CASCADE PACIFIC ACTION ALLIANCE
IMPROVING COMMUNITY HEALTH & SAFETY

Reference Guide

Request for Proposals – May 30, 2018

2A – Bi-Directional Integration of Care

Bi-Directional Care Integration focuses on delivering whole-person care, addressing physical and behavioral health in an integrated system where medical and behavioral health providers work together to coordinate and deliver care. Moving into an integrated system means closing the gap between primary care and behavioral health services by implementing core principles of collaborative care: patient-centered team care, population-based care, measurement-based treatment to target, evidence-based care, and accountable care. Partners can participate in this project by implementing collaborative care through offsite enhanced collaboration, co-located enhanced collaboration, or co-located integrated care.

Interventions:

Integrating Behavioral Health into Primary Care Settings

- Collaborative Care Model
    - Patient Identification & Diagnosis: Screen for behavioral health problems using valid instruments. Diagnose behavioral health problems and related conditions. Use valid measurement tools to assess and document baseline symptom severity.
    - Engagement in Integrated Care Program: Introduce collaborative care team and engage patient in integrated care program. Initiate patient tracking in population-based registry.
    - Evidence-based Treatment: Develop and regularly update a biopsychosocial treatment plan. Provide evidence-based counseling and psychotherapy. Prescribe and manage psychotropic medications as clinically indicated. Change or adjust treatments if patients do not meet treatment targets.
    - Systematic Follow-up, Treatment Adjustment, and Relapse Prevention: Use population-based registry to systematically follow patients. Proactively reach out to patients who do not follow-up. Monitor treatment response at each contact with valid outcome metrics. Monitor treatment side effects and complications. Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment. Create and support relapse prevention plan when patients are substantially improved.
    - Communication & Care Coordination: Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location. Facilitate and track referrals to specialty care, social services, and community-based resources.
    - Systematic Psychiatric Case Review & Consultation (in-person or via telemedicine): Conduct regular (e.g., weekly) psychiatric caseload review on patients who are not improving.
    - Program Oversight and Quality Improvement: Provide administrative and clinical support to an integrated team. Routinely examine provider- and program-level outcomes (e.g., clinical

outcomes, quality of care, patient satisfaction) and use this information for quality improvement.

- Please visit http://aims.uw.edu/collaborative-care/principles-collaborative-care to learn more about the Collaborative Care Model.
- Bree Collaborative Behavioral Health Integration minimum standards
    - Integrated care team: Each member of the integrated care team has clearly defined roles for both physical and behavioral health services, either in person or virtually.
    - Routine access to integrated services: Access to behavioral health and primary care services are available routinely, as part of the care team's daily work flow and on the same day as patient needs are identified as much as feasible, in person or virtually.
    - Accessibility and sharing of patient information: The integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care. All clinicians collaborate to jointly support their roles in the patient's shared care plan.
    - Access to psychiatry services: Access to psychiatry consultation services is available in a systematic manner to assist the care team in developing a treatment plan.
    - Operational systems and workflows support population-based care: A structured method is in place for proactive identification and stratification of patients for behavioral health conditions, and each patient is engaged and treated-to-target.
    - Evidence-based treatments: Age-appropriate, measurement-based interventions for physical and behavioral health interventions are adapted to the specific needs of the practice setting. Integrated practice teams use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether their patients are improving.
    - Patient involvement in care: The patient's goals are incorporated into the care plan. The team communicates effectively with the patient about their treatment options and asks for patient input and feedback into care planning
- Please visit http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Draft-Recommendations-2017-01.pdf to learn more about the Bree Collaborative Behavioral Health Integration Recommendations

Integrating Primary Care into Behavioral Health

- Off-site enhanced collaboration
    - Providers have regular contact and view each other as an interdisciplinary team, working together in a client-centered model of care.
    - A process for bi-directional information sharing, including shared treatment planning, is in place and is used consistently.
    - Providers may maintain separate care plans and information systems, but regular communication and systematic information sharing results in alignment of treatment plans and effective medication adjustments and reconciliation to effectively treat beneficiaries to achieve improved outcomes.
    - Care managers and/or coordinators are in place to facilitate effective and efficient collaboration across settings ensuring that beneficiaries do not experience poorly coordinated services or fall through the cracks between providers.
    - Care managers and/or coordinators track and monitor physical health outcomes over time using registry tools, facilitate communication across settings, and follow up with patients and care team members across sites

- Co-located enhanced collaboration or co-located integrated care
    - Patient Identification: Screen for and document chronic diseases and conditions, such as obesity, diabetes, heart disease and others. Diagnose chronic diseases and conditions. Assess chronic disease management practices and control status.
    - Engagement in Integrated Care Program: Introduce collaborative care team and engage patient in integrated care program. Initiate patient tracking in population-based registry.
    - Evidence-based Treatment: Develop and regularly update a biopsychosocial treatment plan. Provide evidence-based self-management education. Provide routine preventative care. Prescribe and manage medications as clinically indicated.
    - Systematic Follow-up, Treatment Adjustment: Use population-based registry to systematically track and follow up with identified patients. Monitor treatment response at each contact with valid outcome metrics.
    - Communication & Care Coordination: Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location. Facilitate and track referrals to specialty care, social services, and community-based resources.
    - Systematic Case Review & Consultation (in person or via telemedicine): Conduct regular (e.g., weekly) chronic disease and condition caseload review on patients who are not improving.
    - Program Oversight and Quality Improvement: Provide administrative and clinical support to an integrated team. Routinely examine provider-level and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use to inform quality improvement processes and activities.
    - Please visit https://www.milbank.org/wp-content/files/documents/papers/Integrating-Primary-Care-Report.pdf to learn more about integrating primary care into behavioral health

2B – Community Based Care Coordination (Pathways)

This project will implement the Pathways Community HUB model of care coordination in the CPAA region. CHOICE Regional Health Network will staff and manage the CPAA Community HUB. Project partners can participate by becoming a *Care Coordinating Agency (CCA)*, and/or by contributing to one or more *HUB Development Projects*. Partners wishing to participate in this project should review the following documents:

- Pathways Community Quick Start – Overview of work to implement the Pathways model. Includes all 20 standardized Pathways CCAs must offer.
- Pathways Prerequisites and Standards – Requirements CCAs and the Pathways HUB must follow to be nationally certified.

Partners interested in becoming *Care Coordinating Agencies* should be prepared to fully implement the Pathways model, including the following key elements in their plans:

- Employ care coordinators with shared lived experiences with the target population and similar skill set as Peer Counselors or Community Health Workers
- Participate in training and ongoing quality improvement coordinated through the Pathways Community HUB
- Utilize the CCS Software Platform and keep timely and accurate records using the platform
- Accept outcome based payments from the HUB as a primary source of reimbursement for delivering Pathways care coordination services

2C – Transitional Care

CPAA aims to limit the time between patient discharge and follow-up appointments, reduce hospital readmissions, improve coordination between medical and community resources for high risk patients, and expand admission screenings to identify high risk patients.

Interventions:

1. **Transitional Care Model:**

- Transitional Care model is a nurse led model of transitional care for high risk patients that provides comprehensive in-hospital planning and home follow-up.

MTP Toolkit Recommended Components

- Use of advanced knowledge and skills by a transitional care nurse (TCN) to deliver and coordinate care of high risk patients *within* and *across* all health care settings. The TCN is the primary coordinator of care throughout potential or actual episodes of acute illness;
- Comprehensive, holistic assessment of each patient's priority needs, goals, and preferences and continued engagement with a focus on meeting those goals
- Collaboration with high risk patients, family caregivers, and team members in implementation of a streamlined, evidenced-based plan of care designed to promote positive health and cost outcomes;
    - Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months;
- Continuity of health care between settings facilitated by the TCN accompanying patients to visits to prevent or follow-up on an acute illness care management;
- Emphasis on patients' early identification and response to health care risks and symptoms to achieve *longer term* positive outcomes and avoid adverse and untoward events that lead to acute care service use
- Multidisciplinary approach that includes the patient, family caregivers, and health care providers as members of a team;
    - Ongoing investment in optimizing transitional care via performance monitoring and improvement.

- More information: www.nursing.upenn.edu/ncth/transitional-care-model/

2. **Care Transitions Interventions:**

- Care Transitions Interventions is a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives.

MTP Toolkit Recommended Components

- A meeting with a Transitions Coach® in the hospital (where possible, as this is desirable but not essential) to discuss concerns and to engage patients and their family caregivers.
- Set up the Transitions Coach® in home follow-up visit and accompanying phone calls designed to increase self-management skills, personal goal attainment and provide continuity across the transition.

- More information: http://caretransitions.org/ and the mental health adaption by Viggiano et al., http://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf

3. **Provide services that address social determinants of health including but not limited to health literacy, food insecurity, transportation instability, housing instability**

3A – Opioid Response

CPAA Opioid Response aims to use practical, evidence-based approaches to prevent initiation of use by changing the way opioids are prescribed, prevent overdose deaths, reduce stigma and judgement, and increase recovery supports and access to medication assisted treatment (MAT). Please visit http://www.cpaawa.org/wp-content/uploads/2018/05/CPAA-Overview_Onesheet_3A.pdf to learn more about CPAA's Opioid Response project.

Interventions:

Standardize Opioid Prescribing Practices and Monitoring of Patients on Opioids for Chronic Pain

- Develop or adopt practice measures that include the PMP and Prescribing Practices
- Use of best practices among health care providers for prescribing opioids for acute and chronic pain:
  - Use of the PDMP and its linkage into electronic health record systems in an effort to increase the number of providers regularly using the PDMP and the timely input of prescription medication data into the PDMP.
  - Train, coach, and offer consultation with providers on opioid prescribing and pain management.
  - Promote the integration of telehealth and telephonic approaches. Support innovative telehealth in rural and underserved areas to increase capacity of communities to support OUD prevention and treatment.
  - Build capacity of health care providers to recognize signs of possible opioid misuse, effectively identify OUD, and link patients to appropriate treatment resources. Effective treatment of OUD includes medication and psychosocial supports.
  - Educate providers across all health professions on how to recognize signs of opioid misuse and OUD among patients and how to use appropriate tools to identify OUD.
  - Offer patients brief interventions and referrals to medication assisted treatment (MAT) and psychosocial support services, if needed.
  - Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options. Pharmacists utilize tools on where to refer patients who may be misusing prescription pain medication.

Expand Access to Opioid Replacement Therapy/Medication Assisted Treatment

- Expand access to, and utilization of, clinically-appropriate evidence-based practices for OUD treatment in communities, particularly medication assisted treatment (MAT):
  - Increase the number of providers certified to prescribe OUD medications in the region; promote the application and receipt of physician, ARNP, and Physician Assistant waivers for providers in a variety of settings (e.g. hospitals, primary care clinics, correctional facilities, mental health and SUD treatment agencies, methadone clinics, and other community based sites).
  - Build structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers and staff to implement and sustain medication assisted treatment, such as methadone and buprenorphine; examples of evidence-based models include the Hub and Spoke and Nurse Care Manager models.
  - Promote and support pilot projects that offer low barrier access to buprenorphine in efforts to reach persons at high risk of overdose (e.g. emergency departments, correctional facilities, syringe exchange programs, SUD and mental health programs).

- Build linkages/communication pathways between those providers providing medication assisted treatment and those providing psychosocial therapies.
- Expand access to, and utilization of, OUD medications in the criminal justice system. Train and provide technical assistance to criminal justice professionals to endorse and promote medication assisted treatment for people under criminal sanctions.
- Optimize access to chemical dependency treatment services for offenders who have been released from correctional facilities into the community and for offenders living in the community under correctional supervision through effective care coordination and engagement in transitional services.
- Ensure continuity of treatment for persons with an identified OUD need upon exiting correctional facilities by providing direct linkage to community providers for ongoing care.

Overdose Prevention

- Naloxone Education, Administration, and Distribution
    - Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage beneficiaries in support services.
    - Educate individuals who use heroin and/or prescription opioids, and those who may witness an overdose, on how to recognize and appropriately respond to an overdose
    - Provide technical assistance to first responders, chemical dependency counselors, and law enforcement on opioid overdose response training and naloxone programs.
    - Assist emergency departments to develop and implement protocols on providing overdose education and take home naloxone to individuals seen for opioid overdose.
    - Make system-level improvements to increase availability and use of naloxone
    - Establish standing orders in all counties and all opioid treatment programs to authorize community-based naloxone distribution and lay administration.
    - Promote co-prescribing of naloxone for pain patients as best practice per AMDG guidelines.
    - Together with the Center for Opioid Safety Education, promote awareness and understanding of Washington State's Good Samaritan Law. Educate law enforcement, prosecutors and the public about the Good Samaritan Response Law.

Recovery Supports: Promote long-term stabilization and whole-person care

- Peer Based Recovery Supports
    - Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.
    - Establish or enhance community-based recovery support systems, networks, and organizations to develop capacity at the local level to design and implement peer and other recovery support services as vital components of recovery-oriented continuum of care.
    - Support whole person health in recovery: Connect substance use disorder providers with primary care, behavioral health, social services, and peer recovery support providers to address access

3B – Reproductive, Maternal, Child Health

CPAA aims to improve support for the whole family through interventions that support a healthy pregnancy, keep children safe through routine preventative care, and ensure access and utilization of effective family planning strategies.

Interventions:

1. One Key Question

- The One Key Question intervention encourages all primary care health teams to routinely ask women of reproductive-age, "Would you like to become pregnant in the next year?" and have four response options of Yes, No, Unsure, and OK Either Way. Women are then offered follow-up preventive reproductive health services depending on their needs before conception, whether before a first or a subsequent pregnancy.

    - https://www.arhp.org/uploaddocs/RH13_Presentation_One_Question.pdf
    - https://www.marchofdimes.org/materials/one-key-question-overview.pdf

2. Long Acting Reversible Contraceptives

- Training and education for providers or other non-clinical staff on LARCS (IUDs and contraceptive implants). This could include screening, outreach and awareness for patients, insertion procedure, and counseling around side effects.

    - https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception
    - https://www.upstream.org/partner-resources/administrative-tools/

3. Nurse Family Partnership

- Nurse-Family Partnership® (NFP) is an evidence-based, community health program that serves low-income women pregnant with their first child. Each vulnerable new mom is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits. Applicants are encouraged to consider how to expand their current NFP program to reach more patients or target high risk populations.

    - https://www.nursefamilypartnership.org/about/

4. Early Head Start Home-Based Model

- Early Head Start Home-Based Model (EHS) works with parents to improve child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. Applicants are encouraged to consider how to expand their current NFP program to reach more patients or target high risk populations.

    - https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/poi/miechv-ehs/miechv.html

5. Parents as Teachers

- Parents as Teachers promotes optimal early development, learning, and health of young children by supporting and engaging their parents and caregivers. Applicants are encouraged to consider how to expand their current NFP program to reach more patients or target high risk populations.

    - https://parentsasteachers.org/evidence-based-model/

6. Bright Futures

- Bright Futures is intended to support primary care practices in providing well-child and adolescent care. Implementing agencies must meet all fidelity, essential requirements and/or program standard requirements as defined by the model developer. Applicants are encouraged to consider how to expand their current Bright Futures to improve regional well-child visit rates (for ages 3-6) and childhood immunization rates.

    - https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx

7. Enriched Medical Home Intervention Screening

- Hospital Enriched Medical Home Intervention (EMHI) voluntary program is offered to families whose children are considered at-risk for poor outcomes due to health care disparities utilizing trained health community workers who compiled patient immunization history and socio-demographic data.

    - https://www.stonybrook.edu/newsroom/children/home-intervention-improves-child-vaccination-rates-among-children-living-in-poverty.php

8. School Based Health Center

- Piloting a school-based health center leveraging community resources and partnerships.

    - http://www.sbh4all.org/school-health-care/aboutsbhcs/

9. Other: Indicate any additional evidence based interventions that seek to improve Maternal and Child Health

3D – Chronic Disease Prevention and Control

CPAA aims to reduce number of risk factors, incidence, and relevance of chronic disease, raise awareness of chronic disease prevention through community outreach and education, educate communities on chronic disease prevention and treatment, increase frequency of preventative screenings for common chronic diseases, expand community paramedicine resources (EMS), and improve coordination between medial and community resources for high-risk patients.

Interventions:

1. **Implement Wagner's Chronic Care Model**

- The Chronic Care Model creates practical, supportive, evidence-based interactions between an informed, activated patient and a prepared, proactive health care team.
- Specific Strategies for consideration within the Chronic Care Model Approach:
    a. Stanford Chronic Disease Self-Management Program https://www.selfmanagementresource.com/
    b. Million Hearts Campaign https://millionhearts.hhs.gov/
    c. CDC National Diabetes Prevention Program https://www.cdc.gov/diabetes/prevention/index.html,
    d. Adopt Policy, Systems, & Environmental change based on the CDC Community Guide https://www.thecommunityguide.org/

MTP Toolkit Recommended Components

- *Self-Management Support:* strategies and resources to "empower and prepare patients to manage their health and health care" such as: incorporate the 5As into regular care; complete and update Asthma Action Plans; provide access to Asthma Self-Management Education, Diabetes Self-Management Education, Stanford Chronic Disease Management Program; support homebased blood pressure monitoring; provide motivational interviewing; ensure cultural and linguistic appropriateness.
- *Delivery System Design*: strategies to support effective, efficient care, such as: implementing and supporting team-based care strategies, increasing the presence and clinical role of non-physician members of the care team; increasing frequency and improving processes of planned care visits and follow-up; referral processes to care management and specialty care.
- *Decision Support:* strategies to support clinical care that is consistent with scientific evidence and patient preference, such as: development and/or provision of decision support embed evidence-based guidelines and prompts into EHRs; provide education as needed on evidence-based guidelines; establish collaborative management practices and communication with specialty providers; incorporate patient education and engagement strategies.
- *Clinical Information Systems*: strategies to organize patient and population data to facilitate efficient and effective care, such as: utilization of patient registries; automated appointment reminder systems; bi-directional data sharing and encounter alert systems; provider performance reporting.
- *Community-based Resources and Policy*: strategies to activate the community, increase community-based supports for disease management and prevention, and development of local collaborations to address structural barriers to care such as: Community Paramedicine, tobacco free policy expansion, tobacco cessation assistance, nutritional food access policies, National Diabetes Prevention Program, home-based and school-based asthma services, worksite nutritional and physical activity programs behavioral screen time interventions.
- *Health Care Organization*: strategies that ensure high quality care, such as: engagement of executive and clinical leadership; support for quality improvement processes; shared learning

structures; intersection with Care Coordination efforts; financial strategies to align payment with performance.

- More information: www.improvingchroniccare.org

2. **Implement Evidence-Based Mobile Integrated Healthcare/ Community Paramedicine Model**.

- Community Paramedicine Model expands the role of paramedics to address care gaps and facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations.

MTP Toolkit Recommended Components

  - A detailed explanation about how the community paramedics would be trained and would maintain their skills and how appropriate medical supervision would be ensured.
  - A description of how data to evaluate quality assurance and quality improvement activities would be obtained and monitored.
  - An evaluation plan for assessing the impacts on quality and cost of care, and how the local EMS agency will ensure that all patients are treated equally regardless of insurance status and health condition, among other factors.
  - A plan for integrating the CP program with other community-based health care and social service programs and for analyzing the potential impacts of the CP program on these providers, including safety-net providers.
  - How to leverage the potential of electronic health records (EHRs) and Health Information Exchange (HIE) to facilitate communication between community paramedics and other health care providers.
- More information: http://www.communityparamedic.org/Program-Handbook and https://www.naemt.org/docs/default-source/community-paramedicine/naemt-mih-cp-report.pdf includes advisory elements but is not intended to be prescriptive

3. **Provide services that address social determinants of health including but not limited to health literacy, food insecurity, transportation instability, and housing instability**