**ATTACHMENT C: DSRIP PLANNING PROTOCOL**

**Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration
Approved January 9, 2017**

I.  **Preface**

On January 9, 2017, the Centers for Medicare and Medicaid Services (CMS) approved Washington State's request for a section 1115(a) Medicaid demonstration entitled *Medicaid Transformation Project* demonstration (hereinafter MTP or "demonstration"). Part of this demonstration is a Delivery System Reform Incentive Program (DSRIP), through which the state will make performance-based funding available to regionally-based Accountable Communities of Health (ACHs) and their partnering providers. The demonstration is currently approved through December 31, 2021.

The Special Terms and Conditions (STCs) of the demonstration set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period. The DSRIP requirements specified in the STCs are supplemented by two attachments to the STCs. The DSRIP Planning Protocol (this document, Attachment C) describes the ACH Project Plans, the set of outcome measures that must be reported, transformation projects eligible for DSRIP funds, and timelines for meeting associated metrics.

This protocol is supplemented by a Project Toolkit and Project Measure and Performance Table. The toolkit provides additional details and requirements related to the ACH projects and will assist ACHs in developing their Project Plans.

In accordance with STC 34, the state may submit modifications to this protocol for CMS review and approval. Any changes approved by CMS will apply prospectively unless otherwise specified by CMS.

II.  **ACH Project Plan Requirements**

a.  *Introduction*

ACH Project Plans will provide an outline of the work that an ACH, through its partnering providers, will undertake. The plans must be developed in collaboration with community stakeholders and be responsive to community needs. The plans will provide details on how the selected projects respond to community-specific needs and further the objectives of the demonstration.  The plans also will describe the ACH's capacities, composition and governance structure. In order to be eligible to receive DSRIP incentive payments, an ACH must have an approved Project Plan.

There are three steps for ACH Project Plan approval:

1. ACHs must satisfy a two-phase certification process that will confirm the ACHs are prepared to submit Project Plan applications. Completion of each phase will qualify the ACHs for Project Design funding. Certification criteria will be set forth by the state, and ACHs will submit both phases of certification information to the state within the required time frames. The state will review and approve each certification phase prior to distribution of Project Design funds for that phase.

   a. Phase 1 certification requirements must be submitted to the state by May 8, 2017.
   b. Phase 2 certification requirements must be submitted to the state by August 7, 2017.

2. ACHs must develop and submit a Project Plan application for approval. The components of the Project Plan are described in STC 36 and further detailed in this protocol. Completed Project Plan applications are due to the state by October 23, 2017.

3. The state and its contracted Independent Assessor will evaluate and (if appropriate) approve ACH Project Plans. ACHs with approved Project Plans are eligible to receive performance-based incentive payments. The state and the Independent Assessor will approve Project Plans as early as November 20, 2017, and no later than December 22, 2017.

The state will develop and post a draft Project Plan Template for public feedback prior to releasing a final version. Design funds attached to each certification phase will support ACHs as they address specific requirements and submit their Project Plans. As ACHs develop Project Plans, they must solicit and incorporate community and consumer input to ensure that Project Plans reflect the specific needs of the region. After the Project Plans are submitted to the state, they will be reviewed by an Independent Assessor contracted by the state. The Independent Assessor will review and make recommendations to the state for approval of Project Plans. The state must approve of Project Plans in order to authorize DSRIP incentive funding. Project Plans may be subject to additional review by CMS.

b. *ACH Certification Criteria*

The certification process is intended to ensure that each ACH is prepared to serve as the lead entity and single point of accountability to the state for the transformation projects in its region. The certification application solicits information to ensure that: (a) the ACH is qualified to fulfill the role of overseeing and coordinating regional transformation activities; (b) the ACH meets the composition standards outlined in STC 23; and (c) the ACH is eligible to receive project design funds. There are two phases to the certification

process. According to a timeline developed by the state, each ACH must complete both phases and receive approval from the state before submitting a Project Plan application.

Phase 1 Certification: Each ACH must demonstrate compliance and/or document how it will comply with state expectations in the following areas, at a minimum:

1. Governance and Organizational Structure, including compliance with principles outlined in STC 22 and decision-making expectations outlined by the state.
2. Initiation or continuation of work with regional Tribes, including adoption of the Tribal Engagement and Collaboration Policy or alternate policy as required by STC 24.
3. Community and Stakeholder Engagement to demonstrate how the ACH is accountable and responsive to the community.
4. Budget and funds flow, including how design funds will support project plan development.
5. Clinical capacity and engagement to demonstrate engagement and input from clinical providers.
6. Other requirements as the state may establish.

Phase 2 Certification: Each ACH must demonstrate that it is in compliance with state expectations in the following areas, at a minimum:

1. Governance and Organizational Structure, including compliance with principles outlined in STC 22 and decision-making expectations outlined by the state. ACHs will describe whether any developments or adjustments have occurred since Phase 1 Certification.
2. Tribal Engagement and Collaboration describing specific activities and events that further the relationship between the ACH and Tribes.
3. Community and Stakeholder Engagement to describe concrete actions that have occurred since Phase 1 Certification. Provide details for how the ACH will satisfy public engagement requirements for Project Plan development outlined in STC 23.
4. Budget and funds flow to summarize strategic use of funding and decision making processes regarding incentive funding distribution.
5. Data-informed decision making strategies, including processes for applying available data to project selection and implementation planning.
6. Transformation project planning to describe progress on project selection processes.
7. Other requirements as the state may establish.

c. *ACH Project Plan Requirements*

As part of this demonstration, each ACH and its regional participating providers will be responsible for implementing a set of projects selected from the Project Toolkit. The Project Plan:

- Provides a blueprint of the work that each region, coordinated by the ACH, will undertake through the implementation of these projects.
- Explains how the regional work responds to community-specific needs, relates to the mission of the ACH, and furthers the objectives of the demonstration.
- Provides details on the ACH's composition and governance structure, specifically any adjustments to refine the model based on initial lessons learned.
- Demonstrates ACH compliance with the terms and conditions of participation in the demonstration.
- Incorporates the voice and perspective of the community and consumers through outreach and engagement.

Each ACH will submit a Project Plan to the state for review. The Project Plans will be used by the state to assess ACH preparedness in planning and implementing its local demonstration program and the regional alignment with the demonstration's overall objectives and requirements. The state's contracted Independent Assessor will review and evaluate Project Plans and make recommendations to the state for approval/remediation of each Plan. In addition, commitments made by an ACH in its Project Plan must be consistent with the terms of a contract between the state and the ACH, outlining the requirements and obligations of the ACH as the lead and other partnering providers in the ACH in order to be eligible to receive DSRIP incentive funding.

The Project Plan Template will provide a structured format and outline the information required to be submitted by each ACH as part of its Project Plan. The template will be divided into two main sections and will include scoring criteria. Section I will focus on how the ACH, through its partnering providers, is being directly responsive to the needs and characteristics of the community it serves. It will include details regarding the ACH's overall programmatic vision, composition, and decision-making processes. Section II will ask ACHs to provide detailed project-specific plans. The state may add additional requirements to the Project Plan application in addition to what is outlined below.

The categories for Section I of the Project Plan template will include:

1. *ACH Theory of Action and Alignment Strategy*: Rationale explaining how the ACH plans to improve the quality, efficiency, and effectiveness of care processes in its community.

2. *Governance*: Description of how the ACH complies with the state's governance and decision-making expectations.

3. *Regional Health Needs Inventory:* Description of how the ACH used available data to identify target populations and ensure that project selection responds to community-specific needs, aims to reduce health disparities, and furthers the objectives of the demonstration.

4. *Community and Consumer Engagement and Input*: Evidence of public input into the project plans, including consumer engagement. ACHs must demonstrate that they solicited and incorporated input from community members and consumers. The plan must also describe the processes the ACHs will follow to engage the public and how such engagement will continue throughout the demonstration period.

5. *Tribal Engagement and Collaboration*: Demonstration that the ACH has complied with the Tribal Engagement and Collaboration requirements.

6. *Budget and Funds Allocation*: Description of how decisions about the distribution of funds will be made, the roles and responsibilities of each partner in funds distribution and a detailed budget for the remaining years of the demonstration.

7. *Value-based Payment Strategies:* Description of the regional strategies to support attainment and readiness of statewide VBP targets.

For each selected project, Section II requires, that ACHs provide details regarding:

1. *Partnering Organizations*: Description of the partnering providers, both traditional and non-traditional, that have committed to participate in projects. Partnering providers must serve and commit to continuing to serve the Medicaid population. ACHs must ensure that together, these partnering providers serve a significant portion of Medicaid covered lives in the region and represent a broad spectrum of care and related social services that are critical to improving how care is delivered and paid for. Additional details on recommended implementation partners will be provided in Project Toolkit guidance documents.

2. *Signed Attestations:* The ACH will submit a description of any initiatives that its partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place. Partnering providers must attest that submitted projects are not duplicative of other funded projects and do not duplicate the deliverables required by the former project(s). If projects are built on one of these other projects, or represent an enhancement of such a project, that may be permissible. However, it must be clearly identified as such in the Project Plan.

3. *Monitoring and Continuous Improvement*: Description of the ACH's plan for monitoring project implementation progress and continuous improvement or adjustments in alignment with Section V (Process for ACH Project Plan Modification).

4. *Expected Outcomes*: Description of the outcomes the ACH expects to achieve in each of the project stages, in alignment with the metrics and parameters provided by the state.

5. *Regional Assets, Anticipated Challenges and Proposed Solutions*: Description of the assets that the ACH and partnering providers bring to the delivery system transformation efforts, and the challenges or barriers they expect to confront in improving outcomes and lowering costs for the target populations. For identified challenges, the ACH must describe how it expects to mitigate the impact of these challenges and what new capabilities will be required to be successful.

6. *Implementation Approach and Timing*: Explanation of the planned approach to accomplishing each set of required project milestones for each of the selected projects.

**III.**    **Project Toolkit**

*a. Overview of Project Categories*

Each ACH, through its partnering providers, is required to implement at least four transformation projects and participate in statewide capacity building efforts to address the needs of Medicaid beneficiaries. These projects will be spread across the following three domains:

1. Health Systems and Community Capacity Building
2. Care Delivery Redesign (at least two projects)
3. Prevention and Health Promotion (at least two projects)

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.

For selected projects, ACHs will develop detailed implementation plans. As described in Section IV, project performance will be measured based on state-defined milestones and metrics that track project planning, implementation, and sustainability.

b. *Description of project domains*

i. **Health Systems and Community 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.

ii. **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.

iii. **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.

**Table 1. Menu of Transformation Projects**

| # | Project | Description |
|---|---------|-------------|
| | **Health Systems and Community Capacity Building** | Foundational activities that address the core health system capacities to be developed or enhanced to transition the delivery system in accordance with the demonstration's goals and transformation objectives. |
| | **Financial sustainability through value-based payment** | Paying for value across the continuum of care is necessary to ensure the sustainability of the transformation projects undertaken through this 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. |
| | **Workforce** | 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. |
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| **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. 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. |
| **Care Delivery Redesign** | | Strategies that focus on innovative models of care to improve the quality, efficiency, and effectiveness of care processes. Person-centered approaches and integrated models are emphasized. |
| 2A | **Bi-directional integration of care and Primary care transformation** | 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. |
| 2B | **Care coordination** | 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. |
| 2C | **Transitional care** | Points of transition out of intensive services/settings, such as individuals discharged from acute care, inpatient care or from jail or prison into the community are critical intervention points in the care continuum. Transitional care services provide opportunities to reduce or eliminate avoidable |

| | | admissions, readmissions and jail use. 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. This project includes multiple care management and transitional care approaches. |
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| 2D | **Diversion interventions** | 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.  This strategy promotes more appropriate use of emergency care services and also supports person-centered care through increased access to primary care and social services, especially for medically underserved populations. |
| **Prevention and Health Promotion** | | Projects focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations. |
| 3A | **Addressing opioid use public health 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. This project will support strategies focused on addressing prevention, treatment, overdose prevention and recovery supports aimed at supporting whole-person health |
| 3B | **Reproductive and maternal/child Health** | Focusing on the health of women and children 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. This project focuses on ensuring access to ongoing women's health care to improve utilization of effective family planning strategies. It further focuses on providing mothers and their children with home visits that have 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. |
| 3C | **Access to oral health services** | Oral health impacts overall health and quality life, and most oral disease is preventable. Oral disease 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. 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 |

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| | | 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. |
| 3D | **Chronic disease prevention and control** | 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. |

## IV. Project Stages, Milestones, and Metrics

### a. Overview

In accordance with STC 35, over the duration of the demonstration, the state will shift accountability from a focus on rewarding achievement of process milestones in the early years of the demonstration to rewarding improvement on performance metrics in the later years of the demonstration. During Years 2, 3 and 4, ACHs will be required to report progress against several process milestones for each project, as described further below and as detailed in the Project and Metrics Specification guide. These process milestones are, by definition, 'pay-for-reporting' or 'P4R,' since ACHs will be rewarded based on reported progress. Project progress milestones are defined in the Project Toolkit, specific to each project focus, and organized into three core categories: project planning milestones, project implementation progress milestones, and scale and sustain milestones.

To monitor performance, ACHs will be accountable for achieving targeted levels of improvement for project-specific outcome measures. These measures are primarily "pay-for-performance," or "P4P," since ACHs are only rewarded if defined outcome metric targets are achieved. However, a subset of these measures will be rewarded on a P4R basis for reasons that include: to allow ACHs time for project implementation activities; to allow time to establish necessary reporting infrastructure; and to allow for the testing of new, innovative outcome measures for project areas where there is a lack of nationally-vetted, widely used outcome measures. Performance metrics are monitored systemwide and at the project level and are consistent with the objectives of the demonstration as outlined in STC 30.

Table 2 below summarizes the different categories of measures. Each category is described in further detail below.

**Table 2. Demonstration Milestone/Metric Categories**

| Milestone/Metric Type | DY1 (2017) | DY2 (2018) | DY3 (2019) | DY4 (2020) | DY5 (2021) |
|---|---|---|---|---|---|
| Project Process Milestones | NA | P4R | P4R | P4R | NA |
| Performance Metrics | NA | NA | P4R/P4P | P4R/P4P | P4R/P4P |
| Value-based Payment Metrics | P4R/P4P | P4R/P4P | P4R/P4P | P4R/P4P | P4P |

b. *Process Milestones (Capacity Building Elements, Progress/Planning Milestones, and Metrics)*

During demonstration Year 1, each ACH will be responsible for the development, submission and approval of a Project Plan application. As part of the Project Plan application, the ACH will provide a timeline for implementation and completion of each project, in alignment with process milestones specified in the Project Toolkit and accompanying documents. General categories of planning and progress milestones required to be completed for each project include:

- Identify target population and assess partnering providers' capacity to fulfill project requirements. Collectively, partnering providers should serve a significant portion of Medicaid covered lives in the region and represent a broad spectrum of care and related social services that are critical to improving how care is delivered and paid for.
- Engage and obtain formal commitment from partnering providers responsible for carrying out project activities.
- Develop a detailed implementation plan, including timing of activities, financial sustainability, workforce strategies, and population health management.
- Ongoing reporting of standardized process measures, including number of individuals served, number of staff recruited and trained, and impact measures as defined in the evaluation plan.

c. *Performance Metrics* (Statewide and Project-level Outcome Metrics)

See Appendix II for the project outcome and system transformation metrics that will be used to measure progress against meeting project goals and targeted levels of improvement against outcome-based performance indicators. Section III of the Funding and Mechanics Protocol provides further detail on how identified measures will be used to evaluate ACH performance.

d. *Value-based Payment Milestones*

Pursuant to STC 40, the state will update its Value-based Roadmap annually, which will address how the state will achieve its goal of converting 90 percent of Medicaid provider payments to reward outcomes by 2021. This Roadmap is a document that describes the payment reforms required for a high-quality and financially sustainable Medicaid delivery system and establishes VBP targets and incentives for the Managed Care Organizations (MCOs) and ACHs. This document also serves to revise and clarify the details surrounding Washington State's VBP incentives and framework.

Achievement of VBP targets will be assessed at both a regional and MCO-specific level. As indicated in Table 3, ACHs and MCOs will be rewarded based on reported progress in the early years of the demonstration. This will shift to rewarding for performance on the VBP targets.

#### Table 3. Value-based Payment Milestone Categories

| Value-based Payment DSRIP Pool | DY 1 | | DY 2 | | DY 3 | | DY 4 | | DY 5 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | P4R | P4P | P4R | P4P | P4R | P4P | P4R | P4P | P4R | P4P |
| MCO VBP Incentives | 75% | 25% | 50% | 50% | 25% | 75% | 0% | 100% | 0% | 100% |
| ACH VBP Incentives | 100% | 0% | 75% | 25% | 50% | 50% | 25% | 75% | 0% | 100% |

Through this demonstration, the DSRIP program and initiatives such as the Health Care Payment Learning Action Network will yield new best practices. Therefore, this Roadmap will be updated annually throughout the demonstration to ensure long-term sustainability of the improvements made possible by the DSRIP investment and that best practices and lessons learned can be incorporated into the state's overall vision of delivery system reform.

Washington will submit quarterly progress updates to CMS, which will include the progress made both in terms of total dollars included in VBP arrangements and quantitative and qualitative lessons learned.

## V.    Process for Project Plan Modification

No more than twice a year, ACHs may submit proposed modifications to an approved Project Plan for state review and approval/denial. In certain limited cases it may become evident that the methodology used to identify a performance goal and/or improvement target is no longer appropriate, or that unique circumstances/developments outside of an ACH's control require the ACH to modify its original plan. Examples of these circumstances could include a significant regulatory change that requires an ACH to cease a planned project intervention or initiate substantial changes to the way a standard performance metric is measured, requiring an ACH to modify its planned approach.

In order to request a Project Plan modification, an ACH must submit a formal request, with supporting documentation, for review by the state. The state will have 60 calendar days to review and respond to the request. Project Plan modifications may not decrease the scope of a project unless commensurate with a decrease to the project valuation, nor may they lower expectations for performance because of greater than expected difficulty in meeting a milestone.

VI. **Health Information Technology**. (The state will discuss how it plans to meet the Health IT goals/milestones outlined in the STCs.)

In accordance with STC 39, the state will use Health Information Technology ("Health IT") and Health information exchange services to link core providers across the continuum of care to the greatest extent possible. To detail how the state will achieve its stated Health IT goals, the state will provide a Health IT strategy by April 1, 2017.  That document provides detailed tactics and initiatives, technical gaps addressed, critical actions, policy levers and key metrics in place or planned for the following key business processes:

1. Addressing data needs and gaps
2. Acquiring Clinical Data
3. Leveraging Data Resources
4. Supporting clinical decisions with integrated patient information
5. Ensuring data integrity
6. Making large sets of clinical data available for program and business decisions

**Appendix I: Project Toolkit**
**Appendix II: Project Measure and Performance Table**

**MEDICAID TRANSFORMATION
PROJECT TOOLKIT**

# Contents

## Domain 1: Health and Community Systems Capacity Building

This domain addresses the core health system capacities to be developed or enhanced to transition the delivery system according to Washington's Medicaid Transformation demonstration.

## Financial Sustainability through Value-based Payment

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

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

**Annual Targets:**

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

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

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

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| **Planning** | **Statewide Planning Activities:** | **Regional Planning Activities:**<br><br>To support the MVP Action Team, the ACHs will: |

The MVP Action Team will assist HCA in performing an assessment to capture or validate a baseline of the current VBP levels. To the extent assessments have already been conducted, the MVP Action Team will build from those assessments.

Building from existing work when applicable, the MVP Action Team will:

- Assist HCA in deploying survey/attestation assessments to facilitate the reporting of VBP levels to understand the current types of VBP arrangements across the provider spectrum.
- Validate the level of VBP arrangements as a percentage of total payments across the region to determine current VBP baseline.
- Perform assessments of VBP readiness across regional provider systems.
- Develop recommendations to improve VBP readiness across regional provider systems.

- Inform providers of various VBP readiness tools and resources. Some viable tools may include:
  - JSI/ NACHC Payment Reform Readiness Toolkit
  - AMA Steps Forward – Preparing your practice for value-based care: https://www.stepsforward.org/modules/value-based-care#section-references
  - Rural Health Value Team's comprehensive Value-Based Care Strategic Planning Tool: http://cph.uiowa.edu/ruralhealthvalue/TnR/VBC/VBCTool.php
  - Assessments deployed by the Practice Transformation Support Hub and the Transforming Clinical Practice Initiative (TCPI)
  - Adoption of diagnostic coding in dental for bi-directional medical/dental data sharing and population health.
- Connect providers to training and technical assistance developed and made available by the HCA and the statewide MVP Action Team.
- Support initial survey/attestation assessments of VBP levels to help the MVP Action Team substantiate reporting accuracy.
- Disseminate learnings from the MVP Action Team and other state and regional VBP implementation efforts to providers.

Using the recommendations of the MVP Action Team, the ACHs will:

- Develop a Regional VBP Transition Plan that:

| | | o Identifies strategies to be implemented in the region to support attainment of statewide VBP targets.<br>o 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).<br>o Defines a plan for encouraging participation in annual statewide VBP surveys. |
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| **Implementation** | **Statewide Implementation Activities:**<br><br>• Implement strategies to support VBP transitions in alignment with Medicaid transformation activities.<br>  o By the End of Calendar Year 2017, achieve 30% VBP target at a regional and MCO level<br>  o By the End of Calendar Year 2018, achieve 50% VBP target at a regional and MCO level<br>  o By the End of Calendar Year 2019, achieve 75% VBP target at a regional and MCO level<br>  o By the End of Calendar Year 2020, achieve 85% VBP target at a regional and MCO level<br>  o By the End of Calendar Year 2021, achieve 90% VBP target at a regional and MCO level<br>• Perform ongoing monitoring to inform the annual update of the Value-based Roadmap. | **Regional Implementation Activities**:<br><br>• Implement strategies to support VBP transitions in alignment with Medicaid transformation activities.<br>  o By the End of Calendar Year 2017, achieve 30% VBP target at a regional level<br>  o By the End of Calendar Year 2018, achieve 50% VBP target at a regional level<br>  o By the End of Calendar Year 2019, achieve 75% VBP target at a regional level.<br>  o By the End of Calendar Year 2020, achieve 85% VBP target at a regional level.<br>  o By the End of Calendar Year 2021, achieve 90% VBP target at a regional level.<br>• Continue to engage in and contribute to the MVP Action Team, to include ongoing refinement of the VBP Transition Plan as needed.<br>• Achieve progress toward VBP adoption that is reflective of current state of readiness and the implementation |

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| | strategies within the Transformation Project Toolkit (Domain 2 and Domain 3). |

## Workforce

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

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| **Governance** | Throughout the design and implementation of transformation efforts, ACHs and partnering providers must consider workforce needs pertaining to selected projects and the broader objectives of the Medicaid Transformation demonstration. There are several statewide taskforces and groups with expertise in identifying emerging health workforce needs and providing actionable information to inform the evolving workforce demands of a redesigned system of care. ACHs should leverage existing resources available to inform workforce strategies for the projects their region is implementing. |
| **Planning** | **Statewide Planning Activities:** <br>• Provide recommendations and guidance to support and evolve the health care workforce consistent with Medicaid Transformation goals and objectives. <br>• Identify existing educational and other resources available to educate, train, and re-train individuals to promote a workforce that supports and promotes evolving care models. <br><br>**Regional Planning Activities:** <br>• Consider workforce implications as part of project implementation plans and identify strategies to prepare and support the state's health workforce for emerging models of care under Medicaid Transformation. <br>• Develop workforce strategies to address gaps and training needs, and to make overall progress toward the envisioned future state for Medicaid transformation: <br>  - Identify regulatory barriers to effective team-based care <br>  - Incorporate strategies and approaches to cultural competency and health literacy trainings <br>  - Incorporate strategies to mitigate impact of health care redesign on workforce delivering services for which there is a decrease in demand |

| Implementation | • Implement workforce strategies.<br>• Administer necessary resources to support all efforts. |
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## Systems for Population Health Management

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

| Governance | *For purposes of this demonstration, population health management is defined as:*<br>• *Data aggregation*<br>• *Data analysis*<br>• *Data-informed care delivery*<br>• *Data-enabled financial models*<br><br>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.<br>• 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.<br>• The HCA will coordinate efforts among multiple state government agencies to link Medicaid claims, social services data, population health information, and social determinants of health data, as well as direct efforts to increase accessibility of data in line with current legislation.<br>• 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. | |
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| **Planning/<br>Implementation** | **Statewide Planning Activities:** | **Regional Planning Activities:**<br>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: |

- Assess current population health management capacity in service of Domain 2 and Domain 3 projects.
- 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 must address Systems for Population Health Management within their project implementation plans. This must include:

- Define a path toward information exchange for community-based, integrated care. Transformation plans should be tailored based on regional providers' current state of readiness and the implementation strategies selected within Domain 2 and Domain 3. Include plan for development or enhancement of patient registries, which will allow for the ability to track and follow up on patients with target conditions.
- Respond to needs and gaps identified in the current infrastructure.

## Domain 2: Care Delivery Redesign

Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes.

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

**Project Objective:** Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through MCOs, for people enrolled in Medicaid.

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

**Project Metrics:**

Systemwide Metrics:
- Outpatient Emergency Department Visits per 1000 Member Months
- Inpatient Utilization per 1,000 Member Months
- Plan All-Cause Readmission Rate (30 Days)
- Psychiatric Hospital Readmission Rate
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- Controlling High Blood Pressure
- Adult Mental Health Status

Project-level Metrics:
- Antidepressant Medication Management
- Child and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Medication Management for People with Asthma (5 to 64 Years)
- Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence
- Follow-up After Hospitalization for Mental Illness
- Mental Health Treatment Penetration (Broad Version)
- Substance Use Disorder Treatment Penetration

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Adult Body Mass Index Assessment
- Depression Screening and Follow-up for Adolescents and Adults
- Depression Remission or Response for Adolescents and Adults
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

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

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

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

These approaches are described in the report "*Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness,*" http://www.milbank.org/wp-content/files/documents/papers/Integrating-Primary-Care-Report.pdf.

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

*For either approach, apply core principles of the Collaborative Care Model (see above) to integration into the behavioral health setting.*

| Project Implementation Stages |
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| **Stage 1 – Planning** |

- 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
    - - 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 and Primary Care providers, and other critical partners to develop a plan and description of a process and timeline to transition to fully integrated managed care. This plan should reflect how the region will enact fully integrated managed care by or before January 2020. For regions that have already implemented fully integrated managed care, implementation plans should incorporate strategies to continue to support the transition.

Develop a Project Implementation Plan that demonstrates progression from the current state, including**:**

- Selected evidence-based approaches to integration and partners/providers for implementation to ensure the inclusion of strategies that address all Medicaid beneficiaries (children and adults) particularly those with/or at-risk for behavioral health conditions

- Implementation timeline.
- Description of the service delivery mode, which may include home-based and/or telehealthoptions.
- Roles and responsibilities of key organizational and provider participants that promote partnerships across the care continuum, including payer organizations, social services organizations, and across health service settings.
- Description of how project aligns with related initiatives and avoids duplication of efforts.
- 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.
- Provide list of target providers and organizations with formal commitment to participate in the project.
- Complete plan that describes the process and timeline for pursuing and implementing fully integrated managed care.
- Complete Project Implementation Plan.
- 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.**

  - o <u>Option 1</u>: Develop policies and procedures and implement the core components of the selected evidence-based approaches that are consistent with the **standards adopted by the Bree Collaborative in the Behavioral Health Integration Report and Recommendations**.
    *Summary of Core Elements and Minimum Standards for Integrated Care Element Specifications under consideration by the Bree Collaborative:*
    - <u>Integrated Care Team:</u> Each member of the integrated care team has clearly defined roles for both physical and behavioral health services. Team members, including clinicians and non-licensed staff, may participate in team activities either in person or virtually.
    - <u>Routine Access to Integrated Services</u>: Access to behavioral health and primary care services are available routinely, as part of the care team's daily work flow and on the same day as patient needs are identified as much as feasible. Patients can be engaged and receive treatment in person or by phone or videoconferencing, as convenient for the patient.

- Accessibility and Sharing of Patient Information: The integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care. All clinicians work together to jointly support their roles in the patient's shared care plan.
- Access to Psychiatry Services: Access to psychiatry consultation services is available in a systematic manner to assist the care team in developing a treatment plan and to advise the team on adjusting treatments for patients who are not improving as expected.
- Operational Systems and Workflows Support Population-based Care: A structured method is in place for proactive identification and stratification of patients for behavioral health conditions. The care team tracks patients to make sure each patient is engaged and treated-to-target (i.e., to remission or other appropriate individual improvement goals).
- Evidence-based Treatments: Age-appropriate, measurement-based interventions for physical and behavioral health interventions are adapted to the specific needs of the practice setting. Integrated practice teams use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether their patients are improving.
- Patient Involvement in Care: The patient's goals are incorporated into the care plan. The team communicates effectively with the patient about their treatment options and asks for patient input and feedback into care planning.

o 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 (such as tested in the IMPACT model). Many successful Collaborative Care pilot programs begin with an initial focus on depression and later expand to treat other behavioral health conditions, including substance use disorders.
  *Implement the core components and tasks for effective integrated behavioral health care, as defined by the AIMS Center of the University of Washington and shown here:*
  - Patient Identification & Diagnosis:
    - Screen for behavioral health problems using valid instruments.
    - Diagnose behavioral health problems and related conditions.
    - Use valid measurement tools to assess and document baseline symptom severity.
  - Engagement in Integrated Care Program:
    - Introduce collaborative care team and engage patient in integrated care program.
    - Initiate patient tracking in population-based registry.
  - Evidence-based Treatment:
    - Develop and regularly update a biopsychosocial treatment plan.

- - Provide patient and family education about symptoms, treatments, and self-management skills.
  - Provide evidence-based counseling (e.g., Motivational Interviewing, Behavioral Activation).
  - Provide evidence-based psychotherapy (e.g., Problem Solving Treatment, Cognitive Behavioral Therapy, Interpersonal Therapy).
  - Prescribe and manage psychotropic medications as clinically indicated.
  - Change or adjust treatments if patients do not meet treatment targets.
- Systematic Follow-up, Treatment Adjustment, and Relapse Prevention:
  - Use population-based registry to systematically follow all patients.
  - Proactively reach out to patients who do not follow-up.
  - Monitor treatment response at each contact with valid outcome metrics.
  - Monitor treatment side effects and complications.
  - Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment.
  - Create and support relapse prevention plan when patients are substantially improved.
- Communication & Care Coordination:
  - Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
  - Engage and support family and significant others as clinically appropriate.
  - Facilitate and track referrals to specialty care, social services, and community-based resources.
- Systematic Psychiatric Case Review & Consultation (in-person or via telemedicine) :
  - Conduct regular (e.g., weekly) psychiatric caseload review on patients who are not improving.
  - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
  - Provide psychiatric assessments for challenging patients, either in-person or via telemedicine.
- Program Oversight and Quality Improvement:
  - Provide administrative support and supervision for program.
  - Provide clinical support and supervision for program.
  - Routinely examine provider- and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use this information for quality improvement.

- **Integrating Primary Care into Behavioral Health Setting**

o 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 that includes tracking physical health outcomes, with the following core components:

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

o 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 and others.
  - Diagnose chronic diseases and conditions.
  - Assess chronic disease management practices and control status.
- Engagement in Integrated Care Program:
  - Introduce collaborative care team and engage patient in integrated care program.
  - Initiate patient tracking in population-based registry.
- Evidence-based Treatment:
  - Develop and regularly update a biopsychosocial treatment plan.
  - Provide patient and family education about symptoms, treatments, and self-management skills.
  - Provide evidence-based self-management education.
  - Provide routine immunizations according to ACIP recommendations as needed.

- Provide the U.S. Preventive Services Task Force screenings graded A & B as needed.
- Prescribe and manage medications as clinically indicated.
- Change or adjust treatments if patients do not meet treatment targets, refer to specialists as needed.

- Systematic Follow-up, Treatment Adjustment:
  - Use population-based registry to systematically follow identified patients.
  - Proactively reach out to patients who experience difficulty following up.
  - Monitor treatment response at each contact with valid outcome metrics.
  - Monitor treatment side effects and complications.
  - Identify patients who are not improving to target them for specialist evaluation or connection to increased primary care access/utilization.

- Communication & Care Coordination:
  - Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
  - Engage and support family and significant others as clinically appropriate.
  - Facilitate and track referrals to specialty care, social services, and community-based resources.

- Systematic Case Review & Consultation (in person or via telemedicine):
  - Conduct regular (e.g., weekly) chronic disease and condition caseload review on patients who are not improving.
  - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.

- Program Oversight and Quality Improvement:
  - Provide administrative support and supervision to support an integrated team.
  - Provide clinical support and supervision for care team members that are co-located.
  - Routinely examine provider-level and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use to inform quality improvement processes and activities.

- **In addition to implementing the core components for the selected evidence-based approach:**
  - Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to perform their role in the integrated model.
  - Implement shared care plans, shared EHRs and other technology to support integrated care.

- Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care models.
- Establish a performance-based payment model to incentivize progress and improvement.

**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.

## Project 2B: Community-Based Care Coordination

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

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

**Project Metrics**:

Systemwide Metrics:
- Inpatient Utilization per 1,000 Medicaid Member Months
- Outpatient  Emergency Department Visits per 1000 Member Months
- Plan All-Cause Readmission Rate (30 Days)
- Percent Homeless (Narrow Definition)
- Percent Employed (Medicaid)
- Home and Community-ased Long Term Services and Supports Use
- Mental Health Treatment Penetration (Broad Version)
- Substance Use Disorder Treatment Penetration


Project-Level Metrics:
- To be determined based on approval of region-specific target populations and selected interventions.

**Evidence-based Approach:**
1. Pathways Community HUB https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf.


**Project Implementation Stages**

**Stage 1 – Planning**

Prepare for implementation of a community-based coordination model, such as the Pathways Community HUB model. 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 systemwide plan completed within Domain 1 for:
    - <u>Population Health Management/HIT</u>: 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.
    - <u>Workforce</u>: Capacity and shortages for workforce to implement the selected care coordination focus areas; incorporate content and processes into the implementation 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.
        - Training and technical assistance to ensure effective referral structures and prepared, proactive community partners; and to address cultural and linguistic competency, health literacy needs.
    - <u>Financial Sustainability</u>: 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.
    - Implementation timeline.
    - Roles and responsibilities of HUB implementation partners, including payer organizations.
    - 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 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:
  - o Create and implement checklists and related documents for care coordinators.

- o Implement selected pathways from the Pathways Community HUB Certification Program or implement care coordination evidence-based protocols adopted as standard under a similar approach.
- o Develop systems to track and evaluate performance.
- o Hire and train staff.
- o Train care coordinator and other staff at participating partner agencies.
- o 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

- 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 the model.
- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support HUB model.
- Develop payment models to support care coordination model.
- Implement VBP strategies to support the HUB care coordination model.

### 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 by focus area or pathway: projected vs. actual and cumulative.
- Begin pay for *performance* of select outcome metrics.

## Project 2C: Transitional Care

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

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

**Project Metrics**:

Systemwide Metrics:
- Percent Homeless (Narrow Definition)
- Inpatient Utilization per 1,000 Medicaid Member Months
- Psychiatric Hospital Readmission Rate
- Plan All-Cause Readmission Rate (30 Days)
- Ambulatory Care - Emergency Department Visits per 1,000 Member Months
- Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence
- Follow-up After Hospitalization for Mental Illness

Project-Level Metrics:
- To be determined based on approval of region-specific target populations and selected interventions.

**Evidence-based Approaches for Care Management and Transitional Care:**

1. Interventions to Reduce Acute Care Transfers, INTERACT™4.0, https://interact.fau.edu/ - a quality improvement program that focuses on the management of acute change in resident condition.
2. Transitional Care Model (TCM), http://www.nursing.upenn.edu/ncth/transitional-care-model/ - a nurse led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up.
3. The Care Transitions Intervention® (CTI®), http://caretransitions.org/ - a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives. *Note: The Care Transitions Intervention® is also known as the Skill Transfer Model™, the Coleman Transitions Intervention Model®, and the Coleman Model®.*

4. Care Transitions Interventions in Mental Health, http://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf - provides a set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness (SMI).

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

Despite the relative dearth of specific, outcomes-focused research on effective integrated health and behavioral health programs for people leaving incarceration, considerable evidence on effective integrated care models, prison/jail reentry, and transitional programming has paved the way for increased understanding of critical components of an integrated transitional care approach. Refer to the following:

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

| Project Implementation Stages |
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| **Stage 1 – Planning** |
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- Assess the current state of capacity to effectively deliver care transition services 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 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.
- Specialized training needs to complete certifications requirements of selected approach (if applicable).
  - <u>Financial Sustainability</u>: 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 manner;
  - 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:
  o 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;
  o 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
  o 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 and/or evidence-informed, and for each:
  o Complete Project Implementation Plan
  o 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.
    - 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**
  - 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 approaches 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.

- **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.

## Project 2D: Diversion Interventions

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

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

**Project Metrics:**

Systemwide Metrics:
- Percent Homeless (Narrow Definition)
- Percent Arrested
- Outpatient Emergency Department Visits per 1000 Member Months
- Adult Access to Preventive/Ambulatory Care

Project-Level Metrics:
- To be determined based on approval of region-specific target populations and selected interventions.

**Evidence-supported Diversion Strategies:**

1. **Emergency Department (ED) Diversion**, http://www.wsha.org/quality-safety/projects/er-is-for-emergencies/, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4038086/ - a systematic approach to re-directing and managing persons who present at the ED for non-emergency conditions, which may be oral health, general physical health, and/or behavioral health conditions.

2. **Community Paramedicine Model**, http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf - an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations. Additional resources include: http://communityparamedic.org/, http://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf, and https://www.ruralhealthinfo.org/topics/community-paramedicine.

3. **Law Enforcement Assisted Diversion, LEAD®** http://www.leadbureau.org/ - a community-based diversion approach with the goals of improving public safety and public order, and reducing the criminal behavior of people who participate in the program.

**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 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 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.
        - 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:**
    - 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 manner.
    - Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts. In the case of ED Diversion, explain how the project will build on the Washington State Hospital Association's "ER is for Emergencies" and "Seven Best Practices" initiatives.
    - Implementation timeline.
    - Description of the service delivery mode, which may include home-based and/or telehealth options.
    - 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.

- **Community Paramedicine**

  Approved Medical Program Directors (MPDs), working with first responders, ED practitioners, and primary care providers to develop protocols, which may include transporting beneficiaries with non-emergency needs to alternate (non-ED) care sites, such as urgent care centers and/or patient-centered medical homes. Providers may collaborate to develop Community Paramedicine programs. Core issues to be addressed in the design of a community paramedicine program should include:
  - A detailed explanation about how the community paramedics would be trained and would maintain their skills.
  - A description of how appropriate medical supervision would be ensured.
  - A description of how data to evaluate quality assurance and quality improvement activities would be obtained and monitored.
  - An evaluation plan for assessing the impacts on quality and cost of care, and how the local EMS agency will ensure that all patients are treated equally regardless of insurance status and health condition, among other factors.
  - A plan for integrating the CP program with other community-based health care and social service programs and for analyzing the potential impacts of the CP program on these providers, including safety-net providers.
  - How to leverage the potential of electronic health records (EHRs) and Health Information Exchange (HIE) to facilitate communication between community paramedics and other health care providers.

- **Law Enforcement Assisted Diversion (LEAD®)**

  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.
- **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 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.

## 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)*

**Overarching Goal:** Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.

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

**Project Metrics:**

Systemwide Metrics:
- Opioid Related Deaths (Medicaid Enrollees and Total Population) per 100,000
- Non-fatal overdose involving prescription opioids (Draft specification as of 02/2017)
- Substance Use Disorder Treatment Penetration (Opioid)

Project Level Metrics:
- New opioid users that become chronic users (in development)
- Patients on high-dose chronic opioid therapy by varying thresholds (in development)
- Patients with concurrent sedatives prescriptions (in development)
- Non-fatal overdose involving prescription opioids (in development)
- Medication Assisted Therapy (MAT) With Buprenorphine (Count and %)
- Medication Assisted Therapy (MAT) With Methadone (Count and %)

**Recommended Approach:**

Clinical Guidelines

1. AMDG's Interagency Guideline on Prescribing Opioids for Pain, http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf.
2. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016, http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.
3. Substance Use during Pregnancy: Guidelines for Screening and Management, http://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy/13_PregSubs_E16L.pdf.

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

**Project Implementation Stages**

**Stage 1 – Planning**

**Assess the current regional capacity to effectively impact the opioid crisis and include strategies to leverage current capacity and address identified gaps.**

*Within Domain 1, regional, systemwide plan, include:*

- Include strategies within the regional plan for linkages to Domain 1:
    - Population Health Management Systems/HIT: Adoption of technology with the capability to support identification of persons at high-risk for opioid overdose, notifications to health care providers of opioid overdose events, monitoring of prescribing practices, and implementation of quality improvement processes; a plan to build enhancements in EHRs and other systems to support clinical decisions in accordance with guidelines; an assessment of the current level of use of the Prescription Drug Monitoring Program (PDMP) and the Emergency Department Information Exchange; and strategies to increase use of PDMP and interoperability with EHRs. Overall, in line with Goal 4 of the State Interagency Opioid Working Plan, develop a plan to use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.
    - Workforce: Capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:
        - Efforts to enhance medical, nursing, and physician assistant school curricula on pain management, the PDMP, and recognition and treatment of opioid use disorder (OUD).
        - Partnering with professional associations and teaching institutions to educate dentists, osteopaths, nurses, and podiatrists on current opioid prescribing guidelines.
        - Encouraging licensing boards of authorized prescribers to mandate CEUs on opiate prescribing and pain management guidelines.
        - Encouraging family medicine, internal medicine, OB/GYN residency programs to train residents on care standards/medications for OUD.

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

- Planning steps must include:
    - Identify communities or sub-regions of focus for this project, based on regional needs. Consider areas with limited access to treatment for opioid disorder, 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, physical, mental health and substance use disorder, (SUD) providers and teaching institutions.

- Develop a Regional Opioid Working Plan that provides a detailed description of how the ACH will implement selected strategies and activities that together create a comprehensive strategy addressing prevention, treatment, overdose prevention, and recovery supports aimed at supporting whole-person health. The regional plan will include, at minimum:
    - Implementation timelines for each strategy.
    - Roles and responsibilities of key organizational and physical, mental health and substance use disorder (SUD) provider participants, including community-based service organizations, along with justification 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.
    - Specific strategies and actions to be implemented from the activities listed below in alignment with the 2016 Washington State Interagency Opioid Working Plan.

**CORE COMPONENTS FOR REGIONAL OPIOID WORKING PLAN**:

1) PREVENTION: Prevent opioid misuse and abuse
    - **Promote use of best practices among health care providers for prescribing opioids for acute and chronic pain:**

- Promote the use of the PDMP and its linkage into electronic health record systems in an effort to increase the number of providers regularly using the PDMP and the timely input of prescription medication data into the PDMP.
        - Train, coach and offer consultation with providers on opioid prescribing and pain management.
        - Promote the integration of telehealth and telephonic approaches.
        - Support innovative telehealth in rural and underserved areas to increase capacity of communities to support OUD prevention and treatment.
    - **Together with the Center for Opioid Safety Education and other partners, such as statewide associations, raise awareness and knowledge of the possible adverse effects of opioid use, including overdose, among opioid users:**
        - Promote accurate and consistent messaging about opioid safety and to address the stigma of addiction by public health, health care providers, law enforcement, community coalitions, and others specific to the region and local communities.
    - **Prevent opioid initiation and misuse in communities, particularly among youth:**
        - Build awareness and identify gaps as they relate to ongoing prevention efforts (e.g. school-based programs); connect with local health jurisdictions and Washington State Department of Health and Department of Behavioral Health and Recovery to understand the efforts currently underway in the region.
    - **Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse:**
        - Identify and map Drug Take Back programs to highlight where additional programs could be implemented or expanded to meet community need.
        - Promote the use of home lock boxes to prevent unintended access to medication.

2) TREATMENT: Link individuals with OUD to treatment services
    - **Build capacity of health care providers to recognize signs of possible opioid misuse, effectively identify OUD, and link patients to appropriate treatment resources:**
        - Effective treatment of OUD includes medication and psychosocial supports. Conduct inventory of existing treatment resources in the community (e.g. formal treatment programs and practices/providers providing Medication Assisted Treatment, [methadone, buprenorphine, naltrexone]).
        - Educate providers across all health professions on how to recognize signs of opioid misuse and OUD among patients and how to use appropriate tools to identify OUD.
        - Offer patients brief interventions and referrals to medication assisted treatment and psychosocial support services, if needed.

- Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options.
- Give pharmacists tools on where to refer patients who may be misusing prescription pain medication.

- **Expand access to, and utilization of, clinically-appropriate evidence-based practices for OUD treatment in communities, particularly MAT:**
  - Increase the number of providers certified to prescribe OUD medications in the region; promote the application and receipt of physician, ARNP and Physician Assistant waivers for providers in a variety of settings for example: hospitals, primary care clinics, correctional facilities, mental health and SUD treatment agencies, methadone clinics and other community based sites.
  - Together with the Health Care Authority, identify policy gaps and barriers that limit availability and utilization of buprenorphine, methadone, and naltrexone and contribute to the development of policy solutions to expand capacity.
  - Build structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers and staff to implement and sustain medication assisted treatment, such as methadone and buprenorphine; examples of evidence-based models include the hub and spoke and nurse care manager models.
  - Promote and support pilot projects that offer low barrier access to buprenorphine in efforts to reach persons at high risk of overdose; for example in emergency departments, correctional facilities, syringe exchange programs, SUD and mental health programs.
  - Build linkages/communication pathways between those providers providing medication and those providing psychosocial therapies.

- **Expand access to, and utilization of, OUD medications in the criminal justice system:**
  - Train and provide technical assistance to criminal justice professionals to endorse and promote agonist therapies for people under criminal sanctions.
  - Optimize access to chemical dependency treatment services for offenders who have been released from correctional facilities into the community and for offenders living in the community under correctional supervision, through effective care coordination and engagement in transitional services.
  - Consider pilot programs that begin treatment for persons with OUD for persons in correctional facilities followed by direct linkage to community providers for ongoing care.

- **Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage beneficiaries in support services, including housing:**
  - Provide technical assistance to local health jurisdictions and community-based service organizations to organize or expand syringe exchange and drug user health services.

- Develop/support linkages between syringe exchange programs and physical health providers to treat any medical needs that require referral.

- **Identify and treat OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns:**
    - Disseminate the guideline Substance Abuse during Pregnancy: Guidelines for Screening and Management.
    - Disseminate the Washington State Hospital Association Safe Deliveries Roadmap standards to health care providers.
    - Educate pediatric and family medicine providers to recognize and appropriately manage newborns with NAS.
    - Increase the number of obstetric and maternal health care providers permitted to dispense and prescribe MAT through the application and receipt of DEA approved waivers.
    - Establish or enhance community pathways to support PPW with connecting to care services that address whole-person health, including physical, mental and substance use disorder treatment needs during, through and after pregnancy.

3) OVERDOSE PREVENTION: Intervene in opioid overdoses to prevent death
    - **Educate individuals who use heroin and/or prescription opioids, and those who may witness an overdose, on how to recognize and appropriately respond to an overdose**
        - Provide technical assistance to first responders, chemical dependency counselors, and law enforcement on opioid overdose response training and naloxone programs.
        - Assist emergency department to develop and implement protocols on providing overdose education and take home naloxone to individuals seen for opioid overdose.
    - **Make system-level improvements to increase availability and use of naloxone**
        - Establish standing orders in all counties and all opioid treatment programs to authorize community-based naloxone distribution and lay administration.
        - Promote co-prescribing of naloxone for pain patients as best practice per AMDG guidelines.
    - **Together with the Center for Opioid Safety Education, promote awareness and understanding of Washington State's Good Samaritan Law**
        - Educate law enforcement, prosecutors and the public about the Good Samaritan Response Law.

**4)** RECOVERY: Promote long-term stabilization and whole-person care

- Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.

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

### Stage 1 – Planning: Progress Measures

- Completed Workforce, Technology, and Financial Sustainability plans, as defined in Domain 1, reflective of support for Project 3A efforts.
- List of implementation partners, must include physical health, mental health and SUD providers with formal written commitment to participate.
- Number and locations of MDs, ARNPs, and PAs who are approved to prescribe buprenorphine.
- Number and locations of mental health and SUD providers delivering acute care and recovery services to people with OUDs.
- Identify the system supports that need to be activated to support an increase in the number of 1) providers prescribing buprenorphine; 2) patients receiving medications approved for treatment of OUD,; 3) the different settings in which buprenorphine is or should be prescribed and 4) the development of shared care plans/communications between the treatment team of physical/mental health and SUD providers.
- 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 Regional Opioid Working Plan; one or more such partnerships may be convened.
  - Each partnership should include health care service, including mental health and SUD providers, community-based service providers, executive and clinical leadership, consumer representatives, law enforcement, criminal justice, emergency medical services, and elected officials; identify partnership leaders and champions. Consider identifying a clinical champion and one or more community champions.
  - Establish a structure that allows for efficient implementation of the 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 Regional Opioid Working Plan across the core components: 1) Prevention; 2) Treatment; 3) Overdose Prevention; 4) Recovery Supports.
- Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into 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

- Develop a plan to address gaps in the number or locations of providers offering recovery support services, (this may include the use of peer support workers).

## 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 the CDC Guideline for Prescribing Opioids for Chronic Pain and the AMDG's Interagency Guideline on Prescribing Opioids for Pain.
- Number of providers with waiver authority to prescribe buprenorphine and the types and numbers of settings in which they are prescribing
- Number of patients currently being prescribed buprenorphine.
- Number of health care organizations with EHRs or other systems newly put in place that provide clinical decision support for the opioid prescribing guideline, such as defaulting to recommended dosages or linking to the PDMP.
- Number of local health jurisdictions and community-based service organizations that received technical assistance to organize or expand syringe exchange programs.
- Number of emergency department with protocols in place for providing overdose education and take home naloxone to individuals seen for opioid overdose.
- Begin pay for *reporting* of newly developed project outcome metrics.

## 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 Regional 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 OUD prevention and management in the transition to VBP for services.
  - Encourage payment models that support practices that have implemented a Hub and Spoke, or Nurse Care Manager Model.
  - Encourage payment models that support the care of persons across the continuum of care from diagnosis, through treatment and for ongoing recovery support.

## 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 or linking to the PDMP.
- Number of local health jurisdictions and community-based service organizations that received technical assistance to organize or expand syringe exchange programs.
- Number of emergency department with protocols in place for providing overdose education and take home naloxone to individuals seen for opioid overdose.
- Number and types of access points in which persons can receive medication assisted therapy, such as EDs, SUD and mental health settings, correctional settings or other non-traditional community based access points.

## Project 3B: Reproductive and Maternal/Child Health

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

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

**Project Metrics:**

Systemwide Metrics:
- Rate of Teen Pregnancy (15 – 19)
- Unintended Pregnancies
- Low Birth Weight Rate

Project Level Metrics:
- Prenatal care in the first trimester of pregnancy
- Mental Health Treatment Penetration (Broad Version) (women and children)
- Substance Use Disorder Treatment Penetration (women and children)
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Well-Child Visits in the First 15 Months of Life
- Chlamydia Screening in Women Ages 16 to 24
- Contraceptive Care – Most & Moderately Effective Methods
- Contraceptive Care – Access to LARC
- Contraceptive Care – Postpartum
- Childhood Immunization Status

**Approaches to Improve Women and Children's Health:**

1. Strategies to improve women's and men's health to ensure families have intended and healthy pregnancies that lead to healthy children. In particular, ACHs should consider evidence-based models to improve utilization of effective reproductive health strategies, including pregnancy intention counseling, healthy behaviors and risk reduction, effective contraceptive use, safe and quality perinatal care, interconception care, and general preventive care.
   a. If applicable, consider leveraging the Reproductive Health Pathway to align with Project 2B.

2. Evidence-based home visiting model for pregnant high risk mothers, including high risk first time mothers. Potential approaches can include Nurse Family Partnership (NFP) **or other federally recognized evidence-based home visiting model currently operating in Washington State.** The project must demonstrate a valid need for home visiting service expansion and that services will be coordinated. The following federally recognized evidence-based home visiting models are currently operating in Washington State:

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

3. Evidence-based model or promising practice to improve regional well-child visit rates and childhood immunization rates. Possible approaches include:
   a. Bright Futures. https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx.
   b. Stony Brook Children's Hospital Enriched Medical Home Intervention (EMHI). http://sb.cc.stonybrook.edu/news/children/home-intervention-improves-child-vaccination-rates-among-children-living-in-poverty.php.

**Project Implementation Stages**

**Stage 1 – Planning**

Plan for implementation of the selected approach(es).
- Utilize the Regional Health Needs Inventory data 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.
- List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely manner.
- Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts. 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.
- Roles and responsibilities of partners.

### Stage 1 – Planning: Progress Measures

- Selection of 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

- **Implementation of evidence-based and emerging strategies to improve reproductive health**. The CDC has provided 10 recommendations that aim to improve a woman's health before conception, whether before a first or a subsequent pregnancy.
  - Washington has acted on these recommendations by providing a program for uninsured people to obtain basic family planning services (Take Charge, http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/apple-health-take-charge-family-planning) and working with providers to improve obstetric outcomes (http://www.hca.wa.gov/about-hca/clinical-collaboration-and-initiatives/ob-outcomes) and grants (Personal Responsibility and Education Plan, http://www.doh.wa.gov/CommunityandEnvironment/Schools/PersonalResponsibilityandEducationPlan), and through other actions.
  - This project builds on current efforts, and provides a mechanism for communities to further the implementation of the recommendations.

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

- **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.

- **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

- 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.
- Incorporate VBP strategies to support the program.

## Stage 3 – Scale & Sustain: Progress Measures

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

## Project 3C: Access to Oral Health Services

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

**Target Population:** All Medicaid beneficiaries, especially adults.

**Project Metrics**:

Systemwide Metrics:
- Oral health services utilization among Medicaid beneficiaries
- Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers
- Outpatient Emergency Department Visits per 1000 Member Months

Project Level Metrics:
- Ongoing Care in Adults with Chronic Periodontitis
- Periodontal Evaluation in Adults with Chronic Periodontitis
- Caries at Recall (Adults and Children)
- Adult Treatment Plan Completed
- Sealants - % Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk
- Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk

**Evidence-based Approaches for Access to Oral Health Services:**

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.

**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 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 dentist, hygienist, and other dental care providers, and primary care providers
    - Access to periodontal services
    - Training and technical assistance to ensure cultural and linguistic competency, health literacy needs
  - Financial Sustainability: Alignment between current payment structures and integration of oral health services; incorporate current state and anticipated future state of Value Based Payment arrangements to support access to oral health efforts into the regional VBP transition plan; promote VBP readiness tools and resources, such as the adoption of diagnostic coding in dental for bi-directional medical/dental data sharing and population health.

- **Plan for implementation of the selected evidence-based approach(es).**
  - 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. 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. Plans should include strategies to educate oral health providers about opioid prescribing practices, especially for adolescents and young adults.

- List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely manner; 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.
- 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.
  - 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.
  - 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.

- o 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**

- **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; 6) referrals to dental.
    - Document the findings as structured data to organize information for decision support, measure care processes, and monitor clinical outcomes so that quality of care can be managed.
  - ▪ Establish and implement workflows to operationalize the protocol, specifying which member of the care performs each function, inclusive of when referral to dentist or periodontist is needed.
  - ▪ Ensure each member of the care team receives the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.
  - ▪ Establish referral relationships with dentists and other specialists, such as ENTs and periodontists.

- ▪ Engage with payers in discussion of payment approaches to support the model.

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

- **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.
  - ▪ Establish a performance-based payment model to incentivize progress and improvement; may include adoption of dental diagnostic coding to assess and document severity level for both cares and periodontal disease.

### 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.

## Project 3D: Chronic Disease Prevention and Control

**Overarching Goal:** Integrate health system and community approaches to improve chronic disease management and control.

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

**Project Metrics:**

Systemwide Metrics:
- Outpatient Emergency Department Visits per 1000 Member Months
- Inpatient Utilization per 1000 Medicaid Member Months

Project Level Metrics:
To be determined based on approval of region-specific target populations and selected interventions.
May Include:
- Child and Adolescents' Access to Primary Care Practitioners
- Adult Access to Preventive/Ambulatory Care
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Medical attention for nephropathy
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Well-Child Visits in the First 15 Months of Life
- Medication Management for People with Asthma (5 – 64 Years)
- Comprehensive Diabetes Care: Blood Pressure Control
- Influenza Immunizations 6 months of age and older
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)
- Adult Body Mass Index Assessment

**Evidence-based Approach:**

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

**Regions are encouraged to focus on more than one chronic condition under the Chronic Care Model approach.**
**Examples of Specific Strategies to Consider within Chronic Care Model Approach:**

- *The Community Guide ([https://www.thecommunityguide.org/](https://www.thecommunityguide.org/))*
- *Million Hearts Campaign ([http://millionhearts.hhs.gov](http://millionhearts.hhs.gov))*
- *Stanford Chronic Disease Self-Management Program ([http://patienteducation.stanford.edu/programs/cdsmp.html](http://patienteducation.stanford.edu/programs/cdsmp.html))*
- *CDC-recognized National Diabetes Prevention Programs (NDPP) ([http://www.cdc.gov/diabetes/prevention/index.html](http://www.cdc.gov/diabetes/prevention/index.html))*
- *Community Paramedicine models, ([http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf](http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf) and [https://www.ruralhealthinfo.org/topics/community-paramedicine](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.

## Project Implementation Stages

### Stage 1 – Planning

- 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.
- Implementation plan may include multiple target chronic conditions and/or population-specific strategies.
- Planning steps must include:
    - Select specific target population(s), guided by disease burden and overall community needs, ACH will identify the population demographic and disease area(s) of focus (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.
    - Integration of socio-ecological model and social determinants of health within chronic care management.
    - 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](www.improvingchroniccare.org)).
- Assess the current state of capacity to effectively impact chronic disease control 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 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 licensureTraining and technical assistance to ensure a "prepared, proactive practice team" and "prepared, proactive community partners;" ([www.improvingchroniccare.org](www.improvingchroniccare.org))
  - Cultural and linguistic competency, health literacy needs
- Financial Sustainability: Alignment between current payment structures and guideline-concordant care, inclusive of community-based services (such as home-based asthma visits, Diabetes Self-Management Education, and home-based blood pressure monitoring); incorporate current state and anticipated future state of VBP arrangements to support chronic disease control efforts into the regional VBP transition plan. Consider inclusion of the following within reimbursement models: bundled services, group visits, once-daily medication regimens, community-based self-management support services.

- **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](www.improvingchroniccare.org)), such as: incorporate the 5As into regular care; complete and update Asthma Action Plans; provide access to Asthma Self-Management Education, Diabetes Self-Management Education, Stanford Chronic Disease Management Program; support home-based blood pressure monitoring; provide motivational interviewing; ensure cultural and linguistic appropriateness.

- **Delivery System Design** strategies to support effective, efficient care, such as: implementing and supporting team-based care strategies, increasing the presence and clinical role of non-physician members of the care team; increasing frequency and improving processes of planned care visits and follow-up; referral processes to care management and specialty care.
- **Decision Support** strategies to support clinical care that is consistent with scientific evidence and patient preference, such as: development and/or provision of decision support tools (guideline summaries, flow sheets, etc.); embed evidence-based guidelines and prompts into EHRs; provide education as needed on evidence-based guidelines via case-based learning, academic detailing or modeling by expert providers; establish collaborative management practices and communication with specialty providers; incorporate patient education and engagement strategies.
- **Clinical Information Systems** strategies to organize patient and population data to facilitate efficient and effective care, such as: utilization of patient registries; automated appointment reminder systems; bi-directional data sharing and encounter alert systems; provider performance reporting.
- **Community-based Resources and Policy** strategies to activate the community, increase community-based supports for disease management and prevention, and development of local collaborations to address structural barriers to care such as: Community Paramedicine, tobacco free policy expansion, tobacco cessation assistance, nutritional food access policies, National Diabetes Prevention Program, home-based and school-based asthma services, worksite nutritional and physical activity programs behavioral screen time interventions.
- **Health Care Organization** strategies that ensure high quality care, such as: engagement of executive and clinical leadership; support for quality improvement processes; shared learning structures; intersection with Care Coordination efforts; financial strategies to align payment with performance.

▪ Justification demonstrating that the selected strategies and the committed partner/providers are culturally relevant and responsive to the specific population health needs in the region.

▪ Strategies to identify and focus efforts in high risk neighborhoods or geographic locations within the region, with attention to addressing health care disparities related to selected diseases.

**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.
- 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
  - 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

- 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.

**APPENDIX II:**

**Transformation Metrics - Quality and Outcome Measures**

<u>Overview:</u>

In accordance with STC 35, the state will shift accountability over the duration of the demonstration, from a focus on rewarding achievement of process milestones in the early years of the demonstration to rewarding improvement on performance metrics in the later years of the demonstration.

To monitor performance, ACHs will be accountable for achieving targeted levels of improvement for project-specific outcome measures. These measures are primarily 'pay-for-performance,' or 'P4P,' since ACHs are only rewarded if defined outcome metric targets are achieved. However, a subset of these measures will be rewarded on a P4R basis for reasons that include: to allow ACHs time for project implementation activities, to allow time to establish necessary reporting infrastructure, and to allow for the testing of new, innovative outcome measures for project areas where there is a lack of nationally-vetted, widely used outcome measures. Performance metrics are monitored at the project-level and systemwide and are consistent with the objectives of the demonstration as outlined in STC 30 and specific project focus.

<u>Performance Measurement:</u>

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. At a minimum, the project-specific measures should be reported at the ACH level. They should be reported as frequently as feasible and relevant; frequency may vary by measure.

Measures from the Washington State Common Measure Set, Cross-Agency HB 1519/SB 5732 and managed care contracts were prioritized to ensure alignment. However, in order to monitor and measure project performance, particular project areas may require measures not currently included in existing measures lists or managed care contracts. For some projects, final project-level measures will be determined based on final approval of region-specific target populations and selected interventions. Additional detail pertaining to measurement specifications will be included in the Measures Specification and Reporting Manual to be developed in DY1.

In accordance with STC 32, the state and CMS will accept GPRA measures in lieu of comparable statewide common performance measures when such substitution will reduce duplicative reporting and avoid excessive administrative burdens on tribes and IHCPs.

Additional Notes:

- Statewide measures denote measures for which the state is accountable for achieving statewide performance targets. A portion of the total statewide funding amount is at risk based on this performance, per STC 44.
- "P4R = Pay for Reporting"; "P4P = Pay for Performance"
- Acronyms:
    - NCQA:  National Committee for Quality Assurance
    - NQF: National Quality Forum
    - AHRQ: Agency for Healthcare Research and Quality
    - HEDIS: Healthcare Effectiveness Data and Information Set
    - HCA: Washington State Health Care Authority
    - DSHS: Washington State Department of Social and Health Services
    - RDA: Washington State Department of Social and Health Services, Division of Research and Data Analysis
    - DOH: Washington State Department of Health
    - WA IIS: Washington State Immunization Information System
    - DQA: Dental Quality Alliance
    - PQA: Pharmacy Quality Alliance
    - ACH: Accountable Communities of Health
    - BRFSS: Behavioral Risk Factor Surveillance System
    - PRAMS: Pregnancy Risk Assessment Survey
    - ACES: DSHS Economic Services Administration's Automated Client Eligibility System
    - NNOHA: National Network of Oral Health Access

| Medicaid Transformation Demonstration Toolkit Measures | | | | | | | | | | | Active Demonstration Years (DY): Pay for Reporting (P4R), Pay for Performance (P4P) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Measure Name | NQF# | Specification Version | Measure Description | Measure Steward | Reporting Responsibility | Data Source | Periodicity | Unit of Analysis | Population: Total population, Medicaid | Statewide Accountability Measure (Y/N) | DY 3 (2019) | DY 4 (2020) | DY 5 (2021) | Associated Project Areas |
| Outpatient Emergency Department Visits per 1000 Member Months | | Modified HEDIS 2016 | The rate of Medicaid enrollee visits to emergency department per 1000 member months, including visits related to mental health and chemical dependency. Separate reporting for age groups 10-17, 18-64, and 65+. | NCQA/RDA | HCA | Claims, encounter data | Semi-annual | State, ACH | Medicaid | Y | P4P | P4P | P4P | 2.a, 2.b, 2.c, 2.d, 3.a, 3.d |
| 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 | RDA | Claims, ACES | Semi-Annual | State, ACH | Medicaid | N | Inactive | P4P | P4P | 2.b, 2.c, 2.d |
| Inpatient Utilization per 1000 Medicaid Member Months | | HEDIS 2017 | Summarizes utilization of acute inpatient care and services in the following categories among adult Medicaid enrollees: Total Inpatient, Maternity, Surgery, and Medicine. Rate reported for all Medicaid enrollees, and stratified by behavioral risk factors to assess trends separately for those with identified mental illness, substance use disorder, co-occurring disorders and serious mental illness populations. | NCQA | HCA | Claims, encounter data | Semi-Annual | State, ACH | Medicaid | N | Inactive | P4P | P4P | 2.a, 2.b, 2.c, 3.d |
| Plan All-Cause Readmission Rate (30 Days) | 1768 | HEDIS 2017 | The proportion of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days among Medicaid enrollees ages 18-64 years old. | NCQA | RDA | Claims | Semi-Annual | State, ACH | Medicaid | Y | P4P | P4P | P4P | 2.a, 2.b, 2.c |
| Mental Health Treatment Penetration (Broad Version) | | | Percent of Medicaid enrollees with a mental health service need who received at least one qualifying service during the measurement year. Separate reporting by age groups: 12-17 years and 18-64 years. | RDA | RDA | Claims, encounter data | Semi-Annual | ACH | Medicaid | Y | P4P | P4P | P4P | 2.a, 2.b, 3.b |
| Substance Use Disorder Treatment Penetration | | | The percentage of Medicaid enrollees with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting by age groups: 12-17 years and 18-64 years. | RDA | RDA | Claims, encounter data | Semi-Annual | ACH | Medicaid | Y | P4P | P4P | P4P | 2.a, 2.b, 3.b |
| Adult Access to Preventive/Ambulatory Care | | HEDIS 2016 | Percent of adult Medicaid enrollees who had a visit with a PCP, reported separately for the following three age groups: 20-44 years, 45-64 years, and 65+ years. | NCQA | HCA | Claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 2.d, 3.d |
| Comprehensive Diabetes Care: Eye Exam (retinal) performed | 0055 | HEDIS 2017 | Percentage of Medicaid enrollees 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period. | NCQA | HCA | Claims | Semi-Annual | ACH | Medicaid | N | Inactive | P4P | P4P | 2.a, 3.d |

| Medicaid Transformation Demonstration Toolkit Measures | | | | | | | | | | | Active Demonstration Years (DY): Pay for Reporting (P4R), Pay for Performance (P4P) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Measure Name | NQF# | Specification Version | Measure Description | Measure Steward | Reporting Responsibility | Data Source | Periodicity | Unit of Analysis | Population: Total population, Medicaid | Statewide Accountability Measure (Y/N) | DY 3 (2019) | DY 4 (2020) | DY 5 (2021) | Associated Project Areas |
| Psychiatric Hospital Readmission Rate | | | For Medicaid enrollees 18 years of age and older, the proportion of acute inpatient psychiatric stays during the measurement year that were followed by an acute psychiatric readmission within 30 days. | RDA | RDA | Claims, encounter data | Semi-annual | State | Medicaid | Y | P4P | P4P | P4P | 2.a, 2.c |
| Child and Adolescents' Access to Primary Care Practitioners | | HEDIS 2017 | Percent of children enrolled in Medicaid who had a visit with a primary care provider. Reported separately for the following four age groups: 12-24 months, 2-6 years, 7-11 years,  and 12-19 years. | NCQA | HCA | Claims | Semi-Annual | ACH | Medicaid | N | Inactive | P4P | P4P | 2.a, 3.d |
| Comprehensive Diabetes Care: Medical attention for nephropathy | 0062 | HEDIS 2017 | The percentage of Medicaid enrollees 18–75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period. | NCQA | HCA | Claims | Semi-Annual | ACH | Medicaid | N | P4P | P4P | P4P | 2.a, 3.d |
| Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life | 1516 | HEDIS 2017 | The percentage of Medicaid-covered children 3-6 years of age who had one or more well-child visits with a primary care provider during the measurement year. | NCQA | HCA | Claims | Semi-Annual | ACH | Medicaid | Y | P4P | P4P | P4P | 2.b, 3.b, 3.d |
| Well-Child Visits in the First 15 Months of Life | 1392 | | The percentage of  children 15 months old enrolled in Medicaid  who had the recommended number of well-child visits with a primary care provider during their first 15 months of life. | NCQA | HCA | Claims | Semi-Annual | ACH | Medicaid | N | Inactive | Inactive | P4P | 2.b, 3.b, 3.d |
| Medication Management for People with Asthma (5 – 64 Years) | 1799 | HEDIS 2017 | The percentage of Medicaid enrollees 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. | NCQA | HCA | Claims | Semi-Annual | ACH | Medicaid | Y | P4P | P4P | P4P | 2.a, 3.d |
| Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence | 2605 | HEDIS 2017 | The percentage of discharges for Medicaid enrollees 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence. Two rates are reported: (1) The percentage of discharges for enrollees who received follow-up within 30 days of discharge; (2) The percentage of discharges for enrollees who received follow-up within 7 days of discharge. | NCQA | RDA | Claims, encounter data | Semi-annual | ACH | Medicaid | N | Inactive | P4P | P4P | 2.a, 2.c |

| Medicaid Transformation Demonstration Toolkit Measures | | | | | | | | | | | Active Demonstration Years (DY): Pay for Reporting (P4R), Pay for Performance (P4P) | | | |

| Measure Name | NQF# | Specification Version | Measure Description | Measure Steward | Reporting Responsibility | Data Source | Periodicity | Unit of Analysis | Population: Total population, Medicaid | Statewide Accountability Measure (Y/N) | DY 3 (2019) | DY 4 (2020) | DY 5 (2021) | Associated Project Areas |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Follow-up After Hospitalization for Mental Illness | 0576 | HEDIS 2017 | The percentage of discharges for Medicaid enrollees 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: (1) The percentage of discharges for enrollees who received follow-up within 30 days of discharge; (2) The percentage of discharges the enrollees who received follow-up within 7 days of discharge. | NCQA | RDA | Claims, encounter data | Semi-annual | ACH | Medicaid | N | Inactive | P4P | P4P | 2.a, 2.c |
| Influenza Immunizations 6 months of age and older | 0041 | | Percentage of persons who received influenza vaccinations during the measurement year for two groups: (1) children 6 months to 17 years of age (2) adults 18 years and older | DOH | DOH | 1.)WA IIS 2.)BRFSS | Annual | ACH | Total population | N | P4R | P4R | P4R | 2.a, 3.d |
| Oral Health Services Utilization by Medicaid Beneficiaries | | | Oral health services utilization among eligible members. | HCA | HCA | Claims | Semi-Annual | State, ACH | Medicaid | N | P4R | P4R | P4R | 3.c |
| Low Birth Weight Rate | 0278 | | Low birth weight (< 2,500 grams) infants among newborns among Medicaid enrollees. | AHRQ | HCA, DSHS | DSHS | Semi-Annual | State, ACH | Medicaid | N | Inactive | P4P | P4P | 3.b |
| Percent Arrested | | | Percent of Medicaid enrollees who were arrested at least once during the measurement year. | RDA | RDA | DSHS | Semi-Annual | ACH | Medicaid | N | Inactive | P4P | P4P | 2.d |
| Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers | 1419 | | Among eligible Medicaid enrollees, the measure quantifies a) the application of fluoride varnish (FV) as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) examination by the PCMP or clinic and b) each billing entity's use of the EPSDT with FV codes increases from year to year. | DQA | HCA | Claims | Semi-Annual | State, ACH | Medicaid | N | P4R | P4P | P4R | 3.c |
| Antidepressant Medication Management | 0105 | HEDIS 2017 | The percentage of Medicaid enrollees 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. | NCQA | HCA | Claims | Semi-Annual | ACH | Medicaid | Y | P4P | P4P | P4P | 2.a |

| Medicaid Transformation Demonstration Toolkit Measures | | | | | | | | | | | Active Demonstration Years (DY): Pay for Reporting (P4R), Pay for Performance (P4P) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Measure Name | NQF# | Specification Version | Measure Description | Measure Steward | Reporting Responsibility | Data Source | Periodicity | Unit of Analysis | Population: Total population, Medicaid | Statewide Accountability Measure (Y/N) | DY 3 (2019) | DY 4 (2020) | DY 5 (2021) | Associated Project Areas |
| Prenatal care in the first trimester of pregnancy | | | Percentage of pregnant women enrolled in Medicaid who began prenatal care in the first trimester of pregnancy during the measurement period. | HEDIS NCQA | HCA, DSHS | Claims/First Steps Database | Semi-Annual | ACH | Medicaid | N | Inactive | P4P | P4P | 3.b |
| Chlamydia Screening in Women Ages 16 to 24 | 0033 | | The percentage of female Medicaid enrollees 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. | NCQA | HCA | Claims | Semi-Annual | ACH | Medicaid | N | Inactive | Inactive | P4P | 3.b |
| Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults | 0712 | HEDIS 2017 | The percentage of Medicaid enrollees age ≥12 with a diagnosis of major depressive disorder or dysthymia who had a PHQ-9 tool administered at least once during a 4-month period. | HEDIS NCQA | HCA | Hybrid data (Claims and medical record) | Annual | ACH | Medicaid | N | Inactive | P4R | P4R | 2.a |
| Percent Employed (Medicaid) | | | Percent of Medicaid enrollees with any earnings reported in the Employment Security Department (ESD) employment data in the measurement year. | RDA | RDA | DSHS | Semi-Annual | State | Medicaid | N | P4R | P4R | P4R | 2.b |
| Comprehensive Diabetes Care: Blood Pressure Control | 0061 | | The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading is <140/90 mm Hg. | HEDIS NCQA | HCA | Hybrid data (Claims and medical record) | Annual | State | Medicaid | Y | Active monitoring by the state | Active monitoring by the state | Active monitoring by the state | Statewide Measure, 2.a |
| Non-fatal overdose involving prescription opioids (Measure specification in development) | | | Measure in development. Percent of non-fatal overdoses in at least one quarter in the year diagnosis from inpatient care and emergency department care (ED data may not be available) by age and gender. Reported separately for total population and Medicaid enrollees. | DOH, DSHS | (HCA) | DSHS | Annual | State | Total population, Medicaid | N | P4R | P4R | P4R | 3.a |
| Depression Screening and Follow-up for Adolescents and Adults | | HEDIS 2018* | The percentage of Medicaid enrollees age ≥12 who were screened for clinical depression using a standardized tool and, if screened positive, who received appropriate follow-up care. This measure is adapted from a provider-level measure stewarded by CMS (NQF 0418). Planned for implementation in HEDIS 2018. | HEDIS NCQA | ACH, HCA | Hybrid data (Claims and medical record) | Annual | ACH | Medicaid | N | Inactive | P4R | P4R | 2.a |
| Depression Remission or Response for Adolescents and Adults | | HEDIS 2017 | The percentage of Medicaid enrollees 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 or PHQ-A score, who had evidence of remission or response within 5–7 months of the elevated score. | HEDIS NCQA | ACH, HCA | Hybrid data (Claims and medical record) | Annual | ACH | Medicaid | N | Inactive | P4R | P4R | 2.a |

| Medicaid Transformation Demonstration Toolkit Measures | | | | | | | | | | | Active Demonstration Years (DY): Pay for Reporting (P4R), Pay for Performance (P4P) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Measure Name | NQF# | Specification Version | Measure Description | Measure Steward | Reporting Responsibility | Data Source | Periodicity | Unit of Analysis | Population: Total population, Medicaid | Statewide Accountability Measure (Y/N) | DY 3 (2019) | DY 4 (2020) | DY 5 (2021) | Associated Project Areas |
| Contraceptive Care – Most & Moderately Effective Methods | 2903 | | The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception. | US Office of Population Affairs | RDA | Claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.b |
| Adult Mental Health Status | | | Percentage of adults 18 years of age and older who reported having poor mental health for 14 or more days in the past 30 days during the measurement period. | DOH | DOH | BRFSS | Annual | State | Total population | N | P4R | P4R | P4R | 2.a |
| 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 among Medicaid enrollees. Separate reporting for age groups 18-64 and 65+ years. | RDA | RDA | DSHS | Semi-Annual | State | Medicaid | N | P4R | P4R | P4R | 2.b |
| Rate of Teen Pregnancy (15 – 19) | | | Rate of females 15 through 19 years of age who were pregnant, per 1,000. Rates reported for 15-17 year old, 18-19 year old and combined 15-19 year old females. | RDA | RDA | Birth certificate data, Abortion data | Annual | State, ACH | Medicaid | N | P4R | P4R | P4R | 3.b |
| Contraceptive Care – Access to LARC | 2904 | | Percentage of female Medicaid enrollees aged 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems (IUD/IUS). | US Office of Population Affairs | RDA | Claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.b |
| Statin Therapy for Patients with Cardiovascular Disease (Prescribed) | | HEDIS 2017 | Percentage of male Medicaid enrollees 21 to 75 years of age and female Medicaid members 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 | HCA | Claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.d |
| Contraceptive Care – Postpartum | 2902 | | Among female Medicaid enrollees ages 15 through 44 who had a live birth, the percentage that is provided: 1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery. 2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery. | US Office of Population Affairs | RDA | Claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.b |

| Medicaid Transformation Demonstration Toolkit Measures | | | | | | | | | | | Active Demonstration Years (DY): Pay for Reporting (P4R), Pay for Performance (P4P) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Measure Name | NQF# | Specification Version | Measure Description | Measure Steward | Reporting Responsibility | Data Source | Periodicity | Unit of Analysis | Population: Total population, Medicaid | Statewide Accountability Measure (Y/N) | DY 3 (2019) | DY 4 (2020) | DY 5 (2021) | Associated Project Areas |
| Childhood Immunization Status | 0038 | HEDIS 2017 | Percentage of children 2 years of age who received the combo 10 HEDIS vaccine series (4DTaP/DT/Td, 3 Hib, 3 polio, 3 Hep B, 1 MMR, 1 Varicella, 2 Hep A, 2 flu, 4 PCV, 2 rotavirus) during the measurement period. | DOH | DOH | WA IIS, Claims | Annual | ACH | Total population | N | P4R | P4R | P4R | 3.b |
| Unintended Pregnancies | | | Estimated proportion of pregnancies that are unintended. | DOH | DOH | PRAMS, Birth data, Abortion data | Annual | State, ACH | Total population | N | P4R | P4R | P4R | 3.b |
| Opioid Related Deaths (Medicaid Enrollees and Total Population) per 100,000 | | | Rate of opioid related deaths per 100,000 population (calculated separately for Medicaid enrollees and total population). Measure includes rates for prescription opioids, heroin, and combined. | DOH, DSHS | DOH, DSHS | DSHS | Annual | State | Medicaid | N | P4R | P4R | P4R | 3.a |
| Ongoing Care in Adults with Chronic Periodontitis | | | Percentage of Medicaid enrollees age 35 years and older with chronic periodontitis who received ongoing periodontal care at least 2 times within the reporting year. | DQA | HCA | Claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.c |
| Periodontal Evaluation in Adults with Chronic Periodontitis | | | Percentage of Medicaid enrollees 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. | DQA | HCA | Claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.c |
| Substance Use Disorder Treatment Penetration (Opioid) (Measure specification in development) | | | Percent of Medicaid enrollees with a diagnosis of opioid use disorder who have a substance use service need who received at least one qualifying service during the measurement year. Reported separately for adults and for children. | RDA | RDA | DSHS | Semi-Annual | State | Medicaid | N | P4R | P4R | P4R | 3.a |
| New opioid users that become chronic users (Measure specification in development) | | | Measure specifications in development. Among Medicaid enrollees who are identified as new opioid patients, percent who are prescribed chronic opioids in the next quarter. | Bree Collaborative | HCA | Administrative claims, Pharmacy claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.a |
| Patients on high-dose chronic opioid therapy by varying thresholds (Measure specification in development) | | | Measure specifications in development. Among Medicaid enrollees, percent of chronic opioid therapy patients receiving doses: >50 mg. MED in a quarter, doses >90 mg. MED in a quarter. | Bree Collaborative | HCA | Administrative claims, Pharmacy claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.a |

| Medicaid Transformation Demonstration Toolkit Measures | | | | | | | | | | | Active Demonstration Years (DY): Pay for Reporting (P4R), Pay for Performance (P4P) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Measure Name | NQF# | Specification Version | Measure Description | Measure Steward | Reporting Responsibility | Data Source | Periodicity | Unit of Analysis | Population: Total population, Medicaid | Statewide Accountability Measure (Y/N) | DY 3 (2019) | DY 4 (2020) | DY 5 (2021) | Associated Project Areas |
| Patients with concurrent sedatives prescriptions (Measure specification in development) | | | Measure specifications in development.  Among Medicaid enrollees receiving chronic opioid therapy, what percent had more than 45 days of Sedative Hypnotics/ Benzodiazepines/ carisoprodol/ barbiturates dispensed in the quarter. | Bree Collaborative | HCA | Administrative claims, Pharmacy claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.a |
| Non-fatal overdose involving prescription opioids (Measure specification in development) | | | Measure specifications in development. Number of events and events per 100,000 population and percent of overdoses among patients who received chronic opioid therapy in at least one quarter in the year diagnosis from inpatient care and emergency department care (ED data may not be available) by age and gender, among Medicaid enrollees. | Bree Collaborative | HCA | Administrative claims, Pharmacy claims | Annual | State | Medicaid | N | P4R | P4R | P4R | 3.a |
| Medication Assisted Therapy (MAT)  With Buprenorphine (Count and %) | | | The percentage of Medicaid members with a documented diagnosis of opioid abuse/dependence who are engaged in Medication Assisted Treatment (MAT): Buprenorphine. | HCA | HCA | Administrative claims, Pharmacy claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.a |
| Medication Assisted Therapy (MAT)  With Methadone (Count and %) | | | The percentage of Medicaid members with a documented diagnosis of opioid abuse/dependence who are engaged in Medication Assisted Treatment (MAT): Methadone. | HCA | HCA | Administrative claims, Pharmacy claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.a |
| Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) | 0059 | | The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) | NCQA | HCA | Hybrid (Claims and clinical data) | Annual | ACH | Medicaid | Y | Active monitoring by the state | Active monitoring by the state | Active monitoring by the state | Statewide Measure, 2.a |
| Controlling High Blood Pressure | 0018 | | The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. | NCQA | HCA | Hybrid (Claims and clinical data) | Annual | ACH | Medicaid | Y | Active monitoring by the state | Active monitoring by the state | Active monitoring by the state | Statewide Measure, 2.a |
| Adult Body Mass Index Assessment | 0023 | | Percentage of adults 18 years old or older with valid BMI documentation in the past 24 months. | NCQA | HCA | Hybrid (Claims and clinical data) | Annual | ACH | Medicaid | N | Inactive | P4R | P4R | 2.a, 3.d |
| Medication Safety: Proportion of Days Covered - Adherence to Prescribed Medications (3 types) | 0541 | | The percentage of Medicaid enrollees with proportion of days covered >=80%.  Separate rates reported by therapeutic category: A.) Cholesterol lowering medications;  B.   Diabetes medications; C.) Hypertension medications | PQA | HCA | Claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 2.b |

| Medicaid Transformation Demonstration Toolkit Measures | | | | | | | | | | | | Active Demonstration Years (DY): Pay for Reporting (P4R), Pay for Performance (P4P) | | | |
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| Measure Name | NQF# | Specification Version | Measure Description | Measure Steward | Reporting Responsibility | Data Source | Periodicity | Unit of Analysis | Population: Total population, Medicaid | Statewide Accountability Measure (Y/N) | DY 3 (2019) | DY 4 (2020) | DY 5 (2021) | Associated Project Areas |
| 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)) during the measurement period. | DOH | DOH | WA IIS | Annual | ACH | Medicaid | N | P4R | P4R | P4R | 2.b |
| Annual Monitoring for Patients Persistent Medications (Hypertension Medications) | 2371 | | The percentage of Medicaid enrollees 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 | HCA | Claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 2.b |
| Pneumonia Vaccination Status for Older Adults | 0043 | | Percentage of adults 65 years of age and older who ever received a pneumococcal vaccination. | DOH | DOH | BRFSS | Annual | ACH | Total population | N | P4R | P4R | P4R | 2.b |
| Caries at Recall (Adults and Children) | | | The Caries at Recall measure assesses the percent of Medicaid enrollees who complete a periodic oral evaluation and have a caries diagnosis. This measure tracks progress in dental disease prevention and examines the extent in which patients' dental disease is being managed. | NNOHA Dashboard | TBD | NNOHA Dashboard | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.c |
| Adult Treatment Plan Completed | | | Percent of Medicaid enrollees who complete their recommended treatment within a six-month time frame. This measure tracks the degree to which patients' oral health treatment needs are being met. | NNOHA Dashboard | TBD | NNOHA Dashboard | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.c |
| Sealants - % Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk | 2509 | | Percentage of children enrolled in Medicaid in the age category of 6-9 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year. | DQA | HCA | Claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.c |
| Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk | 2508 | | Percentage of children enrolled in Medicaid in the age category of 10-14 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year. | DQA | HCA | Claims | Semi-Annual | ACH | Medicaid | N | P4R | P4R | P4R | 3.c |