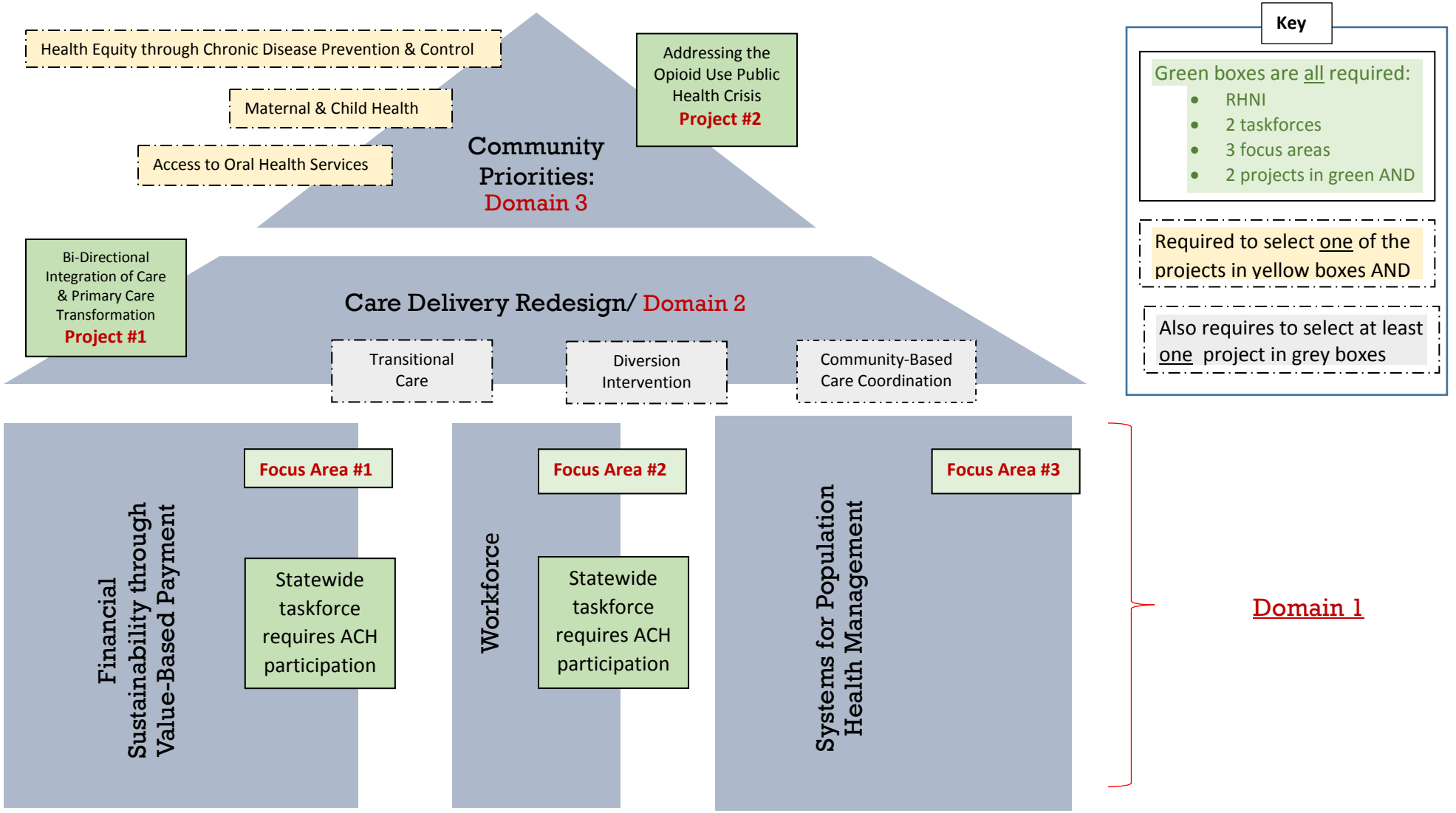
North Sound ACH, revised January 5, 2017

Initiative I: Medicaid Transformation 5-Year Demonstration via ACHs



EXPANDED Regional Health Needs Inventory

HCA will provide standard form and data & ACHs will fill in gaps using local data sources. "Each ACH will be required to complete a comprehensive Regional Health Needs Inventory (RHNI) ahead of finalizing project implementation plans." (p6)

Foundational *and* Formative

TBD which data HCA will provide or on what timeframe.

Summary of DRAFT Toolkit Project REQUIREMENTS:

Domain 2 requires TWO projects: Bi-Directional Integration of Care and Primary Care Transformation and at least **ONE of 2B** (community-based care coordination) **2C** (Transitional Care) **or 2D** (Diversion Interventions)

Domain 2 **REQUIRED PROJECT** #2A **Bi-Directional Integration of Care and Primary Care Transformation**

Purpose: This project will advance Healthier Washington's initiative to bring together the payment and delivery of physical and behavioral health services for people enrolled in Medicaid, through managed care.

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

Recommended Implementation Partners:

Behavioral Health Providers,
Primary Care Providers,
County Government,
Local Public Health Agencies,
Tribal Governments,
Indian Health Care Providers,
Managed Care Organizations, Criminal Justice,
Department of Social and Health Services.

Partners for Primary Care Transformation should include:

Primary Care Providers (including independent practices), hospital-affiliated health centers, and Federally Qualified Health Centers and Rural Health Clinics serving Medicaid beneficiaries.

One: Select at least 1 of the following evidence-based approaches to integrate BH into Primary Care Setting:

Option 1: *Patient-Centered Medical Home (PCMH)*

Option 2: *Collaborative Care Model (Core Principles defined by the AIMS Center of the University of WA)*

☐ **Two: Select at least 1:** of the following approaches based on emerging evidence to integrate Primary Care into BH Setting:

Option 1: *Off-site, Enhance Collaboration*

Option 2: *Co-located, Enhanced Collaboration*

Option 3: *Co-located, Integrated*

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

Planning: Rely on the Regional Health Needs Inventory to identify target population and providers serving Medicaid beneficiaries.
Assess the target providers' current capacity to effectively deliver integrated care in 1) Pop. Health Management/HIT, 2) Workforce, and 3) Financial Sustainability;
Include strategies within the system-wide plan completed within Domain 1 for 1) Pop. Health Management/HIT, 2) Workforce, and 3) Financial Sustainability:

Stage 1 Requirements include:

A) Assess the current state of provider capacity and Integrated Care Model Adoption

B) Engage and obtain formal agreements from participating behavioral and physical health providers, organizations, and relevant committees or councils

C) Engage and convene County Commissioners, Managed Care Organizations, Behavioral Health providers and other critical partners to develop a plan and description of a process and timeline to transition to fully integrated managed care. This plan should reflect *how in the region will enact fully integrated managed care by no later than January 2020*; include an explanation of the process for obtaining county commitment to pursue full integration.

D) Complete plan for pursing fully integrated managed care[1]
E) Binding letters from counties w/in RSA to implement full integration by 2020
F) Complete project implementation plan[3]
G) Complete Financial Sustainability, Workforce, and Systems for Pop. Health Management strategies.[4]

From DOMAIN 2, **ONE** Optional Project **will be REQUIRED**

ACHs will be required to implement at least ONE additional project from the three optional projects listed in Domain 2

☐ 2B: Community Based Care Coordination

Purpose: This required project is an evidence-based model for establishing a Pathways Community HUB *or* similar approach. Pathways Community HUB is a model to coordinate care coordinators, adopt standardized pathways, and establish of centralized processes, systems, and resources to allow accountable tracking of those being served, and a method to tie care coordination work products or units to payment and to outcomes. The HUB leverages existing care coordination capacity, reduces that potential for duplication of efforts, and increases accountability. **Importantly, activities are not a replacement for existing care coordination services provided under the Medicaid State Plan nor is this intended to produce an additional service array beyond what is already established in contracts and in the Medicaid State Plan.** Alternatively, the ACH may establish a "HUB-like" centralized care coordination system that includes the core elements of the Pathways HUB model.

Target Population: Medicaid beneficiaries (adults and children) with one or more chronic disease or condition and at least one risk factor

Recommended Implementation Partners:

Behavioral Health Providers,	*Tribal Governments,*	*Care Management Agencies,*
Primary Care Providers,	*Indian Health Care Providers,*	*Home Health,*
Managed Care Organizations,	*Criminal Justice,*	*Health Home Providers,*
Department of Social and Health Services,	*Law Enforcement,*	*Housing,*
Local Public Health Agencies,	*Hospitals,*	*Emergency Medical Services,*
Area Agencies on Aging,	*Long-Term Care,*	*and Community-Based Service Organizations.*

Evidence-based Approach: Pathways Community HUB

*HCA targeting Medicaid clients with one or more chronic disease condition(*such as, serious mental illness, moderate to severe substance use disorder, HIV, birth defects, cancer, diabetes, depression, heart disease and stroke*)* and at least one risk factor (e.g., obesity, unstable housing, food insecurity, high EMS utilization). [2]

- **Stage 1 Requirements include**: A) Obtain binding letter of intent from HUB lead entity)
  B) List implementation partners w/ formal written commitment to participate
  C) Complete Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2B efforts
  D) Complete Hub Implementation Plan

☐ 2C: Transitional Care

Purpose: Transitional care services provide opportunities to eliminate avoidable admissions and readmissions. This project includes multiple care management and transitional care approaches from which the **ACH will select at least one**.

Target Population: Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including:

- ☐ beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with SMI discharged from inpatient care,
- ☐ or clients returning to the community from prison or jail.

Recommended Implementation Partners:

Behavioral Health Providers,	*Tribal Governments,*	*Tribal Governments,*
Primary Care Providers,	*Indian Health Care Providers,*	*Indian Health Care Providers,*

*notes 2, 3 & 4: Confirm with HCA that these are **stage 1** requirements*

[2] *Pre-draft indicated likely inclusion of: (1) Behavioral Health Pathway, (2) Immunization Pathway, (3) Medical Home Pathway, (4) Medication Assessment & Management Pathways, & (5) Smoking Cessation Pathway*

Managed Care Organizations, *Hospitals,* *Hospitals,*
Department of Social and Health Services, *Long-Term Care,* *Long-Term Care,*
and other Community-Based Service Organizations (particularly those working in prison and jail reentry both independent of or in coordination with local reentry councils and committees).

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

1. Interventions to Reduce Acute Care Transfers, INTERACT™4.0, - a quality improvement program that focuses on the management of acute change in resident condition
2. Transitional Care Model (TCM), a nurse led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up
3. The Care Transitions Intervention® (CTI®), 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, provides set of components of effective transitional care that can be adapted for managing transitions for those 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 on critical components of an integrated transitional care approach. **Refer to** the following:

Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison,
A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model,
American Association of Community Psychiatrists' Principles for Managing Transitions in Behavioral Health Services

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

☐ 2D: Diversion Interventions

Purpose: 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 lead to more positive outcomes VIA offer comprehensive assessment, care/case planning and management. Promote more appropriate use of emergency care services and also support person-centered care through increased access to primary care and social services, especially for medically underserved populations.

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

Recommended Implementation Partners:

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

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

1. Emergency Department (ED) Diversion via WSHA or NCBI,.
2. Community Paramedicine Model, -Additional resources on page 36
3. Law Enforcement Assisted Diversion, LEAD®

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

Domain 3 requires TWO additional projects: Addressing the Opioid Use Public Health Crisis and at least **ONE of 3B** (Maternal and Child Health) **3C** (Access to Oral Health Services) **or 3D** (Chronic Disease Prevention and Control)

Domain 3 REQUIRED PROJECT #3A **Addressing the Opioid Use Public Health Crisis**

Purpose: ACHs will support achievement of the goals outlined in Executive Order 16-09. This project aligns with the state opioid response plan and focuses on strategies under three of the plan goals: (1) Prevent opioid misuse and abuse by improving prescription practices, (2) expand access to opioid dependence treatment, (3) intervene in opioid overdoses to prevent death, and (4) use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions

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

Recommended Implementation Partners:

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

Recommended Approach:

- **Clinical Guidelines:**
  - AMDG's Interagency Guideline on Prescribing Opioids for Pain
  - Substance Use During Pregnancy: Guidelines for Screening & Management
- **Statewide Plans:**
  - 2016 Washington State Interagency Opioid Working Plan
  - Substance Abuse Prevention & Mental Health Promotion Five-Year Strategic Plan
- **Other Resources**
  - CDC Guideline for Prescribing Opioids for Chronic Pain United States, 2016
- **Stage 1 Requirements include**:
  - A) Completed Workforce, Technology, and Financial Sustainability plans, as defined in Domain 1, reflective of support for Project 3A efforts
    B) List implementation partners w/ formal written commitment to participate;
    C) Number and list of MDs, ARNPs, and Pas who are approved to prescribe buprenorphine
    D) Completion of Regional Opioid Working Plan

At least **ONE** Optional Project from DOMAIN 3 **will be REQUIRED**

ACHs will be required to do implement a 4th project from the optional projects listed in Domain 3

☐ **3B: Maternal and Child Health**

Purpose: Maternal and child health are a primary focus for HCA as more than half of births in the state and health insurance for more than half of WA's children are covered by the state. Help the children of Washington get the healthiest start possible by supporting pre-conception, maternal and child health.

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

Recommended Implementation Partners:

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

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

1. Implementation of an evidence-*based home visiting model for pregnant high risk mothers*, including high risk first time mothers. Potential programs can include Nurse Family Partnership (NFP) or other federally recognized evidence-based home visiting model currently operating in Washington State. **If a program currently exists in the ACH region**, it can only be selected for this project **if there is a valid justification for an expansion** of the program and a demonstration that duplication of effort will not occur. **ACHs must also demonstrate how they are coordinating across existing services.**

a. Nurse Family Partnership (NFP), - 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), which works with parents to improve child health; prevent child abuse and neglect; encourage positive parenting; and promote child development and school readiness.

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

3. Implementation of recommendations to Improve Preconception Health and Health Care, In particular, ACHs should consider evidence-based models to improve utilization of effective family planning strategies. If applicable, ACHs could leverage the Family Planning Pathway to align with Project 2B.

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

☐ 3C: Access to Oral Health Services

Purpose: Oral health impacts overall health and quality life, and most oral disease is preventable. Oral disease has been referred to as a "silent epidemic" and has been associated with increased risk for serious adverse health outcomes. While many initiatives have addressed the oral health needs of children during crucial preventive windows, less attention has been paid to increasing access to oral health services for adults.

Target Population: All Medicaid beneficiaries, especially adults.

Recommended Implementation Partners:

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

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

1. Oral Health in Primary Care, integrating oral health screening, assessment, intervention, and referral, into the primary care setting
2. Mobile/Portable Dental Care, adapt national maternal and child health resource center manual to guide planning and implementation of mobile dental units and portable dental care equipment for school-age children for adults

Additional Resources: on page 55

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

☐ 2D: Health Equity through Chronic Disease Prevention and Control

Purpose: Integrate health system and community approaches to improve chronic disease management and control. The ACH can tailor single approach to address specific populations and disease categories. This model is applicable to most preventive and chronic care issues, and once applied to implement system changes, "paves the way for new guidelines or innovation." There is opportunity to include specific change strategies that target the regionally defined health disease/condition and to address the identified barriers to care for Medicaid beneficiaries experiencing the greatest burden of chronic disease.

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

Recommended Implementation Partners:

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

Evidence-based Approach: Chronic Care Model

Specific Strategies to Consider Including within Chronic Care Model Approach are on page 60.

- **Stage 1 Requirements include**: 1) List implementation partners, including PCP and CBOs, with formal written commitment to participate in the project
  2) Complete Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 3D efforts
  3) Complete Chronic Care Implementation Plan, to include identification of specific change strategies