SECTION II: PROJECT-LEVEL: Care Coordination

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
☐	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
X	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

Project Description and Justification

Abstract

"Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health services.[1]" Physical health, behavioral health and social support systems generally do not coordinate their services well. Numerous barriers prevent patients moving effectively from one service system to another. Our region seeks to improve the care coordination that is occurring between systems of care by implementing the Pathways Community HUB. The HUB is an evidence-based model to improving care coordination by working with care coordinators to identify high-risk individuals, complete a comprehensive health assessment, identify risk factors, and determine what standardized "pathways" a care coordinator should employ with the individual. By implementing this model, we aim to strengthen the coordination of care between different entities in the community to improve the health outcomes of the most vulnerable in the region.

Justification for Selecting Project and How It Addresses Regional Priorities

Improving care coordination is a critical priority for the region due to disparities in many of the social determinants of health. The Robert Wood Johnson Foundation County Health Rankings analyze a full spectrum of health determinants. The counties in the CPAA region have a very poor average ranking – the second worst among ACHs. Higher unemployment, higher percent of children living in poverty and in single parent households, higher percentages of obesity and smoking, and care providers stretched to

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[1] Chapter 2. What is Care Coordination?. Content last reviewed June 2014. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html

serve many more people per provider are some of the clear examples of disparities in the CPAA region compared to the state[2].

The challenge of having many social and health problems with more limited resources to address them than other parts of the state is well understood among CPAA members. We know we need to do more with less, and we have prioritized improving coordination and collaboration across sectors and services to achieve this. Community-based care coordination is a strategy that helps leverage our limited resources to deliver whole-person care and become more effective and efficient at improving health outcomes. In addition, community-based care coordination helps simplify the complex web of services provided to individuals with complex needs.

The Pathways Community HUB model aligns with all five shared regional health priorities identified by CPAA: improve healthcare access, improve care coordination and integration, prevent and manage chronic disease, prevent and mitigate adverse childhood experiences, and enhance economic and educational opportunities. See appendix ?? (CPAA Compass) There is a body of research that supports the effectiveness of the Pathways approach[3,4,5,6]. In addition, the model is consistent with CPAA's history and approach to addressing community-based health needs.

Based on our region's needs, CPAA considers care coordination an essential strategy that can improve health outcomes and generate systems savings in short to medium time frames. In 2016, CPAA received technical assistance to simulate the impact of several broad health improvement strategies through the Rethink Health model. Experts in using the model helped develop reasonable assumptions about the region to run in the model. Results showed care coordination has the most promise for rapid return on investment. See appendix ?? (ReThink Modeling)

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

The Care Coordination Medicaid Transformation Project will support sustainable health system transformation for the selected target population/s by creating a new structure, the Pathways HUB, that interconnects providers to an enhanced workforce of care coordinators and introduces standardized health information systems and processes for care coordination. Increased care coordination outcomes will lead to less costly care for individual patients by preventing more serious symptoms from occurring and mitigating the impact of existing symptoms. This will lead to overall savings for providers. The value-based payments embedded within the Pathways model will lead to sustainable financing for care

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[2] See County Health Rankings and Roadmaps.

[3] Redding S, Conrey E, Porter K, et al. Pathways Community Care Coordination in Low Birth Weight Prevention. J Matern Child Health 2015;19(3):643-50. First online: 20 August 2014. http://link.springer.com/article/10.1007/s10995-014-1554-4.

[4] Zeigler BP, Carter E, Redding S, et al. Care Coordination: Formalization of Pathways for Standardization and Certification. National Science Foundation Grant Award No. CMMI- 1235364. https://www.rockvilleinstitute.org/files/Care_Coordination_Formalization_of_Pathways_for_Standardization_and_Certification.pdf.

[5] Alley DE, Asomugha CN, Conway PH, et al. Accountable health communities: addressing social needs through Medicare and Medicaid. N Engl J Med 2016 Jan 7;374(1):8-11. PMID:26731305.

[6] Zeigler B, Redding S, Leath B, et al. Guiding principles for data architecture to support the Pathways Community HUB Model. eGEMs (Generating Evidence & Methods to improve patient outcomes) 2016;4(1):Art. 1.

coordination services delivered through the HUB system. As care providers become accustomed to working with care coordinators through the Pathways model, the changes will become hard coded into their operations, creating lasting impact on the care target populations receive.

CPAA and its administrative support organization, CHOICE Regional Health Network, have successfully transitioned pilot projects to ongoing programs by demonstrating value and cost-effectiveness to funders. We intend to use data generated by the Pathways HUB to make the case for continued funding post Transformation.

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

Although care coordination is not new to the CPAA region, the Pathways Community HUB model is a new model for our providers. There can only be one certified HUB per service area, and there are no existing HUBs or organizations pursuing certification in our region. Through the CPAA Council, local forums, and the Care Coordination Work Group, CPAA has ensured there is widespread awareness that we are undertaking this project, with CPAA serving as the HUB Administrator. CPAA created an open Request for Qualifications (RFQ) process to solicit project ideas from providers for this and other Medicaid Transformation project areas, notifying all council and work group members of the opportunity and asking them to share the RFQ with colleagues in their local communities. The RFQ process allowed interested organizations to begin coordinating with us to align their efforts through this project. We will conduct an environmental scan in early 2018 that will specifically study care coordination services in the region to ensure that the Care Coordinating Agencies we work with through Pathways are not duplicating existing care coordination services. In early meetings of the Care Coordination Work Group, we identified a need for the Pathways project to avoid duplication with the Health Homes model of care coordination that is already implemented across Washington State. Health Homes providers participate in the Care Coordination Work Group, and CPAA will continue to work with these agencies to ensure we target different populations and develop a bi-directional referral process between Health Homes and Pathways.

Anticipated Project Scope

Anticipated Target Population

The Medicaid Transformation Toolkit suggests a broad population for this project, namely Medicaid beneficiaries with one or more chronic disease or conditions, or mental illness/depressive disorders, or moderate to severe substance use disorder and at least one risk factor. Based on feedback from the creator of the Pathways model, Dr. Sarah Redding, we are aware of the need to set a narrower population target that will be used during initial start-up implementation of the model, and then scale up and include additional target populations over time. The Care Coordination Work Group has had multiple meetings to explore viable target populations. Knowing we want to avoid overlap with the Health Homes population (the most acute patients, top 1% of Medicaid service utilizers), and we want to create systems cost savings with this project by connecting with people before their health conditions become costly and difficult to manage, we are focusing on Medicaid beneficiaries who represent the next level of rising risk below the most costly and most acute patients served by Health Homes.

To further refine our target population, the Care Coordination Work Group has identified several more specific population sub-groups that we can combine with a broad focus on co-occurring physical and behavioral health concerns. We identified pregnant mothers, homeless individuals, and frequent EMS

utilizers as populations we are particularly concerned with that could lead to significant savings in our region as we improve health outcomes with the Pathways model. The Care Coordination Work Group will make final determinations about the initial group to target during implementation planning and which populations should be added, as we expand the capacity of our region to serve additional clients. This process will be informed by data generated by Providence CORE, our strategic data analytics partner, identifying high needs groups likely to benefit from care coordination. Current data analysis suggests that up to 37% of the Medicaid beneficiaries in our region, or 55,200 people, could benefit from the program. Based on uptake rate of the Health Homes program, we project reaching up to 2% of the total Medicaid population, or 3,800 Medicaid beneficiaries, during the demonstration period. Please see the "Level of Impact" section below for further details.

Involvement of Partnering Providers

The Community Based Care Coordination project requires strong involvement from referral sources, Care Coordinating Agencies, and payers to create a coherent and effective implementation of the Pathways Community HUB model. There is also a need to understand and act on input from consumers and other stakeholders who understand the current flaws in existing care coordination efforts. CPAA has made concerted efforts to involve all of these perspectives into the project plan design process.

The Care Coordination Work Group has brought many of the region's major Medicaid providers together to discuss needs and the fitness of the Pathways model for our region. Since expanding the work group to consider all Domain 2 projects and the Chronic Disease Project, hundreds of organizational stakeholders have provided input on appropriate target populations, assets, challenges, strategies, and other considerations for implementation of the Pathways model.

Clinical providers, who are likely referral sources and potential Care Coordinating Agencies, help us understand what sub-populations of their clients have the most need for care coordination and identify some of the barriers for accessing services that care coordination could alleviate if done well. Non-clinical providers, also likely referral sources and potential Care Coordinating Agencies, help us understand the needs and challenges to successfully navigate across multiple organizations and systems of care. MCOs' input has helped highlight value-based payment opportunities and potential for savings created by the Pathways model. MCOs are also an important partner for the long-term sustainability of the model, indicating their interest in potentially becoming payers for Pathways outcome-based payments.

CPAA has conducted a Request for Qualifications (RFQ) process to understand the interest of project partners in specific projects. Twenty out of 37 RFQ responses received list care coordination as an area of interest, indicating widespread support for the project among partners. Comparing the RFQ responses to the analysis of major Medicaid providers in the region, conducted by CORE, we are confident we can develop relationships with an adequate number of Care Coordinating Agencies to meet our population target goals. See appendix ?? (RFQ Summary)

Level of Impact

Although we will conduct further data analysis in demonstration year two to finalize the specific population we will target during project start-up, the Care Coordination Work Group has had several conversations to develop our strategic thinking regarding where we can achieve the greatest impact

with this project. Within clinical setting, patients with chronic conditions, such as congestive heart failure, can generate significant costs. Through review of the pay for performance project metrics, we identified a need to focus on people with co-occurring diagnoses of behavioral and physical health conditions. The table below shows that co-occurring diagnoses are more prevalent than diagnoses with a singular behavioral health concern.

Category	Count	Percent (total n = 150,321)
SUD only	5,484	3.65%
SUD + 1 chronic condition	4,763	3.17%
SUD + more than 1 chronic condition	10,585	7.04
All SUD (total)	20,832	13.86%
MH only	12,598	8.38%
MH + 1 chronic condition	10,731	7.14%
MH + more than 1 chronic condition	19,187	12.76%
All MH (total)	42,516	28.28%
SUD + MH only	2,179	1.45%
SUD + MH + 1 chronic condition	2,510	1.67%
SUD + MH + more than 1 chronic condition	7,422	4.94%
All SUD + MH (total)	12,111	8.06%

Health Care Authority Category 1 Behavioral Health and Chronic Conditions, 2016

When considering the impact of this project during the Transformation period, we must be realistic about the time it will take to implement the model and build out the caseload. Based on the recent implementation and scaling of Health Homes, we anticipate standardizing access to treatment through the Pathways model for up to 2% of our Medicaid population, approximately 3,800 people, during the Transformation period. With this level of reach during the Transformation period, we will embed the systems changes the model creates into several large Medicaid providers and demonstrate the effectiveness of the model, creating the momentum towards continued spread and scale of the model to reach more Medicaid beneficiaries over time.

Another way the Care Coordination project has focused on maximizing impact is through creating synergies between this project and the other areas of our overall Medicaid Transformation portfolio. The target populations the Care Coordination Workgroup has identified will directly tie patients served by our Pathways project to the other projects. Focusing on people with co-occurring physical and behavioral health needs connects with the Bi-directional Integration project and the Opioid Response project. The high risk OB population connects with the Reproductive Maternal and Child Health Project. The homeless population connects with the Care Transitions project. The population of frequent EMS utilizers connects with the Community Paramedicine work within our Chronic Disease project.

The Care Coordination Work Group will continue to analyze the level of impact through this project by strategically selecting target populations for the start-up and scaling of our Pathways model implementation. We will use data from our environmental scan to model where we are likely to find specific population groups, what providers would make ideal Care Coordinating Agencies to reach the desired populations, and what case load targets we should set to achieve a meaningful impact during the Transformation period. Measurement data generated as a part of the Pathways model implementation will be used throughout the Transformation to monitor and assure target impacts are achieved.

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

Both the Pathways model and the CPAA process for identifying target populations have a strong grounding in health equity. The Pathways model puts the people served at the center of care and empowers them to meet their own goals. By providing someone with a single contact who can help them navigate multiple complex systems and advocate for them along the way, clients are more likely to access the services they need to be healthy and have more personal capacity to engage in their own care. CPAA's target population identification process has focused on understanding health disparities so we can implement Pathways for populations that have a deeper need for additional supports.

One strategy for understanding health equity in relation to this project has been to analyze potential target populations through an equity lens. Differences in mortality rates across census tracts in the region were taken as a proxy measure for health equity, and a map was generated to identify the areas in each county with the highest concentrations of disparities. In these census tracts with high rates of death, people die at around twice the rate compared to census tracts with low rates of death. People in census tracts with high rates of death also experience higher concentrations of many poor social determinants of health, such as higher poverty, lower educational attainment, less access to transportation and employment, and higher concentrations of risk factors such as tobacco use and obesity.
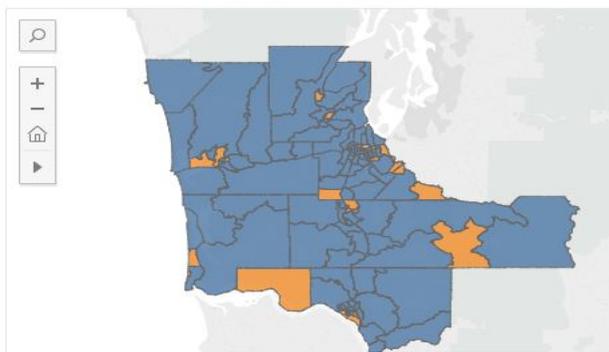
Areas in orange represent highest rate of mortality by

We plan to use the Mortality Map by Census Tract as an important decision making tool when selecting Care Coordinating Agencies to ensure we are accounting for health equity in the populations we target with this project.

Employing Community Health Workers (CHWs) as care coordinators represents another important and effective strategy for addressing health equity by providing more culturally competent and linguistically relevant care. As CPAA implements the HUB, efforts will be made to hire individuals who reflect the diversity of the target populations served. CHWs hired by the project will be drawn from the communities where clients are served and demonstrate an understanding of local, cultural norms.

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

The Care Coordination project creates lasting benefits to the overall population by establishing effective structures for care coordination that transform how care is delivered in the CPAA region. The patient-centered way referrals are made, the population health management data system established by the

HUB, the standardization of effective practices supported through training and technical assistance, the ability to identify and refer people to other appropriate programs (such as Health Homes), and the adjustment of business models to embrace value-based purchasing all represent substantial changes in workflows that will not revert to the way they were after the Transformation period ends. As major Medicaid providers see the benefit to their clients who are engaged in Pathways, they will recognize the value in expanding Pathways to serve additional clients. Some providers will recognize the opportunity to meet value-based contracting goals with MCOs through Pathways, and will become payers for specific pathways, further supporting sustainability of the model. As MCOs see the data on how Pathways contributes to reaching value-based purchasing goals, they will expand their role as payers into the Pathways HUB, creating sustainable funding that can grow as additional populations are reached. As Medicaid beneficiaries receive Pathways services and realize the benefits of whole person, truly coordinated care, demand for the services from the overall Medicaid population will expand. The Care Coordination Project is a self-reinforcing anchor strategy for CPAA, shifting the entire delivery system towards better care that effectively delivers improved outcomes and reduces the overall cost to our Accountable Community of Health, its partners, stakeholders, and communities served.

Implementation Approach and Timing (Supplemental Workbook Tabs)

See 2B 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 State 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 convenes a Care Coordination Work Group and has been meeting at least monthly to collect information and design the project plan. The work group includes representatives from physical and behavioral health, as well as social service organizations from every county in the region. Members have played an active role in project design and the development of this application and are fully engaged in the care coordination project.

To ensure a significant portion of the Medicaid population will be served in this Transformation, CPAA partnered with CORE to analyze which providers serve the majority of Medicaid clients. See appendix ??

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 assessment is to better understand who the major stakeholders are in the CPAA region, who is already engaged in Transformation projects, and who still needs to be contacted to engage. To populate this tool, we used Provider data supplied by the 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's initiatives, and create new tools to monitor existing project efforts.

The Care Coordination project in particular has also ensured participation from social service agencies such as Community Action Programs and housing providers who serve clients with limited income who are likely to also be Medicaid recipients. Across all seven counties, at least one health provider or social service agency for each county that serves a large portion of Medicaid clients has indicated interest in the Care Coordination project. Please see the section above, "Involvement of Participating Providers," for additional details.

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 a first step to understanding what Medicaid populations providers intend to serve, which in turn helps to inform our conversation about choosing specific target populations.

 The Care Coordination Project will take a phased approach to implementing the project, initially starting with CPAA serving as the HUB and up to six Care Coordinating Agencies (CCAs), and increasing the number of CCAs and caseloads within each CCA after the initial start-up period. Partnering providers interested in the initial start-up include major Medicaid providers. Contracts with CCAs will include a commitment to serve the Medicaid population as an additional assurance. 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. CPAA will monitor this commitment by tracking progress on project implementation and outcomes for performance metrics. 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 is Represented

CPAA engages key partnering providers in the Transformation in various ways. A number of key implementation partners 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.

Additionally, 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.

Convening the Care Coordination Workgroup and conducting the RFQ process have already brought widespread engagement into the design of the project. The Clinical Provider and Consumer Advisory Groups are additional resources we will continue to use throughout implementation planning, start-up, and scaling of the project. As we continue working with clinical and social service providers as referral sources and Care Coordinating Agencies, the variety of organizations involved helps us keep our perspective broad and focused on the patient experience and outcomes we are working to achieve. As we complete our current state assessment and select Care Coordinating Agencies for the initial start-up, the Care Coordination Work Group will identify engagement gaps of social service providers and additional Medicaid providers that should be included as the project scales up and expands. The Pathways Program Manager will be responsible for engaging additional providers as necessary.

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. Content experts from MCOs have joined the Care Coordination Work Group as active members and have made themselves available to CPAA staff for additional requests for information. 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

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. These partners have shown consistent engagement in project work groups, advisory committees, and the council and board of directors.

CPAA and its project partners have brought together significant resources to ensure this project is well designed and effectively implemented. CPAA's Care Coordination Work Group convenes a wide variety of subject matter experts and key stakeholders who have contributed hundreds of hours of in-kind time to the project. This widespread engagement will ensure Care Coordinating Agencies can easily interact with referral sources and get to full caseloads early in project implementation. CPAA is also developing relationships with national experts in the Pathways model to ensure we avoid common pitfalls and have adequate guidance for implementing the model to fidelity. CPAA is in the process of exploring a contract with Foundation for Healthy Generations, Pathways Community HUB Institute, and Care Coordination Systems to provide technical assistance in tailoring the implementation of Pathways to our region, training care coordinators and supervisors in the Pathways model, successfully completing the rigorous HUB certification process, and implementing a health information technology platform to support Care Coordination Agencies and the HUB. CPAA also makes use of the wide variety of data sources available to inform planning and has partnered with CORE to strengthen our analytical capacity. CPAA has engaged in a dialog with other ACHs working on the Pathways strategy to learn from their experiences and explore opportunities to create statewide economies of scale with the infrastructure that will be built for this project (e.g. training capacity, software platform, contracting with MCOs as payers).

Challenges to Improving Outcomes and Lowering Costs for Target Population and Strategy to Mitigate Risks and Overcome 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 care coordination:

- **Complexity:** The geographic make-up and inclusion of many distinct communities within the CPAA region will require a thoughtful approach to scaling and spreading the reach of the project to ensure we maximize potential impact on the target population for the region as a whole. With many rural areas with low population density, limited workforce, and large geographical distances between patients and the services they need, the CPAA region is a complex environment in which to implement the Pathways model.
- **Care Coordination Workforce**: The existing workforce of community health workers, who the Pathways model is designed around, is small in the CPAA region. Care coordinators can be recruited from within the region, but we will need to ensure we have robust training available since most workers will be new to the role.
- **Pathways Software Platform:** While Pathways can be implemented using paper records for reporting, it is much more efficient to utilize a sophisticated software platform capable of taking real-time data from CCAs across the region. Additional software features are desirable to create interoperability with other providers' electronic medical records and other health information technology that are already deployed across the region.
- **Sustainable Funding for Pathways**: Braiding funding sources to create sustainable funding for the outcome based payments in the Pathways model is the final major challenge.

CPAA Strategy to Mitigating Identified Risks and Overcoming Barriers

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	Partner with state, MCOs, providers, and other ACHs in

Information Systems	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
Complexity	• The Rockville Institute provides a rigorous HUB certification process that CPAA will follow. This process is designed to mitigate most of the common challenges HUBs face during start-up. • Additionally, we will use technical assistance from national Pathways model and community health worker experts to inform our planning and implementation.

Care Coordination Workforce	• We will support community health worker workforce expansion and training in two phases.
	    o Initially we will contract to provide training to an initial cohort of care coordinators provided by experts in the Pathways model.
	    o In the second phase, HUB staff will become certified to provide training in our region and beyond.

Pathways Software Platform	• Care Coordination Systems has developed a software platform specifically for the Pathways model and has implemented it in 44 sites across the nation. We are working with CCS to license their platform, provided that their product meets the unique needs of our region and can be secured at a sustainable price point. This includes efforts to integrate the CCS platform with other large IT systems in Washington State.
Sustainable Funding for Pathways	• To ensure sustainable funding for outcome-based payments, CPAA will work with MCOs as partners throughout the Transformation period to demonstrate the value of the model in producing value for patients and to negotiate the role of MCOs as payers within the model. The data generated by the Pathways model will be used to justify specific levels of outcome-based payment and will create accountability MCOs can rely on. • In addition to MCOs, we will work with providers interested in outcomes for specific Pathways, state agencies, and other potential payers to develop a robust braided system of sustainable funding.

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. 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 (project managers). It is the responsibility of the project 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. For example, if a provider is working to reduce readmissions, CPAA will need to advise practices on clients with high hospital admission rates and clients with conditions that put them at high risk for readmission. This will enable provider practices to proactively engage these clients and provide care and patient education interventions to reduce the incidence of readmissions. Second, CPAA will need to report to provider practices their overall progress on meeting the required metrics for each project. For example, CPAA will need to monitor hospital utilization to determine readmission rates and will need to correctly associate individual clients with responsible practices. CPAA or its designated partner will provide regular reports (e.g., quarterly) to providers for this purpose.

As detailed above, 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 that 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 that 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 (board membership overlaps the council). 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

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

There are a number of factors that make it highly likely that our region will be able to sustain this project and provide lasting impact on Washington's health system transformation beyond the Transformation Project period:

1. The Pathways program will create lasting benefits that extend beyond the period of the Medicaid Transformation. The HUB will establish braided funding that creates a lasting revenue source for Care Coordinating Agencies and a clear value proposition for payers that seek to purchase care based on value rather than volume. The HUB will also establish a robust data platform that produces more detailed information about gaps in the overall system of care that will inform future regional planning. The Pathways model will expand the employment of care coordinators across the region, creating new job opportunities that can often be filled by people without advanced degrees and who share the same lived experiences as the clients being served. Additionally, clients of Pathways will receive help reducing a wide variety of risk factors in their lives, leading to less likelihood of needing help after exiting Pathways services.

2. CPAA and CHOICE have a proven track record of developing innovative projects with pilot finding and then developing ways to sustain these efforts into the future. Key to our success has been our ability to demonstrate to stakeholders, including payers, clinical providers, public health, and community-based organizations, that the project has enabled the stakeholders to achieve efficiencies, improve outcomes, or avert future costs. Recent examples of such projects include the Youth Behavioral Health Care Coordination Project, Youth Marijuana Prevention and Education Project.

3. As detailed above, in the course of this project, important investments into our region's health system transformation will be made that provide lasting benefits. The improvements to key health information systems; the expertise gained and skills built by training our partnering providers' workforce; the deep changes made to the workflows and business practices of our partners in the course of this project; and the partnerships built and strengthened through the collaborative planning and implementation of this project all combine to ensure that the improvements resulting from project initiative will be ongoing and sustained by our partners.

4. The HUB will create a sustainable financial structure for operation of the Pathways model during the Transformation period. We will bring together a diverse group of payers to create braided funding that pays for client outcomes. During the Transformation period, we will use earned DSRIP dollars to help care coordinating organizations build their capacity, enabling them to move to full VBP by the end of the Transformation period.

5. Our region will explore whether to establish a regional utility to make it possible for smaller

agencies, especially social service providers, to bill Medicaid or be reimbursed for services rendered to Medicaid beneficiaries. Currently, many small providers are not equipped to administer Medicaid billing and reimbursement due to high administrative burden and costs, which limits their ability to provide services to the Medicaid population. CPAA may serve as a regional back office for small providers to handle Medicaid billing and reimbursements, thereby not only removing a major barrier to provider capacity expansion in our region, but also providing a stable funding source for the Pathways Hub.