3D: Chronic Disease Prevention and Control

Project Stage Milestones	Completion Deadline (Demonstration Year, Quarter)	ACH Approach for Accomplishing Milestones
Stage 1: Planning		
Assess current state capacity to effectively impact chronic disease	DY 2, Q2	Building on past regional capacities, CPAA will conduct an online survey of key clinical providers and public health departments in the region to gauge the current state capacity for implementing the Chronic Care Model and specific corresponding strategies outlined in the Project Toolkit by the end of DY2, Q2. Particular emphasis will be placed on potential partnering providers, i.e., key partners identified during the project design phase to date. We will augment this survey through a discussion of survey results with key partners, advisory committees, and work groups. In addition to understanding the impact of the Chronic Care Model, CPAA will identify how specific strategies, such as the Community Guide, Million Hearts Campaign, Stanford Chronic Disease Self-Management Program (CDSMP), and Community Paramedicine model, are being implemented to get a better understanding of alignment opportunities with other project areas and how current capacities can be expanded.
Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project	DY 2, Q2	By the end of DY2, Q2, CPAA will finalize the specific Domain 1 strategies which support the project. 1) Systems for Population Health Management: Population health data analysis will continue to be used to refine target populations, including identifying sub-groups and sub-regions. Additionally, we will develop an inventory of our partnering providers' electronic health record (EHR) systems to develop strategies for information sharing. This will include push and pull notifications based on the level of system interoperability. CPAA will also explore opportunities for expanding the use of EPIC among partnering providers, given that approximately 40% of our region (especially hospital systems) is already using this technology platform. Connection of health information technology systems is integral to

		the Chronic Care Model and emphasizing the importance of producing better information on patient intake procedures will assist clinicians to better address the chronic disease aspects of a patient's care. Additionally, CPAA will explore the interoperability capabilities of EDIE, which is used by most emergency departments, and the different population health systems used by emergency medical services (EMS). 2) Workforce: CPAA has solicited feedback from the Domain 2 Work Group to identify training needs to support the development of provider workforce capacity. One workforce enhancement strategy will be to increase the use of lay health advisors that have experienced chronic disease. CPAA will continue this assessment of provider workforce needs during implementation planning through an online survey of providers. Survey results will be discussed by the Clinical Provider Advisory Committee to interpret the results and ensure completeness. We will solicit the technical assistance and expertise of the HCA, DOH, and EMS personnel, among others, to provide additional support and training. We will bring together the expertise of training partners and the internal, in-depth knowledge of our providers to develop innovative workflows and new roles and responsibilities for health care personnel that will help mitigate unmet workforce needs. One strategy focuses on frontline clinical staff and developing increased skills in awareness of community resources and best referrals for patients with chronic health conditions. Another is training on how to effectively engage challenging clients with multiple conditions. CPAA will continue to explore provider workforce recruitment and retention support strategies that benefit all project areas, such as offering loan forgiveness and conditional scholarships. Additional workforce mitigation strategies CPAA will explore shared workforce strategies, such as expanding access to telehealth, changing overly burdensome licensing requirements for certain practitioners, developing internships for college students, and establishing a learning collaborative of partnering providers. As with

		investments in Systems of Population Health Management, our investments in Workforce training, recruitment, and retention will be coordinated across all project areas to develop synergies. 3) Value-based Purchasing: Given the importance of MCOs in funding clinical care for Medicaid beneficiaries, CPAA has included MCO representatives in all stages of project selection and planning, including project work groups. This ensures that our project design and implementation aligns well with current and emerging VBP approaches. Since HCA contracts with MCOs, working closely with HCA will be crucial. CPAA will work with the statewide VBP Task Force to assess how VBP contracts can support chronic disease prevention and control efforts. This will allow partnering providers to assess VBP options and prepare their organizations for value-based care delivery. Again, CPAA's efforts to support provider movement to value-based care will not be specific to chronic disease prevention and control, but support all project areas.
Finalize specific target population(s), guided by disease burden and overall community needs, ACH will identify the population demographic and disease area(s) of focus, ensuring focus on population(s) experiencing the highest level of disease burden. Select evidence-based guidelines and best practices for chronic disease care and management using the Chronic Care Model approach to improve asthma, diabetes, and/or heart disease control, and address obesity in their region. -Region may pursue multiple target chronic conditions and/or population-specific	DY 2, Q2	By the end of DY2, Q2, CPAA will refine the selection of target populations. To date, CPAA determined it will target efforts in counties with the highest percentage of chronic disease diagnoses coupled with lower rates of required detection screenings. As a result of the analysis, we identified target populations and project areas that would address gaps and have the deepest impact for populations who would most benefit from needed interventions. As a proxy to identify areas where there are significant health disparities, CPAA looked at Medicaid claims data and mortality rates in counties by census tracts and the Healthier Washington Data Dashboard to identify specific target populations and sub-regions for our projects. Examples of such groups include: • Individuals with two or more chronic disease(s) • Individuals diagnosed with diabetes in Grays Harbor, Mason, and Pacific counties • Individuals diagnosed with heart disease in Lewis, Grays Harbor, Mason and Pacific counties

strategies in their overall approach.		• Individuals diagnosed with asthma in Grays Harbor, Lewis, and Wahkiakum counties • Individuals with a chronic condition and behavioral health disorder Addressing health disparities will help improve health equity in our community. Going forward, we will review the target population(s) prioritized by other project areas to determine whether there are shared population(s) across project areas with an emphasis on Care Coordination and Bi-Directional Integration of care. CPAA will perform a similar cross-analysis of sub-populations and sub-regions. Aligning our target populations and sub-regions across project areas to the greatest extent possible will generate maximum synergies and impact. In support of this analysis, we will continue to work with CORE to refine our data tools. As we progressively narrow down our target population(s) through these efforts, our work group and partnering providers will be able to make a final determination about the project's target population(s).
Identify, recruit, and secure formal commitments for participation from all implementation partners, including health care providers (must include primary care providers) and relevant community-based service organizations. Form partnerships with community organizations to support and develop interventions that fill gaps in needed services (www.improvingchroniccare.org).	DY 2, Q2	CPAA identified key clinical partnering providers for this project using (1) the well-established network of partnerships with a broad range of clinical providers through CHOICE Regional Health Network's health improvement projects; (2) responses to a Request for Qualifications (RFQ) that was issued this summer; and (3) an analysis of the main Medicaid providers and community-based organizations in the CPAA region by our strategic data analytics partner, CORE. In the coming months, we will be systematically reaching out to those main Medicaid providers that have not yet engaged in project planning to introduce the project and encourage participation in project design and implementation planning. Concurrently, we will reach out to social service providers and community resources in our region whose support is crucial to fill gaps between needed chronic disease services. The recruitment of specific partnering providers - both clinical and community-based - will be guided by our final decision about the target population(s) and sub-regions for this project. Partnering organizations and providers will receive detailed technical

		support to ensure participants are well-versed on the Chronic Care Model and specific strategies to be implemented in conjunction with the Model. In order to secure formal commitments for participation from implementation partners, CPAA will define the specific scope of work for each partnering provider (what and where will investments be made); reporting requirements of partnering providers (what measures and how frequently will reports be made); and payment of partnering providers (how much and when payment occurs). Partnering providers will only commit to participating in the Transformation if they are clear on expectations and can assess the risks and rewards of their participation. CPAA will work with its Finance Committee and TA partners (e.g., Health Management Associates, Manatt, etc.) to establish the necessary payment framework. CPAA will work with its Clinical Provider Advisory Committee to clarify the scope of work of prospective partnering providers. CPAA will use its Support Team to assess partnering providers' scope of work across project areas. CPAA looks at the Transformation projects as an integrated project portfolio; hence, our partnering providers will be asked to engage in integrated project initiatives, rather than discreet, stand-alone projects. We anticipate partnering providers will make a firm commitment to participating in the Transformation once they have a full understanding of their implementation role across the entire project portfolio. These commitments will be memorialized in written agreements/contracts by the end of DY2, Q2.