2A: Bi-Directional Integration of Physical and Behavioral Health Through Care Transformation

Why the Project is Needed

Addressing behavioral and physical health needs is a complex challenge for the health systems, communities, and families in the North Sound. Regionally, 33% of Medicaid enrollees in the North Sound were identified as having mental health illness needs, 21% were diagnosed with a serious mental illness and 12% were identified as having substance use disorder treatment needs.[1] Only 41.5% of those patients with mental health treatment needs, 29% of those with substance use treatment needs and 11% of serious mental illness received needed treatment in 2015.[2,3] For patients with co-morbidities of behavioral health needs and chronic disease, there are disparities in access to and utilization of significant preventative care; for example, Medicaid enrollees with diabetes and substance use disorder were 65% more likely to have not received recommended A1c checks for blood glucose control.[4]

There are several reasons populations with co-occurring mental health illness, substance use disorder, or chronic disease fail to get adequate care in the existing health system. The delivery system's separation of behavioral and physical health services creates coordination and referral complexity with over half of referrals failing. Navigating this bifurcated system is daunting for trained health professionals and next to impossible for the lay public seeking help and struggling with physical and behavioral health conditions. This contributes to poorly coordinated and delivered care, increased burden of chronic disease, substance abuse disorder, and early death in vulnerable populations.

Separation of the two delivery systems creates difficulty organizing and coordinating care at multiple levels. Regulations are separated with different administrative frameworks and clinical expectations coded into state law. Licensing, oversight, contracting and payment of services are currently held separate. This creates situations where an otherwise fully licensed medical (physical health) organization is unable to contract to provide behavioral health or substance abuse services. Facilities and managed care entities do not routinely or easily share health information about people utilizing care and remain highly separated into siloes. Program investments in behavioral health care that decrease the overall cost of care for the SMI population are not as effective as they could be if funding mechanisms were integrated.

Despite the system siloes, there are several promising developments toward integrating care between behavioral and physical health services in the North Sound ACH region. PeaceHealth Pediatrics and PeaceIsland Medical Center have reported to the North Sound ACH that they have, physical health settings have integrated psychiatric providers into the care team through co-located and tele-psychiatry consultations. Lake Whatcom Center, a residential behavioral health facility in Whatcom county, has integrated an Advanced Registered Nurse Practitioner (ARNP) to provide physical health services to their patients. With the support for bi-directional integration through the Practice Transformation Support Hub, dozens of physical health care and behavioral health practices across the North Sound ACH region have engaged Hub support and begun the process of bi-directional integration. In October 2017, the Interlocal Leadership Group of county governments across the North Sound ACH region committed to moving the delivery of behavioral health services to Fully Integrated Managed Care by January 1, 2020.

Through a whole-person approach, bi-directional integration of care has the potential to impact all Medicaid enrollees in the North Sound ACH by targeting the expansion of health services to two key demographics--

[1] ACH Profiles Future, DSHS/RDA, released April 11, 2017.
[2] Measure Decomposition Data, RDA/DSHS, released July 7, 2017.
[3] ACH Profiles Future, DSHS/RDA, released April 11, 2017.
[4] Measure Decomposition Data, RDA/DSHS, released July 7, 2017.

enrollees with behavioral health needs currently using the primary care system, and people with serious mental illness (SMI) currently using the North Sound Behavioral Health Organization (BHO) system of behavioral health care. Key ACH partners in this project area are the Health Systems Advisory Coalition (HSAC) and the North Sound BHO. The HSAC has participated in the North Sound ACH's planning for integration efforts and will be involved in implementation, including its more than 205,000 self-reported, attributed Medicaid enrollees. The North Sound Behavioral Health Organization network serves 37,202 Medicaid enrollees and are critical partners in integrating care for the North Sound ACH region, providing workgroup leadership for this project area and support for implementation activities. Both directions of integration will use the main elements of the Collaborative Care model to transform clinical practice to team-based medicine that serves the whole-person in either practice setting.

Target Population

The target population for bi-directional integration strategies are all Medicaid enrollees (children and adults), particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD). Among the region's 286,760 enrollees, 83,176 identified with mental illness needs, 52,634 diagnosed with Serious Mental Illness (SMI) and 30,540 identified with substance use disorder treatment needs.

As required during the 2018 planning period, North Sound ACH staff will conduct further statistical analysis and facilitate planning processes necessary for final target population selection due in June 2018. The North Sound ACH will work with implementation planning teams, Community Leadership Council and the Data and Learning Team to use the best available research, regional data, and community input to identify a final high-need target population, with consideration for how strategic investments can impact performance metrics during the Medicaid Transformation Project period.

Targeted Universalism[5] will be used throughout the planning phase as an approach and analysis framework for selecting target populations to ensure that health equity features strongly in this process. Targeted Universalism will be applied when measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriately targeted strategies.

North Sound ACH staff will continue to collaborate with ACH's across the state and the Health Care Authority's AIM Team to identify shared data-driven processes and target population selection methodology. To maximize the reach and impact of the demonstration projects and increase the likelihood of region-wide success in moving the metrics, the North Sound ACH aims to align target populations across the project portfolio.

The North Sound ACH used a common format for each project area to summarize the anticipated reach of target population(s) and identify performance metrics and health disparities project strategies aim to impact, as follows below.

North Sound Project Area Reach & Impact
Project Area 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation

[5] Targeted Universalism is a different way—a powerful way—to make the transformational changes we need. Changes we need to improve life chances, promote inclusion, and enhance and sustain equitable policies and programs. Means setting universal goals that can be achieved through targeted approaches. Ultimately, this approach shows how a universal goal can be a good thing, but a one size fits all approach is not always the solution. John Powell, Haas Institute, 2017

Potential Target Population Reach:

- 83,176 identified with mental illness needs
  - 13,677 Disabled, 10,130 Non-Disabled Adults, 35,974 Newly Eligible Adults, 18,600 Non-Disabled Children, 4,795 Elders
- 52,634 diagnosed with Serious Mental Illness (SMI)
  - 10,893 Disabled, 5,970 Non-Disabled Adults, 20,297 Newly Eligible Adults, 12,374 Non-Disabled Children, 3,100 Elders
- 30,540 identified with substance use disorder treatment needs
  - 4,998 Disabled, 4,070 Non-Disabled Adults, 17,883 Newly Eligible Adults, 2,934 Non-Disabled Children, 655 Elders

Project Area Impact:

Performance Measures

- 21% received behavioral health services from the BHO in 2015
- 29% of those identified with substance use treatment needs received treatment in 2015
- 27,635 Medicaid enroll lees with a serious mental illness and received care in 2015
- 34% of Adult (18+) Medicaid enrollees with depression diagnosis remained on antidepressants for 6 months.
- 89% of children (Under 19) with Medicaid coverage had a visit with a PCP
- 43% of patients with behavioral health service needs received behavioral health treatment.

Geographic Disparities

- Of the 27,583 Medicaid enrollees with SUD treatment needs, 61% reside in Snohomish County
- 27% of Medicaid enrollees in Island (3,364) and Whatcom (13,302) Counties were diagnosed with mental illness, Snohomish has the largest count with 34,312 Medicaid enrollees with a mental illness
- 85% of children (under 19) with Medicaid in Island County have a visit with PCP (4% lower than ACH average)
- 80% of children (2-6 years old) with Medicaid in Island county had a visit with a PCP (6% lower than ACH average)
- 24% of Medicaid adults with diabetes in Island received an eye exam (7% lower than average)
- 76% of patients with diabetes in San Juan had blood sugar (HBA1c) check compared to 84% region-wide.

Demographic Disparities

- Among the 27,596 Medicaid enrollees diagnosed with depression:
  - 77% are White
  - 66% are women
  - 85% were adults (19+)
- American Indian/Alaskan Natives were 2x more likely to not receive follow-up care after hospitalization for mental illness

Co-morbid Disparities

- Patients with Substance Use Disorders, 65% more likely to not have received A1C checks

Data Sources: 1) RHNI Starter Kit, HCA, released May 8, 2017. 2) Measure Decomposition Data, RDA/DSHS, released July 7, 2017. 3) ACH Toolkit Historical Data, HCA, released August 17, 2017. 4) ACH Profiles Future, DSHS/RDA, released April 11, 2017. 5) BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017.
* Note: Regional Medicaid population counts differ slightly due to selected month and/or year of data and the reporting agency's definition of Medicaid population. Most behavioral health and substance abuse data products from HCA and/or DSHS-RDA include Medicaid only and Medicaid/Medicare dual-eligibles.

Current State

National research indicates, 56% of Medicaid enrollees with a mental illness reported fair or poor health status, compared to 26% of enrollees without mental illness.[6] Adults living with serious mental illness (SMI) have worse health outcomes, resulting in early mortality (an average of 25 years earlier than adults without SMI) attributed to common, chronic health conditions such as respiratory problems, cancer, and heart disease.[7] Most Medicaid enrollees earn less than $25,000 per year,[8] annual out of pocket spending among enrollees was nearly four times greater among those with mental illness ($310) than among enrollees without a mental illness ($80).[9]

Failing to address the physical health and social determinant needs of Medicaid enrollees with or at-risk for behavioral health conditions adequately is both inequitable and expensive to our health care systems. In the North Sound ACH region, data supports the need for integrating primary care and behavioral health care and promoting a "whole person" approach in order to meet the health needs of high risk community members with co-occurring behavioral health and chronic disease diagnoses, ultimately improving quality of life and life expectancy.

Mental illness, substance abuse and chronic conditions exacerbate one another. The magnitude of these conditions on Medicaid enrollees in the North Sound are tremendous and evident in the various data provided by the HCA:

- Mental and behavioral disorders (14.5%) are the leading cause of hospitalizations for Medicaid enrollees.[10]
- 83,176 (33%) of jointly served (HCA/DSHS) Medicaid individuals have mental health needs.
- 30,350 (12%) of jointly served (HCA/DSHS) Medicaid individuals have substance abuse disorder treatment needs.
- 21,000 (8%) of jointly served (HCA/DSHS) Medicaid individuals were diagnosed with co-occurring disorders.
- 40,626 of Medicaid enrollees were diagnosed with a Mental Illness and one or more chronic condition.
- 20,135 of Medicaid enrollees were diagnosed with a Substance Use Disorder and one or more chronic condition.
- Adult Medicaid enrollees who were arrested in the last year are nearly five times as likely to need substance abuse treatment compared to those not arrested.[11]
- Adults with Medicaid and behavioral health needs were two times as likely to utilize the emergency department three or more times per year, those with co-occurring disorders were over four times as likely to visit the emergency department.[12]
- Medicaid adults with substance use disorders or co-occurring MI/SUD are more than 3 times more likely to be experiencing homelessness.

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[6] The Role of Medicaid for People with Behavioral Health Conditions, The Kaiser Commission on Medicaid and Uninsured, November 2009.

[7] National Association of State Mental Health Program Directors Council. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: Parks, J., et al. Retrieved January 16, 2015

[8] Eligibility Overview Washington Apple Health (Medicaid) Programs, HCA, April 2017.

[9] The Role of Medicaid for People with Behavioral Health Conditions, The Kaiser Commission on Medicaid and Uninsured, November 2009.

[10] RHNI Starter Kit, HCA, released May 8, 2017

[11] Utilization for MH Service Needs, RDA-DSHS, July 2017

[12] ACH Profiles: ESA Profiles Program Participants, RDA/DSHS, released September 22, 2017

- Between 2012-2016, 607 individuals died from an opioid-related overdose in the North Sound, with Snohomish County accounted for 80% (488) of the opioid-related deaths during this timeframe—a rate 1.3 times higher than that for all of Washington.[13]
- Overall rate of suicide in the North Sound is 14.6 per 100,000 and varies considerably by county: Skagit (14.1), Snohomish (15.2) and Whatcom (15.8) county's rates are lower than the Washington State rates, while Island (19.9) and San Juan (18.5) are the highest in the North Sound ACH region.[14]

Several other North Sound ACH project areas will be implementing strategies designed to address the relationship between mental illness, substance use disorder, and chronic disease as well, including Diversion Interventions, Transitional Care, Addressing the Opioids Crisis, Chronic Disease, and Care Coordination.

Project Strategies

North Sound ACH intends to use the Collaborative Care model to normalize the integration of physical and behavioral health services. There are five core elements of the model: creating a patient-centered care team, measuring symptoms and treating to target, using population-based care tools, accountable care, and using evidence-based treatment. Both behavioral and physical health settings of outpatient care will use these elements to transform the systems of care delivery, and improve physical health and behavioral health outcomes. During the 2018 planning year, the North Sound ACH will adapt the model elements to the North Sound ACH region's diverse geographic and workforce resources and needs, implementing elements of the Collaborative Care model as appropriate to improve health outcomes and reduce health disparities across all community-based and geographic contexts.

There is strong evidence that integrating behavioral health services into physical health care improves patient outcomes while reducing cost of care for depression and anxiety disorders, as well as the control of diabetes and hypertension. Integration of behavioral health in primary care through the Collaborative Care model for people suffering from depression has reduced serious cardiovascular events compared to those receiving usual care years after treatment of depression, suggesting long-term benefits of the intervention. Integrated care in physical health care settings reaches a large population with behavioral health needs that do not currently have access to care and allows their condition to stabilize and improve before the use of crisis services or higher levels of care are needed.

In the Physical Health Care Setting

Leadership from large physical health care practices across the North Sound counties have agreed to implement the Collaborative Care model methods in their physical health care clinic settings, including:

- **Screening** for depression, and alcohol and opiate use as an expected component of physical health care. Screening may be expanded for additional conditions as experience and capabilities grow, and may include anxiety, PTSD, ADHD, and other substances of abuse.
- **Brief counseling interventions** for identified behavioral health conditions by behavioral health counselors embedded in the physical health care practice.
- **Medication Assisted Therapies for** depression and opiate abuse, which may expand as experience and capabilities grow. Primary Care practice leaders are committed to developing Suboxone treatment for opiate addiction identified within their physical health care systems to ensure access to Suboxone treatment.
- **Registry development** to track patients with identified behavioral health conditions.
- **Treat-to-target** those with identified behavioral health conditions.

[13] Opioid-related Deaths in Washington State 2006–2016, WADOH, May 2017

[14] RHNI Starter Kit, HCA, released May 8, 2017

- **Psychiatric Consultation** for physical health care providers, which in some practices may include direct patient consultation or tele-psychiatry depending on system capacity, geography, or other factors.
- **Referral** to specialty behavioral health services, including the need for improved referral mechanisms and information exchange with specialty behavioral health providers.

The physical health care practices involved maintain different levels of integration in this model, and the North Sound ACH will work with partners to identify and target strategies appropriate for smaller and rural practices. To help onboard and advance practices through the continuum of integration, individual practices will be evaluated based on several factors, and grouped into cohorts supported by the University of Washington Advancing Integrated Mental Health Solutions (UW AIMS) Center and Healthier Washington Practice Transformation Support HUB training to enhance learning and transformation.

In the Behavioral Health Setting

Behavioral health providers will pursue integrated care by adapting the Collaborative Care model elements into the behavioral health setting. Nationally, fewer models and metrics are available for integration of physical care into behavioral health settings. The North Sound ACH has identified two behavioral health providers leading the move to integration by providing access to physical care in the behavioral health practice setting. The North Sound ACH seeks to expand this work by engaging leadership from behavioral health practices across the North Sound ACH region to implement the following methods:

- **Screening** for chronic health conditions in clinic by a physical health provider.
- **Counseling interventions** connected to health behaviors and the maintenance or improvement in chronic health conditions using the existing workforce.
- **Physical health interventions** including prescribing and tracking changes in chronic physical health conditions.
- **Registry development** to track patients physical and behavioral health improvement and to identify people that aren't improving.
- **Treat-to-target** for both behavioral health and physical conditions as allowable by existing evidence based clinical tools.
- **Consultation** with physical health providers around complex health situations.
- **Referral** to specialty physical health providers for more complex physical health needs, specific conditions, or specialty screenings.

Behavioral health providers in the North Sound ACH region have training and experience in providing evidence-based interventions. Using regular symptom measurement tools, treating to target, population health tools, and managing chronic physical disease are new components for many behavioral health providers that will require training, implementation support and ongoing education.

Partnering with the UW AIMS Center, Healthier Washington Practice Transformation Support Hub and The National Council of Behavioral Health - Case to Care trainings, are all being considered to enhance existing efforts, expand the scope of integration, and reduce duplication of services. Further, the North Sound ACH is collaborating with North Sound ACH regional leaders in bi-directional integration projects such as the North Sound BHO, Compass Health, and PeaceHealth to ensure projects enhance and expand integration without duplicating existing efforts.

ACH Role & Supports for Partners

The North Sound ACH will support practice transformation by: convening the North Sound ACH Data & Learning team to address challenges and performance gaps and advise on solutions and course corrections; leading regional efforts to identify and implement health registries that are interoperable with existing

systems (e.g. EDIE and OneHealthPort); using population health management technologies to identify key segments of target populations that are not responding to interventions, and assisting practices in connecting with tools, trainings, technologies, experts, etc. that can assist in improving responsiveness; supporting behavioral health and physical health practices in adapting to billing and coding changes by leveraging expertise from the UW-AIMS center; and participating in state efforts to mitigate regulatory barriers to integration.

Metrics and Health Outcomes

Bi-directional integration is part of broader health infrastructure transformation, and has the possibility of moving many health metrics for the North Sound ACH region. Metrics connected to chronic health conditions and medication adherence are improved by the implementation of health registries in both physical and behavioral health clinics. These include: Antidepressant Medication Management, Child and Adolescent Access to Primary Care Practitioners, Comprehensive Diabetes Care: Eye Exam (retinal) performed, Comprehensive Diabetes Care: Hemoglobin A1c Testing, Comprehensive Diabetes Care: Medical Attention for Nephropathy, and Medication Management for People with Asthma (5-64 years). These metrics are also improved by increasing physical health service access for the SMI population in behavioral health clinics that are currently underserved for these chronic health conditions, reducing disparities and improving overall health outcomes.

Early interventions, increased access to behavioral health care through bi-directional integration, and the associated increase in information sharing that occurs through financial and HIT integration will reduce unnecessary utilization of crisis services, emergency departments, and inpatient hospital stays for the SMI population. As such, the project will seek to induce movement in the following metrics: Follow-up after Discharge from ED for Mental Health, Alcohol or other Drug Dependence, Follow-up after hospitalization for mental illness, Inpatient Hospital Utilization, Mental Health Treatment Penetration, and Outpatient Emergency Department Visits per 1000 Member Months.

Health Equity

The North Sound ACH will use health equity as a lens for all our project areas. In order to be truly transformational and meet the needs of our community, disparities by race/ethnicity, socioeconomic status, geographic area, and other categories must be brought to the forefront. In the bi-directional integration project area, strategies will be adapted when possible to each community to ensure that clinical and community interventions are both culturally appropriate and accessible (for example, hiring bilingual community health workers and clinic staff; hiring staff from within the communities they will serve; requiring training on cultural humility, undoing institutional racism, implicit bias, and more).

Lasting Impact

As the North Sound ACH region moves toward Fully Integrated Managed Care in 2020, the implementation of Bi-Directional integrated care will be a significant priority of the North Sound ACH and its partners. The implementation of population health management systems and Collaborative Care team structures will help partners sustain the integration of care beyond the Medicaid Transformation project. By putting whole person care – both physical and behavioral health services – in all health care delivery settings, this effort will produce a lasting impact in improve overall health for the population of the North Sound ACH region.

2A: Partnering Providers

The organizations and stakeholders listed in the Partnering Providers Tab of the Supplemental Workbook represent partners who have been substantively engaged in the project planning workgroups to date or that we expect will be engaged in the planning phase in 2018. Some, but not necessarily all of these partners will eventually be entered into the financial executor portal to receive payment.

In the bi-directional integration project area, the North Sound ACH has engaged stakeholders representing both community-based behavioral health service providers and physical health providers, each with an interest in coming together for the purpose of integration and forming workgroups. Workgroup leads included leadership staff from the BHO, and a regional community behavioral health provider: Compass Health.

In Spring 2017, the North Sound ACH began moving from broad stakeholder engagement into workgroups, comprised of potential partnering providers who serve or are interested in serving the Medicaid population. Eight workgroups were formed, with an open invitation extended to providers and stakeholders who wanted to engage. These included behavioral health and SUD providers, community-based organizations, county health and human services and public health leaders, physical health care providers, Tribal partners, health systems, and Managed Care Organizations. Two or more subject matter experts were invited to serve in a lead role for each workgroup, which were supported by North Sound ACH staff. As information from HCA became available, the focus and process for workgroups evolved accordingly. An initial inquiry was made for workgroup members and coalitions to draft "Statements of Interest" highlighting their individual interest and ideas for project frameworks. Staff and workgroup leads compiled these submissions to produce the outlines of a regional approach in each area.

Workgroups further honed these ideas at monthly face-to-face meetings with remote access for those who could not join in person. North Sound ACH staff encouraged workgroups to focus on guidance from the Project Toolkit, including indicated target populations and seeking a strategy capable of incorporating participation from partnering providers, aiming to move the North Sound ACH region's pay-for-performance metrics. This dialogue included the subpopulations indicated in the toolkit and the partnering providers necessary to reach them. Due to the open and inclusive nature of stakeholder engagement in the workgroups, a broad spectrum of partnering providers are represented in the Supplemental Workbook and remain a value for future engagement.

Concurrently, a coalition of health system physical health care providers agreed to become an advisory body to staff, wherein staff convene regular meetings, assist with agenda setting, scheduling, and note-taking. This Health System Advisory Coalition includes leadership from the largest hospital systems providing physical health care in the North Sound ACH region, regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. The group has self-reported coverage of over 205,000 Medicaid primary care assignees in the North Sound ACH region. Staff are continuing with further outreach to other partnering providers, including those located in more rural settings and smaller in size. These efforts form the foundation of the strategy to ensure inclusion of physical health providers serving a significant majority of the Medicaid population, similar to the reach that the North Sound BHO has with providers working in behavioral health and SUD settings.

The North Sound ACH recognizes the importance of Managed Care Organizations to the success of Medicaid Transformation in the North Sound ACH region, especially after the North Sound ACH region's Interlocal Leadership Structure elected to move toward Fully Integrated Managed Care by 2020. Managed Care Organization partners are engaged on the Board of Directors, the Program Council and represented in each of the workgroups, including serving as leads in the areas of Care Transitions and Chronic Disease. MCO partners have thus provided significant expertise and guidance to the project planning to date and will continue to do so throughout. In the case of Care Coordination, the North Sound ACH has participated in a series of meetings with MCO partners and representatives of the North Sound ACH region's Health Home providers regarding coordination of these services in the development of the Pathways HUB. Through existing channels of governance and the workgroup format, the North Sound ACH will consult and leverage MCO expertise in project planning and eventual implementation, while simultaneously avoiding duplication.

2A: Regional Assets, Anticipated Challenges and Proposed Solutions

The North Sound ACH has willing partners through the North Sound BHO network and Physical Health Care leaders for engagement in integration of care that provides services to a large portion of the Medicaid population.

Clinical Service Delivery and Expertise

- The North Sound ACH region has large Primary Care networks, including Providence, PeaceHealth, Sea Mar, Family Care Network, Snohomish CHC and Unity Care NW, with broad experience in integrated health and utilizing aspects of the Collaborative Care model including tele-psychiatry for remote clinic sites. They provide clinical expertise and implementation knowledge that is vital to successful implementation.
- The North Sound ACH region has two behavioral health providers, Compass Health and Lake Whatcom Center that have integrated physical health services into their behavioral health clinics. Compass Health has used a co-located model and Lake Whatcom Center directly hired physical health staff for integration of care using the Collaborative Care model.
- Skagit County's Screening, Brief Intervention and Referral to Treatment (SBIRT) initiative, focused on implementing SBIRT in all physical health care settings county-wide, increases the behavioral health services being provided in physical health settings in Skagit county. Because most delivery systems in Skagit County cross county borders, this initiative will be a regional benefit and serve as a potential pilot project for eventual spreading to the entire North Sound ACH region.

Nonclinical Service Delivery and Expertise

- The North Sound Interlocal Leadership Group of county governments, North Sound ACH, the BHO and a tribal representative, provides a venue for facilitating and discussing clinical integration of services prior to and after steps toward Fully Integrated Managed Care.
- County governments and community services provide significant non-clinical services to populations experiencing behavioral health service needs, including shelter, housing, employment services, nutrition, and other critical services that support patient outcomes and reduce readmission rates and ED utilization.

Data, Analytic Tools, and Infrastructure

- The North Sound Behavioral Health Organization (BHO) will provide administrative and data support to the clinical integration efforts in partnership with the ACH.
- All hospitals in the North Sound ACH region are connected to the EDIE/PreManage HIE infrastructure for reporting ED visits and hospitalization of patients. As physical health care and behavioral health clinics are connected to PreManage, this existing infrastructure will allow providers quick and seamless notification when any of their patients visit the ED or are admitted for physical health or psychiatric hospitalization.

CHALLENGES AND STRATEGIES TO OVERCOME THEM

Below are several of the challenges inherent in these strategies and an early assessment of ways to mitigate issues arising. All of these will depend on continuous performance monitoring and application of quality improvement techniques to resolve problems.

Anticipated Challenges	Possible Solutions
Implementation of Collaborative Care model not meeting	• Convene data and learning team to review gaps in performance measures.

performance measures, such as comprehensive diabetes screenings, behavioral health treatment penetration, or access to physical health care for Medicaid Expansion population.	• Explore reasons for performance gaps and consider revisions or enhancements to improve rate for target population. • Use population health management technologies to identify key target populations that are not responding to intervention. • Implement needed mid-course corrections, including integration of new partners or new strategies.
The North Sound ACH region's providers use a variety of health information systems with different population health registry capabilities.	• The North Sound ACH will explore health registries that are interoperable with existing systems. • Existing HIE systems such as EDIE and OneHealthPort can support population management across different systems and EHRs.
Billing and coding support will be needed for both behavioral health and physical health systems to bill for services not previously provided.	• Leveraging expertise from the UW-AIMS center and cross sector workgroup support can provide information on proper billing and coding.
The Substance Use Disorder providers are still adjusting to the BHO managed care system and clinical expectations and will need substantial support re: information technology and clinical systems to transition to integrated care.	• Engagement with SUD providers through the BHO provider group for evaluation of current capacity and needs. Connecting the SUD service agencies with the Healthier Washington Practice Transformation Support Hub and resources through the project plan can mitigate this barrier.
Reimbursement rates for traditional physical care services do not support the more complex and longer appointment times needed to serve a population with multiple co-morbid conditions and behavioral health symptom barriers.	• Implementation of the Collaborative Care model can assist in developing a team-based care approach and minimize the impact of such interventions on a provider's time. Exploring sustainability with the local Managed Care Organizations will be needed to continue integrated services. Team based care can result in improved performance for clinical quality measures and increased shared savings reimbursements to providers under value based payment contracts.
Access to Care Standards and BHO contract limitations will continue to exist prior to full financial integration creating contracting barriers with physical health systems and clinical bifurcation of service systems.	• Pursuing deemed licensure for integrated service providers or modification of the BHO state contract to allow financial payment can help mitigate this barrier.
Regulatory requirements of behavioral health services are not designed for the physical health care setting or brief therapy models.	• Connecting with state efforts to align service requirements and engaging with providers that have managed the requirements in a physical health care setting can assist to mitigate this barrier.

Limited workforce to build capacity. Bi-directional integration will require an increase in regional workforce.	• Both embedded behavioral health specialists in primary care environments and physical health providers in behavioral health clinics will be needed. • The model uses consultation in-person and through telehealth and training to assist the providers involved to practice at the top of their license to decrease workforce demand as much as possible.
Limited partner capacity (for training, implementing new programs, willingness to take on new projects)	• Support the dedication of provider time to Collaborative Care model trainings and workflow modification activities. • Identify financial opportunity for participation in Medicaid Transformation project through improved efficiency and outcomes that support organizational budgets beyond funding incentives. • Integrate and support front-line providers in planning and implementation process, so projects are appropriate to provider needs and capacity.
HIT/HIE systems not compatible with EHRs used by delivery systems or not functional for behavioral health integration purposes.	• Coordinate with vendors and systems to troubleshoot issues with interoperability/compatibility/functionality, including software updates and custom programming if no other solution available. • Explore contracts with other vendors who are able to provide more interoperable or functional solutions. • Train providers and clinical staff in use of HIT systems to improve functionality and engagement with population health management technologies.

2A: Monitoring and Continuous Improvement

Summary

The North Sound ACH will implement a monitoring and continuous improvement plan, which will include quality improvement processes, that leverages existing infrastructure, such as internal clinical quality improvement (QI) teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data, as well as identifying gaps in information and explore opportunities for data collection systems with multiple ACH's. The identification and use of measures for monitoring and continuous improvement will emphasize pragmatic, real-time measurement data sources that track progress through automated systems without requiring a heavy burden of manual measurement and tracking. Methodologies used will include embedded evaluation tools and continuous quality improvement techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles, and run charts to track project success and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis in order to determine success of evidence-based approaches. When projects or approaches are identified as in need of improvement or modification by stakeholders through a deliberative process, ACH will consult with Program council and implementation planning teams to provide assistance and explore solutions before engaging with the Health Care Authority (HCA) engage in a project plan modification.

Information Management & Data Sources

Tracking measures for monitoring and continuous improvement will include data from ongoing survey-based assessments of training effectiveness and implementation milestones to partnering providers, regular review of clinical quality measures aligned with toolkit pay-for-performance measures, HCA reports on performance measure benchmarks, and other proxy metrics for assessing implementation success. While some measures will require manual tracking, such as training enrollment forms, tally sheets for workflow revisions, and

manual chart review, special consideration will be given to measures that can provide real-time, automated tracking of progress that have a low-impact on partner organizations' staff time.

Project Managers will serve as liaisons and primary contacts with implementation partners, ensuring that monitoring and continuous improvement measures are submitted or collected on a monthly or quarterly basis for review by the data and learning team. As stated in Section I, Sub-section Governance, Project Managers will be assigned specific projects and groups of providers to monitor. Functions performed by Project Managers will include site visits, meetings with providers to identify successes and challenges, and periodic surveys to measure progress toward contractual goals.

The North Sound ACH will collaborate with partners to identify and capture clinical quality measures and related proxy measures for tracking and quality improvement purposes, based on automated or custom-built reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform, syndromic surveillance systems, or cloud-based registries. Because these measures use data directly managed from HIT systems they provide a nearly real-time (within 24 hours) view of performance, the ACH Data and Learning team will be able to quickly identify and respond to delays in implementation or gaps in performance. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems. A full inventory of available data sources for monitoring of implementation progress will be developed as part of the ACH current state assessment process. Selection of measures within these data sources will be informed by the planning processes among the Implementation Teams and the North Sound ACH Current State Assessment.

As illustrated in Figure 1, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular monitoring of community feedback and indicators by the Project Managers in their capacity as Activity Leads. In the latter case, surfacing performance gaps will be a primary function of the Activity Teams. Independently and in cooperation with the team, Leads will routinely probe for indicators of lagging achievement, employing site visits, meetings with providers, and periodic surveys. When a performance gap is identified through either signal path, the Lead (i.e. the responsible project manager) will lead the Activity Team to develop a remediation plan.

In some cases, adequate remediation may be inhibited by resource constraints or sub-optimal coordination within the ACH or the community. If Leads are unable to resolve these impediments themselves (e.g. through cross-team problem solving), they will elevate unresolved issues to the Executive Director (ED). The ED will then make prioritization decisions and provide direction as necessary. When high-level or systemic obstacles are at play, the ED will request Board assistance to resolve them and then translate Board decisions into instructions for Leads to implement.

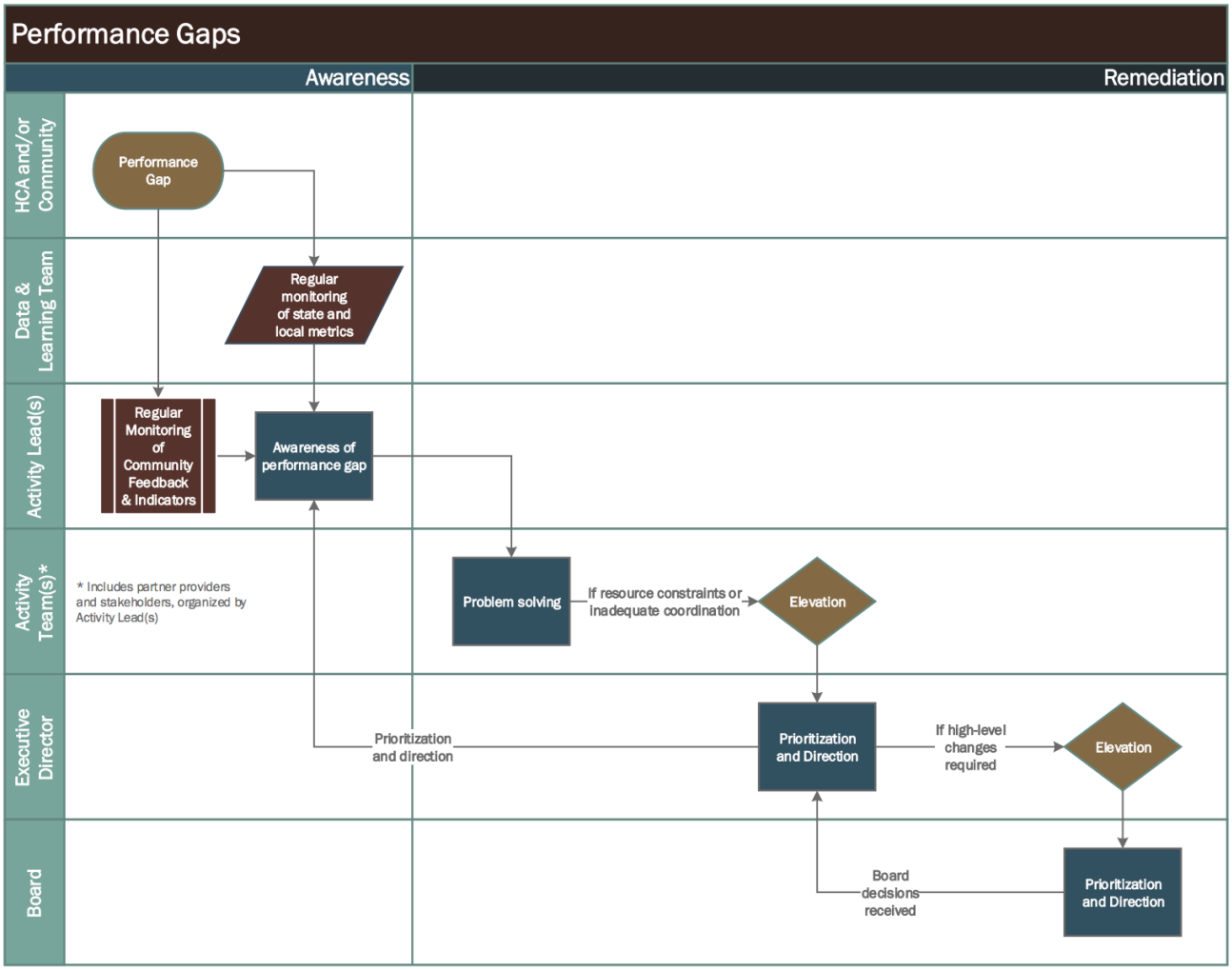

Figure 1: Performance Gaps Process Map

Quality Improvement Planning Process

Internal or embedded implementation teams will work with the most immediate data, based on quality improvement plans, internal quality improvement tracking mechanisms such as clinical quality measures, provider dashboards, and tally sheets. These will be reported to Project Managers and shared with the data and learning team for oversight. Additionally, the data and learning team will continuously identify and use HIT and HIE systems for tracking performance data such as hospital admission, ED utilization, and immunization status based on population health management technologies such as CMT's EDIE/PreManage platform, immunization registries, syndromic surveillance, and third-party registries. These platforms can provide a picture of regional performance on some monitoring and continuous measures with a delay as small as 24 hours. When these systems identify performance gaps, the data and learning team will collaborate with implementation teams via the Project Managers to solve the challenges. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems, such as a performance management portal.

The North Sound ACH implementation planning teams will embed continuous tracking mechanisms in their implementation plans as part of their quality improvement planning process, to include surveys, regular automated or manual reports of metrics, and other means for tracking success. This quality improvement planning will emphasize rapid-cycle process improvement strategies that will identify points of failure and improvement for quick response through PDSAs or workflow redesign. The ACH will engage existing

quality improvement teams at clinical or community-based implementation partners to provide expertise and support ongoing, real-time review and improvement of evidence-based approach implementation. Where possible, implementation partners will be encouraged to use these internal quality improvement teams to track their performance and PDSA improvements as needed.

The North Sound ACH Data and Learning team will support this strategy through the development of a suite of monitoring and evaluation measures for each evidence-based approach that provide an ongoing, actionable dashboard for tracking progress. The Data and Learning team will convene to regularly review metrics and assess implementation delays or gaps in performance that require changes or improvements.

Process Improvement and Project Plan Modification

Implementation delays will be identified through regular monitoring and oversight of performance and tracking measures by internal implementation teams at partner organizations. When implementation is delayed or encounters a barrier, these teams will first attempt rapid cycle improvement processes including Plan-Do-Study-Act (PDSA) cycles to solve these challenges and report outcomes to Project Managers. If this method does not lead to improvement, Project Managers will collaborate with implementation partners, the data and learning team, program council, and technical assistance consultants to address implementation delays.

When changes or improvements are identified as necessary by the ACH Data and Learning Team, the North Sound ACH staff will first work to support project implementation teams through internal QI activities, workflow redesign, PDSA cycles, resource allocation, staff training, collaborative conversations across sectors and ACHs, and other forms of assistance to improve performance (Figure 2). Technical assistance, trainings, and other resources will be supplied as needed to partner organizations and individual providers for these additional supports based on data and a deliberative process between North Sound ACH staff, the Data and Learning team, and implementation partners, as well as with feedback from the program council.

Modifications to project plans will occur after the North Sound ACH staff and implementation planning team leads report to the Program Council that a project has gaps, delays, or areas of improvement that could not be solved through other forms of assistance, as described above. North Sound ACH staff, project partners, key stakeholders, and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Prior to applying for a project plan modification in these instances, the North Sound ACH will coordinate with the Health Care Authority to identify potential alternative solutions.

Technical Assistance

Potential sources of technical assistance in developing our quality improvement plans, training our teams in continuous improvement, and identifying tracking measures include Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations.

2A: Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
XX	

2A: Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
XX	

2A: Project Sustainability

The North Sound ACH is committed to working with partners in the North Sound ACH region to develop strategies and initiatives that will move the metrics outlined in the Project Toolkit, and achieve long-term sustainability while impacting Washington's health system transformation beyond the Medicaid Transformation project period. A virtuous cycle results when clinical transformation improves provider performance on clinical quality measures in value based contracts, payers such as Managed Care Organizations reap savings, and reinvestments can be made back into the community, and community-based organizations to address upstream, social determinants of health. To ensure lasting impact we will optimize project strategies that hold promise for additional financial earnings and substantial buy-in from both clinical and community-based partners. The implementation of projects will foster meaningful relationships among partnering providers, so implementation is realized on the regional level and extends beyond the Medicaid Transformation project.

The North Sound ACH plans to leverage its unique position as a regional convener and facilitator to identify additional long-term supports for transformative changes to our health systems. Whenever possible, the North Sound ACH will seek to braid together DSRIP earnings with other sources, including philanthropy, and other investment by partners, including the Managed Care Organization partners. Philanthropic support and investment from foundations and community development organizations at the local, state, and federal level will be pursued and leveraged wherever possible.

Within the clinical environment, the North Sound ACH will work with partnering providers to foster systems transformation, evidence-based practices, and team-based workflows to drive performance on clinical quality measures and thereby increase reimbursements for value-based contractual agreements, as the state moves toward HCA goals for increased VBP adoption. Improving utilization of non-clinical staff in the clinical environment can increase the ability to pursue payments for additional services billable to Medicaid, such as those supporting behavioral health practitioners performing assessments or other interventions. Finally, establishing improved linkages and care coordination between clinical settings and community-based resources can improve patient engagement and satisfaction, also bolstering clinical quality measure performance and subsequent reimbursements. Through the Pathways and other models incentivizing value-based or population health models over fee-for-service models ensures a more holistic approach to achieving health equity in the North Sound ACH region.

The North Sound ACH plans to advocate at city, county, and state level for policies that will support this work, and reduce regulatory barriers to successful project implementation. This includes advocacy for policies that impact bi-directional integration and clinical transformation, social determinants of health, such as housing, access to transportation, childcare, employment, food access, environmental pollutants, etc. Additionally, the North Sound ACH will advocate for changes in programs and policies within partner organizations and systems, to support the implementation of services that support Medicaid Transformation and address health disparities.

Domain 1 areas of Workforce and Population Health Management offer substantial opportunities to ensure long-term sustainability and transformation. Training new members of the health workforce (or retraining current members) is an upfront and self-sustaining investment, particularly if partners are able to train staff in-house, building capacity for these providers in the long-term. Supporting implementation of systems for Health Information Technology or Exchange (HIT/HIE), is an up-front investment and will help defray costs over the long-term. Additionally, improved interoperability, communication and patient service resulting from improved technology and systems will reduce costs and improve patient satisfaction in the long-term, likewise driving increases in reimbursements for value-based contractual agreements.

Specific to bi-directional integration, opportunities for sustainability include exploring billing practices capable of supporting additional activities in clinical environments and leveraging the Pathways framework to sustain the activities of community health workers to improve care coordination systems among their own communities. Other areas include training and expansion in the use of Medicare billing codes for behavioral health providers that can support sustainable payments for integration of the Collaborative Care model in a physical health care setting, including for services provided by non-clinical behavioral health care managers.