Program Council AGENDA

North Sound ACH
Building Healthier Communities
In Snohomish, Skagit, Island, San Juan & Whatcom Counties

Date: 4.20.17

Location: NORTH SOUND BHO
Call in option: 1.866.348.8234

Time	Topic / discussion points	Lead	Desired outcome	Supporting documents
1:00pm	1. Welcome • Agenda review • 4/6/17 Minute approval	Jennifer Johnson		Attachment A
1:10	2. Program Council Formation • Affirm current membership • Expand PC • Method of further population the council	Liz Baxter		Attachment B
1:30	3. Mid adapter incentive payment	Joe Valentine	• Understanding of opportunities and risks	
1:50	4. Funding protocol	Liz Baxter		Attachment C
2:10	5. Pathways			Attachment D
2:40	6. Workgroup Statements of Interest • Due 4/27 for preliminary review and feedback to the May 4 PC meeting	Chris Phillips Group leads		Attachment E Attachment F Attachment G
3:30	7. Adjournment	Jennifer Johnson		

1

Attachment A) Minutes

April 06, 2017 1 – 3 PM
Program Council Meeting
1.866.348.8234

North Sound ACH

Building Healthier Communities
In Snohomish, Skagit, Island, San Juan & Whatcom Counties

Program Council Members:

- ■ Greg Arnold
- ☐ Ryan Blackwell
- ■ Siobhan Brown
- ■ Federico Cruz-Uribe, MD
- ■ Connie Davis
- ■ Jennifer Johnson, Chair
- ■ David Kincheloe, PhD
- ☐ Laurel Lee
- ☐ Peter Mayer
- ■ Robin Fenn, PhD
- ■ Stephen Gockley, JD
- ■ Linda McCarthy
- ■ Chris Phillips, Vice Chair
- ■ Glenn Puckett
- ☐ Tom Sebastian
- ☐ Greg Winter
- ■ Laura White
- ■ Caitlin Safford
- ☐ Janette Schurman

Guests/alternates:

- ■ Jeff Ketchel
- ■ Dan Murphy
- ■ Anji Jorstad
- ■ Laura Johnson
- ■ Allan Fisher
- ■ Barbara LaBrash

Staff Members:

Liz Baxter
Tiffany Edlin
Emily Henke (contractor)
Lee Che Leong

DRAFT Minutes

1. **Welcome and Meeting Minute**

Motion: to approve 3.16.17 meeting minutes (Linda). Seconded (Federico). All in favor, no abstentions. **Approved.**

2. **Toolkit Update**
   - Statewide and regional metrics
   - Changed a few of the names of the priority list: “Reproductive, Maternal and Child Health” and “Chronic Disease Prevention & Control.”
   - Each workgroup will do a deeper dive on what changed on their priority
   - Added pathways model to the toolkit
   - The annotated “user guide” will be more helpful for the workgroup level

3. **Process Framing**
   - Each provisional work group lead will review toolkit and bring list of deliverables back to Program Council
   - Creating a statement of interest for each group

Motion: to use timeline in attachment C, "Growing Project Proposals or Stages of PWG Development," as a framework moving forward. Seconded. All in favor, no abstentions. **Approved.**

- Would like workgroups to bring forward projects and ideas along the way, to allow feedback and allow only "yes/no" voting at end of process.
- Project selection needs to occur by July/August
- Plan to have public/stakeholder input in step 3 of timeline

4. Workgroup progress

Behavioral Health Integration:

- Working on draft charter and ensuring they are not missing any representation on their group.
- Small group has met to work out process and hope to have the larger group scheduled soon.
- Looking at teamwork as a tool for the group
- Looking at integrating AIM primary care model, payment integrations and specialty care into their work
- Fiscal constraints have been an issue and would like guidance if this is a decision at workgroup or Program Council level. Talk of two different groups, financial and work or keep as one group
- Will have mid-adopter on agenda for next meeting
- Chris Phillips will forward additional participant name to Greg Arnold

Chronic Disease Prevention & Control:

- Now has a chair, Dr. Connie Davis
- Group has not met yet. Hope to has more to report back on next time.

Reproductive & Maternal/Child Health:

- Invited 22 people to join their next meeting
- The intention is to reduce unintended pregnancy and improve maternal and child health
- Already have surveys out scanning region on what has already been done/currently being done/what could we grow

Care Coordination:

- Small subgroup met in Seattle producing more questions than answers.
- Lumped care delivery design priorities into one group. Need to separate them out into 3 provisional groups.
- Meeting directly after Care Coordination group
- Pushing pathways model as an anchor strategy
- There is a lot of energy at the local level for first responders and the work they are doing. Hope to have a group formed soon.
- Kim Williams and Dan Murphy are working on Care transitions.
- Robin will reach out and see if Tim or others are interested in diversion group. Snohomish doing great work with their CHART program and Whatcom county is looking at replicating it.
- A lot of discussion around Pathways and how if/want to integrate the model into the North Sound.
- Next meeting will discuss the Pathways model and we will get materials out for everyone to review prior to the meeting.

Access to Oral Health Services:

- Conversations are continuing around dental.
- There is not an official group, but Glenn is networking.
- Also hope to integrate oral health into all projects and not necessarily have its own group. Please include Glenn Puckett in all meeting invites.

Reminders:

- In hopes to centralize and keep the lists organized, please send the meeting details/attendees and materials to Tiffany Edlin for circulation. This information should be distributed by the North Sound.
- Would like to have consumers on each work group.

Motion: to ensure that there is a minimum of 1 consumer per group (Anji). Seconded. After discussion, an amendment was put forward.

Motion: every provisional workgroup/lead will do their best effort to engage and include consumers in their workgroup. Projects proposals that include consumer engagement will be evaluated more favorably (Chris). Seconded (Barbara). All in favor, no abstentions. **Approved.**

5. **Assessment and RHNI update**
   - Regional Health Need Inventory (RHNI) falls into our purview.
   - This group hopes to meet soon on how the local health jurisdictions (LHJ's) and the North Sound ACH can collaborate and get this work done.

6. **Next Steps:**
   - April 20th meeting will include mid-adopter information/discussion, and pathways. Due to the amount of information that needs to be discussed we are extending the meeting 1 hour.
   - If possible, workgroups should send work summaries to be included in packet to save time.

7. **Adjourn** at 3:09pm

Attachment B) Members

Program Council Members approved on 3.16.17

Sector	Number	Organization	Person
Behavioral Health	2	BHO Compass Health	Greg Arnold Tom Sebastian
Health System / Hospital	3	PeaceHealth Skagit Regional Providence	Chris Phillips Connie Davis, MD Janette Schurman
Health Plan/ MCO	3	Molina Amerigroup CHPW	Laurel Lee Caitlin Safford Siobhan Brown
FQHC	2	Sea Mar TBD	Federico Cruz-Uribe, MD TBD
Public Health Department	2	Skagit Public Health Snohomish	Jennifer Johnson Peter Mayer
Long Term Care	2	NWRC Snohomish County Human Services & Long Term Care	Ryan Blackwell Laura White
Community Health Coalitions	5	San Juan (CHIC) Snohomish (TBD) Skagit (Pop Trust) Whatcom (WAHA) Island (TBD)	
Social determinant providers and advocates	2	Opportunity Council Verdant	Greg Winter Robin Fenn
Consumers	2		Stephen Gockley David Kincheloe
Specialty providers	2	Planned Parenthood WDSF	Linda McCarthy Glenn Puckett
Tribal	TBD	TBD	TBD
Other (Category only if needed, e.g. current Governing body members without assignment)	TBD	TBD	TBD

Program Council Members for Consideration:		
Name	Organization	Email
Jeff Ketchel	Snohomish Public Health Department (to replace Peter)	
Anji Jorstad	Snohomish County	
David Jefferson	Skagit Population Trust Advisory Board	
Bill Henkel	Community Action of Skagit County	
Janet St. Clair	Island County Community Health Advisory Board	
Carol Gipson	WAHA	
Barbara LaBrash	San Juan County	

ATTACHMENT D: DSRIP FUNDING AND MECHANICS PROTOCOL

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

I. Preface

a. Medicaid Transformation: Delivery System Reform Incentive Program

On January 9, 2017, the Centers for Medicare and Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration entitled *Medicaid Transformation Project*. Under this demonstration, the state will make performance-based funding available to regionally-based Accountable Communities of Health (ACH) and their partnering providers with the goal of transforming the delivery system for Medicaid beneficiaries. This transformation will be supported by payment reform efforts to move Medicaid payment from primarily volume-based to primarily value-based payment over the course of the demonstration period.

The Special Terms and Conditions (STC) 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 Delivery System Reform Incentive Program (DSRIP) requirements specified in the STCs are supplemented by two attachments to the STCs. The DSRIP Funding and Mechanics Protocol (this document, Attachment D) describes the process for applying incentive payment methodologies, reporting requirements, and consequences if an ACH fails to demonstrate progress and meet performance targets for project metrics.

In accordance with STC 35, 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. Accountable Communities of Health

a. Introduction

This demonstration aims to transform the health care delivery system through regional, collaborative efforts led by ACHs. ACHs are self-governing organizations with multiple community representatives that are focused on improving health and transforming care delivery for the populations that live within the region. Providers within ACH regions will partner to implement evidence-based programs and promising practices, as defined in the DSRIP Planning Protocol (Attachment C), that address the needs of Medicaid beneficiaries. ACHs, through their governing bodies, are responsible for managing and coordinating the projects undertaken with partnering providers.

This protocol provides detail and criteria that ACHs and their partnering providers must meet in order to receive DSRIP funding and the process that the state will follow to ensure that ACHs will meet these standards.

b. ACH Service Regions

There are nine ACHs that cover the entire state, with the boundaries of each aligned with the state's Medicaid Regional Service Areas (RSA). The RSA designation was directed by the state's Legislature in 2014 through legislation that further required the state to regionalize its Medicaid purchasing approach. The RSA geographic boundaries were designated by assessing the degree to which they:

- Support naturally occurring health care delivery system and community service referral patterns across contiguous counties;
- Reflect active collaboration with community planning that prioritizes the health and well-being of residents;
- Include a critical mass of beneficiaries (at least 60,000 covered Medicaid lives) to ensure active and sustainable participation by health insurance companies that serve whole region; and
- Ensure access to adequate provider networks, consider typical utilization and travel patterns, and consider the availability of specialty services and the continuity of care.

ACH	Counties
Better Health Together	Adams, Ferry, Lincoln, Pend Oreille, Spokane Stevens
Greater Columbia ACH	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima
Southwest Washington ACH	Clark, Klickitat, Skamania
Cascade Pacific Action Alliance	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum
Olympic Community of Health	Clallam, Kitsap, Jefferson
King County ACH	King
Pierce County ACH	Pierce
North Sound ACH	Island, San Juan, Skagit, Snohomish Whatcom
North Central ACH	Chelan, Douglas, Grant, Okanogan

c. ACH Composition and Partnering Provider Guidelines

Each ACH consists of partnering providers. The commitment to serving Medicaid beneficiaries, as well as the diversity and expertise of those providers and social service organizations, will be important criteria in evaluating Project Plan applications. Expectations around ACH decision-making composition is specified in STC 23.

The ACH will serve as the lead for the projects with partnering providers who are participating in Medicaid transformation projects. The ACH will submit a single Project Plan application on behalf of the partnering providers, and serve as the single point of performance accountability to the state. The ACH's responsibilities include supporting participating providers in planning and implementing projects in accordance with requirements of the demonstration; developing budget plans for the distribution of DSRIP funds to partnering providers in accordance with the funding methodology provided in this protocol; collaborating with providers in ACH leadership and oversight; and leading and complying with all state and CMS reporting requirements.

d. ACH Governance and Management

Each ACH must describe its primary decision-making process, process for conflict resolution, and its structure (e.g., a Board or Steering Committee) that is subject to the outlined composition and participation guidelines. Each ACHs will leverage its primary decision-making body for final decisions regarding the selection of transformation projects. Each ACH and the state will collaborate and agree on each ACH's approach to its decision-making structure for purposes of this demonstration.

The overall organizational structure of the ACH must reflect the capability to make decisions and oversee regional efforts in alignment with the following five domains, at a minimum:

- Financial
- Clinical
- Community
- Data and Performance Monitoring
- Program management and strategy development

As part of Project Plan development, the ACH will use its governance structure to facilitate and oversee decision-making.

III. Projects, Metrics and Metric Targets

a. Overview of Projects

ACHs will select and implement at least four Transformation projects from the Project Toolkit (described in the DSRIP Planning Protocol [Attachment C]). ACHs must provide project details in the Project Plan application and describe how selected projects are directly responsive to the needs and characteristics of the Medicaid populations served in the region.

Projects described in the DSRIP Planning Protocol (Attachment C) are grouped into three domains: Health Systems and Community Capacity, Care Delivery Redesign, and Prevention and Health Promotion. The ACHs will be responsive for demonstrating progress against process milestones and outcome metrics for each project.

b. Project Metrics

As part of their Project Plans, ACHs will develop timelines for implementation of projects, in alignment with state-specified process milestones included in Attachment C. Metrics that track progress in project planning, implementation, and efforts to scale and sustain project activities will be used to assess ACH performance.

ACHs will report on these metrics in their semi-annual reports (described in Section V). For each reporting period, ACHs will be eligible to receive incentive payments for progress milestones and improvement toward performance metric targets. For designated performance metrics, ACHs will be awarded Achievement Values (AV), based on the mechanism described in Section IV of this protocol.

c. Performance Metric Goals and Improvement Target

ACHs will have a performance goal for each performance metric. For each semi-annual reporting period, the state will measure ACH improvement from a baseline toward this goal to evaluate whether or not the ACH has achieved the metric improvement target. Each ACH will have its own baseline starting point, based on historical data that will be generated when complete data is available for the baseline time period. For certain measures, which may include newly created measures, baseline data will be collected during DY1, at which point the performance goal and annual ACH improvement targets will be established for Demonstration Years (DY) 3, 4 and 5.

Performance targets will be developed by the state during DY1, based on indicators of high quality of care and performance for state or national data, or an alternative method approved by CMS. The state's goals for metrics may be based on Washington State Medicaid results (preferred source) or national data where possible and on DY1 results for metrics where state or national data are unavailable.

Annual improvement targets for ACH performance metrics will be established using the methodology of reducing the gap to the goal by up to 10 percent. Baseline data will be established as soon as complete data is available for the baseline period and will be used as the foundation to determine the gap to goal to set the improvement target. This will be specified in a Measures Specification and Reporting Manual developed during DY1.

An example to illustrate the gap to goal methodology: If the baseline data for a measure is 52 percent and the goal is 90 percent, the gap to the goal is 38. The target for the project's first year of performance would be a 3.8 percent increase in the result (target 55.8%). Each subsequent year would continue to be set with a target using the most recent year's data. For example, should an ACH meet or exceed the first year's target of 55.8 percent, the next annual target would be 10 percent of the new gap to the goal. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.

In cases where ACH performance meets or exceeds the defined performance target, incentives will be earned based on maintaining the defined performance target.

IV. Incentive Funding Formula and Project Design Funds

a. Demonstration Year 1 (DY1)

i. Project Design Funds

In accordance with STC 35(i) and STC 45, during DY1, the state will provide project design funds to ACHs for completing the designated certification process. The design funds will be a fixed component distributed equally across ACHs for completing the certification process and can be used to develop specific and comprehensive Project Plans. This funding allows ACHs to begin to develop the technology, tools, and human resources to support the necessary capacity ACHs need to pursue demonstration goals in accordance with community-based priorities.

Design funds payments will total up to 20 percent of allowable expenditures in DY1 with payments distributed mid-year of 2017. As described in the DSRIP Planning Protocol (Attachment C), ACHs will be required to complete the two-phase certification process for receipt of design funds. In order to be eligible for any incentive payment beyond design funds, an ACH will need to submit and receive state approval of a Project Plan.

ii. Project Funding

The state will award the remaining DY1 DSRIP funding (excluding state administrative expenses) to certified ACHs upon approval of the Project Plan application. The amounts of DSRIP funding available for each ACH will be scaled based on application scoring by the Independent Assessor.

b. Demonstration Years 2 through 5 Funding and Project Valuation

In accordance with STC 35(h), the state developed criteria and methodology for project valuation by which ACHs will continue to earn incentive payments in DY 2 through 5 by achieving defined reporting-based progress measures and performance-based outcome metrics. Project valuation will be calculated during DY1 once each certified ACH submits a Project Plan application detailing project selection and implementation strategies. Based on this content, the state will determine maximum incentive payments allotted to each ACH by project to be distributed to partnering providers. As described in STC 35, the annual maximum project valuation will be determined based on the attributed number of Medicaid beneficiaries residing in the ACHs regional service area(s) and on the Project Plan application scores.

The maximum amount of ACH incentive funding will be determined according to the methodology described in (c) below. Once each project is assigned a maximum valuation, the project's corresponding, individual progress measures and outcome metrics will be valued according to the methodology described in (d) below.

Maximum ACH and project valuations are subject to monitoring by the state and CMS. In the event that an ACH does not meet the expected targets for each project's reporting-based progress measures and performance-based outcome metrics, the ACH's project valuation may be commensurately reduced from the maximum available project valuation. In addition, ACHs may receive less than their maximum available project valuation if DSRIP funding is reduced based on performance of the statewide measure bundle described in Section VII.

c. Calculating Maximum ACH Project Valuation

<u>Step 1: Assigning Project Weighting</u>

The State has weighed the projects in the Transformation Project Toolkit (Attachment C) relative to one another as a percentage of the total DSRIP project funding available, known as the project weight. ACHs must select at least four projects, including Project

2A (Bi-Directional Integration of Care and Primary Care Transformation), Project 3A (Addressing the Opioid Use Public Health Crisis) and least two additional projects, one from Domain 2 and one from Domain 3.

Each project has associated project metrics that ACHs must achieve to earn funding associated with that project. An ACH's payment for project implementation will be based on pay-for-reporting (P4R) in DY1 and DY2 and based on both P4R and pay-for-performance (P4P) between DY3 and DY5. The maximum amount of incentive funding that an ACH can earn is determined based on the ACH's project selection, the value of the projects selected, the quality and score of Project Plan applications, and the size of the ACH's Medicaid beneficiary population. Project weights outlined in Table 1 were assigned with consideration of the following factors:

- Alignment with statewide measures to better incentivize the achievement of statewide objectives.
- Strength of measures (P4R/P4P)
- Number of Medicaid beneficiaries within scope and capacity of projects to address population need and improve population health.
- Potential cost-savings to ensure that the State's Medicaid per-capita cost is below national trends.
- Strong evidence-based strategies to ensure a reduction in avoidable use of intensive services.
- Focus on quality, rather than quantity, to accelerate transition to value-based payment.

Table 1. Transformation Project Weighting

Project Weighting	
Project	Weight
2A: Bi-Directional Integration of Care and Primary Care Transformation	32%
2B: Community-Based Care Coordination	22%
2C: Transitional Care	13%
2D: Diversions Interventions	13%
3A: Addressing the Opioid Use Public Health Crisis	4%
3B: Maternal and Child Health	5%
3C: Access to Oral Health Services	3%
3D: Chronic Disease Prevention and Control	8%

Projects listed in order of Project Weighting

Project 2A (Bi-Directional Integration of Care and Primary Care Transformation) provides the broadest support for achievement of statewide objectives and measures as it requires the highest level of integration of the other projects and moves toward P4P with the largest set of P4P metrics. Furthermore, the project has the potential to touch the vast majority of Medicaid members through the evidence-based approach and is likely to result in significant

cost-savings. Regions that have implemented fully integrated managed care will be better positioned to scale project 2A and will be eligible for an enhanced DY1 valuation.

Project 2B (Community-Based Care Coordination) has the potential of serving a large proportion of the Medicaid population through an evidence-based approach and potential to see a reduction in health care costs. To earn payments for this project, an ACH must transition early in the demonstration to P4P.

The project weights of Project 2C (Transitional Care) and Project 2D (Diversion Interventions) are each 13 percent. Both projects allow ACHs to select one or more evidence-based approaches to result in cost-savings for a smaller population of Medicaid beneficiaries compared to Projects 2A and 2B. In addition, these two projects have a smaller number of measures moving to P4P throughout the demonstration period compared to other Domain 2 projects.

Project 3D (Chronic Disease Prevention and Control) has the largest project weight of the Domain 3 projects, at 8 percent. Project 3D has the potential to touch a large population of Medicaid beneficiaries by including multiple chronic diseases within the project. By affecting a large population through an evidence-based model, Project 3D has the potential to result in significant cost savings.

Project 3B (Maternal and Child Health) impacts a large subpopulation of Medicaid beneficiaries. This project offers several optional evidence-based approaches to drive success and a suitable number of metrics to measure performance.

Project 3A (Addressing the Opioid Use Public Health Crisis) will affect a defined population of Medicaid beneficiaries, anticipated to be proportionally smaller than most other Domain 3 projects, by aligning with Governor Inslee's Executive Order 16-09.

Project 3C (Access to Oral Health Services) is primarily targeted at the adult population, who will benefit from the evidence-based approach selected by the ACH, and there is a defined number of P4R metrics that will be used to measure an ACH's performance.

Step 2: Calculating Maximum ACH Project Funding

In accordance with STC 28 and STC 35(b), the state has developed an allocation methodology for maximum ACH project funding based on project selection, transformation impact of projects, and attribution based on residence. The state will use the defined RSA boundaries to determine attribution for the funding methodology. Maximum funding by project is calculated by multiplying the total state ACH project funds available by the respective project weight (see Table 1 for project weighting).

Maximum Statewide Funding by Project = [Total Statewide ACH Project Funds available] x [Project Weight]

In order to determine the maximum ACH funding by project, the maximum statewide funding by project is multiplied by total Medicaid beneficiaries residing in the RSA.

Maximum ACH Funding by Project = [Maximum Statewide Funding by Project] x [% of Total Attributed Medicaid Beneficiaries]

This formula will be repeated for all selected projects, and the sum of selected project valuations equals the maximum amount of financial incentive payments each ACH can earn for successful project implementation over the course of the demonstration. Each ACH is required to select at least four projects, including Project 2A and Project 3A. If ACHs choose fewer than the total eight projects, project weights will be rebased proportionately for DY2 through DY5. This maximum ACH valuation will be earned upon achieving defined reporting-based progress measures and performance-based outcome metrics and may be reduced based on application of the statewide penalty described in Section VII.

For DY1, the maximum ACH Funding by Project will be adjusted based on Project Plan scores. Each ACH Project Plan will receive a score based on the quality of the application. This project plan application score will be used as a variable in calculating the maximum ACH valuation for DY1. Each project plan score will be expressed out of 100. The scoring criteria will be developed in conjunction with the Project Plan template (see DSRIP Planning Protocol).

d. Earning Incentive Payments

In DY2 through DY5, ACHs will earn incentive payments for successful implementation of selected projects. Successful implementation is defined for each project as meeting the associated reporting-based progress measures and performance-based outcome metrics.

Within each payment period, ACHs will be evaluated against these designated metrics and awarded Achievement Values (AV), which are point values assigned to each metric that is payment-driving. This maximum value of an AV is one in the instance when an ACH meets the designated metric.

ACHs may earn partial AVs in proportion to the progress made in achieving the performance metric targets during the performance period. A minimum threshold of 25 percent of the gap-to-goal closure must be reached in order to earn a portion of the AV.

Based on the progress reported, each metric will be categorized as follows to determine the applicable achievement value for the metric:

- Full achievement of performance goal (achievement value = 1)
- Less than full achievement of performance goal and at least 75 percent achievement of performance goal (achievement value = .75)
- Less than 75 percent achievement of performance goal and at least 50 percent achievement of performance goal (achievement value = .50)
- Less than 50 percent achievement of performance goal and at least 25 percent achievement of performance goal (achievement value = .25)
- Less than 25 percent achievement of performance goal (achievement value = 0)

To determine Total Achievement Value (TAV) for each project in a given payment period, the AVs earned within the project will be summed according to their relative weighting as illustrated in Table 2. From there, the Percentage Achievement Value (PAV) is calculated by dividing the TAV by the weighted total of possible AVs for the project in that payment

period. The purpose of the PAV is to represent the proportion of metrics an ACH has achieved for each project in each payment period and will be used to determine the distribution of dollars earned out of the maximum ACH project funding as follows:

Table 2. Example Calculation of Achievement Values

Measure/Metric	Achievement Value	Weighting
Progress Measure 1	1	25%
Outcome Metric 1	0	25%
Outcome Metric 2	1	25%
Outcome Metric 3	0.5	25%
TAV	**2.5**	
PAV	**62.5%**	

Note: for a subset of outcome metrics that are associated with multiple projects selected by an ACH, in a given payment period, the metric will earn an AV within the project where the metric is associated with the highest possible funds and for all other selected projects, the funds associated with that metric will be redistributed across the remaining measures and metrics so as to not duplicate payment for an outcome. The applicable subset of outcome metrics will be defined within the Measures and Metrics Specification Guide.

To support the expected outcomes from successful project implementation, ACHs will be solely responsible for reporting-based (P4R) progress measures in DY1 and DY2. The state will then transition a robust set of outcome metrics to be performance-based (P4P), meaning a portion of project funds will be dependent on ACH demonstrating improvement toward performance targets in the out years. Table 3 illustrates the timing and distribution of transition to P4P:

Table 3. Transition to Pay-for-Performance, Percentage of Annual DSRIP Incentive Payment Allocation

Metric Type	DY1	DY2	DY3	DY4	DY5
P4R	100%	100%	75%	50%	25%
P4P	0%	0%	25%	50%	75%

e. Managed Care Integration

A primary goal of the demonstration is to support implementation of a fully integrated managed care system. Although there are regional service areas that have made progress toward integration, a large portion of the state needs to make significant investments to achieve this transition by January 2020. The Transformation Project Toolkit (Attachment C) calls for the submission of binding letters of intent to implement full integration by 2020 as an Implementation Stage 1 progress measure under Project 2A (Bi-Directional Integration of Care and Primary Care Transformation).

Regions that implement fully integrated managed care prior to 2020 will be eligible to earn incentive payments above the maximum valuation for project 2A. The incentive payment is calculated using a base rate of up to $2 million and a per member rate based on total attributed Medicaid beneficiaries, with payments distributed to the ACH in the calendar year of completion.

> **Integration Incentive** = [$2 million] + [$36 x Total Attributed Medicaid Beneficiaries] x [Phase Weight]

The incentives for fully integrated managed care will be distributed in two phases associated with reporting on progress measures: binding letter(s) of intent, and implementation. These phases represent two key activities towards integration. ACHs and partnering providers are eligible for an incentive payment for completion of each phase.

Table 4. Weighting of Integration Progress Measures by Phase

Phase Weights	
Phase 1: Binding Letter(s) of Intent	40%
Phase 2: Implementation	60%

f. Value-based Payment Incentives

In accordance with STC 42 and the state's Value-based Roadmap (Attachment F), the state will set aside no more than 15 percent of annually available DSRIP funds to reward MCO and ACH partnering providers for provider level attainment and improvement toward VBP targets.

V. ACH Reporting Requirements

These activities are detailed below.

a. Semi-Annual Reporting for ACH Project Achievement

Two times per year, ACHs seeking payment under the demonstration shall submit reports that include the information and data necessary to evaluate ACH projects using a standardized reporting form developed by the state. ACHs will use the document to report on their progress against the milestones and metrics described in their approved Project Plans. Based on these reports, as well as data generated by the state on performance metrics, the state will calculate aggregate incentive payments in accordance with this protocol. The ACH reports will be reviewed by state and the Independent Assessor. Upon request, ACHs will provide back-up documentation in support of their progress. These reports will be due as indicated below after the end of each reporting period:

- For the reporting period encompassing January 1 through June 30 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before July 31.
- For the reporting period encompassing July 1 through December 31 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before January 31.

The state shall have 30 calendar days after these reporting deadlines to review and approve or request additional information regarding the data reported for each milestones/metric and measure. If additional information is requested, the ACH shall respond to the request within 15 calendar days and the state shall have an additional 15 calendar days to review, approve, or deny the request for payment, based on the additional information provided. The state shall schedule the payment transaction for each ACH within 30 calendar days following state approval of the semi-annual report. Approved payments will be transferred to the Financial Executor until the ACH provides direction for payment distribution to partnering providers.

VI. State Oversight Activities

The state will provide various types of oversight to ensure accountability for the demonstration funds being invested in Washington State, as well as to promote learning with the state and across the country from the work being done under the demonstration. Throughout the demonstration, the state and/or its designee will oversee the activities of ACHs and submit regular reports to CMS pursuant to STC 37.

Each ACHs must enter into a contract with the Washington State Health Care Authority (HCA) to be eligible to receive project design funds as well as other incentive funding under the demonstration. This contract will set forth the requirements and obligations of the ACHs as the leads for DSRIP and other partnering providers. The contract will address reporting requirements, data sharing agreements, performance standards, compliance with the STCs of the demonstration, and the ACH's agreement to participate in state oversight and audit activity to ensure program integrity of the demonstration. In the contract, HCA will require ACHs to participate in semi-annual reporting outlined in this protocol as a condition for qualifying for demonstration funds.

The state will support ACHs by providing guidance and support on the state's expectations and requirements. Additionally, state activities designed to ensure program integrity are detailed below:

a. Quarterly Operational Reports

The state will submit progress reports on a quarterly basis to CMS. The reports will present the state's analysis of the status of implementation; identify challenges and effective strategies for overcoming them; review any available data on progress toward meeting metrics; and describe upcoming activities. The reports will provide sufficient information for CMS to understand progress of the demonstration.

b. Learning Collaboratives

Annual learning collaboratives will be sponsored by the state to support an environment of learning and sharing among ACHs. Specifically, the collaboratives will promote the exchange of strategies for effectively implementing projects and addressing operational and administrative challenges. ACHs will be required to participate and contribute to learning collaboratives.

c. Program Evaluation

In accordance with STCs 35 and 107, the state will develop an evaluation plan for the DSRIP component of the draft evaluation design. The state will contract with an independent evaluator to evaluate the demonstration. The evaluator will be selected after a formal bidding process that will include consideration of the applicant's qualifications, experience, neutrality, and proposed budget. The draft evaluation report will be submitted to CMS by January 31, 2022.

VII. Statewide Performance and Unearned DSRIP Funding

a. Accountability for State Performance

The state will be accountable for demonstrating progress toward meeting the demonstration's objectives. Funding for ACHs and partnering providers may be reduced in DY3, DY4, and DY5 if the state fails to demonstrate quality and improvement on the 11 statewide measures listed below. STC 44 specifies the amount of annual DSRIP funding at risk based on statewide performance on these measures. The funding reductions will be applied proportionally to all ACHs based on their maximum Project Funding amount.

A statewide performance goal will be established for the statewide metrics. The state will be accountable for achieving these goals by the end of the demonstration period, DY5. During DY3 and DY4, annual assessment of quality and improvement from a defined baseline toward these goals will be used to evaluate whether or not the statewide metric improvement target has been achieved.

Statewide Accountability Metrics

1. Mental Health Treatment Penetration
2. Substance Use Disorder Treatment Penetration
3. Psychiatric Hospital Readmission Rate
4. Outpatient Emergency Department Visits per 1000 Member Months
5. Plan All-Cause Readmission Rate (30 days)
6. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
7. Antidepressant Medication Management
8. Medication Management for People with Asthma (5 – 64 Years)
9. Controlling High Blood Pressure
10. Comprehensive Diabetes Care - Blood Pressure Control
11. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control

The state will establish a baseline performance for each measure. The state will adapt the Quality Improvement Score (QIS) methodology, originally developed by HCA for measuring MCO performance, to determine statewide performance across the 11 statewide accountability measures for the demonstration. Each measure will be assessed for both achievement of quality and improvement on an annual basis beginning DY3. The weighted sum of all the individual measure quality improvement scores will yield the

overall QIS. The overall QIS will then be used to indicate whether a reduction of funding is warranted, and to calculate the percentage of funding at risk that should be reduced for that demonstration year. Annual improvement will reflect closing of the relative gap between prior performance year and the goal by up to 10 percent each year, as described in Attachment C, Section III(c). Quality will be assessed based on existing national benchmark standards where possible. For newer, innovative measures that do not have established national estimates, quality will be determined based on historical state data and the input of subject matter experts.

If the state fails to achieve its annual quality improvement score on a given statewide accountability metric, funding will be reduced by the amount tied to the quality improvement score.

b. Reinvestment of Unearned DSRIP Funding

DSRIP funding that is unearned because the ACH failed to achieve certain performance metrics for a given reporting period may be directed toward DSRIP High Performance incentives. Unearned project funds directed to high performers will be used to support the scope of the statewide DSRIP program or to reward ACHs whose performance substantively and consistently exceeds their targets. The state does not plan to withhold any amounts to subsidize this reinvestment pool.

VIII. Demonstration Mid-point Assessment

In accordance with STC 21, a mid-point assessment will be conducted by the Independent Assessor in DY3. Based on qualitative and quantitative information, and stakeholder and community input, the mid-point assessment will be used to systematically identify recommendations for improving individual ACHs and implementation of their Project Plans. If the state decides to discontinue specific projects that do not merit continued funding, the project funds may be made available for expanding successful project plans in DY 4 and DY5.

ACHs will be required to participate in the mid-point assessment and adopt recommendations that emerge from the review. The state may withhold future DSRIP incentive funds if the ACH fails to adopt recommended changes, even if all other requirements for DSRIP payment are met.

North Sound ACH
Building Healthier Communities
In Snohomish, Skagit, Island, San Juan & Whatcom Counties

MEMO

To: Program Council
From: Liz Baxter
RE: Pathways Model (extracted from an email response)
Date: 4/18/2017

Thanks for sharing the outline and the notes. I want to weigh in on the Pathways discussion, after reflecting on the notes that were attached and well as our discussion on Thursday.

I am recommending that we move forward with Pathways, and am asking for your support in moving this forward. The questions that are raised indeed need to be answered, but I see them as part of a "go" rather than a prerequisite for a go/no-go decision. Some of the questions have answers (how much are the front end costs, how is it staffed, for example) while others are part of laying out the implementation strategies. And for the most part, those questions hold true for each of the other project areas. And committing to Pathways has critical staffing implications, so the work does not fall solely on a volunteer work group to sift through.

My vision sees Pathways as a core coordinating strategy and brings tested tools, building infrastructure to support the work of several if not all of the projects we undertake. Timing of this decision is critical so that North Sound can be part of a multi-ACH working group which has launched and continues to move forward. There are 4 ACHs committed and I want us to be the fifth.

Everything under discussion in all the projects will require that elements of our current infrastructure change and adapt. That is the crux of the Pathways commitment, but it holds true for the BH integration, Opioids, and whatever else we take on. How we approach those changes is the next layer of work. That is what the funds coming to us later in 2017 is meant to support, setting us up for success.

I appreciate the notes and hope that we continue to use your valuable time in the most effective way because there is a lot of work ahead in a short period of time.

Thanks for all you're doing -
Liz

==========

Liz Baxter, MPH
Pronouns: She/Her/Hers

Executive Director
North Sound Accountable Community of Health
PO Box 4256
Bellingham WA 98227

liz@northsoundach.org
360.386.5745 (m)
360-933-3653 (f)

Attachment E) Slides

Topic Areas		Lead Organizations	Conveners
Required	**Behavioral Health Integration**	North Sound Behavioral Health organization Compass	Greg Arnold Tom Sebastian
	Opioids	Skagit Public Health NS-BHO	Kristen Ekstran Linda Crother
Optional	**Care Coordination Diversion Care Transitions**	Sea Mar	Federico Cruz-Uribe, MD
	Avoiding Unintended Pregnancies & Maternal Child Health	Planned Parenthood Whatcom County Public Health	Linda McCarthy Astrid Newell, MD
	Chronic Disease	Skagit Regional Health	Connie Davis, MD Liz McNett-Crowl
Data & Analytic Support		Skagit & Whatcom Public Health Depts.	Jennifer Johnson Regina Delahunt

Developing North Sound ACH Project Proposals

Step 1 → **Step 2** → **Step 3**

STATEMENT OF INTEREST:

- Topics of interest; problems to be addressed
- Types of possible projects
- Other information

PARTICIPANT TABLE:

- Sponsoring organization/ convener
- Listing of participants

STATEMENT OF INTENT:

- Menu of project options and corresponding metrics
- Approach for narrowing options / defining scope
- Process for developing project proposal and considerations for public input

PROJECT PROPOSAL:

- High level project summary
- Current NS community efforts/ coalitions related to topic
- How other ACHs are approaching the issue
- Project options under consideration
- Promising practices
- Metrics
- Possible barriers to consensus/ success in choosing a project
- PC recommendation for moving forward

Statement of Interest

Work Group: Bi-Directional Integration of Physical & Behavioral Health
Lead Organizations: North Sound BHO & Compass
Leads: Greg Arnold and Tom Sebastian

Topics of Interest: (What is the need / impact)

Types of Projects: (include scope, specificity, geographic area: region wide or localized, is there a pilot project already active)

Measures to be used:

Bi-Directional Integration of Physical & Behavioral Health Members:	
Name	Organization
Greg Arnold (Lead)	North Sound Behavioral Health Org.
Tom Sebastian (Lead)	Compass Health
David Kincheloe	Consumer
Janette Schurman	Providence
Laurel Lee	Molina
Laura Johnson	United Health Care
Siobhan Brown	Community Health Plan of Washington
Kat Ferguson – Mehan Latet	Community Health Plan of Washington
Kayla Down	Coordinated Care
David Jefferson	Skagit Public Health
Patty Codd	Island Hospital
T. Jay Thompson	Island Hospital
Jean Maki	Healthcare Compliance Consultant
Patricia Morris	Volunteers of America
Mike Watson	Lake Whatcom Center
Elizabeth Anderson	Mental Health Counselor, NWRC
Jennifer Alderman	Snohomish County
Dean Wight	Consumer
Robert Sullivan	Pioneer Human Services
Des Skubi	Unity Care NW
Lisa Carter	Ferndale Family Medical
	Tribal Representation
Dr. Francie Chalmers	Skagit Pediatrics
Claudia D'Allegri	SeaMar
TBD	PeaceHealth
TBD	WAHA?

Statement of Interest

Work Addressing the Opioid Use Public Health Crisis
Sponsors: Skagit Public Health & North Sound BHO
Leads: Kristen Ekstran & Linda Crothers

Topics of Interest: (What is the need / impact)

Types of Projects: (include scope, specificity, geographic area: region wide or localized, is there a pilot project already active)

Measures to be used:

Addressing the Opioid Use Public Health Crisis Members:	
Name	Organization
Shelli Young	NSBHO
Sharon Toquinto	NSBHO
Linda Crothers (Co-Chair)	NSBHO
Kristen Ekstran (Co-Chair)	Skagit County
Skye Newhirk	Island County Human Services
Des Skubi	Unity Care NW
MCO Reps	
Tribal Reps	
Lorali Gray	NW Educational Service District (please note: she doesn't have bandwidth for two groups and this is her second choice. She may opt out of this group)

Statement of Interest

Work Group: Care Coordination/Diversion from ED and Criminal Justice/Care Transitions
Sponsors: SeaMar
Lead: Federico Cruz-Uribe

Topics of Interest: (What is the need / impact)

Types of Projects: (include scope, specificity, geographic area: region wide or localized, is there a pilot project already active)

Measures to be used:

Care Coordination/Diversion from ED and Criminal Justice/Care Transitions Members:	
Name	Organization
Chris Phillips	Peace Health
Greg Winter	Opportunity Council
Federico Cruz-Uribe (Lead)	SeaMar
Robin Fenn	Verdant
Kayla Down Caitlin Safford Allan Fisher Siobhan Brown Laurel Lee	MCO reps
Joe Nagel	Pioneer Human Services
Elizabeth Anderson	NWRC
Jennifer Alderman	Snohomish County
Ryan Blackwell	NWRC
Kevin Collins Marilyn Scott Jim Steinruck Nickolaus Lewis John Stephens Dana Matthews	Tribal Reps
George Kosovich	Verdant
Steve McGraw	Homage Senior Services
Ryan Blackwell	NWRC
Valeria Jones	BHO
Natasha Raming	Consumer

Statement of Interest

Work Group: Access to Oral Health Services
Sponsors: unknown
Lead: Glenn Puckett

Topics of Interest: (What is the need / impact)

Types of Projects: (include scope, specificity, geographic area: region wide or localized, is there a pilot project already active)

Measures to be used:

Access to Oral Health Members:	
Name	Organization
Glenn Puckett (Lead)	WA Dental Service Foundation
Des Skubi	Unity Care NW
Christina Ortiz	WAHA
Kayla Down Caitlin Safford Allan Fisher Siobhan Brown Laurel Lee	MCO Reps
Kevin Collins Marilyn Scott Jim Steinruck Nickolaus Lewis John Stephens Dana Matthews	Tribal Reps

Statement of Interest

Work Group: Chronic Disease Prevention & Control
Sponsors: Skagit Regional Health
Lead: Dr. Connie Davis & Liz McNett-Crowl

Topics of Interest: (What is the need / impact)

Types of Projects: (include scope, specificity, geographic area: region wide or localized, is there a pilot project already active)

Measures to be used:

Chronic Disease Prevention & Control Members:	
Name	Organization
Greg Winter	Opportunity Council
Des Skubi	Unity Care NW
Astrid Newell	Whatcom County Health Department
Dr. Connie Davis (Lead)	Skagit Regional Health
Judy Ziels	Whatcom County Health Department
Dr. Gerald Yorioka	Snohomish County Medical Society
Dr. Karl Kleeman	League of Woman Voters (retired)
Carol Hawk	United General District 304 (Community Health Outreach Programs)
Liz McNett Crowl (Lead)	Skagit Valley Hospital
Lorali Gray	NW Educational Service District
FQHCs	Federico to poll to populate
Kayla Down Caitlin Safford Allan Fisher Siobhan Brown Laurel Lee	MCO Reps
Kevin Collins Marilyn Scott Jim Steinruck Nickolaus Lewis John Stephens Dana Matthews	Tribal Reps

Statement of Interest

Work Group: Data & Analytic Support
Sponsors: Skagit & Whatcom Public Health Departments
Lead: Jennifer Johnson & Regina Delahunt

Data & Analytic Support Group Members	
Name	Organization
Jennifer Johnson	Skagit
David Jefferson	Skagit
Aaron Ignac	Whatcom
Carrie McLachlan	Snohomish
Linda Gipson	Island
Regina Delahunt	Whatcom

Topics of Interest: (What is the need / impact)

Types of Projects: (include scope, specificity, geographic area: region wide or localized, is there a pilot project already active)

Measures to be used:

METRICS FOR EACH TOOLKIT PROJECT AREA

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.) In reviewing the protocol and the appendix, please note that there are two incentive payment approaches: P4R = Pay for Reporting; and P4P = Pay for Performance

Project 2A: Bi-directional integration of Physical Health and Behavioral Health through Care Transformation

System-wide 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

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, explicit support for Project 2A.

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 and 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

System-wide 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-Based 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.

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 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 and 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

System-wide 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.

Stage 1: Planning Progress Measures

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

Stage 2: Implementation 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 and 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

System-wide 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.

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 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 and Sustain Progress Measures

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

Project 3A: Addressing the Opioid Use Public Health Crisis

System-wide 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 %)

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 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 and 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

System-wide 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

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.

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 and 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

System-wide 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

Stage 1: Planning Progress Measures

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

Stage 2: Implementation 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 and 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

System-wide 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

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 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 and 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.