3C: Transformation Project Description: Access to Oral Health

Introduction

The North Sound region has poor access to oral health services stemming from a lack of provider capacity and a lack of organized systems and processes to link Medicaid enrollees with care sources. Rates of Medicaid service utilization in the North Sound region are currently 7% below statewide averages and two counties, (Island and San Juan) rank 37th and 39th respectively among Washington's 39 counties.[1] Additionally, the 2009-2014 Dental Care Provider Survey found that only 11.3%-28.6% of dental care providers in the North Sound region accepted new Medicaid patients.[2] Insufficient access to dental services has been identified as a high priority in Community Health Assessments and Community Needs Assessments across all five counties. Barriers to accessing care include insufficient capacity to see adult patients, transportation, location, and cost of care. Residents living in poverty in all five counties stated, "not enough preventative dental care" as a barrier to accessing care in County Health Needs Assessments and in County Low Income Needs Assessments. According to the 2015 Snohomish County Low Income Needs Assessment, 11% of low income households listed the location of dental services as prohibitive to oral health.

The highest priority in the region for oral health is expanding access to and utilization of dental services by Medicaid enrolled adults. In the North Sound, 32% of adults overall reported that they had not been to a dentist in the last year and 35% reported not having a dentist.[3] Despite being eligible for dental services, North Sound residents with Medicaid coverage have lower rates (34.6%) of receiving dental services compared to the state average (38.2%).[4] These rates vary by county from 22.5% (San Juan) to 35.6% (Skagit, Snohomish) and only 19.7% of eligible adults (21+) received dental services, while 51.7% of children (20 and under) received care.[5] Among the 9 ACH regions, North Sound ACH ranks third best for overall access, but 9th for adults and 5 of 9 for children.[6]

While oral disease is largely preventable, the current state of Medicaid dental service delivery has led to elevated costs for treatment and care. For example, while the region shows the lowest adult utilization rates, it has a $555 cost per user annually.[7] This is the highest per-user Medicaid cost for adult dental care in Washington State, indicating that adult patients require more complex, expensive care when treated.

Target Population

The strategies described for Access to Oral Health Services has the potential to impact all North Sound Medicaid enrollees, particularly those not receiving any dental care or sufficient recommended dental preventative services. Specifically, the North Sound project will target key sub-populations at higher risk due to underutilization of services and oral-systemic links between oral diseases (such as caries and periodontitis) and health outcomes. These populations include:

- Children ages 6 to 14 at elevated risk of caries and not already receiving sealants
- Adults with chronic periodontitis not already receiving treatment
- Adults and children in primary care medical practices who are not accessing dental services
- Pregnant women
- Individuals with diabetes

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[1] RHNI Starter Kit, HCA, released May 8, 2017.
[2] Health Professional Shortage Areas (HPSA) Designations, WADOH, 2017.
[3] Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2016
[4] RHNI Starter Kit, HCA, released May 8, 2017
[5] RHNI Starter Kit, HCA, released May 8, 2017
[6] RHNI Starter Kit, HCA, released May 8, 2017
[7] RHNI Starter Kit, HCA, released May 8, 2017

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[8] 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.

<table>
<tr><th colspan="2">North Sound Project Area Reach & Impact
Project Area 3C: Access to Oral Health Services</th></tr>
<tr><td colspan="2">Potential Target Population Reach:
• 325,566 total Medicaid enrollees who are eligible for dental services*
  ○ 174,185 Adults (21 and over) with Medicaid who are eligible for dental services
  ○ 151,386 Children (20 and under) with Medicaid who are eligible for dental services
  ○ 50,646 Children (6 and under) with Medicaid who are eligible for dental services
• 22,421 Children (1-17) with Medicaid with dental decay or cavities
• 22,390 diagnosed with Type 1 or 2 diabetes
  ○ 5,868 Disabled, 1,501 Non-Disabled Adults, 8,080 Newly Eligible Adults, 608 Non-Disabled Children, 6330 Elders
• 5,981 pregnant women with Medicaid coverage</td></tr>
<tr><td>Project Area Impact:</td><td></td></tr>
</table>

[8] 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

Performance Measures	Geographic Disparities
• 34.6% of eligible Medicaid enrollees received dental services • 19.3% of Medicaid adults used dental care--lowest ACH rate in the state • 51.7% of enrollees below the age of 20 used dental services • 39.1% of children 6-9 with elevated caries risk received sealants. • 45.7% of children under 6 received preventive dental care • .1% of children received primary caries prevention intervention as part of Well/Ill Child Care provided by Primary Care Medical Providers (PCMP)	• 37% of adults in Skagit County had not visited a dentist in the last year, compared to the regional rate of 32%. • 68% of adults in San Juan county do not have dental insurance, compared to regional rate of 35%. • All counties except Snohomish are lower than statewide averages for adult Medicaid dental utilization. San Juan shows the lowest adult utilization rate, with 7.6% of eligible adults receiving dental care. • Snohomish County has the highest number of fluoridated water systems in the region, while the remaining counties are limited to 1-2 systems. • 11.3% of Skagit county dental providers accept new Medicaid patients, which is the lowest in the region, though 50% of dental providers currently treat Medicaid patients.
Data Sources: 1) RHNI Starter Kit, HCA, released May 8, 2017. 2) ACH Toolkit Historical Data, HCA, released August 17, 2017. 3) Healthier Washington Dental Reports, Washington Dental Services, released April 5, 2017. 4) Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. 5) Chronic Disease Profiles (North Sound) WADOH, April 2016. 6) Public Water Systems that Deliver Fluoridated Water, WADOH, 2017. * Note: Medicaid eligibility counts for dental services varies from the North Sounds total Medicaid population (286,760), this issue has been raised to HCA and a remedy is pending, in general regional counts can vary due time frame of data collection and the reporting agency's definition of Medicaid populations.	

Current State

Existing efforts to expand oral health provider capacity in the North Sound region have been primarily fostered by Federally Qualified Health Centers (FQHCs), in order to meet the need of newly eligible adults included in the Medicaid Expansion. FQHCs accounted for approximately 40% of Medicaid claims for dental care in 2016, with 60% provided by private practice or other dental services.[9] These services were primarily delivered to children age 20 and under, who account for 69.5% of dental services billed to Medicaid in 2016.[10]

The North Sound's three FQHCs are currently engaged in expansion activities that will increase regional FQHC operatory capacity by 15%, dentist staffing by 11% and hygienist staffing by 29%, all through existing funding mechanisms outside of Medicaid Transformation projects. By adding this capacity regionally, the FQHC dentist/Medicaid population ratio drops from 1: 15,431 to 1: 10,287. However, with HRSA Designated Dental Professional Shortage Area rates classifying any regions with a dentist to population ratio of 1: 5,000 as underserved – it is clear this ratio will need to be supplemented with engagement from private practice dentistry.[11]

In order to not duplicate this existing capacity expansion and practice transformation work, the North Sound ACH's strategies are designed to be complementary. These strategies will include initiatives to connect

[9] Preliminary Medicaid Provider Files Dental Tables, HCA released June 27, 2017
[10] Utilization of Dental Services by Users' Region & Age FY 2016, HCA released April 5, 2017
[11] Health Professional Shortage Areas (HPSA) Designations, WADOH, 2017.

patients with the newly expanded capacity at FQHCs through patient outreach and engagement, to coordinate service delivery across the region, and implement innovative population health management methodologies in dental clinics.

Relation to other project areas

Additionally, the region's oral health strategies, in combination with several other project areas such as Care Coordination and Diversion Interventions will address ED utilization linking dental patients with emergent care needs with more appropriate sites of care. Overlapping planning and implementation will need to occur with the Chronic Disease and Bi-Directional project areas due to the oral-systemic links between periodontitis and chronic diseases such as diabetes and heart disease, as well as the connections between oral disease and chronic oral pain on mental health status and substance abuse disorders.

Strategies to Improve Access

North Sound ACH oral health capacity building strategies (I, below) aim to expand access to and utilization of dental care by addressing barriers to care due to lack of capacity and location of care. These strategies include expansion of existing clinic capacity, implementation of new provider models, integration of dental screening and referral into primary care practices, and mobile dental services in community settings. A second set of regional strategies (II, below) are designed to introduce and inculcate population management approaches which are now only in rudimentary form in the oral health delivery system. The ACH and partner organizations will also work to include more diverse partners in this work, and conduct outreach to private dentists to increase participation and collaboration in serving Medicaid patients.

I. Capacity Building: Workforce Strategies

These strategies build capacity by adding to the oral health workforce or use that workforce in different ways. Strategies coordinate with and enhance existing projects currently underway without duplicating the work these partners are engaged in. Each strategy is built off of pilot projects with demonstrated success in the region and demonstrate opportunity for enhancement and expansion.

1) **Pilot New Dental Workforce Models in Tribal Settings**
   a) **What:** North Sound ACH will engage with each Tribal nation in the region to assess interest in workforce expansion using the DHAT (Dental Health Aide Therapist) program. To date, several Tribes in the region have expressed an interest in exploring this opportunity. North Sound ACH will leverage work with the Swinomish Tribe and Skagit Community College, and partner with Northwest Indian Health Board and Olympic Community of Health, to bring DHAT training to Washington State. If Tribes opt to leverage the DHAT training opportunity, North Sound ACH will partner with Arcora Foundation to strategize capital expansion opportunities for those Tribal clinics, so that there is infrastructure to support this new workforce.
   b) **Who**: Swinomish Tribe with possible expansion to additional Tribal dental clinics and training centers, including Lummi and Tulalip Tribal Health Centers.
   c) **Implementation Steps**:
      i) Establish DHAT Training Program.
      ii) Recruit students/secure scholarship funds.
      iii) Hire to work in Tribal settings.

2) **Mobile Dental Hygiene in Community Settings**
   a) **What:** Recruit currently underutilized dental hygienists to provide a range of Medicaid-billable dental services in community settings using mobile dental equipment, focusing on the most underserved areas in the region. This model leverages mobile care strategies as

described in the Medicaid Transformation Project Toolkit by combining a workforce currently underutilized to meet the needs of the region and equipment that can provide billable oral hygiene services outside the walls of a dental clinic, and bring dental hygiene services to where people are in community settings including hospitals, schools, and community centers. Additionally, this strategy will also support referral of patients into dental clinics for care that cannot be delivered through mobile equipment.

b) Potential Partners: A new regional network of approximately 30 hygienists to be recruited and trained for this purpose. Registered dental hygienists throughout the region are already practicing independently and this strategy seeks to build on and connect with this existing workforce.

c) Implementation Steps:

i) Assess workforce needs and hygienist supply regionally.
ii) Recruit hygienists to form network.
iii) Secure Medicaid provider numbers.
iv) Train new workforce and assist in establishing practices across the region.
v) Determine and execute outreach strategy to consumers.

3) Implementing the Oral Health Delivery Framework

a) What: Several large medical groups will expand integration of dental services into medical primary care, using the Oral Health Delivery Framework as an evidence-based model. This toolkit strategy trains medical assistants and other existing personnel in medical practices to screen and refer patients with specific oral health conditions while also directly providing certain preventive services.

b) Potential Partners:

i) Providence Medical group, which has already piloted integration in a single clinic and plans to expand the practice to additional clinics.
ii) Federally Qualified Health Centers with co-located and integrated medical/dental clinic sites.
iii) Additional hospital associated and independent primary care clinics will be solicited to participate.

c) Implementation Steps:

i) Secure final commitments from specific sites, emphasizing underserved geographic areas.
ii) Provide training (via existing Arcora Foundation Program) to providers and clinic staff.
iii) Finalize which preventive services will be offered.
iv) Finalize referral pathways from primary care to dental clinics.

II. Implement Population Health Management Tools in Dental Settings

These tools are used primarily within provider organizations in order to more effectively organize services so the provider system produces improved results for patients. Since most of these tools are not typically yet in place, the work involves setting up new internal business procedures and then using them to reorganize care processes.

a) **What**: Develop internal procedures within provider organizations which will allow for improved care outcomes. These procedures will include:

i) Increased use of registries to monitor performance in priority populations with these registries including:
(1) Adults with chronic periodontitis
(2) People with diabetes

(3) Pregnant women
(4) Sealant status
(5) High-risk adults (for dental issues)
(6) High-risk children (for dental issues)

ii) Create linkages between registry populations and practice call back systems.
iii) Develop use of care management personnel within dental practices (see also B.3) and between medical practices and dental practices in order to improve patient navigation to services.
iv) Institute use of ICD-10 coding at the practice level in order to allow disease severity measurement and improve efficiency of benchmarking.
v) Increase use of silver diamine fluoride.
vi) Improve organization-level dental analytics capability as a way to focus efforts on improved outcomes.

b) **Who**: Initially this strategy will focus on the three regional FQHC systems and then expand to independent private practice dentists and dental hygienists.
c) **Implementation Steps**:
i) Provide technical assistance to clinical partners for setting up these new internal systems.
ii) Monitor implementation progress.
iii) Track progress on metrics.
iv) Make adjustments in processes as needed.

Impact on Metrics

Through expansion of capacity to serve Medicaid eligible patients in existing clinics, the development and expansion of dental provider workforce throughout the region, expanded patient outreach and engagement practices, and the implementation of population health management methodologies, we expect to see movement across the following performance metrics in the Medicaid Transformation project toolkit:

- Dental Sealants for Children at Elevated Caries Risk
- Ongoing Care in Adults with Chronic Periodontitis
- Outpatient Emergency Department Visits per 1000 member months
- Periodontal Evaluation in Adults with Chronic Periodontitis
- Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by
- Primary Care Medical Providers
- Utilization of Dental Services by Medicaid Enrollees

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 Oral Health 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 the communities they will serve; requiring training on cultural humility, undoing institutional racism, implicit bias, and more).

During the planning phase of 2018, the North Sound ACH and regional partners will gather and analyze oral health outcome data to identify geographic and demographic disparities that can be addressed through application of these strategies and the lens of Targeted Universalism. Rural areas such as Island and San Juan counties and the eastern areas of Snohomish, Skagit, and Whatcom counties are particularly lacking access—it will be necessary to address this lack of access through targeted support with mobile dental services, transportation services, and expansion of dental services for people eligible for Medicaid.

Lasting Impact

Much of the activities in the Oral Health project area are low-cost, self-sustaining, and require only an upfront investment to implement. Oral health integration activities (integrating oral health into primary care) involve primarily technical assistance and up-front training costs. Implementation of new population health management tools and coding systems, like ICD-10 coding, use of advanced analytics, and linking registries to call-back systems, are all one-time, up front investments, and once these tools and systems are up and running, require only maintenance and training for new staff and provide long-term sustainability. Through the use of value-based contracting associated with the expansion of managed care to Medicaid dental services, both providers and clinic leadership will have strong incentives to improve their health systems performance and their patients' health outcomes. Transitioning to value-based payment in combination with these other strategies reinforces HCA's mid-ranged payment policy objectives while fostering a sustainable approach, not dependent upon the Medicaid Transformation funding long-term.

3C: Partnering Providers

In the Oral Health project area, the North Sound ACH has high levels of engagement from regional providers of oral health services essential to the project success. These include FQHCs, Tribal Nation partners, foundations, and oral hygienists. Project Leads in this area include representatives from Arcora, a regional dental foundation, and a local expert in regional health services including oral health.

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.

Most key providers are already engaged with North Sound ACH on these strategies. These include CHC Snohomish, Sea Mar, Unity Care which together represent 100% of regional FQHC capacity. The two hygienist societies and key leaders within the region's dental hygiene professional community will also be key participants. Others include the Swinomish Tribe and key advocacy and coordinative groups such as health departments and the Whatcom Alliance for Health Advancement. Additionally, partnerships will be needed with educational institutions to train and develop a new and expanded workforce for providing dental care to the Medicaid population.

Upon news of a successful agreement for the Medicaid Transformation, the North Sound ACH began a process of moving from broader stakeholder engagement into targeting partnering providers based on those currently serving or interested in serving a greater proportion of the Medicaid population. This engagement began with the formation of eight workgroups in each of the Toolkit project areas. An open invitation was extended to providers and stakeholders with interest in specific project areas. These included behavioral health and SUD providers community-based organizations, county governments, primary care providers, health systems, Managed Care Organizations and health departments. Two or more volunteer subject matter experts from the community were invited to serve alongside staff in a lead role for each workgroup. As more information on the Medicaid Transformation Project became available, the focus and process for workgroups evolved accordingly. An initial inquiry was made for workgroup members and coalitions to craft draft "Statements of Interest" highlighting their individual interest and ideas for project frameworks. Staff and leads then gathered these submissions and reflected back a compilation of content to produce the outlines of a regional approach in each area.

Workgroups further honed these ideas during dialogue at monthly face-to-face meetings with remote access capability. 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 across the region, while also aiming to move their respective pay-for-performance metrics. This dialogue on target populations, partnering providers already serving and committed to serve the Medicaid population and effective strategies honed the focus of the workgroups onto Medicaid enrollees, including the subpopulations indicated by 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 and remain a value for future engagement.

Concurrently, a coalition of health system primary care providers formed and eventually agreed to become an advisory body to staff, wherein staff facilitate regular meetings, assist with scheduling, agendas and note-taking. The Health System Advisory Coalition includes members from the largest hospital systems providing primary care in the region, all the regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. Collectively, the group has self-reported coverage of approximately 194,940 Medicaid primary care assignees in the 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 those serving a significant majority of the Medicaid population. Plans to similarly convene partnering providers working in behavioral health and SUD settings will ensure a broad spectrum is represented for the purposes of bi-directional integration.

While Medicaid dental services are currently provided on a fee-for-service basis outside the managed care system, this statewide dental service payment system is expected to transition to managed care during the five years of the transformation project. As such, the North Sound ACH recognizes the importance of Managed Care Organizations to the success of the Medicaid Transformation Project and efforts at systems transformation in our region, including the projects in the Oral Health Project Area. 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. 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.

3C: Regional Assets, Anticipated Challenges and Proposed Solutions

Regional Assets

Oral health providers and advocates in the North Sound ACH area have been involved in developing regional strategies through a region-wide workgroup convened by North Sound ACH staff. Participation has been strong and enthusiasm high. The oral health community in the region has viewed Medicaid transformation as an opportunity for improving care delivery and patient health outcomes as shown below in Table 1. Planning for the strategies described in the project selection section above required regional stakeholders from Federally Qualified Health Centers (FQHC) and other dental care settings to convene, identify priorities, and ultimately collaborate in bringing their plan to the larger group.

Table 1. Capacity and Future Plans of FQHC Partners in North Sound ACH region

FQHCs	What Involvement	Current Dental Clinic Sites	Future Expansion
Community Health Center of Snohomish County	• Population outreach • Population health management systems • Care management • Pay for Performance	6 locations • Snohomish • Arlington • Everett N. • Everett S. • Lynnwood • Edmonds	
Sea Mar Community Health Centers	• Population outreach • Population health management systems • Care management • Pay for Performance	7 Locations • Bellingham • Oak Harbor • Mt. Vernon • Everett • Marysville • Monroe • Burlington	• New site in Lynnwood • Expansion of Oak Harbor site
Unity Care NW	• Population outreach • Population health management systems • Care management • Pay for Performance	3 locations • Bellingham pediatrics • Bellingham adults • Ferndale	• Major expansion in Ferndale
Data Source: Self-report from FQHC leadership.			

The table below (Table 2) summarizes key community sectors and the anticipated contributions of each. Because they are a large sub-segment within the project's strategies, the FQHC providers are detailed below separately.

Table 2. North Sound ACH FQHCs Capacity, Enrollees

County	FQHCs in County	Operatory Supply	Dentist FTE	Hygienist FTE	Future Supply	Medicaid Enrolled Population (Sep 2017)	FQHC Dentists/ Per Medicaid Eligibles
Snohomish	6 locations	70	10	33.75	+ 10 Operatories + 2 Dentists + 1 Hygienist	166,794	1: 16,679
Skagit	1 location	10	1	3	0	36,739	1: 36,739

Whatcom	2 locations	39	6	17	+ 8 Operatories + 6 Operatories + 3 Hygienists	55,850	1: 9308
Island	1 location	2	1	0	+ 1 Dentist + 1 Hygienist	14,942	1:14,942
San Juan	None	N.A.			N.A.	3,437	- 0 -
North Sound	11 locations	121	18	53.75	+ 18 Operatories + 9 Dentists + 5 Hygienists	277,762	1: 15,431
Data Source: Self-report from FQHC leadership, Preliminary Medicaid Provider Files Dental Tables, HCA released June 27, 2017. RHNI Starter Kit, HCA, released May 8, 2017.							

Workforce Assets

The participation of private dental providers will be needed to meet the goals for the region. We have had active participation from oral hygienists, who provide many of the types of services which relate to toolkit metrics, (e.g., sealant applications, periodontal treatment). Independent, private hygienists will organize a network of an estimated 30 providers to serve Medicaid patients with an emphasis on unserved and underserved geographic areas and populations which can be reached on a mobile basis, such as children in school, persons in senior centers and facilities, as well as rural sites identified as underserved.

Table 3 below describes other providers and advocates and the assets they will bring to the project.

Table 3. Assets of North Sound ACH's Regional Providers and Oral Health Advocates

Type of provider or other organization involved with North Sound ACH oral health strategies	Assets brought to the region's project
Oral Health Coalitions and outreach/coordinating groups • Snohomish Oral Health Coalition • Whatcom Oral Health Coalition • Whatcom Alliance for Healthcare Access • ABCD providers (4 of 5 are Health Departments)	• History of engagement and activity with outreach, planning, and coordinating oral health • In several cases, ability to do outreach and engagement of unserved eligible enrollees
Medicaid Health Plan: The region's five health plans as well as Delta Dental may ultimately help to reorganize and better manage the delivery system. They have been engaged with North Sound ACH on oral health.	• Expertise with population health management • Care management and other infrastructure • Advanced analytics capability/ data management • Incentives to better integrate dental care with medical

Tribal Nations: Swinomish Tribe will be engaged with Arcora Foundation and others to train and bring up a new type of mid-level provider--DHATs	• Recent legislation supports this • Opportunity to pilot new roles for this provider type
Private Dentists: Regional coalition will engage private dentists through their Societies-Snohomish Dental Society and Mt. Baker Dental Society - strategy is to test readiness as later adopters	• Way to connect with fragmented community of small dental practices
Private Philanthropy: • Arcora Foundation • Verdant Foundation Both foundations have been very engaged and committed to oral health	• **Arcora**: Expertise, financial resources, willingness to devote staff time, knowledge of innovation across the state • **Verdant**: Strong interest in oral health, history of supporting South Snohomish efforts
Hospitals or Health Systems: • Providence (existing integration pilot) • Island Hospital (considering Oral Health integration/engaged in ACH work) • Peace Health (engaged in ACH work)	• Large numbers of medical primary care providers who may adapt to oral health integration pilots • Potential for scale and infrastructure to adopt population management tools

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.

CHALLENGE	STRATEGY TO ADDRESS CHALLENGE
Implementation of project area strategies not successfully improving performance measures toward goals.	• Convene Data & Learning Team to review gaps in performance measures • 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.
Limited partner capacity (for training, implementing new programs, willingness to take on new projects)	• Support the dedication of provider time to oral health delivery framework trainings and workflow modification activities • Identify financial opportunity for participation in demonstration project through improved efficiency and

	outcomes that supports organizational budgets beyond funding incentives. • Integrate and support front-line providers in planning and implementation process, so that projects are appropriate to provider needs and capacity.
HIT/HIE systems not compatible with EHRs used by delivery systems or not functional for oral health population management 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. • Provide more technical assistance from Arcora Foundation and other sources.
Inability to obtain funding for expanding/spreading successful strategies across regional partners.	• Facilitate site visits for stakeholders and decision makers with ability to provide needed funds, so that the value of the models can be experienced first-hand. • Perform cost effectiveness calculations that demonstrate short and long-term savings for care settings due to oral disease prevention activities
Clinic expansion and workforce development activities not utilized by target patient population.	• Retool patient outreach and engagement processes; use analytics to identify promising demographic areas for patient engagement. • Devote more resource to outreach, analyze what is working and shift in that direction.
Unable to recruit sufficient workforce to build capacity (including hygienists, dentists, or DHAT trainees).	• Promote employment opportunities through avenues of communication and marketing to relevant professional categories. • Explore incentive opportunities to attract sufficient workforce through funding, education waivers, or other solutions. • Investigate opportunities to engage existing regional dental professional workforce to build capacity.

3C: 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.

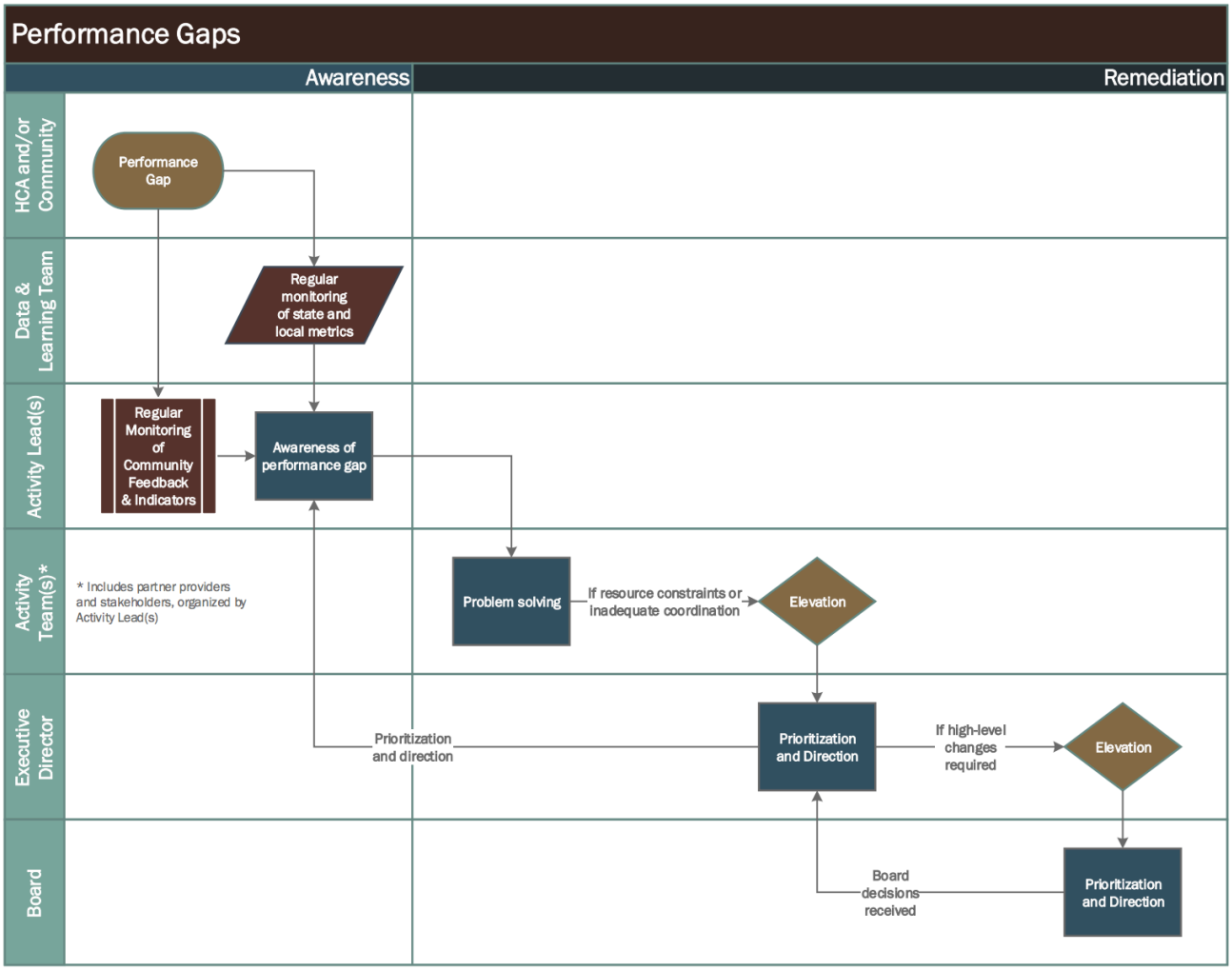

Figure 1: Performance Gaps Process Map

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.

3C: 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	

3C: 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	

3C: Project Sustainability

The North Sound ACH is committed to working with partners in our 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 relationships among partnering providers, so implementation is realized on the regional level and when Medicaid Transformation funds are no longer available, the relationships and transformative changes will continue.

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 Managed Care Organization partners. Additionally, 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 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, child care, employment, food access, environmental pollutants, etc. Additionally, the 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 Oral Health, the ACH and partner organizations will also work to include more diverse partners in this work, and conduct outreach to private dentists to increase participation and collaboration in serving Medicaid patients. Much of the activities in the Oral Health project area are low-cost, self-sustaining, and require only an upfront investment to implement. Oral health integration activities (integrating oral health into primary care) involve primarily technical assistance and up-front training costs. Community outreach to identify new or hard-to-reach patients is primarily an initial one to three-year activity. Finally, implementing new population health management tools and coding systems, like ICD-10 coding, use of advanced analytics, and linking registries to call-back systems, are all one-time, up front investments, and once these tools and systems are up and running, require only maintenance and training for new staff and provide long-term sustainability. Increased provider capacity and patient outreach to fill this capacity are targeted efforts which result in more demand to fill the new capacity created. In contrast, the operational shifts in the delivery system to population management tools and techniques will require ongoing infrastructure. A value-based payment approach linked to the project metrics is proposed as the financial tool to maintain this infrastructure over time.

These strategies are sustainable and will have lasting impacts. Funding to support activities in this project area will primarily be drawn from outside the Medicaid Transformation, through private foundations, existing delivery system budgets, and established Medicaid claims sources--allowing project activities to achieve built-in sustainability after the Medicaid Transformation project is concluded.