers....can include Nurse Family Partnership (NFP) or other federally recognized evidence-based home visiting model currently operating in Washington State.
    a. Nurse Family Partnership (NFP), http://www.nursefamilypartnership.org/communities/model-elements
    b. Early Head Start Home-Based Model (EHS), https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/poi/miechv-ehs/miechv.html
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:

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

**Progress Measures** for each stage include the following:

Planning 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

Implementation Measures

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

Scale/Sustain 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

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

**Rationale:** Oral disease has been referred to as a "silent epidemic" and has been associated with increased risk for serious adverse health outcomes....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....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.

**Evidence-Based Approaches (may select one or both):**

1. Oral Health in Primary Care, http://www.safetynetmedicalhome.org/sites/default/files/White-Paper-Oral-Health-Primary-Care.pdf
2. Mobile/Portable Dental Care, http://www.mobile-portabledentalmanual.com/

Additional Resources:

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

**Progress Measures** for each stage include the following:

Planning 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

Implementation 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

Scale/Sustain Measures

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

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

**Rationale: ...**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....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.

**Evidence-based Approach:**

**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*

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)*

**Progress Measures** for each stage include the following:

Planning 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

Implementation 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
- Begin pay for ***reporting*** of outcome metrics

Scale/Sustain 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