SECTION II: PROJECT-LEVEL: Bi-Directional Care

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
■	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
☐	2B: Community-Based Care Coordination
☐	2C: Transitional Care
☐	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
☐	3A: Addressing the Opioid Use Public Health Crisis (required)
☐	3B: Reproductive and Maternal and Child Health
☐	3C: Access to Oral Health Services
☐	3D: Chronic Disease Prevention and Control

Project Selection & Expected Outcomes (2,000 words)

Project Description and Justification

Abstract

Bi-directional care integration is the integration of behavioral health services into the primary care setting and the integration of primary care services into the behavioral health setting. CPAA intends to address the physical and behavioral health needs of children and adults through an integrated system of care that focuses on whole-person health. Moving into an integrated system, based on Collaborative Care principles, will change the dynamics of health care teams such that providers will use shared care plans, track treatments in new patient registries, use new evidence-based screening tools and treatment, and receive reimbursement for quality of care and clinical outcomes thru value-based payment. Medicaid beneficiaries will benefit from these practice transformations by receiving whole-person care that is dedicated to covering physical and behavioral health conditions as well as improving care coordination to address the social determinants of health. By implementing Collaborative Care principles, we aim to close the gap between primary care and behavioral health, improve health outcomes and wellbeing for the most vulnerable populations, and create sustainable, transformational change to the health care system.

Justification for Selecting Project and How It Addresses Regional Priorities

Bi-directional care integration is necessary for achieving full health system transformation, as integrated care will serve as the foundation for improving primary care and access to behavioral health services, lowering health care costs, and improving health outcomes. Through a whole-person approach to care, providers will be able to overcome health sector silos by having an integrated network of providers and improved care coordination across the entire health care spectrum.

Behavioral health conditions often go untreated and get overlooked due to stigma, lack of screening, and lack of access to appropriate care. Research shows that people who suffer from a chronic disease are more likely to suffer from depression, which highlights the need for integrated care as this co-

morbidity results in an estimated two to three times higher health care costs.[1,2] For example, research shows that "depression is found to co-occur in 17% of cardiovascular cases, 23% of cerebrovascular cases, and 27% of patients with diabetes and more than 40% of individuals with cancer."[3] In 2010-11 state rankings, Washington ranked third for the percent of adults with any mental illness (AMI) and second for the percent of adults with serious mental illness (SMI) at 23.7% and 6.7%, respectively.[4] These rates are even higher in the CPAA region. In FY 2015-2016, individuals within the CPAA region diagnosed with mental illness, serious mental illness, and co-occurring substance-use disorder and mental illness (SUD + MI) were 30.6%, 23%, and 9.3%, respectively.[5]

Providing whole-person care in the setting in which individuals are most likely to seek care is a key building block for CPAA to achieve its overarching goals of improved health, better quality, and lowered costs. Through local forums in the CPAA region and in collaboration with partnering providers, community members, and managed care organizations (MCOs), five regional health priorities were identified. Four out of five of these regional priorities address regional needs and community interests specific to this project: improving access to health care (including adult and pediatric primary care and behavioral health), improving care coordination & integration, preventing & managing chronic disease, and preventing and mitigating adverse childhood experiences (ACEs).

CPAA has elected to use all of the "models" put forward in the project toolkit to ensure the full continuum of primary care and behavioral health settings are working on integration approaches. Within the primary care setting, CPAA will utilize the Collaborative Care Model (CoCM) and the Bree Collaborative Behavioral Health Integration Recommendations as the evidence-based approaches for bi-directional care integration. In the primary care setting, research supports the effectiveness of the CoCM in improving outcomes and lowering costs for patients with common mental disorders such as depression when compared to usual care.[6,7] In behavioral health settings, primary care integration approaches focus on implementing off-site, enhanced collaboration; co-located, enhanced collaboration; or co-located, integrated care, along with the core principles of collaborative care. We anticipate implementing the aforementioned approaches in primary care and behavioral health settings will result in improvements to a number of the metrics related to this project and shared across other project areas, ultimately improving care and wellbeing for the residents of the CPAA region.

How Project Will Support Sustainable Health System Transformation for the Target Population

Bi-directional care integration will support sustainable health system transformation for the chosen

[1] Centers for Disease Control and Prevention. *Mental Health and Chronic Diseases*. NCCDPHP Issue Brief No. 2, October 2012. Accessed: November 2017. Available: https://www.cdc.gov/workplacehealthpromotion/tools-resources/pdfs/issue-brief-no-2-mental-health-and-chronic-disease.pdf

[2] Bree Collaborative. Behavioral Health Integration Report and Recommendations, 2017. Accessed: November 2017. Available: http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Draft-Recommendations-2017-01.pdf

[3] Centers for Disease Control and Prevention. *Mental Health and Chronic Diseases*. NCCDPHP Issue Brief No. 2, October 2012. Accessed: November 2017. Available:

[4] Washington State Institute for Public Policy. Inpatient Psychiatric Capacity and Utilization in Washington State, February 2015. Accessed: November 2017. Available: http://wsipp.wa.gov/ReportFile/1585/Wsipp_Inpatient-Psychiatric-Capacity-and-Utilization-in-Washington-State_Report.pdf

[5] Healthier Washington, Department of Social and Health Services Research and Data Analysis (RDA) ACH Profiles. Accessed: November 2017. Available: https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard

[6] Health Home Information Resource Center. The Collaborative Care Model: An Approach for Integrating Physical and Mentalh Health Care in Medicaid Health Homes, May 2013. Accessed: November 2017. Available: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-irc-collaborative-5-13.pdf

[7] Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P. Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD006525. DOI: 10.1002/14651858.CD006525.pub2

target population by assisting providers to adopt a whole-person approach to care that is patient-centered and focused on providing accountable care. This will require changes in partnering providers' workflows, business practices, and staffing patterns to support team-based care, treatment to target, and population-based care. Investments in this project will be supported by the other projects that the CPAA is implementing, including Community Care Coordination (Regional Pathways HUB), Transitional Care, Reproductive and Maternal/ Child Health, Chronic Disease Prevention and Control, and Opioid Response. The project metrics and populations targeted by these other project areas overlap those served under this project, and many of their strategies will support success in this initiative as well. For example, the Chronic Care Model has served as the conceptual base for several integrated care models by providing a clinical framework that offers direct connections to community resources, better chronic disease education, and use of patient registries to monitor and track patient data. CPAA anticipates interventions and resources developed in this project also will be shared across other projects, therefore, benefiting target populations in multiple project areas. For example, implementing pediatric integrated behavioral health care will aid in early identification of behavioral health conditions. Once these investments have been made, they will become permanent, as the care systems have become permanently reoriented to these new norms and standard processes and procedures.

CPAA and its administrative partner, CHOICE Regional Health Network, have a proven track record transitioning pilot projects, similar to this one, to ongoing programs in the region. CHOICE has accomplished this by using collective impact and demonstrating cost-effectiveness to participating funders, who then maintained funding for these efforts on a continuing basis. CPAA will apply this approach to assure sustainability of bi-directional care integration post Transformation.

How CPAA Will Ensure Project Coordinates With and Does Not Duplicate Existing Efforts

CPAA and CHOICE have worked closely with the community for over 20 years and are thus familiar with both health care needs and existing services provided in the region. CPAA's governance and advisory structure bring to the table a wide-range of service providers, stakeholders, and organizational leaders in the CPAA region, including the two Behavioral Health Organizations and all five Managed Care Organizations that serve Medicaid beneficiaries. This broad range of partner representation already in place throughout the CPAA structure enables us to hear real-time concerns about health issues, including implementation of bi-directional care integration. There is a high level of understanding in the Bi-Directional Care Integration Work Group of the need for more streamlined, cross-system coordination without duplicating existing services, along with guidance on transforming individual organizations to meet standards outlined in the Project Toolkit.

CPAA is taking great care to build upon our region's collective work to improve bi-directional care integration and avoid duplicative efforts and capacity for this project. This is in keeping with one of CPAA's foundational principles, namely to build upon existing assets in the region and strengthen existing infrastructure and care systems to the greatest extent possible. Therefore, one of the first implementation steps in this project area will be to complete a current state assessment of integrated care across the region by the end of Q1 2018 that will serve to provide a baseline understanding of the levels of integrated care at our partnering providers. In addition, CPAA will continue coordinating with Qualis Health to compile their integrated care data already being collected from the Patient Centered Medical Home-A (PCMH-A) and Maine Health Access Foundation (MeHAF) assessments that identify the current state of care integration in primary care clinics and behavioral health settings, respectively (see Appendix XX). Data from these assessments will assist with capacity building and be used to track, monitor, and coordinate implementation efforts.

CPAA began taking stock of project areas in which partnering providers are planning to implement interventions by opening a Request for Qualifications (RFQ) process that prompted providers to describe new project ideas, how new projects will avoid duplicating efforts, and which partners are working in collaboration. It has been well-communicated through project work groups and correspondence with partners that Transformation funding can only be used for new projects and/or enhancing current projects. To date, we have received 38 RFQ responses, of which 17 pertain to the bi-directional care integration project area (see Appendix XXX).

Additionally, CPAA conducted a landscape analysis of major Medicaid providers and payers, as well as public health departments in the region (see Appendix XXX). For providers, this includes dental, primary care, FQHCs, hospitals, and major health systems. The purpose of this assessment is to better understand who the major stakeholders are in the CPAA region, who is already engaged in the Transformation projects, and who CPAA still needs to engage in the Transformation work. During a review of this tool by the CPAA Council and Domain 2 Work Group, a number of key providers yet to be engaged were identified. To populate this tool, we used Provider data supplied by the HCA and included providers in the table who served approximately 90% of Medicaid beneficiaries in 2016. By analyzing the provider landscape, CPAA is able to facilitate new partnerships between providers, keep track of individual provider's initiatives, and create new tools to monitor existing project efforts. CPAA is well positioned to develop oversight, monitoring, and continuous quality improvement (CQI) mechanisms to assure timely implementation of project interventions, and promote fidelity to evidence-based practices that do not duplicate efforts.

Anticipated Project Scope

Anticipated Target Population

Broadly, bi-directional care integration has the potential to serve all Medicaid beneficiaries, both children and adults, with behavioral health conditions. In the primary care setting, this means particularly patients suffering from depression or anxiety as well as serious mental illness, and in the behavioral health setting, patients suffering from serious mental illness. In both settings, subset populations will be patients with depression or serious mental illness who have one or more chronic conditions such as diabetes, asthma, heart disease, or obesity. Populations with behavioral health conditions and co-morbidities will overlap with the target populations from Project 3A, 3B, and 3D.

CORE has conducted an analysis for CPAA that highlights sub-regions and subgroups with poorer health outcomes or more limited access to services (see Appendix XX). CPAA reviewed these CORE findings with the project work groups and asked members to identify additional subgroups and sub-regions for further consideration. Based on work group members' feedback, we compiled the following qualitative list: people who are homeless, individuals new to the area, those without a PCP using the ED as their main access point for care, those with transportation barriers in urban and rural settings, patients in hospice seeking care, Hispanic families with fear around accessing care, elderly individuals, young parents ages 18-24, and the geographic area of East Lewis County.

In FY 2015-2016, a total of 170,627 Medicaid beneficiaries, both children and adults, were served jointly by HCA-DSHS in the CPAA region. Based on a review of this data, we anticipate a maximum reach would include just under 115,000 Medicaid beneficiaries with the following diagnoses:

- 52,175 diagnosed with mental illness (MI);
- 39,298 diagnosed with serious mental illness (SMI);

- 23,310 with SUD treatment need.[8]

One additional analysis to estimate the reach of this project focuses on cross-referencing data from the HCA with utilization measures required for the Transformation. As described above, 115,000 individuals were diagnosed with MI, SMI or SUD treatment need. In the CPAA region, 74% of adult Medicaid beneficiaries accessed preventive/ambulatory health services. As a proxy measure, implementation of this project has the potential to reach 85,000 adults and children accessing preventive/ambulatory services.

CPAA notes that bi-directional care integration represents several gradations of effort, ranging from better coordination between distinct primary care and BH practices, to on-site integration of PCP and BH services. We estimate that, by the end of the project period, approximately 85,000 potential patients will receive some level of integrated care.

Involvement of Partnering Providers

CPAA is keenly aware that we need to engage the right providers in order to meet our region's transformation goals. With that in mind, CPAA has conducted three efforts to identify partnering providers: 1) a Request for Qualifications (RFQ) to identify and engage partnering providers; 2) a table that includes providers who served approximately 90% of Medicaid beneficiaries in 2016; and 3) a table that includes community-based organizations and social services in each county that have already been engaged (see Appendix XXX).

There is strong support from most of the major Medicaid providers in the CPAA region for implementing bi-directional care integration including our region's three Federally Qualified Health Centers (FQHCs). The clinical providers identified in the CORE analysis represent the main clinical access points for Medicaid beneficiaries. With strong involvement from our clinical partners across the region, we can expect to serve a large population of Medicaid beneficiaries, specifically the target populations detailed above, which is critical for the success of this project. Many of our clinical partners have engaged with CPAA from the start and have been involved in work groups to design this project application. This project promotes and supports specific changes in clinical delivery that have a strong evidence base for improving patient outcomes. Additionally, our clinical partners implementing this project will follow the evidence-based models outlined in the Project Toolkit, which are the proven strategies for achieving care delivery redesign. CPAA continues to engage non-clinical partners with the understanding that their involvement will play a key role in achieving the required level of integrated care. Future work will involve strengthening partnerships between our clinical and non-clinical partners.

Level of Impact

When considering the level of impact for this project's anticipated target population, our initial analysis focused on identifying providers that serve 90% of Medicaid beneficiaries in the CPAA region. By outlining the providers that are serving the majority of Medicaid beneficiaries, we expect to reach the maximum number of patients, and therefore maximizing the level of impact. Further analysis of the CPAA region allowed us to better understand diagnostic data related to this project and to highlight health trends in specific demographics and individual counties. For example, ED utilization per 1000 member months is highest in Mason, Grays Harbor, Lewis, and Pacific counties,[9] which may correlate

[8] Healthier Washington, Department of Social and Health Services Research and Data Analysis (RDA) ACH Profiles. Accessed: November 2017. Available: https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard

[9] Healthier Washington Data Dashboard. Accessed: November 2017. Available: https://www.hca.wa.gov/about-hca/healthier-washington/data-

with a subgroup of patients presenting in the ED without a PCP or a lack of access to primary care. By focusing on these counties to reduce ED utilization, we can maximize the level of impact for Medicaid beneficiaries and reduce county metrics to match the State average.

Additionally, CPAA harnessed the local knowledge of our provider networks to suggest subgroups and sub-regions within each county that suffer from health disparities and lack of access to care. From this local knowledge, we learned that East Lewis County in particular is disproportionately affected by limited access to care.

One additional method that helped us understand this project's level of impact was detailed by our partnering providers in their RFQ responses. For each RFQ response, providers listed the anticipated target population that would be served, allowing us to further identify regions and populations suffering from the greatest health disparities. Up to this point, all of the activities and analysis regarding target populations were designed to give us the most comprehensive picture of where the health care needs and the patient populations are the greatest. Further refinement of our target population will take place during the planning phase through continued work with our partnering providers, supported by further analysis by our data contractor, CORE.

How CPAA Will Ensure Health Equity is Addressed in the Project Design

Addressing health equity has been built into the CPAA's general approach to the Medicaid Transformation projects. CPAA is developing an adaptation of health equity tools used by other organizations such as King[10] and Multnomah[11] counties that will inform the methods behind finalizing target populations and implementing specific project area interventions. By analyzing health outcome data with our clinical and non-clinical partners in the project work groups, we are able to focus our intervention efforts on reaching populations that experience geographic barriers and those underserved by the health care system. The process by which we gathered local knowledge on subgroups and sub-regions speaks to our effort to better understand health disparities in our region. For example, we learned that patients receiving treatment for a chronic disease may have an undiagnosed mental health condition, which untreated, can result in the increased use of emergency departments.

We are engaging consumers in our region to help with the identification and selection of the right target population/s for this and our other project areas. In late October, consumers from throughout the seven-county region came together within the CPAA Consumer Advisory Committee to advise on project planning methods and activities to date.

We are consulting with our Tribal partners, some of whom have been involved in our work groups, to ensure health equity is thoroughly considered in our project planning and implementation. For instance, we recently met with the health director of the Nisqually Indian Tribe, to learn about the Tribe's greatest health needs. As a result of these ongoing consultations, the list of priority target populations and interventions may change, reflecting more fully health equity considerations.

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[10] Healthy King County Coalition. Accessed: November 2017. Available: https://static1.squarespace.com/static/5919f644cd0f68629f3f6499/t/59af39dabe42d610797aa8d3/1504655838013/2016-Equity-Impact-Assessment-Tool_FINAL-1+%284%29.pdf

[11] Multnomah County. Equity and empowerment Lens. Accessed: November 2017. Available: https://multco.us/diversity-equity/equity-and-empowerment-lens

Project's Lasting Impacts and Benefit to the Region's Overall Medicaid Population

During DY 2, CPAA will formalize commitments with partnering providers on implementing project-specific interventions. Implementing bi-directional care integration will have lasting practice transformation effects that will result from a shift in "practice as usual." Moving into an integrated system will change the dynamics of health care teams such that providers will start using shared care plans, tracking treatments in new patient registries, using new evidence-based screening tools and treatment, and receiving reimbursement for quality of care and clinical outcomes through value-based payment. Medicaid beneficiaries will benefit from these practice transformations by receiving whole-person care that is dedicated to covering physical and behavioral health conditions as well as improving care coordination to address the social determinants of health.

CPAA will be a driving force behind this collective effort by tracking project implementation progress and individual project metrics. As providers implement integrated care throughout the Transformation, the door will open for further cross-project collaboration that will more effectively serve Medicaid patients entering the health care system from different access points.

Building on infrastructure already in place, providers have the opportunity to demonstrate how system-wide transformation in care delivery will result from investments in workforce, value-based payment, and population health management. Investments in the three Domain 1 areas will directly translate into lasting impact for patients. After the Transformation period, these investments will result in overarching infrastructure and capacity changes necessary to support care delivery redesign long-term. Additionally, the change to fully integrated managed care will coincide with care integration efforts at the clinical level, and CPAA anticipates that once these major changes are made to both business and clinical practices, the system will be permanently reset and interventions will be sustained beyond the Transformation period.

CPAA and CHOICE have proven track records for developing innovative projects with pilot funding and developing ways to sustain these efforts into the future. Key to our success is our ability to demonstrate to stakeholders, including hospitals and CBOs, that the project has enabled the stakeholders to achieve efficiencies, improve outcomes, or avert future costs. We expect this experience, along with the trusted relationships we have already built with providers in our region, will support our ability to a develop path toward sustainability for this project.

Implementation Approach and Timing (Supplemental Workbook Tabs)

See 2A Implementation Approach tab in ACH Project Plan Supplemental Data Workbook for a brief description of how CPAA will accomplish each set of project milestones in Stage 1, Stage 2, and Stage 3.

Partnering Providers (500 words + Supplemental Workbook Tabs)

How CPAA Has Included Partnering Providers That Collectively Serve a Significant Portion of the Medicaid Population

CPAA is well positioned to bring major partnering providers in the region together to create collective impact. A principal asset in this engagement process is the well-established provider relationships CHOICE has cultivated over the last two decades; a number of key Medicaid providers are members of

CHOICE, including two of the region's three Federally Qualified Health Centers (Valley View Health Center and Sea Mar) and all of the region's hospitals in five of the seven counties covered by CPAA, including our largest tertiary hospital, Providence St. Peter Hospital. From the beginning, CPAA has included a broad range of providers in its work across our seven-county region, including providers that collectively serve a significant portion of the Medicaid population.

CPAA convened a Bi-Directional Care Integration Work Group and has been meeting at least monthly to collect information and design the project plan. The work group includes representatives from mental health, substance abuse treatment, and primary care organizations from every county in the region. Members have played an active role in project design and on the development of this application and are fully engaged in the bi-directional care integration project.

To ensure a significant portion of the Medicaid population will be served in this Transformation, CPAA partnered with CORE to analyze provider claims data provided by the HCA to develop a landscape analysis of the major Medicaid providers and payers as well as public health departments in the CPAA region. This list has been cross-referenced with RFQ responses received from partners to ensure a significant portion of Medicaid recipients can be reached through the partners engaged in each project. For providers, this includes dental, primary care, FQHCs, hospitals, and major health systems. The purpose of this tool is to better understand who the major stakeholders are in the CPAA region, who is already engaged in Transformation projects, and whom we still need to contact for engagement. To populate this tool, we used Provider data supplied by HCA and included providers who collectively served approximately 90% of Medicaid beneficiaries in 2016. By analyzing the provider landscape, CPAA can engage and connect stakeholders with the goal of creating new partnerships and coordinating intervention efforts. The CPAA is well positioned to facilitate new partnerships between providers, keep track of individual provider initiatives, and create new tools to monitor existing project efforts.

Process for Ensuring Partnering Providers Commit to Serving the Medicaid Population

As previously mentioned, CPAA conducted a Request for Qualifications (RFQ), prompting providers to describe the target population and estimated number of Medicaid lives served. This preliminary information is the first step in understanding which Medicaid populations will be served and will allow us to further the conversation about choosing specific target populations. In DY 2, we will secure formal commitments from our partnering providers to implement the evidence-based approaches outlined in the project toolkit that will include a commitment to serve specific Medicaid populations. These commitments will be made in the form of contracts with partnering providers that specify the specific scope of work for each implementation partner, reporting requirements, and payment arrangements. CPAA will monitor these commitments by tracking progress on project implementation and outcomes for performance metrics per agreed upon contracts with partnering providers. Additionally, CPAA will ensure providers interested in participating in the Transformation that have a lower than average Medicaid population commit to increasing their access to the Medicaid population.

Process for Engaging Partnering Providers That are Critical to the Project's Success, and Ensuring That a Broad Spectrum of Care and Related Social Services are Represented

CPAA engages key partnering providers in the Transformation in various ways. A number of key implementation partners already serve on our project work groups. Work groups consist of individuals from partnering organizations, including large and small, urban and rural clinical providers that encompass behavioral health and primary care, social services, community-based organizations, MCOs, and public health departments.

At work group meetings, we identify gaps in our partner participation by asking our members to identify missing organizations and individuals to ensure thorough representation from all necessary health and social service organizations. One method we have employed to identify key service providers yet to engage is a comparison of RFQ responses received and major Medicaid providers identified in the region. This has allowed us to make connections with new providers as well as prompt existing partnering providers to submit a RFQ response for bi-directional care integration. To date, we have received 38 RFQ responses, of which 17 pertain to the bi-directional care integration project area.

Finally, the CPAA Council includes members from different health and social services organizations. CPAA does extensive outreach to organizations that need to be involved and is asking existing partners, including our Provider Champions – clinicians who have agreed to assume a leadership role in liaising with our provider community – to bring other providers to the table that are essential to project success. CPAA's approach to governance and project management relies on strong provider engagement. All five work groups, the Support Team, and the Council include key partners representing different practices and organizations.

How CPAA is Leveraging MCO's Expertise in Project Implementation, and Ensuring There is No Duplication

MCOs have been active participants in the all work groups, the Clinical Advisory Committee, and the CPAA Council and Board of Directors. MCO representatives have contributed to the identification of regional health priorities, have provided input into the project planning process, and will continue to be key partners throughout Transformation implementation. CPAA encourages MCO representatives to share developments in their organizations regarding VBP strategies, moving to fully integrated managed care, and any additional guidance for working with providers at the clinical level on integrated care. MCOs are critical to the success of this project, as we need to ensure payment mechanisms are aligned with and support our project interventions. All five MCOs that serve our region have participated in the CHOICE-led regional health improvement work over the years and, moving forward, we anticipate that the MCOs will play an active role in the Medicaid Transformation project planning and implementation. This will ensure there is good coordination between payers, their expertise is leveraged, and duplication will be avoided.

Appendix TK lists MCO representatives and the organizations they represent.

Regional Assets, Anticipated Challenges and Proposed Solutions (1,000 words)

Assets CPAA and Regional Partnering Providers Will Bring to the Project

One of the principal assets CPAA brings to this project is CHOICE's broad and well-established network of positive, collegial relationships with clinical providers, community-based organizations, and health plans developed over more than two decades of community-led health improvement and collective action. In its project planning and implementation, CPAA can readily build on this strong, trusting foundation.

Partnering providers throughout the CPAA region bring a wealth of knowledge from many different sectors of health care, urban and rural perspectives, and small clinics to large hospital systems. The amount of in-kind time contributed through work groups and advisory groups is substantial and demonstrates the deep commitment of our partners. Our implementation partners have shown

consistent engagement in project work groups, advisory committees, and the council and board of directors. Additionally, the major Medicaid providers in the CPAA region continue to express their commitment to this ongoing collaborative effort.

Several of our partnering providers already have VBP contracts in place; this creates a foundational platform for increasing the number of contracts in value-based arrangements. Partners currently implement aspects of integrated care to varying degrees. For example, Valley View Health Center began implementing the Collaborative Care Model in 2009 and has demonstrated success in operationalizing the model, shown ability to scale the model, and reflects satisfaction with outcomes from implementation. In addition to Valley View implementing collaborative care, they are also working with the largest behavioral health providers in the CPAA region to partner in co-location and shared learning around integration. Valley View is sharing clinic space with Behavioral Health Resources and Cascade Mental Health. Providence St. Peter Hospital offers behavioral health integration as part of their Family Medicine Residency Program which follows the Collaborative Care Model and uses a patient registry provided by the AIMS Center. Cowlitz Family Health Center has provided integrated behavioral health care in its primary care practice since 2009, and bi-directional primary care and substance use disorder treatment since 2015. CPAA will work with these partners to help facilitate information sharing with other providers on their experiences and expertise with implementing collaborative care.

Another key asset supporting project readiness is that all partnering providers who are interested in implementing collaborative care principles have existing EHR systems, some of which may have interoperability with other data systems.

Challenges to Improving Outcomes and Lowering Costs for Target Population and Strategy to Mitigate Risks and Overcome Barriers

There are a number of challenges and barriers to overcome in order to achieve the intended project outcomes. Broadly speaking, these fall into two categories: (1) general challenges and barriers, and (2) project-specific challenges and barriers.

General Challenges and Barriers

All Transformation projects require:

- **Data:** CPAA must have access to timely, accurate data to:
    - Identify/refine target populations, partnering providers, and interventions, and
    - Monitor the performance of our partnering providers under the Transformation to determine partner compensation, course correct if milestones and performance metrics are not being achieved, and conduct continuous quality improvement efforts.
- **Health Information Systems:** Our partnering providers must have the ability to exchange information about patients and care plans in order to avoid care gaps and duplication of services. Currently, there is no consistent standard and/or IT system for information sharing in our region, especially between providers that serve patients with multiple chronic illnesses and behavioral health conditions.
- **Workforce:** Our partnering providers must have access to the right workforce to implement the evidence-based interventions in the chosen project areas. This includes personnel with the right general professional qualifications, expertise and experience in the project area, and training in

the specific methods and approaches of the chosen interventions. Ensuring ready access to this workforce is a major concern, especially in rural, under-resourced areas.

- **Finances:** Our partners need to be clear on:
    - Fund flows, i.e., they need to understand when, how and how much they will be paid in order to inform their decision-making about investments in the Transformation.
    - Financial sustainability, i.e., they need to understand what payment mechanisms are being developed to sustain their investments beyond the Transformation. The principal barrier in this arena is the fact that the vast majority of purchasing activities occur in other venues and are controlled by other parties. Most medical purchasing is conducted by MCOs, while behavioral health services are currently purchased under the rubric of BHOs.

Project-Specific Challenges and Barriers

In addition to these general challenges and barriers, there are a number of project-specific challenges and barriers to overcome. The following is a list of selected key challenges and barriers specific to bi-directional care integration:

- Workflow Changes
    - Restructuring care teams to fit the Collaborative Care Model;
    - Establishing a starting point for implementing integrated care;
    - Establishing clear language around goals, mutual trust, effective communication, and measurable processes and outcomes within care teams;
    - Behavioral health providers finding physical space for co-located, integrated care;
    - Primary care providers enhancing their level of care around behavioral health services;
    - Establishing effective change management techniques for organizations and clinicians.
- Health Information Technology
    - Access to timely, accurate data on project metrics to allow for more immediate quality improvement;
    - Lack of interoperability between partnering providers' different EHR systems;
    - Data tracking and reporting deficiencies of EHR systems;
    - Documenting and tracking behavioral health information due to deficiencies with EHRs;
    - Implementing and managing new patient registries for Collaborative Care and determining logistics of data entry;
    - Using technology for effective team-based care.
- Lack of Provider Capacity
    - Recruitment
        - Long vacancies for necessary positions include registered nurses, medical assistants, mental health counselors, clinical social workers, and substance abuse/behavioral health counselors;[12]
        - Lack of attractive hiring incentives;
        - Specific shortages in primary care physicians, psychiatrists, and behavioral health clinicians, particularly in rural areas;

[12] Washington Sentinel Network. Health Workforce Council 2016 Annual Report. Accessed: November 2017. Available: http://www.wtb.wa.gov/Documents/HWCReport-FINAL.pdf

        - Lack of funding to support new staff.
    - Retention
        - Provider dissatisfaction;
        - Limited ongoing training;
        - Not clearly managing changes to roles and responsibilities.
    - Training
        - Developing workforce training plans tailored to support the implementation of each project;
        - Coordinating retraining efforts for providers to meet the demands of workflow/care delivery redesign;
        - Ensuring that various training needs are being met across all providers and hospital administrators;
        - Establishing effective scheduling methods between behavioral health clinicians and PCPs;
        - Coordinating training efforts with HCA, DOH, Qualis Health, and the AIMS Center.

- Value-based Purchasing (VBP)
    - Understanding the provider capacity gaps in effectively engaging in VBP contracts;
    - Developing methods to support providers in increasing VBP contracts in primary and behavioral health care;
    - Ensuring organizations and clinicians are trained on implementing new collaborative care codes for Medicaid;
    - Understanding what the critical VBP competencies are across different VBP arrangements;
    - Developing a smooth transition to fully-integrated managed care.

CPAA Strategy for Mitigating the Identified Risks and Overcoming Barriers

The following table lists various mitigation strategies to address the identified challenges and barriers. As new information is released from the HCA and MCO partners, CPAA will continue to develop additional mitigation strategies with our project work groups and advisory committees.

Barrier	Potential Solutions
Data	• Partner with CORE, state and providers to identify/refine target populations, partnering providers, and interventions (underway) • Partner with providers and MCOs to obtain close to real-time provider performance information; explore contracting with a third-party data aggregator with data analytics capabilities (underway).
Health Information Systems	• Partner with state, MCOs, providers, and other ACHs in developing interoperability between health information systems; expedite planning for and implementation of clinical integration of behavioral health.
Workforce	• Invest in training of partnering providers in evidence-based methods/models • Explore shared workforce options, e.g., through telehealth
Finances	• Funds Flows: Work with CPAA Finance Committee to clarify funds flows

	(underway) • Financial Sustainability: Work with payers (health plans and state) to support transition to value-based purchasing; state needs to adjust contracting w/ MCO who in turn modify provider payment approaches accordingly
Workflow Changes	• Contract with the AIMS Center to provide training and technical assistance for implementing collaborative care principles, restructuring care teams, and using patient registries • Coordinate with Qualis Health on implementing PCMH-A and MeHAF assessments that lead to quality improvement and workflow changes (underway) • Establish collaborative care champions at each partnering provider to establish a clear plan for integrating care • Develop guidance on change management principles for partnering providers
Health Information Technology	• Develop an inventory of partnering providers' EHR systems to help CPAA and partners develop creative solutions to data sharing challenges • Develop guidance on overcoming restrictions of behavioral health information for care teams • Work closely with the AIMS Center on evaluating options for patient registries, effectively using patient registries, and understanding logistics of data entry (underway)
Lack of Provider Capacity	• Develop guidance on effective ways to restructure care teams and modify roles and responsibilities of care team members • Ensure providers have the necessary training and expertise to effectively manage workflow changes associated with collaborative care
Value-based Purchasing	• Continue promoting VBP across the region particularly for VBP contracts in relation to collaborative care • Communicate clear guidance on transitioning from fee-for-service contracts to VBP contracts • Identify provider capacity gaps in effectively engaging in VBP contracts • Target Transformation resources to support development of VBP arrangements

Monitoring and Continuous Improvement

Plan for Monitoring Project Implementation Progress, Including Addressing Delays in Implementation

CPAA will implement a rigorous project monitoring approach to implementation of the project. The same approach will be employed across the entire portfolio of projects. This includes entering into contracts that clearly spell out partnering providers' responsibilities, including reporting requirements, and supports CPAA can offer as well as employing project planning software and tools to lay out required deadlines, key tasks, subordinate tasks, and milestones. Each project implementation plan will define critical paths and key dependencies. Key

indicators will be determined for each project area that will serve as an early warning system to detect when implementation challenges are encountered. A monthly performance dashboard report will compare actual performance of key indicators against targets within and across all project areas. This will allow the project managers as well as the CPAA Support Team, which includes the chairs of each project work group, to identify both implementation problems and early wins.

CPAA has hired dedicated support staff for each project area (program managers). It is the responsibility of the program managers to stay in close contact with all partnering providers in their respective project area. Specifically, the project managers are responsible for:

- Identifying support needs of partnering providers throughout the duration of the Transformation;
- Serving as subject matter experts for partnering providers or, if additional expertise is required, identify and facilitate external subject matter experts providing enhanced technical assistance to partnering providers; and
- Monitoring overall partnering provider performance toward milestones and performance metrics (see below for details).

Project implementation monitoring is closely tied to performance monitoring of partnering providers. The next section of the project plan discusses in detail how CPAA will monitor the performance of individual partnering providers. The data reporting and analytics tools used to hold individual partnering providers accountable to agreed upon deliverables will provide CPAA also with a clear sense about the project's overall implementation progress, as individual provider performance data rolls up into a region-wide performance summary. See next section for details.

Plan for Monitoring Continuous Improvement, Supporting Partnering Providers, and Determining Whether or Not CPAA is on Track to Meet Expected Outcomes

CPAA will set up a progressive implementation and performance monitoring structure with tiered interventions up to termination of partnering provider contracts. This will include regular meetings with our partnering providers to assess implementation progress and challenges. If project implementation progress becomes questionable or is delayed, the project manager will inform his or her immediate supervisor (Clinical Director or Care Coordination & Educational Programs Director) of the concern. The senior project management team will assess the severity of the situation. When possible, we will seek to mitigate the risk or delay by providing technical assistance to help the partnering provider/s to get back on track. This will include seeking advice from clinical experts, including Provider Champions serving on the CPAA Clinical Provider Advisory Committee. The partnering provider and CPAA will agree on an action plan (Performance Improvement Plan) to resolve the issue or renegotiate the contract deliverables, if necessary. In severe cases or if the technical assistance does not correct the problem, we will escalate the issue to our Clinical Provider Advisory Committee for a more comprehensive review. The committee may identify additional problem solution strategies, ask our Provider Champions to intervene, help access additional external technical assistance resources, or engage other key stakeholders in addition to affected providers to remedy the cause of delays. If the problem cannot be resolved, is of a major magnitude or involves key partners that serve large numbers of Medicaid beneficiaries, the CPAA Council and Board will be informed. The board will make the final decision about modifying or terminating contracts with partnering providers.

Access to timely and relevant data will be critical to our ability to monitor project implementation and

support continuous improvement. Measurement is an integral part of quality improvement. We will enter into a contract with each partnering provider that will detail the provider's responsibilities, including the nature and scope of investments to be made; implementation of the key components of each selected approach; adherence to project guidelines, policies and procedures, and protocols; the target population(s) and any geographic sub-regions on which the interventions will be focused; reporting requirements (milestones and outcome metrics as well as frequency of reports); participation in peer learning collaboratives; and payment modalities.

Partnering providers will be required to submit performance information monthly. We are exploring utilizing the Washington Hospital Association's (WSHA) updated QBS business intelligence system to capture and analyze provider data that is not already reported through other systems. Our goal is to place minimal reporting burdens on our partnering providers while providing CPAA with an effective performance monitoring tool that provides us with timely performance data, so that we can actively monitor and track partnering provider performance. QBS is easy to populate by our partners (including automated data uploads) and easy for us to analyze (inbuilt reporting tools, including comparison of actual achievement against goals, trend information over time, and comparative performance evaluation across providers). We plan to augment this information system through less frequent region wide data reports on key regional performance measures, including claims-based data. The latter may require us to contract with a third-party data aggregator with sufficient data analytics capability to validate and augment the performance information reported by our providers through the QBS system.

CPAA will be using data from the above sources and analytical tools to issue regular reports to participating providers. These reports will serve two purposes: 1) inform providers on where to target their efforts; and 2) advise providers on progress toward meeting required objectives. CPAA or its designated partner will provide regular reports (e.g., quarterly) to providers for this purpose. When a provider or a group of practices is not making adequate progress on meeting key milestones and metrics, CPAA will reach out to the provider in question and develop a plan of action with the provider to remedy identified gaps or barriers. For example, CPAA and the provider might agree to additional workforce training to assure best practices are fully employed in working with the target population.

Additionally, CPAA will convene all partnering providers once per quarter to participate in a *peer learning collaborative*. Partnering providers will have the opportunity to share successes as well as to raise implementation challenges that the partners can then engage on jointly to resolve. Likely, these meetings will result in the identification of additional technical assistance needs of partnering providers, on which CPAA will follow up accordingly. This learning collaborative will provide an important peer support function to our partnering providers and prove essential for the continuous improvement of our project.

Plan for Addressing Strategies That are Not Working or Not Achieving Outcomes

A similar approach will be used to assess overall progress of project initiatives and the efficacy of strategies within those initiatives. CPAA will use its quarterly performance reports along with semi-annual reports provided by the state with key metrics to determine whether the project initiative as a whole is on track and/or whether specific strategies within project areas are working as intended.
If the reports indicate one or more strategies within the project area are not working, CPAA will convene key stakeholders to assess the reasons for the lack in effectiveness. This will include partnering providers, Provider Champions (Clinical Provider Advisory Committee), consumers (Consumer Advisory Committee), and subject matter experts (e.g., technical assistance providers). Based on this analysis, a recommendation will be made whether to continue the strategy in question with a revised approach or whether to discontinue the strategy in favor of a different one. The decision to change the approach or pursue a different strategy altogether rests with the CPAA Board based on a discussion and

recommendation by the CPAA Council. However, given their key implementation role, any decision to change elements of a strategy or switch out an entire strategy will require the consent of our partnering providers. It may also require the approval of the state. If the CPAA Board authorizes a different approach or strategy, the project implementation plan will be revised accordingly and CPAA will enter into a new or revised contract with partnering providers as the case may be.
Similarly, if the reports indicate an entire project initiative is not achieving desired outcomes, CPAA will convene partnering providers, Provider Champions (Clinical Provider Advisory Committee), consumers (Consumer Advisory Committee), and subject matter experts (e.g., technical assistance providers) to analyze why the initiative is not effective. Every effort will be made to explore whether adjusting program elements or switching out certain strategies may lead to goal accomplishment. This may include consulting with other ACHs that work in a similar project area and are achieving success.

If the group believes changes to the project initiative will rectify the performance problem, a corresponding recommendation will be made to the CPAA Council, which will then discuss the matter and make a recommendation to the CPAA Board. Final decision-making rests with the board. As with switching out a specific strategy or changing a project approach within a project area, any such change requires the consent of our partnering providers that will need to implement the revised set of strategies. State approval may also need to be obtained. Assuming everyone approves the revised strategies, a detailed revised implementation will be developed with clear milestones, performance metrics, etc.

If, however the group of key stakeholders concludes that the project initiative is irreparably compromised and no change in strategies will likely lead to success, a recommendation to discontinue the work in the project area altogether will be made to the CPAA Council. The Council will discuss the matter and make a recommendation to the CPAA Board, which will make the final decision.

Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these

initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

Project Sustainability (500 words)

CPAA's Strategy for Long-Term Project Sustainability and Impact on Washington's Health System Transformation Beyond the Demonstration Period

There is great interest in this project in our region and key stakeholders already made substantial investments to improve bi-directional care integration that will be leveraged by this project. Building on infrastructure already in place, providers have the opportunity to demonstrate how system-wide transformation in care delivery will result from investments in workforce, value-based payment, and population health management. After the Transformation period, these investments will result in the overarching infrastructure and capacity changes necessary to support ongoing care delivery redesign. Additionally, the change to fully integrated managed care will coincide with care integration efforts at the clinical level, and CPAA anticipates that once these major changes are made to both business and clinical practices, the system will be sustained beyond the Transformation period.

CPAA anticipates further development of VBP approaches will support the sustainability of the project. As these approaches are developed, CPAA will work with MCOs to communicate to providers the direction in which VBP is headed with the goal of delivering accountable care that results in improvements to project-specific metrics and HEDIS measures. One of the models selected for this project, the Collaborative Care Model, is an outcome-based strategy, and recently HCA has approved new collaborative care billing codes to support the financial sustainability of this team-based approach. Ideally, partnering providers who elect to implement this strategy will have a greater opportunity to influence regional achievement for the project outcomes. To that end, CPAA will consider advocating for additional improved methods of funding in the Medicaid program to support efforts that demonstrate success.

Healthier Washington sought provider participation in an annual VBP survey to assist HCA in tracking progress of statewide implementation of VBP contracts. CPAA supported this effort by encouraging regional partners to complete the survey. Approximately 25% of all survey respondents throughout the state came from our region. Based on VBP survey data, we identified a preliminary understanding of current VBP practices, barriers, and 12-month VBP plans. For example, the three responses with the highest frequency for providers receiving VBP from any payer that enabled participation in VBP include:

development of medical home culture with engaged providers; aligned quality measurements and definitions; and trusted partnerships and collaboration with payers. The top three reported barriers included lack of interoperable data systems, lack of availability of timely patient/population cost data to assist with financial management, and misaligned incentives and/or contract requirements. The vast majority of providers are planning to increase VBP engagement within 12 months by up to 10% while one provider reported increasing VBP engagement by more than 50%. This readiness to embrace value-base care in our region will serve to support the long-term sustainability of this project.

Finally, CHOICE Regional Health Network and CPAA existed before the Medicaid Transformation and will continue to pursue their long-term goals after the Transformation project is completed. CPAA and CHOICE represent a tested framework for regional collaboration that will endure, which will be critical to the sustainability of this project. Both have proven track records of developing innovative projects with pilot funding and then developing ways to sustain these efforts into the future. Key to our success has been our ability to demonstrate to stakeholders, including hospitals and CBOs, that the project has enabled the stakeholders to achieve efficiencies, improve outcomes, or avert future costs. In the Youth Behavioral Health Coordination Project, CPAA worked with the school system, Behavioral Health Organizations, and medical clinics to help with project development, cost-share on program costs, and create last partnerships. CPAA will continue building on the engagement of social services providers and community-based organizations by facilitating partnerships between clinical and non-clinical providers. Given the importance of this project area to the core mission of many of CPAA's health partners, it is highly likely that our key partners will continue their investments in this project area beyond the duration of the Medicaid Transformation.