Supplemental Workbook – 2A Bidirectional Integration Implementation Approach

Project Stage Milestones	Deadline (DY, Qtr)	ACH Approach for Accomplishing Milestones
Stage 1: Planning		
Assess current state capacity of Integrated Care Model Adoption: **Describe the level of integrated care model adoption among the target providers/organizations serving Medicaid beneficiaries. Explain which integrated models or practices are currently in place and describe where each target provider/organization currently falls in the five levels of collaboration as outlined in the Standard Framework for Integrated Care**	DY 2, Q2	Building on past regional capacity assessments, CPAA will conduct an online survey of key clinical providers in the region to gauge the current state of capacity for effective bi-directional care integration services delivery by the end of DY2, Q1. 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 clinical partners as well as technical assistance partners (e.g., Qualis Health). We also plan to utilize the results of surveys conducted by other partners, such as the DOH Practice Transformation Hub. In addition to understanding providers' level of integration, CPAA will identify specific care models that are already being implemented, such as the Collaborative Care Model (CoCM), Patient-Centered Medical Home (PCMH), or Bree Collaborative Behavioral Health Integration Recommendations in order to get a better understanding of the alignment needed to achieve all collaborative care principles. To date, CPAA has been coordinating with Qualis Health regarding their work conducting the MeHAF Site Self Assessment and PCMH-A assessments with medical clinics and behavioral health organizations in the CPAA region. The SAMHSA-HRSA Center for Integrated Health Solutions offers additional assessment tools for organizations integrating primary care and behavioral health. A further review of the following assessment tools will be conducted by the Clinical Provider Advisory Committee and/or Bi-Directional Care Integration Work Group to determine which additional tool(s) will best meet the local needs of the CPAA region. Ultimately, these assessments will allow us to describe where each provider/organization falls in the five levels of collaboration defined by *A Standard Framework for Levels of Integrated Care*. The five levels include: 1) minimal collaboration, 2) basic collaboration at a distance, 3) basic collaboration onsite, 4) close collaboration in a partly integrated system, and 5) close collaboration in a fully integrated system. 1) **MeHAF Site Self-Assessment (SSA):** This tool assesses the level of integration achieved by organizations by focusing on two domains: 1) integrated services and patient and family services; and 1) practice/organization. 2) **PCMH-A Assessment:** identifies current level of "medical homeness" and opportunities for improvement. 3.) **AIMS Center Milestones Checklist to Evaluate Your Practice Team's Readiness for Integrated Behavioral Health Care:** This tool features questions and links to determine organizational readiness to launch collaborative care. 4.) **WA Council for Behavioral Health/National Council for Behavioral Health/AIMS Center Milestones Checklist to Evaluate Your Team's Readiness for Integrating Primary Care in Behavioral Health Agencies:** This tool features questions and links to determine if your behavioral health agency is ready to launch integrated primary care in a behavioral health setting.

		5.) **Integrated Practice Assessment Tool (IPAT):** This tool places providers/practices/organizations in one of five levels that determine the current state of integration/collaboration.
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 have finalized the specific Domain 1 strategies that will 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 is already using this technology platform. We are working closely with the AIMS Center on evaluating options for patient registries and determining the best fit for our providers. This is a crucial part of helping care teams to implement Collaborative Care principles and track evidence-based treatments and clinical outcomes for patients over time. Importantly, our investments in Systems of Population Health Management will be coordinated across all project areas so that they become mutually reinforcing. **2) Workforce:** CPAA has solicited feedback from the Domain 2 Work Group to identify training needs to support the development of provider workforce capacity. 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. This includes contracting with the AIMS Center to provide targeted training to clinicians, both in physical and behavioral health settings, on implementing the CoCM and using patient registries. Additionally, we will solicit the technical assistance and expertise of the HCA, DOH, and Qualis Health, 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. 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 in order 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 successful bi-directional care integration and share insights gained on evolving VBP opportunities with partnering providers. 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 bi-directional care integration, but support all project areas, including care integration.
Finalize target population(s) and evidence-based approach (es) informed by regional health needs	DY 2, Q2	By the end of DY2, Q2, CPAA will refine the selection of target populations**.** To date, CPAA has determined it will target efforts in areas where the region underperformed compared to the state average and focus on areas where there was the greatest need for improvement. As a result of the analysis, we identified preliminary target populations that would address gaps and have the deepest impact for populations experiencing the greatest burdens of health disparities. 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 to identify specific target populations and sub-regions for our projects. Examples of such groups include: • Individuals with co-morbid behavioral health issues and chronic diseases • Individuals with inadequate control of behavioral health issues and chronic diseases (e.g., multiple ED visits and hospital readmissions) • Individuals with active involvement by multiple systems of care, including: behavioral health, developmental disabilities, corrections, child welfare, etc. Such individuals may be identified using PRISM risk scores • Individuals identified by providers as having complex needs but very difficult to engage in treatment We believe by addressing health disparities, health equity will improve in our community. To date, we have identified overlapping target populations with multiple project areas including projects 3A, 3B, and 3D. Going forward, we will refine target population(s) prioritized by other project areas to determine the full scale of overlapping populations. 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). The Bi-Directional Care Integration work group identified the CoCM as the evidence-based approach to integrate behavioral health into primary care. Along with core principles of the CoCM, primary care integration into behavioral health will require one of three approaches: off-site, enhanced collaboration; co-located, enhanced collaboration; or co-located, integrated care. In response to regional health needs, CPAA will place an emphasis

		on implementing standardized Collaborative Care principles due to differences in the level of care integration amongst our clinical partners. CPAA will work with the Clinical Provider Advisory Committee to identify additional strategies that may need to be included in order to reach the desired outcomes. With the support of CORE, the work group will vet these strategies as to likely impact and feasibility (cost, provider readiness, etc.) before a final determination about chosen evidence-based approaches will be made.
Identify and engage project implementation partnering provider organizations, including: behavioral and physical health providers, organizations, and relevant committees or councils -Identify, recruit, and secure formal commitments for participation from all target providers/ organizations via a written agreement specific to the role each will perform in the project.	DY 2, Q2	CPAA has already 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 in the CPAA region by our strategic data analytics partner, CORE. In the coming weeks, 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 in our region whose participation is vital for successful bi-directional care integration. We are using our extensive stakeholder list from work that CHOICE has led to improve care integration in the region over the last several years as a starting point. We will augment this list of potential partnering providers with information gleaned from our regional asset mapping (see above) to ensure a comprehensive approach. 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 Collaborative Care Model and its core principles and other evidence-based model standards. 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 utilize 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 that partnering providers will be able to 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.
Develop project implementation plan, which must include: -Implementation timeline -Selected evidence-based approaches to integration and partners/providers for implementation to ensure the inclusion of strategies that address all Medicaid beneficiaries (children and adults) particularly those with/or at-risk for behavioral health conditions -Justification demonstrating that the selected evidence-based approaches and the committed partner/providers are culturally relevant and responsive to the specific population health needs in the region -Description of how project aligns with related initiatives and avoids duplication of efforts -Roles and responsibilities of implementation partners: should include key organizational and provider participants that promote partnerships across the care continuum, including payer organizations, social services organizations, and across health service settings. -Describe strategies for ensuring long-term project sustainability	DY 2, Q3	By the end of DY 2, Q2, the project implementation plan will be developed by CPAA staff in close collaboration with the Clinical Provider Advisory Committee and in consultation with the Support Team to ensure the project implementation plan integrates well with and supports the other Transformation projects pursued by CPAA. This includes alignment with Projects 3A, 3B, and 3D through the comprehensive review and coordination of target populations across different project areas detailed above. Additionally, the Clinical Provider and Consumer Advisory Committees and Bi-Directional Care Integration Work Group will review the project implementation plan to assess feasibility and impact from their respective perspectives and provide guidance on the final implementation plan. This will ensure that the implementation plan employs evidence-based approaches, is culturally relevant and responsive to the needs of the region, and impacts high-need target populations. CPAA will work with partnering providers to establish timelines that meet the needs of our providers, first by focusing on large Medicaid providers and community-based social service providers, and then gradually building out to include smaller clinical and community-based providers. In finalizing commitment letters from partnering providers, CPAA will include final evidence-based approaches each provider will implement and ensure all implementation requirements are met. CPAA will ensure that alignment across project areas is prioritized to serve specific target populations that cross the entire health care system. An assessment of current state capacities will be conducted to avoid duplicating efforts and instead build upon existing assets and resources to the greatest extent possible. Again, this current state assessment will be reviewed across different project areas to develop maximum leverage and avoid duplication. The Bi-Directional Care Integration Program Manager will ensure roles and responsibilities of implementing partners are clearly articulated in both the project implementation plan and our contracts with partnering providers. This includes the description of the service delivery mode. The Program Manager will monitor adherence to the implementation plan by all partners on an ongoing basis. CPAA will work closely with all partnering organizations, including MCOs and BHOs, to ensure that Domain 1 investments are leveraged to support the long-term sustainability of the project (see Domain 1 project support above for details). Additionally, CPAA anticipates working with other ACHs to maximize investments in Domain 1 activities through coordinated investments across the state, or at least those regions that are interested in developing shared capacity, especially around Systems of Population Health Management and workforce development.
Engage and convene County Commissioners, Tribal Governments, Managed Care Organizations, Behavioral Health and Primary Care providers, and other critical partners to develop a plan and description of a process and timeline to transition to fully integrated managed care	DY 2, Q4	By the end of DY2, Q4, CPAA will have developed a process and timeline to transition to fully integrated managed care through working with: **County Commissioners:** CPAA will engage County Commissioners by participating in legislative activities within each county, presenting to each county's Board of Health, and working closely with the HCA to coordinate this effort. The CPAA Board of

-Plan should reflect how the region will enact fully integrated managed care by or before January 2020 -For regions that have already implemented fully integrated managed care, implementation plans should incorporate strategies to continue to support the transition		Directors has a filled seat with a county commissioner from Thurston County. **Tribal Governments:** CHOICE and CPAA are fully committed to engaging our Tribal partners at every stage of the Transformation. CHOICE's designated Community and Tribal Liaison, along with joint efforts by CHOICE's Executive Director, directly engage CPAA's Tribal partners by doing outreach to Tribal leadership and sending invitations to participate in project work groups. We are currently discussing how to best represent Tribes on CHOICE's Council/Board. **MCOs, BH & PC Providers, and Others:** CPAA will continue engaging these providers in project work groups, advisory committees, and council meetings. Additionally, CPAA will draw on the expertise of Molina and Community Health Plan of Washington, as both MCOs have already begun integrated managed care efforts in Southwest WA. CPAA will work with partners and stakeholders in developing a plan, process, and timeline for transitioning to fully integrated managed care by 2020. Identifying strategies to help facilitate the transition to fully integrated managed care will happen at all levels of CPAA's governance
Stage 2: Implementation		
Develop guidelines, policies, procedures and protocols	DY 3, Q1	By the end of DY 3, Q1, CPAA will establish project-specific guidelines, policies, procedures, and protocols necessary to ensure consistent implementation of selected evidence-based strategies and models. In developing these documents, we will build to the greatest extent possible on already existing guidelines, policies, procedures and protocols that the proponents of the selected evidence-based strategies and models have already developed. For instance, there is a readily available set of guidelines and procedures associated with the Collaborative Care Model. With guidance from the Clinical Director, the Program Manager will take the lead on developing any additional guidelines, policies, procedures and protocols necessary to customize the evidence-based strategies and models to our specific regional context, if appropriate. The Clinical Provider Advisory Committee will review the proposed project-specific guidelines, policies, procedures, and protocols and make changes as necessary. We will consult with this Committee as necessary, as well as with other technical assistance providers that have detailed knowledge of the chosen evidence-based strategies and models. The Program Manager will ensure all partnering organizations have access to and understand the guidelines that will be implemented. The program manager is also responsible for monitoring adherence to these guidelines, policies and procedures and protocols through provider spot checks.
Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected approaches.	DY 3, Q2	By the end of DY 3, Q2, CPAA will establish a progressive implementation and performance monitoring system. This will include regular meetings with partnering providers to assess implementation progress and challenges. These meetings will be augmented by regular provider and regional performance reports that demonstrate movement toward critical milestones and achievement of key outcome goals. If performance problems are identified, the Bi-Directional Care Integration Program Manager will take the lead on developing a QIP in consultation with the partnering provider who is underperforming. In developing the

		QIP, the program manager will be supported by the Clinical Director and senior agency leadership, as well as both the Clinical Provider Advisory Committee and the Consumer Advisory Committee. Whenever possible, the QIP will identify technical assistance resources that help the partnering provider to get back on track. CPAA will establish a common format for QIPs detailing strategies, measures, and targets along with timelines for required improvement to ensure accountability.
Implement project, including the following core components across the approaches selected: - Ensure implementation addresses the core components of each selected evidence-based approach - -Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to perform their role in the integrated model. - -Implement shared care plans, shared EHRs and other technology to support integrated care. - -Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care models. - -Establish a performance-based payment model to incentivize progress and improvement.	DY 3, Q4	In implementing the project, we will follow the project implementation plan (see above), which details timelines, action steps and the specific roles and responsibilities of our partnering providers in their implementation of the selected evidence-based strategies. It will be the responsibility of the Program Manager to be in regular contact with our partnering providers to monitor adherence to the implementation plan and to ensure project-specific guidelines, policies and procedures and protocols are followed, so that implementation addresses the core components of the selected evidence-based strategies and models. As detailed below, the Program Manager will utilize regular reports from providers and periodic meetings with partnering providers to monitor partnering provider performance. The Program Manager is also responsible for ascertaining partnering providers' training and technical assistance needs, which are expected to surface through provider reports and regular meetings with providers, and to arrange for necessary trainings and technical assistance. Special emphasis will be placed on making sure that care team members have access to shared care plans. Investments in Domain 1 activities will directly support and offset costs that providers and organizations will need to make in order to implement integrated care. Two examples include building the cost of developing patient registries and cost-sharing for additional FTE positions into the program budget. We anticipate that establishing effective bi-directional communication strategies and systems will be a major emphasis of this project. In monitoring the performance of partnering providers, we will use a combination of quantitative information provided by partnering providers through monthly reports (provider specific project metrics and milestones will be negotiated and contractually agreed upon) and qualitative data gathered through regular check-ins with partnering providers by the project manager as well as quarterly provider peer learning meetings. With the help of the CPAA finance committee a performance-based compensation system will be developed and implemented for all projects, including bi-directional care integration improvements by the end of DY 3, Q4.
Implementation of fully integrated managed care (applicable to mid-adopter regions)	DY 3, Q1	N/A to the CPAA region.
Stage 3: Scale & Sustain		
Implementation of fully integrated managed care (applicable to regions that did not pursue early or mid-adopter status)	DY 4, Q1	CPAA will work closely with our MCO partners, advisory committees, and bi-directional care integration work group in the demonstration years leading up to DY 4 to establish clear guidance on implementing fully integrated managed care. In developing this guidance, we will build upon policies and procedures established in other ACHs with consultation from the HCA and MCO partners. CPAA will include both Behavioral Health

		Organizations (BHOs) throughout the transition process to ensure transparency and continuity of services.
Increase adoption of the integrated evidence-based approach by additional providers/organizations	DY 4, Q4	CPAA will focus initial care integration efforts with large providers in the region, which will coincide with the number of Medicaid beneficiaries served and the greatest health disparities related to project metrics. By DY 4, Q4, we will work with smaller primary care clinics to implement integrated care. CPAA will continue working with Qualis Health until 2019 on helping our partnering providers receive the quality improvement assistance needed to modify work flows and assess current integrated care practices.
Identify new, additional target providers/organizations.	DY 4, Q4	During DY4, CPAA will do a gap analysis of target providers/organizations that have yet to start implementing collaborative care. This gap analysis will allow us to target our outreach efforts and form partnerships with new providers. Additionally, CPAA will identify and engage providers already serving the target population, focusing on those offering primary care and behavioral health.
Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required	DY 4, Q4	Throughout the Transformation Project, CPAA will employ a dynamic quality improvement approach based on the real-life implementation experience of our partners. As implementation challenges are encountered, we will consult with our partnering providers to assess the implementation issues and determine what training and technical assistance resources might help with resolving the challenges. CPAA will help partnering providers reflect on implementation challenges and develop solutions when partnering providers gather periodically (peer learning collaborative) to share lessons learned and problem-solve together. As a result, we anticipate that implementation of collaborative care principles will experience progressive refinement. Correspondingly, project-specific guidelines, policies, and procedures will need to be updated to capture learning. CPAA will incorporate discussion of how existing payment approaches may be modified or enhanced to transition to value-based payment. CPAA has included MCO representation on the Clinical Provider Advisory Committee to help assure the discussion is relevant to the prevailing method of provider reimbursement. At this stage of project implementation, we also anticipate partnering with other ACHs to compare the refinement of the model across ACH regions, further leveraging implementation experience.
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion -Leverage regional champions and implement a train-the-trainer approach to support the spread of best practices.	DY 4, Q4	By DY4, CPAA will have identified training and technical assistance needs of major providers in the region and will continue assessing future needs on an ongoing basis. An emphasis will be placed on using the AIMS Center to provide training and technical assistance on implementing collaborative care principles, using patient registries, and scaling collaborative care to care teams, individual clinicians, and quality improvement teams at our partnering providers. CPAA will have established a learning collaborative by DY 4, which will allow partners to share information and expertise and will serve as a venue for group training. These activities will support continuation and expansion of the project. Throughout the Transformation, CPAA will continue to identify provider champions in primary care and behavioral health at the bi-directional care integration work group and will encourage participation in the Clinical Provider Advisory Committee. The

		expertise of provider champions will be leveraged as a resource to assist additional partnering providers to engage in capacity building around project implementation.
Identify and document the adoption by partnering providers of payment models that support integrated care approaches and the transition to value based payment for services	DY 4, Q4	Throughout the Transformation, CPAA will identify and document adoption of payment models that support integrated care approaches and VBP arrangements using multiple methods including 1) ongoing quality improvement assessments, 2) regular reporting requirements, 3) and ongoing monitoring of the project portfolio. This information will be documented using systematic principles of project management. Additionally, CPAA will work closely with our MCO partners to disseminate updates on VBP arrangements and guidance on implementing collaborative care codes to support integrated care.