Meeting Objectives

• Review Overall ACH Purpose and Structure
• Reviewing the Role of the Provider Integration Panel
• Grounding in the Medicaid Demonstration Framework
  - Deep Dive on Integration of Physical and Behavioral Health
ACH Role

The Pierce County ACH creates collaborative engagement between the community and dedicated community partners.

Together we learn, share, and act, in order to positively transform our health system.
COMMUNITY DRIVEN STRATEGY FOR SHARED LEARNING AND ACTION

Share learnings key cohorts are followed in the data so that impacts and savings can be identified and funds redirected into community priorities for financial sustainability.

Collective action that supports local solutions through pooled resources, and comprehensive systems and policy change strategies.

Systems and structures for data collection, analysis, reporting. Track suboptimal outcomes. Identify optimal populations, places, or care settings to intervene using multi-sector data-driven strategy.

Find out why the patterns you see in the data exist. Leverage local wisdom for solutions.

Braiding of diverse resources for one common RHIP.
Provider Integration Panel Purpose: The Provider Integration Panel is a group of 25 leaders that provide behavioral and physical health care in Pierce County and understand the key components of healthcare transformation. Panelists will represent a specific constituency and will be expected to have the authority to make commitments on behalf of their employers, organizations, or constituencies. Panelists will also be expected to connect to others within their constituencies to ensure sufficient information sharing and necessary subject matter expertise.

Provider Panel - ADHOC Groups
- Quality Improvement
- Interoperability

ADDITIONAL WORKGROUPS
- OPIOID Task Force
- Community Care Coordination
Provider Panel Roles & Responsibilities

With the support of the PCACH Executive Director, the Provider Integration Panel will provide key insights on integration priorities, data and projects for the Pierce County Accountable Community of Health. The PIP will support the planning and implementation phases to address systemic and/or policy barriers, to impact health and stability of Pierce County residents. The RHIP-C Council will use the PIP proposals to ensure fidelity to the PCACH mission and financial feasibility.

• Recommend Chair and Vice Chair

• Next steps - Chair works w/ a few members to develop out charter
Mid-Adopter Status Report
Medicaid Transformation Demonstration Project Toolkit

Transforming Health Systems

**Required projects:**
- Bi-directional integration of care and primary care transformation
- Addressing the opioid use public health crisis
- Community-based care coordination – (RHIP/CVC Recommended - Board Adopted)

Choose at least one:
- Transitional care
- Diversion interventions
- Maternal and child health
- Access to oral health services
- Chronic disease prevention and control

Health Systems & Community Capacity Building

These required elements are the foundation for transformation projects:
- Financial sustainability through value-based payment (VBP)
- Workforce development related to specific initiatives
- Systems for population health management
Medicaid Transformation Demonstration Project Toolkit Summary
## Bi-Directional Integration of Care and Primary Care Transformation ("Integration")

<table>
<thead>
<tr>
<th>Objective</th>
<th>Strategies / Approaches</th>
</tr>
</thead>
</table>
| • Address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to services they need. | Integrating behavioral health into primary care:  
• Bree Collaborative’s Behavioral Health Integration Report / Recommendations  
• Collaborative Care Model |
| • Bring together the financing and delivery of physical and behavioral health services, through Managed Care Organizations, for Medicaid members. | Integrating primary care into behavioral health settings:  
• Off-site, enhanced collaboration  
• Co-located, enhanced collaboration |
## Integration: Project Ideas

### Planning
- Identify population and providers serving Medicaid beneficiaries and assess those providers’ capacity to effectively deliver integrated care.
- Assess level of Integrated Care Model Adoption across key providers / organizations serving Medicaid beneficiaries.
- Recruit and secure formal agreements from participating providers and community.
- Develop a Project Implementation Plan.

### Implementation
- Develop policies and procedures and implement selected evidence-based approaches (e.g., integrated care teams, routine access to integrated services, accessibility and sharing of patient information, access to psychiatry services, proactive identification and monitoring of patients, evidence-based treatments, and patient involvement, etc.)
- Improve collaboration and coordination between primary care and behavioral health providers that are located at a distance from one another, and those that are co-located.
- Ensure providers receive needed training and technical assistance.

### Scale & Sustain
- Increase adoption of integrated, evidence-based approaches by more providers.
- Identify new providers / organizations to work with.
- Implement train-the-trainer approach to spread best practices.
- Implement VBP strategies.
- Complete contracting for fully integrated managed care.
## Integration: Progress Measures

<table>
<thead>
<tr>
<th>Planning</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Complete assessment for the current state of integrated care</td>
<td>• Provide list of target providers and organizations with formal commitment to participate in the project</td>
</tr>
<tr>
<td>• Complete plan that describes the process and timeline for pursuing and implementing fully integrated managed care</td>
<td>• Complete Project Implementation Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Number of practices and providers implementing integrated evidence-based approaches</td>
<td>• Number of practices and providers trained on evidence-based practices</td>
</tr>
<tr>
<td>• Number of primary care practices / providers achieving PCMH recognition</td>
<td>• Number of primary care providers achieving special recognitions / certifications / licensures (e.g., for MAT)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scale &amp; Sustain</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Number of practices trained on selected evidence-based practices</td>
<td>• Number of practices implementing evidence-based practices</td>
</tr>
<tr>
<td>• Number of practices and provides to achieve performance targets for outcomes metrics</td>
<td></td>
</tr>
</tbody>
</table>
# Integration: Incentive Measures

## System-Wide
- Emergency Department visits per 1,000 member months ($)
- Plan All-Cause Readmission Rate (30 day) ($)
- Psychiatric Hospital Readmission Rate ($)
- Inpatient Hospital Utilization
- Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- Controlling High Blood Pressure
- Adult Mental Health Status

## Project-Level
- Antidepressant Medication Management ($)
- Medication Management for People with Asthma ($)
- Follow-up After Hospitalization for Mental Illness ($)
- Mental Health Treatment Penetration (Broad Version) ($)
- Substance Use Disorder Treatment Penetration ($)
- Child and Adolescent Access to Primary Care Practitioners
- Diabetes Care: Eye Exam
- Diabetes Care: Medical Attention for Nephropathy
- Follow-up After Discharge from ED for Mental Health, Alcohol, or Other Drug Dependence
- Adult Body Mass Index (BMI) Assessment
- Depression Screening and Follow-up for Adolescents and Adults
- Depression Remission or Response for Adolescents and Adults
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
## Addressing the opioid use public health crisis ("Opioid Use")

<table>
<thead>
<tr>
<th>Objective</th>
<th>Support the state’s goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.</th>
</tr>
</thead>
</table>
| Strategies / Approaches | Clinical Guidelines  
- AMDG’s Interagency Guidelines on Prescribing Opioids for Pain  
- CDC Guideline for Prescribing Opioids for Chronic Pain (2016)  
- Substance Use during Pregnancy: Guidelines for Screening & Management  
  
Statewide Plans  
- Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan (2012) |
<table>
<thead>
<tr>
<th>Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess regional capacity to effectively impact the opioid crisis, including: HIT infrastructure, workforce capacity, payment structures.</td>
</tr>
<tr>
<td>• Identify communities of focus, based on regional needs (e.g., limited access to treatment, rates of opioid use / misuse).</td>
</tr>
<tr>
<td>• Develop a Regional Opioid Working Plan that addresses prevention, treatment, overdose prevention, and recovery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Convene or leverage existing partnerships to implement the Regional Plan</td>
</tr>
<tr>
<td>• Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or clinical guidelines</td>
</tr>
<tr>
<td>• Develop plan to scale and sustain - add new partners, reach new communities, etc.</td>
</tr>
<tr>
<td>• Develop plan to address gaps in number / location of providers offering recovery support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scale &amp; Sustain</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Facilitate shared learning and exchange of best practices</td>
</tr>
<tr>
<td>• Provide / support ongoing training, technical assistance, and community partnerships</td>
</tr>
<tr>
<td>• Continue implanting / spreading Regional Opioid Working Plan</td>
</tr>
<tr>
<td>• Encourage MCOs to develop / refine benefits aligned with clinical guidelines and VBP</td>
</tr>
</tbody>
</table>
# Opioid Use: Progress Measures

## Planning
- Number and location of MDs, ARNPs, and Pas who are approved to prescribe buprenorphine
- Number and location of mental health and SUD providers delivering acute care and recovery services to people with opioid use disorder
- Completion of Regional Opioid Working Plan
- *Completion of Workforce, Technology, and Financial Sustainability plans to support project*

## Implementation
- Number and list of community partnerships
- Number of health care providers trained on opioid prescribing guidelines (CDC / AMDG)
- Number of providers (and their settings) with waiver authority to prescribe buprenorphine
- Number of patients currently being prescribed buprenorphine
- Number of health care organizations with EHRs or other systems newly in place that provide clinical decision support for opioid prescribing guidelines
- Number of local health jurisdictions and community-based organizations getting technical assistance for syringe exchange programs
- Number of emergency departments with protocols for overdose education and take home naloxone to individuals seen for opioid overdose

## Scale & Sustain
- Number and type of access points in which persons can receive medication assisted therapy (MAT), such as EDs, SUD and mental health settings, correctional settings, or other non-traditional community-based access points.
# Opioid Use: Incentive Measures

## System-Wide
- ED visits per 1,000 member months ($)
- Opioid Related Deaths (Medicaid Enrollees and Total Population) per 100,000
- Non-fatal overdose involving prescription opioids (in development)
- Substance Use Disorder Treatment Penetration (Opioid)

## Project-Level
- New opioid users that become chronic users (in development)
- Patients on high-dose chronic opioid therapy by varying thresholds (in development)
- Patients with concurrent sedative prescriptions (in development)
- Non-fatal overdose involving prescription opioids (in development)
- Medication Assisted Therapy (MAT) with buprenorphine (count and %)
- Medication Assisted Therapy (MAT) with methadone (count and %)
## Community-Based Care Coordination

<table>
<thead>
<tr>
<th>Objective</th>
<th>Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.</th>
</tr>
</thead>
</table>
| Strategies / Approaches | Pathways Community HUB  
• Coordinate care beyond the walls of health care  
• Pay for outcomes  
• Reduce duplication of care coordination services |
## Community-Based Care Coordination: Project Ideas

<table>
<thead>
<tr>
<th>Planning</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess current capacity and existing care coordination activities</td>
<td>• Complete HUB Operations Manual and HUB Quality Improvement Plan</td>
</tr>
<tr>
<td>• Determine HUB leadership and governance</td>
<td>• Develop polices and procedures</td>
</tr>
<tr>
<td>• Recruit and secure formal commitments from implementation partners</td>
<td>• Create tools and resources for care coordinators</td>
</tr>
<tr>
<td>• Develop HUB Implementation Plan</td>
<td>• Hire and train staff</td>
</tr>
<tr>
<td></td>
<td>• Conduct community awareness campaign</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scale &amp; Sustain</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recruit additional community organizations and partners to participate in HUB</td>
</tr>
<tr>
<td>• Implement additional focus areas or pathways</td>
</tr>
<tr>
<td>• Continuous quality improvement</td>
</tr>
<tr>
<td>• Provide training, technical assistance, learning collaboratives to support HUB</td>
</tr>
<tr>
<td>• Develop payment models to support care coordination model</td>
</tr>
<tr>
<td>• Implement VBP strategies to support HUB care coordination model</td>
</tr>
</tbody>
</table>
## Community-Based Care Coordination: Progress Measures

<table>
<thead>
<tr>
<th>Planning</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Binding letter of intent from HUB / lead entity</td>
<td></td>
</tr>
<tr>
<td>• Formal commitment from implementation partners</td>
<td></td>
</tr>
<tr>
<td>• Complete Implementation Plan</td>
<td></td>
</tr>
<tr>
<td>Implementation</td>
<td></td>
</tr>
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<td>• Complete HUB Operations Manual</td>
<td></td>
</tr>
<tr>
<td>• Complete HUB Quality Improvement Plan</td>
<td></td>
</tr>
<tr>
<td>• Policies and procedures in place</td>
<td></td>
</tr>
<tr>
<td>• Number of partners participating and the number implementing each selected Pathway</td>
<td></td>
</tr>
<tr>
<td>• Number of partners trained</td>
<td></td>
</tr>
<tr>
<td>Scale &amp; Sustain</td>
<td></td>
</tr>
<tr>
<td>• Number of partners participating in the HUB and the number implementing each selected Pathway</td>
<td></td>
</tr>
<tr>
<td>• Number of partners trained by focus area or Pathway</td>
<td></td>
</tr>
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<td>• Number of partners to achieve performance targets for outcomes metrics</td>
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</tr>
</tbody>
</table>
Community-Based Care Coordination: Incentive Measures

| System-Wide | • Emergency Department visits per 1,000 member months ($)  
|• Plan All-Cause Readmission Rate (30 days) ($)  
|• Inpatient Utilization ($)  
|• Percent Homeless (Narrow Definition) ($)  
|• Mental Health Treatment Penetration (Broad Version) ($)  
|• Substance Use Disorder Treatment Penetration ($)  
|• Percent Employed (Medicaid)  
|• Home and Community-based Long Term Services and Supports Use |

| Project-Level | To be determined based on approval of region-specific target populations and selected interventions. Will likely be related to pathways chosen for implementation.  
May include measures such as:  
• Well child visits  
• Low birth weight |
## Transitional Care

<table>
<thead>
<tr>
<th>Objective</th>
<th>Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.</th>
</tr>
</thead>
</table>
| Strategies / Approaches | **Evidence-based approaches for care management and transitional care**  
  - Interventions to Reduce Acute Care Transfers, INTERACT™ 4.0  
  - Transitional Care Model (TCM)  
  - Care Transitions Intervention® (CTI®)  
  - Care Transitions Interventions in mental Health  
  
  **Evidence-informed approaches to transitional care for people with health and behavioral health needs leaving incarceration**  
  - Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison  
  - A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: the APIC Model  
  - American Association of Community Psychiatrists’ Principles for Managing Transitions in Behavioral Health Services |
Transitional Care

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- Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison  
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## Transitional Care: Project Ideas

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<thead>
<tr>
<th>Planning</th>
<th>Implementation</th>
<th>Scale &amp; Sustain</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess current capacity to effectively delivery care transition services</td>
<td>• Implement one or more of the evidence-based strategies: INTERACT™ 4.0, Transitional Care Model, Care Transitions Intervention®, Care Transitions Interventions in Mental Health.</td>
<td>• Expand to service additional high-risk populations and communities</td>
</tr>
<tr>
<td>• Select population and determine evidence-based approach(es)</td>
<td>• Establish policies and protocols to support consistent implementation of model(s)</td>
<td>• Continuous quality improvement</td>
</tr>
<tr>
<td>• Recruit and secure formal commitments for participation from partners</td>
<td>• Increase availability of POLST forms across communities / organizations</td>
<td>• Ongoing training, technical assistance, learning collaboratives to support approaches</td>
</tr>
<tr>
<td>• Develop Project Implementation Plan</td>
<td>• Ensure training and technical assistance for providers and organizations</td>
<td>• Develop payment models to support care transitions approaches</td>
</tr>
<tr>
<td></td>
<td>• Implement communications to ensure care team and clients have access to care plan</td>
<td>• Implement VBP strategies to support transitional care</td>
</tr>
<tr>
<td></td>
<td>• Coordinate care management and transitional care plans with related services</td>
<td></td>
</tr>
</tbody>
</table>
# Transitional Care: Progress Measures

| Planning                           | • Select evidence-based / evidence-informed strategies  
|                                   | • Complete Project Implementation Plan  
|                                   | • List implementation partners with formal commitment to participate |
| Implementation                    | • Adopt guidelines, policies, protocols specific to selected approach  
|                                   | • Number of partners / providers implementing evidence-based approaches  
|                                   | • Number of partners / providers trained on evidence-based approaches (projected vs. actual and cumulative) |
| Scale & Sustain                   | • Number of partners participating in the care transition program  
|                                   | • Number of partners trained on the approach (projected vs. actual and cumulative) |
# Transitional Care: Incentive Measures

<table>
<thead>
<tr>
<th><strong>System-Wide</strong></th>
<th><strong>Project-Level</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>✷ Emergency Department Visits per 1,000 member months ($)</td>
<td>To be determined based on approval of region-specific target populations and selected interventions.</td>
</tr>
<tr>
<td>✷ Plan All-Cause Readmission Rate (30 Days) ($)</td>
<td></td>
</tr>
<tr>
<td>✷ Psychiatric Hospital Readmission Rate ($)</td>
<td></td>
</tr>
<tr>
<td>✷ Percent Homeless (Narrow Definition) ($)</td>
<td></td>
</tr>
<tr>
<td>✷ Inpatient Utilization ($)</td>
<td></td>
</tr>
<tr>
<td>✷ Follow-up After Discharge from ED for Mental Health, Alcohol, or Other Drug Dependence ($)</td>
<td></td>
</tr>
<tr>
<td>✷ Follow-up After Hospitalization for Mental Illness ($)</td>
<td></td>
</tr>
</tbody>
</table>
# Diversion Interventions

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

## Strategies / Approaches

### Evidence-supported Diversion Strategies
- Emergency Department Diversion
- Community Paramedicine Model
- Law Enforcement Assisted Diversion, LEAD®
### Diversion Interventions: Project Ideas

<table>
<thead>
<tr>
<th><strong>Planning</strong></th>
<th><strong>Implementation</strong></th>
<th><strong>Scale &amp; Sustain</strong></th>
</tr>
</thead>
</table>
| • Assess current capacity to effectively deliver diversion interventions  
• Identify priority communities and partners  
• Determine which non-emergent population should be the focus  
• Establish a community advisory group (LEAD®)  
• Recruit and secure formal commitments from implementation partners  
• Develop Project Implementation Plan | • Establish linkages between ED and primary care providers for notification and care coordination. Ensure patients are connected with primary care providers.  
• Develop protocols and plan for transporting patients with non-emergent needs to alternate care sites.  
• Engage law enforcement and tailor LEAD® intervention for community  
• Ensure training and technical assistance is available for partners  
• Implement communication strategies between care team and clients  
• Coordinate care management plans with related community services | • Expand the model to additional communities or partners  
• Continuous quality improvement  
• Ongoing training, technical assistance to support models  
• Develop payment and VBP models to support diversion strategies |
### Diversion Interventions: Progress Measures

| Planning | • Complete Project Implementation Plan for each selected approach  
|          | • List Community Advisory Group members (LEAD®)  
<table>
<thead>
<tr>
<th></th>
<th>• List implementation partners</th>
</tr>
</thead>
</table>
| Implementation | • Adopt guidelines, policies, protocols for the selected approach(es)  
|          | • Number of partners / providers implementing evidence-based approaches  
<table>
<thead>
<tr>
<th></th>
<th>• Number of partners / providers trained on evidence-based approach (projected vs. actual and cumulative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale &amp; Sustain</td>
<td>• Number of partners trained (projected vs. actual and cumulative)</td>
</tr>
</tbody>
</table>
### Diversion Interventions: Incentive Measures

| System-Wide | • Emergency Department visits per 1,000 member months ($)  
|             | • Percent Homeless (Narrow Definition) ($)  
|             | • Adult Access to Preventive / Ambulatory Care  
|             | • Percent Arrested  

| Project-Level | To be determined based on approach of region-specific target populations and selected interventions. |
Funding Mechanics
DISCLAIMER:
Information in this slide deck is based on documentation provided by the Health Care Authority and Manatt. Information presented here is not endorsed by HCA and is subject to change pending CMS approval.
FUNDS FLOW ON MULTIPLE LEVELS

CMS will invest $1.5B in WA over the 5-year waiver

$1.12B for delivery system transformation (via Accountable Communities of Health)
$205M for Foundational Community Support Services
$177M for Long Term Services and Supports (LTSS)

Health Care Authority will distribute $ to ACHs in multiple phases

ACHs are responsible for distributing $ to community
FUNDS FLOW: CMS to Washington

If the state does not meet Value-Based Payment goals and quality measures agreed upon with CMS each year, Washington will not receive all of the $1.12 billion.

How much money is at risk?

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent at risk</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>$ at risk</td>
<td>-</td>
<td>-</td>
<td>$11.8M</td>
<td>$21.7M</td>
<td>$38M</td>
</tr>
</tbody>
</table>

Note: funds are only for the 5-year waiver period; intent is that projects will be sustainable.
What are the Value-Based Payment goals and quality measures that Washington is accountable to CMS for during the 5-year waiver period?

**VBP Goals**

*Percentage of provider payments that must be in HCP-LAN alternate payment methodology categories 2C-4B*

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>30%</td>
<td>50%</td>
<td>75%</td>
<td>85%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Quality Measures**

- Emergency Department Visits per 1,000 mm
- Plan All-Cause Readmission Rate
- Mental Health Treatment Penetration (Broad)
- Substance Use Disorder Treatment Penetration
- Psychiatric Hospital Readmission Rate
- Well Child Visits in the 3, 4, 5 and 6th Years of Life
- Medication Management for People with Asthma
- Antidepressant Medication Management
- Comprehensive Diabetes Care: Blood Pressure Control
- Comprehensive Diabetes Care: HbA1c Poor Control
- Controlling High Blood Pressure
FUNDS FLOW: Washington to ACHs

ACHs are eligible to earn dollars from different “pools”

HCA
$1.12B for Delivery System Transformation

Remaining $149M for:
- State admin costs
- VBP incentives
- MCO incentives

$70M for Integration Incentives
ACHs can earn these dollars by meeting milestones and timelines for achieving financial integration of behavioral health.

$54M for Design Pool
ACHs can earn these dollars in year 1 (2017) through the certification and project planning process.

$847M for Project Pool
ACHs can earn these dollars in years 2 - 5 for meeting pay for reporting milestones and pay for performance measures.
FUNDS FLOW: Washington to ACHs

Not all dollars go directly to the ACH

- **HCA**
  - $1.12B for Delivery System Transformation

- **$70M for Integration Incentives**
- **$54M for Design Pool**
- **$847M for Project Pool**

ACH tells the Financial Executor how / where to distribute Project Pool funds

Financial Executor (HCA contractor)

Community Partners and Clinical Providers
Initiative 1 Funds Will Flow to Participants through Several Distinct “Pools”

**Total Initiative 1 DSRIP Transformation Funds ($1.12 billion)**

- **State Administration Funding ($52M)**
- **DSRIP Project Pool ($847M Max)**
- **Design Pool (Y1 Only) ($54M Max)**
- **Reinvestment Pool (Partnering Providers) ($113M Max + Un-earned Funds)**
- **Challenge Pool (MCOs) ($56M Max)**
- **Integration Incentive Pool ($70M Max)**
- **VBP Incentive Pools ($169M Max)**

Un-earned Project Pool funding will be available to be re-earned through high performance on statewide quality measures via the Reinvestment Pool.

Similarly, un-earned Challenge Pool funding could also be redistributed based on exceptional quality performance.

VBP Incentive Pool funds that remain after Integration Incentive Pool are divvied into Provider pool (2/3 of remaining) and MCO pool (1/3 of remaining).
**FUNDS FLOW: Washington to ACHs**

Integration Incentives
ACHs that implement fully integrated managed care (“financial integration”) before 2020 (“mid-adopters”) are eligible for additional incentive payments.

<table>
<thead>
<tr>
<th>ACH</th>
<th>$ for LOI (millions)</th>
<th>$ for Implementation (millions)</th>
<th>Total $ for Integration (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pierce</td>
<td>$4.0</td>
<td>$5.9</td>
<td>$9.9</td>
</tr>
</tbody>
</table>

To earn integration incentive dollars, ACHs must:

1. Submit a binding Letter of Intent by Sept 15, 2017
2. Implement new integrated MCOs on Nov 1, 2018 OR Jan 1, 2019

Integration incentive dollars are intended to support providers with the transition to integrated managed care, for example, new billing systems or technical assistance to navigate medical billing or business processes.

*Note ACHs will also work on clinical integration of behavioral health as part of the project pool.*
FUNDS FLOW: Washington to ACHs

Design Pool

**Phase 1**
- ACH submits Phase 1 Certification to HCA by May 15th
- HCA reviews to ensure ACH meets minimum “acceptable” in 6 categories
- ACH - HCA contract signed
- **ACH receives Design Payment 1 (~June)**
  - $1 million per ACH

**Phase 2**
- ACH submits Phase 2 Certification to HCA by Aug 14th
- HCA reviews Phase 2 application. Scoring criteria in development.
- **ACH receives Design Payment 2 (~September)**
  - *Up to $5 million per ACH based on application scoring.*
- If an ACH does not earn the full $5M for Phase 2, unearned funds will be added to the Project Pool.

Design pool funding is intended to support ACH capacity building, for example hiring staff, community convening, or tribal consultation. HCA may release additional documentation on what design pool funds can and cannot be used for.
ACHs must submit a Project Plan by Oct 23, 2017. HCA’s Independent Assessor will evaluate and score the Project Plan based on quality, completeness, projects. *Criteria under development*

Project Plan scoring affects the amount of Year 1 funds available to the ACH. *Methodology under development.*

**ACHs must include at least 4 projects in the Project Plan**

<table>
<thead>
<tr>
<th>Care Delivery Redesign</th>
<th>Prevention and Health Promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A: Bi-directional integration of behavioral health and primary care*</td>
<td>3A: Addressing the opioid use public health crisis*</td>
</tr>
<tr>
<td>2B: Community-based care coordination</td>
<td>3B: Maternal and child health</td>
</tr>
<tr>
<td>2C: Transitional care</td>
<td>3C: Access to oral health services</td>
</tr>
<tr>
<td>2D: Diversion interventions</td>
<td>3D: Chronic disease prevention and control</td>
</tr>
</tbody>
</table>

*Required projects

Project Plans must also describe ACH efforts related to Value-Based Payment, workforce development, and population health management.
Funds available to the ACHs are adjusted based on the percentage of Medicaid members in the region. Funds are also adjusted based on the number and weight of projects selected. If an ACH selects fewer than 8 projects, weights will be rebased. *Methodology under development.*

<table>
<thead>
<tr>
<th>ACH</th>
<th>Estimated Medicaid Share</th>
<th>Estimated Year 1 Project Pool Funding (millions)</th>
<th>Estimated TOTAL Project Pool Funding (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pierce</td>
<td>12%</td>
<td>$17</td>
<td>$102</td>
</tr>
</tbody>
</table>

Final % Medicaid share will be updated using Nov 2017 enrollment.

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A: Bi-Directional Integration of Care and Primary Care Transformation*</td>
<td>32%</td>
</tr>
<tr>
<td>2B: Community-Based Care Coordination</td>
<td>22%</td>
</tr>
<tr>
<td>2C: Transitional Care</td>
<td>13%</td>
</tr>
<tr>
<td>2D: Diversions Interventions</td>
<td>13%</td>
</tr>
<tr>
<td>3A: Addressing the Opioid Use Crisis*</td>
<td>4%</td>
</tr>
<tr>
<td>3B: Maternal and Child Health</td>
<td>5%</td>
</tr>
<tr>
<td>3C: Access to Oral Health Services</td>
<td>3%</td>
</tr>
<tr>
<td>3D: Chronic Disease Prevention / Control</td>
<td>8%</td>
</tr>
</tbody>
</table>

*Required projects
FUNDS FLOW: Washington to ACHs

Project Pool

ACHs will be paid for reporting and paid for performance throughout the waiver period.

Project Pool funds shift from pay for reporting to pay for performance over time. P4P begins in Year 3 (2019).

Pay for Reporting
ACHs will report on process metrics and milestones, e.g.,
# of participating providers, # of trainings or policies, or completing implementation plans for projects.

Pay for Performance
ACHs will be expected to make progress from their baseline toward performance goals on selected P4P measures (e.g., emergency department visits, or hospital readmissions).

Pay for Reporting → Pay For Performance

- Year 1: 100%
- Year 2: 75%
- Year 3: 50%
- Year 4: 25%
- Year 5: 0%

Reporting requirements are under development.
FUNDS FLOW: Washington to ACHs

Project Pool

Measure Weighting

ACHs will be expected to make progress from their baseline toward performance goals on selected P4P measures.

Progress will be measured semi-annually.

Pay for Performance dollars are adjusted based on how much progress an ACH has made toward the performance goal; an Achievement Value will be calculated for each measure.

<table>
<thead>
<tr>
<th>ACH Progress</th>
<th>Measure Achievement Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hit target performance</td>
<td>1</td>
</tr>
<tr>
<td>Between 75 - 99% of target performance</td>
<td>0.75</td>
</tr>
<tr>
<td>Between 50 - 75% of target performance</td>
<td>0.50</td>
</tr>
<tr>
<td>Between 25 - 50% of target performance</td>
<td>0.25</td>
</tr>
<tr>
<td>Less than 25% of target performance</td>
<td>0</td>
</tr>
</tbody>
</table>

In other words, even if ACHs do not meet their target performance, they will still be eligible to earn some portion of payment on a sliding scale.
FUNDS FLOW: Washington to ACHs

Project Pool

**Measure Weighting**

Achievement Values (AV) will be added up based on ACH performance on all measures (P4R and P4P) for a project.

The Percentage Achievement Value will then be applied to the total available funds for that project.

*If this example project was worth $4M: $4M * 62.5% = $2.5M earned for the project in this measurement period.*

Unearned funds from each project will be re-allocated through other pools or may be earned by high performing ACHs. *Methodology under development.*

---

**EXAMPLE: ACH Project Scoring**

<table>
<thead>
<tr>
<th>Measures</th>
<th>AV</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress Measure 1</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td>ACH met target performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P4R Measure 1</td>
<td>0</td>
<td>25%</td>
</tr>
<tr>
<td>ACH was less than 25% of target performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P4R Measure 2</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td>ACH met target performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P4P Measure 1</td>
<td>0.5</td>
<td>25%</td>
</tr>
<tr>
<td>ACH between 50 - 75% of target performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Achievement Value</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>Percentage Achievement Value (2.5 / 4 total possible) =</td>
<td>62.5%</td>
<td></td>
</tr>
</tbody>
</table>
In summary, total amounts that ACHs may earn are influenced by multiple levels of interconnected scoring and weighting.

ACH Certification Scoring
ACH Project Plan Scoring
ACH Project Selection (# and quality)
Size of Medicaid population in region
ACH performance on process and outcome measures
ACHs determine how to allocate Project Pool funds
Actual distribution of funds occurs via the Financial Executor

$847M for Project Pool

ACH tells the Financial Executor how / where to distribute Project Pool funds

Financial Executor (HCA contractor)

Community Partners and Clinical Providers

ACHs may decide to keep some of the Project Pool funds to support ongoing operations, project implementation, or backfill investments made using Design Pool funds.

ACHs determine which community partners and providers are eligible for Project Pool funds, including how funds are earned (e.g., P4P at the provider level, community grants, “everyone wins”, etc.)
Outstanding Questions

Much of the methodology is still under development and pending final CMS approval

Some unanswered questions include:

- Some pay for performance measures are included in multiple projects (e.g., ED utilization), but may only “count” for the highest weighted project - how will payment work for these measures?
- Which measures are included as part of pay for reporting, and what are the reporting requirements?
- How will ACH Project Plans be scored? How will scoring affect Project Pool funds available?
- How does project weighting change with project selection?
- Will ACHs be required to have contracts or MOUs in place with community organizations and providers to distribute Project Pool dollars?
- ACHs will be measured and paid 2x/year, but additional clarity is needed on the measurement period, whether ACHs need to meet performance targets every 6 months, how performance targets will be calculated, etc.
For More Information

Washington 1115 Waiver Special Terms and Conditions (STCs)
https://www.hca.wa.gov/sites/default/files/program/Medicaid-demonstration-terms-conditions.pdf

DSRIP Planning Protocol (Project Toolkit)

Financial Executor Overview

ACH Phase 1 Certification Template
https://www.hca.wa.gov/assets/program/ach-phase-cert-template.pdf
MTD Framework & Rules of Engagement
Continuum of Bi-directional Physical and Behavioral Health Integration
## Integration of Services & Clinical Guidelines

### Goals & Key Measures

**Goal:** Fully integrated delivery of physical and behavioral health services; specific population whole person care management supports in place

**Measure(s):**
- ED visits per 1000 Member Months ($)
- Plan All-Cause Readmission Rate (30 Days) ($)
- Psychiatric Hospital Readmission Rate ($)  
- Inpatient Hospital Utilization - Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)- Controlling High Blood Pressure - Adult Mental Health Status

- **Sub Goal:** Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place. **Measure(s)** Percent Homeless (Narrow Definition) ($)  
- Inpatient Utilization ($)  
- Follow-up After Discharge from ED for Mental Health, Alcohol, or Other Drug Dependence ($)  
- Follow-up After Hospitalization for Mental Illness ($)

- **Sub Goal:** Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations. **Measure:** Emergency Department visits per 1,000 member months ($)

- **Sub Goal:** Reduce opioid-related morbidity and mortality
  **Measure(s):**  
  - Emergency Department visits per 1,000 member months ($)  
  - Opioid Related Deaths (Medicaid Enrollees and Total Population) per 100,000  
  - Non-fatal overdose involving prescription opioids (in development)  
  - Substance Use Disorder Treatment Penetration (Opioid)

### Evaluation

**Technology Investments:** Epic Expansion to BH, IT Interface Solutions, Overlay of CORE/CCS platforms  
**Training & TA Investments:** Practice Coaching, Practice Certification, PCMH, Payment Change Mgmt. Support, Workforce development  
**Supports:** Cross sector partnerships, adequate staffing/operations, resources; coordination, & Meaningful Community Advisory  
**Data Capacity:** Systems and structures for data collection, analysis, reporting, and sharing  
**Save, Re-Invest & Sustain:** Advance VBP, Redirect funds into community priorities, pool resources, sustain efforts for community based prevention and mitigation.

---

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Projects</th>
<th>Goals &amp; Key Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key priority impact areas to achieve goals.</td>
<td>Specific activities, programs, policies, and systems change strategies to bring about change.</td>
<td>What we want to achieve and how we will measure success.</td>
</tr>
</tbody>
</table>

#### 1.) Integration of Physical and Behavioral Health VBP contracting to include additional incentives for:

**Potential Priority Projects – Additional Earning Potential**

1.1a) Implement one or more Care Transition Models
1.1b) Connect to Pathways HUB as a Care Coordination Agency
1.1c) Adopt Clinical Opioid Guidelines
1.1d) Implement the Chronic Care Model

**Potential Optional Projects - Additional Earning Potential**

1.2.) Diversion: Ensure patients are connected with primary care providers.
   1.2a) Develop - Telehealth Interventions
   1.2b) Community Paramedicine Partnership

1.3) Oral Health in Primary Care

1.4) Family Planning & Reproductive Health Strategies

1.5) Opioid Bundle
   1.5a) Community-based partnerships for needle exchange expansion
   1.5b) Emergency Room development of protocols in place for providing overdose education and take home naloxone to individuals seen for opioid overdose
### Years 1-2: Plan & Implement (Pay to Participate)

**ACH Supports...**
1. Ensure ACH workgroups/committees support project plan development
2. Coordinate and submit project plans
3. Provide project-specific training
4. Provide project-specific tools/technology
5. Provide plan for performance goals and funding for years 3-5.

**Participant Does...**
1. Formal commitment to participate in project (development and planning)
2. Be trained in project-specific evidence-based practices
3. Implement project-specific evidence-based approaches
4. Report project progress to ACH
5. Participate in monitoring performance related to measures and targets

### Years 3-5: Achieve (Pay for Performance)

**ACH Supports...**
- Pay for Performance (Years 3-5)

**Participant Receives...**
Receive funding for meeting performance targets related to project participation (Years 3-5)

---

**AIM**
System of Services to Promote and Improve Health and Well-Being

**Value:** Services and Outcomes are Sustainable, Equitable, and Whole Person

---

**To achieve a Sustainable, Equitable, Whole-Person System of Services** we need to:

- Integration of Services
- Coordination of Services
- Clinical Guidelines
- Prevention Services
- Diversion Services

- Logistically Supported: process, training, tools, workforce, etc.
- Informed by Community-Voice
- Informed by Data
- Incentivizing Value (Pay to Participate and Pay to Perform)
### Program Design Projects/Interventions Investments Planning: Outcomes

<table>
<thead>
<tr>
<th><strong>Move to Financial Integration (Mid-Adopter):</strong> Finalize binding letter, Begin RFP process with payers, state, county for financial integration.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assess Clinical Integration:</strong> Identify population and providers serving Medicaid beneficiaries and assess those providers’ capacity to effectively deliver integrated care. Assess level of Integrated Care Model Adoption and/or readiness across key providers / organizations service Medicaid beneficiaries.</td>
</tr>
<tr>
<td><strong>Set Cohort Targets:</strong> Identify the ideal number of providers to target with for clinical integration Cohort.</td>
</tr>
<tr>
<td><strong>Develop Incentive Earning Plan:</strong> Develop incentive rules of engagement for integrating primary care into behavioral health settings supporting VBP contracting and workforce.</td>
</tr>
</tbody>
</table>
| **Develop Request for Participants Process:** Formalize a Request for Proposal and Rules of Engagement Process to include:  
  - Required length of engagement  
  - Choose optional projects if any  
  - Potential incentive earning structure  
  - Training and TA given  
  - Technology investments required/given  
  - Workforce development training and skills given/required  
  - Systems coordination required/given: prevention, policies, intersections with other initiatives |

### Investment Plan: Training, Technical Assistance, Technology, and Infrastructure to include:

- Epic Expansion to BH
- IT Interface Solutions
- Practice Coaching
- Practice Certification
- PCMH
- Payment Change Mgmt. Support
- Overlay of CORE/CCS platforms
- Broad Community Connections/Partnerships

### Potential Optional Projects - Additional Earning Potential w/ New Partners

- **1.2) Diversion:** Ensure patients are connected with primary care providers.  
  - 1.2a) Develop - Telehealth Interventions  
  - 1.2b) Community Paramedicine Partnership

- **1.3) Oral Health in Primary Care**

- **1.4) Family Planning & Reproductive Health Strategies**

- **1.5) Opioid Bundle**  
  - 1.5a) Community-based partnerships for needle exchange expansion  
  - 1.5b) Emergency Room development of protocols in place for providing overdose education and take home naloxone to individuals seen for opioid overdose

### Systems Change Outcomes

- Integrated and Coordinated Care
- Common Metrics
- Aligned Payment Systems (APM/VBP) $\
- Cultural Competency
- Population Health System $\
- Sustainable Workforce $\

### Process Outcomes

- # of practices and providers implementing integrated evidence-based approaches
- # of practices and providers trained on evidence-based practices
- # of primary care practices / providers achieving PCMH recognition
- # of primary care providers achieving special recognitions / certifications / licensures (e.g., for MAT)
- # of practices and providers to achieve performance targets for outcomes metrics
Practice
Transformation Hub &
ACH
INTEGRATION – WHAT HEALTH CARE PROVIDERS WILL NEED

Technical Assistance
Workflow Redesign
Practice Coaching
  • Integration
  • Value Based Payment

VBP Technical Assistance
Sustainable payment model that meets state’s goals for VBP and provides adequate compensation

Assessment and Training
Technical Assistance

Infrastructure
  • Technology
  • Training
  • Convening
  • Transition Assistance
  • Project Incentives
  • Other

Practice Transformation Hub Qualis UW
Link with ACHs to ensure connectivity and to reduce gaps

MCOs

ACH

SOURCE: Dawn Bonder, CEO Southwest Accountable Community of Health
The Hub: Offering a Menu of Services to Support Practice Transformation Efforts

<table>
<thead>
<tr>
<th>Hub Help Desk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalized practice assessment</td>
</tr>
<tr>
<td>Education, tools and resources</td>
</tr>
<tr>
<td>Support for bi-directional physical and behavioral health integration</td>
</tr>
<tr>
<td>Finding and coordinating community-based linkages</td>
</tr>
</tbody>
</table>
### Other Practice Transformation Efforts:
#### Transforming Clinical Practice Initiatives (TCPi)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Features</th>
</tr>
</thead>
</table>
| University of Washington                                                    | - Currently provides support for health systems falling under immediate UW umbrella  
                              | - Plans to expand to other UW-affiliated clinics                                                                                         |
| PeaceHealth                                                                 | - Provides support for their own clinics in OR, WA, and AK                                                                             |
| Department of Health                                                         | - Focus on Pediatric clinics and behavioral health agencies  
                              | - Serves all 9 ACH regions                                                                                                               |
| National Rural Accountable Care Consortium                                   | - Provides support to rural health systems throughout US - WA included  
                              | - Tiered support                                                                                                                         |
Continuum of Bi-directional Physical and Behavioral Health Integration
## Personalized Practice Evaluation

**Patient Centered Medical Home Assessment (PCMH-A)**

- Intended to help sites understand their current level of “medical homeness” and identify opportunities for improvement
- 36 questions
- 12 point assessment scale
Personalized Practice Evaluation

MeHAF (Maine Health Access Foundation)

- 21 questions
- Wording for both primary care and behavioral health providers
- 10 point assessment scale
- Closely aligned to the PCMH-A (Patient Centered Medical Home Assessment)
Support for Successful Bidirectional Behavioral Health Integration

- Regular, on-site technical assistance
- Help understanding appropriate models of integration
- Guidance in screening and assessment of patients, and referrals to behavioral health providers
- Connections to community resources that support integration efforts and improve patient engagement and outcomes
Supporting Practice Transformation

Create an action plan
- Focus on the organization’s priorities
- Provide education, tools and resources

Hold regular, on-site meetings
- Assist organizations with implementation of action plan
Current Practices in Pierce County Enrolled in Technical Assistance

Primary Care Clinics

- Key Medical Center
- Bret Price, ARNP
- Sound Clinical Medicine

Behavioral Health Agencies

- HopeSparks
- Catholic Community Services - Family Behavioral Services
Thank you, Provider Integration Panel, Partners, & Community
SUPPLEMENTAL SLIDES
The Hub: A Four-year, State Innovation Model (SIM) Testing Grant

Three separate contracts, funded by DOH

Qualis Health provides Practice Coaches and Regional Connectors programs

Web Resource Portal offered through partnership with UW Department of Family Medicine Primary Care Innovation Lab
The Practice Transformation Support Hub Resource Portal

Transforming Healthcare Practices Across Washington
Better clinical outcomes, patient satisfaction, lower costs, and greater professional reward.

www.waportal.wa.edu
The Hub: Offering a Menu of Services to Support Practice Transformation Efforts

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</tbody>
</table>
Finding and Coordinating Community-Based Linkages

Practice Coach and Regional Connector capacities

Sustainable, effective community partnerships for better coordination of care

Information and links to other local practice transformation initiatives

Building healthcare resources and relationships to engage and benefit patients
## Other Practice Transformation Efforts: Transforming Clinical Practice Initiatives (TCPi)

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<th>Description</th>
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                                        • Serves all 9 ACH regions                                                   |
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                                              • Tiered support                                                              |
Actively Collaborating with
Regional Resources

Northwest Physicians Network

DOH Pediatric TCPi
Education, Tools and Resources

Practice Coach and Regional Connector capacities

Educational opportunities e.g. webinars and trainings on practice transformation

Help to better understand and prepare for value-based payment and bidirectional behavioral health

Links to a Web Resource Portal with references, tools, and up-to-date information and success stories
Moving from Volume to Value

- Educate about opportunities and models for federal and state-based value-based payment (VBP) programs
- Coach on QI methodology to assist in capturing appropriate data in planning for VBP
Personalized Practice Evaluation

1. Identify where organizations are in the process and address specific needs and challenges
2. Provide a gap analysis and action plan; help set goals for change
3. Help implement specific, quality improvement strategies
Continuum of Bi-directional Physical and Behavioral Health Integration
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For More Information

Hub Help Desk:
(206) 288-2540 or (800) 949-7536 ext. 2540
Email HubHelpDesk@qualishealth.org

Healthier Washington Practice Transformation Support Hub websites:
http://bit.ly/2e0PpmF
www.QualisHealth.org/hub

Hub Resource Portal website:
http://www.waportal.org/

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