SECTION II: PROJECT-LEVEL: Transitional Care

Section II (including selection of the relevant project from the menu) will need to be duplicated for each project selected (at least a minimum of four).

Transformation Project Description

Select the project from the menu below and complete the Section II questions for that project.

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
X	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

Abstract

Our health care system is highly fragmented, resulting in poor transitions of care and reduced health outcomes as patients struggle to navigate a confusing health system. Care for individuals with complex health needs, who require assistance from multiple service systems (medical, behavioral health and social services) is a significant challenge in this fragmented system. This is of particular concern for individuals suffering from mental health and chemical dependency issues who require cross-sector assistance. Region-wide, emergency department utilization is still higher than the state average (57 visits per 1,000 member months, compared to 51 visits statewide)[1]. We are aiming to improve transitions of care by implementing Intervention to Reduce Acute Care Transfers, Transitional Care Model, The Care Transitions Intervention, and Care Transitions Interventions in Mental Health set forth in the Medicaid Transformation Project Toolkit to reduce unnecessary emergency department visits and readmissions. We aim to improve care transitions so that community members are getting the right care in the right place at the right time.

Project Description and Justification

Justification for Selecting Project and How It Addresses Regional Priorities

Effective transitions of care play a pivotal role in health care systems for improving health outcomes, reducing hospital readmissions, and reducing avoidable health care spending. There are numerous potentially preventable causes of hospital readmissions such as poor planning for care transitions,

[1] Healthier Washington Dashboard

failure to ensure patients understand medication guidelines, premature discharges, and ineffective communication between hospital staff, patients and caregivers.[2] Poor transitions of care, especially in community outpatient settings, are a major driver of costly emergency department visits and hospital readmissions that could have been avoided. Improving transitional care services is necessary for health system transformation and will reduce burdens in multiple health care settings including emergency departments, outpatient clinics, and psychiatric settings.

Transitional care has been a focus for aligned action among health care providers in the CPAA region for a number of years. Led by CHOICE Regional Health Network, the organization providing administrative support to CPAA, our region has worked on improving transitions of care in community settings. The goal is to improve connections between different care systems that are currently highly fragmented, including acute care, behavioral health, primary care, home health and other social support services, such as housing and transportation assistance, through standardized practices and procedures that support successful transitions. Our region has identified the drivers of poor care transitions and developed a regional action plan for improving transitions of care with key health care providers and payers.

The action plan includes five major action areas that need to be addressed in order to achieve better health outcomes for patients, avoid preventable emergency department visits and hospital readmissions, and reduce health care costs:

1. **Target the intervention:** Implement and apply in each hospital a systematic screening to determine the risk of hospital readmission for all patients admitted and target the transitions intervention at high-risk patients.
2. **Identify key care providers:** For identified high-risk patients, determine, document and appropriately share key contact information with a focus on caregivers, primary care providers, and care coordinators/case managers who have a close relationship with the high-risk patient. Where available, involve the Pathways HUB care coordinator.
3. **Notify key care providers:** Contact primary care providers and other key care providers of high-risk patients as soon as possible after hospital admission to facilitate comprehensive care planning and care plan sharing.
4. **Coordinate transitions:** Carry out warm handovers of high-risk patients from the hospital to primary care or another medical provider willing to assume care, including timely access to clinical records from the hospital stay.
5. **Activate patients:** Inform and involve in discharge and transitions care coordinators/case managers who can effectively assists a high-risk patient's safe transition and engagement with necessary aftercare due to their existing working relationship with the patient.

The importance of improved transitional care was confirmed when CPAA conducted a regional health needs assessment and identified five shared regional health needs as the collaborative's focus areas: improving healthcare access (provider capacity), improving care coordination and integration, preventing and managing chronic disease, mitigating adverse childhood experiences, and enhancing educational and economic opportunities. The first three strategic action areas in particular are central to improving transitions of care.

[2] (Theresa Viggiano, 2012)

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

The Transitional Care Project will support sustainable health system transformation for the selected target population/s by adopting a multi-agency care team approach that is patient centered and focuses on coordinating activities between different care parties around a shared care plan. This will require (1) targeted investments in the capabilities of our partnering providers to exchange relevant care information in a timely manner, (2) changes in partnering providers' workflows, business practices, and staffing patterns to support team-based care, (3) awareness of other care parties and the capacity to build strong working relations among the multi-agency care team, and (4) payment mechanisms that support care coordination. All of these changes are strongly connected with our Care Coordination Project 2B, and will be supported by the implementation of the Pathways model. Once these investments have been made, new capabilities have been developed, and practice changes have been implemented, they will become permanent, as the care systems have become permanently reoriented to these new norms and standard processes and procedures.

CPAA has a proven track record of transitioning pilot projects, similar to this one, to ongoing programs in the region. This has been accomplished by demonstrating effectiveness and cost-effectiveness to participating providers, who then maintained funding for these efforts on a continuing basis. CPAA will apply this approach to assure sustainability of transitional care improvements post-Transformation.

How CPAA Will Ensure Project Coordinates With and Doesn't Duplicate Existing Efforts

Improving transitional care depends vitally on establishing a coordinated approach across currently fragmented care systems. Thus, the transitional care strategy is linked closely with behavioral and physical health integration, care coordination between multiple delivery systems, and diversion interventions. The CPAA partners who have been involved in project planning acknowledged this interdependence repeatedly. As a result, four work groups that initially met independently to address their respective project areas (behavioral health integration, community-based care coordination, transitional care, and chronic disease prevention and control) soon came together and have since met as one integrated Domain 2 Work Group. While CPAA is submitting separate project plans per the Project Plan submission guidelines, by design and necessity, our project proposals are interlinked, coordinated with each other, and mutually reinforcing.

CPAA is taking great care to build upon our region's collective work to improve transitions of care and avoid duplicating existing efforts and capacity. This is in keeping with one of CPAA's foundational principles, namely to build upon existing assets and capacities 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 an update of past assessments of our partnering providers' existing care systems and capabilities relating to care transitions. In this assessment, we can build on similar inventories compiled over the past few years and our deep knowledge of existing care capabilities in our region due to CHOICE's health care improvement work over the last two decades. With a broad range of partner relationships in place across the region, we anticipate being able to complete this analysis quickly.

CPAA began taking stock of project areas in which participating 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 RFQs in total, and 11 of those pertain to the transitional care project area (see Appendix XXX).

Additionally, CPAA developed 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 HCA and included providers who collectively 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 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

According to the project toolkit, the broad target population for the Transitional Care project are Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with SMI discharged from inpatient care, or clients returning to the community from prison or jail.

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 findings with the project work groups and asked members to identify additional subgroups and sub-regions for further consideration. The work group identified the following list of potential target populations for this project: people who are homeless, those without a PCP using the ED as their main access point for care, dual eligible Medicaid and Medicare beneficiaries, individuals who are frequent users of emergency departments, urgent cares, or inpatient hospitalizations, individuals involved with the juvenile justice system, and isolated, rural communities.

Using available data, we anticipate that this project will reach up to approximately 90,300 Medicaid beneficiaries with the following diagnoses:

- 38,900 individuals with at least one chronic condition;
- 12,100 individuals with a substance use AND mental health diagnosis;[3]
- 39,298 individuals diagnosed with serious mental illness (SMI);[4]

We will refine the specific target population(s) for this project area during implementation planning to include populations for plan all-cause 30-day readmissions, avoidable ED utilization, psychiatric inpatient 30-day readmission, and others. This will include an assessment of target populations identified in *other* project areas in an effort to align project interventions across our entire project portfolio to the greatest

[3] HCA Cat 1 BH and CC data file

[4] DSHS ACH Profiles. (FY 2016) https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard

extent possible and achieve maximum synergies and impact. The total number of patients reached will continue to be refined as we establish formal commitments with providers in DY2, Q2.

Involvement of Partnering Providers

CPAA has established a work group comprised of key providers and other stakeholders from throughout the region to plan and develop the Transitional Care project. In establishing the work group, CPAA was able to draw upon a large and diverse group of clinical and social service providers from within the region that had previously implemented transitional care programs at their organizations.

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 been engaged (see Appendix).

The analysis of the largest Medicaid providers in the CPAA region by CORE is being used to systematically approach and engage key Medicaid providers that serve large numbers of Medicaid beneficiaries but have not yet responded to the RFQ. As CPAA finalizes the selection of specific target populations, we will further refine this analytical tool to identify those key Medicaid providers that serve our prioritized project target populations, especially those in prioritized sub-regions (e.g., Cowlitz, Lewis, Grays Harbor, Mason, Pacific, and pocket areas of Thurston counties).

In order to meet our region's transformation goals, CPAA will need to engage not only the main Medicaid providers in our region, but also key social services providers that will have an impact on the metrics and success of care transitions improvements. While our initial analyses and outreach focused on medical and behavioral health providers, we are now reaching out to other provider types, such as skilled nursing facilities, nursing homes, area agencies on aging, criminal justice partners, emergency medical services, DSHS community service offices, local public health, Tribal and Indian Health providers, and other community-based organizations. It is important that we focus on whole-person care to address transitional care needs to truly make transformational, sustainable change. During the project implementation planning phase, CPAA will expand this outreach to partnering providers to include these and other service agencies, and we will make explicit connections to other Transformation project areas, such as community-based care coordination, behavioral health care integration, reproductive and maternal/child health, and the opioid response projects.

Level of Impact

Care transitions need improvement across the seven-county region. Our region has worked to strengthen transitional care in community settings for a number of years already. With a 12 percent all-cause readmission rate, the CPAA region is lower than the statewide average (15%), demonstrating we are making progress through our collective efforts. However, our analysis of available data points to certain geographic sub-regions requiring heightened attention because of, for instance, their elevated ED utilization. Region-wide, emergency department utilization is still higher than the state average (57 visits per 1,000 member months, compared to 51 visits statewide), and there are significant variations within CPAA. For instance, ED utilization is highest in Mason and Grays Harbor counties, with 73 and 71 visits per 1,000 member months, respectively (Oct 2015 – Sept 2016, Healthier Washington Data Dashboard), and 16% of ED visits are considered potentially avoidable for adults 18+ (compared to 15% statewide). Potentially avoidable ED visits for children in our region are also highest in Mason County at

26%.[5] Thus, we anticipate that special emphasis will be placed on targeting our interventions at those geographic areas within our region, while ensuring that the project is implemented across the region. By focusing on sub-populations and subgroups with the greatest health disparities, we will maximize the level of impact for Medicaid beneficiaries and reduce county metrics to match State averages.

Similarly, our ongoing analysis of potential target populations for this project area is leading us to specific communities within our region where members of the prioritized target population reside in larger numbers. While it is too early for us to determine with certainty at this time in our project planning which communities will require special attention based on the chosen target population/s, we anticipate that this will become clear during our project implementation planning. If the data shows a specific ethnic group or community has disproportionately higher hospital admissions, CPAA will target those populations who are at highest risk.

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

As per the discussion above, our data analysis points us toward certain target populations and geographic focus areas in the transitional care project. In keeping with the CPAA's broader values, our work groups explicitly considered health equity as a guiding principle. Specifically, the identification of potential target groups in this project area was guided by an analysis of mortality data by census tracks as a proxy measure for health disparities. Our project work group carefully considered this information by overlaying mortality data with other health statistics, which led to the identification of the preliminary target populations above.

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, we began to vet the work of the project work group through a conversation with consumers from throughout the seven-county region coming together within the CPAA Consumer Advisory Committee. This will continue in the coming weeks and months as we work with this committee more closely and seek to engage consumers in the project implementation planning through surveys and community meetings.

We are consulting with our Tribal partners, some of whom have been involved in our work groups, to ensure that 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.

Finally, in keeping with CPAA's commitment to adopt a health equity lens in our planning and implementation of our project portfolio, we are equipping our project partners with information and practical tools to help them keep health equity considerations front and center. For instance, we have used our monthly shared learning sessions at CPAA Council meetings to conduct health equity trainings, and we are developing a decision-making aid that our council, board, and work groups will use to integrate health equity consideration into their decision-making formally.

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

The investments in this project area will generate lasting impacts in a number of ways:

1. **Workforce:** We anticipate making targeted investments in the workforce of our region as part of this project. This will include training partnering provider personnel in evidence-based strategies, such as the Coleman Method, INTERACT, etc. Once partnering providers have been

[5] Healthier Washington Data Dashboard.

trained, the expertise gained and the capacity built through these trainings will be available indefinitely as a resource to our partnering providers and region.

2. **Changes at the Practice Level:** Similarly, we anticipate our partnering providers will make structural changes in their business practices, staffing configurations, and workflows to conform to the evidence-based models and strategies associated with the chosen interventions. Once these changes have been made, they will be "hard-coded" into the service delivery infrastructure (processes and procedures) and provide lasting benefits beyond the Transformation project period. For instance, through this project, we anticipate that primary care providers will adopt a standard scheduling practice of keeping appointment slots open every day for unexpected follow-up appointments with high readmission risk patients.
3. **Health System Infrastructure:** This project includes targeted investments in the ability of our partnering providers to communicate with each other and exchange relevant patient information. The exact nature of these investments will be determined during implementation planning and will, in part, depend on investments the state is going to make in Health Information Exchange systems. Regardless, once these infrastructure investments have been made, they will provide benefits into perpetuity for our region to improve transitions of care specifically and care coordination in general.
4. **Partnerships:** Through this project, partnering providers will learn what community resources and services are available in the region to which they can turn and refer patients in need of social supports and other wrap-around services. Once awareness about available community resources has been raised and interagency relationships have been established, these essential community-clinical linkages will be permanent and provide lasting benefits.
5. **VBP:** In part, the permanence of the transformation of partnering providers' infrastructures, systems and behaviors depends on sustainable payment mechanisms that carry this change into the future beyond the Medicaid Transformation Project. The state's commitment to changing its healthcare purchasing from fee-for-service to value-base care will be a major supporting strategy for sustaining the CPAA's investments in a transformed healthcare delivery system through the investment areas outlined above.

In sum, a number of mutually reinforcing mechanisms will ensure that the benefits of our investments in improved transitional care will not be limited to the five-year Medicaid Transformation performance period.

While our investments in this project area will be targeted at specific target populations as a subset of Medicaid beneficiaries, the workforce trained, the workflows established, the infrastructure built, the partner relations established, the financing mechanisms put into place, and the overall synergies harnessed, are not exclusive to these prioritized populations. Rather, they will benefit all populations, including the entire Medicaid population.

Implementation Approach and Timing (Supplemental Workbook Tabs)

See 2C 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 convened a Transitional Care 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 the development of this application and are fully engaged in the Transitional Care project.

To ensure a significant portion of the Medicaid population will be served in this Transformation, CPAA partnered with CORE to analyze provider claim 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 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.

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.

In order to secure formal commitments for participation from implementation partners, CPAA will define the specific scope of work for each partnering provider (what and where will investments be made); reporting requirements of partnering providers (what measures and how frequently will reports be made); and payment of partnering providers (how much and when payment occurs). Partnering providers will only commit to participating in the Transformation if they are clear on expectations and can assess the risks and rewards of their participation. CPAA will work with its Finance Committee and TA partners (e.g., Health Management Associates, Manatt, etc.) to establish the necessary payment framework. CPAA will work with its project work group to clarify the scope of work of prospective partnering providers. CPAA will utilize its Support Team to assess partnering providers' scope of work across project areas. CPAA looks at the Transformation projects as an integrated project portfolio; hence, our partnering providers will be asked to engage in integrated project initiatives, rather than

discreet, stand-alone projects. We are confident that partnering providers will be able to make a firm commitment to participating in the Transformation once they have a full understanding of their implementation role across the entire project portfolio.

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. This will include entering into formal contracts with partnering providers. 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 are 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.

We are systematically reaching out to key Medicaid providers that have neither participated in the project planning so far, nor responded to the RFQ to ensure that they are aware of this project and engage in the project planning and implementation going forward. A principal asset in this engagement process is the well-established provider relationships that CHOICE Regional Health Network (which supports the CPAA administratively) 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.

In instances where engagement from missing key Medicaid partners should prove challenging, we will ask our Provider Champions from the Clinical Provider Advisory Committee and Transitional Care Work Group, to reach out to their peers at these key Medicaid provider organizations to begin the engagement process. Additionally, we will reach out to our public health department directors to identify community partners not yet engaged. We will then follow up with in-person visits to explain the project and answer any questions for the targeted key providers.

In our outreach to missing social service providers, we can again draw on the CHOICE membership network, which includes five of the seven local health jurisdictions in the CPAA region (public health and social/human services departments at the county level). We can also build upon our extensive network of partners in the region that have come together under the Transitional Care Work Group. Given the well-established relationships that we have been able to forge with these critical partners to date, we anticipate that we will be able to engage any missing social service partners successfully. In sum, we are confident that this systematic, personalized and multi-pronged approach that builds on well-established partnerships in our region will result in the successful engagement of key Medicaid providers in our region as well as a broad range of social service agencies that are essential for effective improvements in care transitions in our region.

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

Assets CPAA and Regional Partnering Providers Will Bring to the Project

One of the principal assets that CPAA brings to this project is a broad and well-established network of positive, collegial relationships with clinical providers, community-based organizations, and health plans. Over two decades, CHOICE has systematically identified health needs and convened key stakeholders to understand and plan responses to those needs. Our region has successfully come together to develop and run mental and oral health access projects, donated care programs, ED diversion interventions, clinical quality improvement projects aimed at standardizing stroke and cardiac arrest treatment protocols, and care transitions improvements, to name but a few. In its project planning and implementation, CPAA can readily build on this strong foundation.

With regard to transitional care, our region can leverage other assets, too, thanks to our region's collaborative work over the last few years to improve transitions of care:

- Our region has a solid understanding of the drivers of poor care transitions.
- Our region has an agreed upon action plan to address key action areas required to achieve better transitions of care.
- Key project partners established the necessary data infrastructure to track community transitions of care and assess the efficacy of intervention strategies:
    - The large hospitals in our region have been running readmission avoidance programs for several years and thus have extensive experience and insights into what works and what still needs to be improved in order to achieve better transitions of care.
    - Several MCOs have partnered with health care providers in our region to pilot innovative care transitions improvement programs.
    - Qualis Health has provided quarterly reports for five of the seven counties in the CPAA region, analyzing care transition trends for the Medicare population. These reports provide important insights into care transition processes and key metrics for all populations.

Collectively, these efforts have resulted in community care transitions improvements. As with selection of the project target population(s), during implementation planning, CPAA will assess the portfolio of interventions and assets that our region identifies for other Transformation project areas, in particular, bi-directional integration of care, community-based care coordination, chronic disease, and opioid response, to leverage the work in those areas and support this program initiative as well.

Attachment: Regional Care Transitions Action Plan

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 care transitions:

- **Lack of Information:** Notification of the patient's key care contacts cannot occur because it is

not known who all of the caregivers and professionals are who are already working with the high-risk patient (key care contacts) who presents at the hospital. This includes primary care providers and other medical and behavioral health practitioner with whom the patient has an established, ongoing care relationship, but also home health agencies and care coordinators/case managers working with a range of agencies (Area Agency on Aging, health plans, Health Home agencies, behavioral health agencies, etc.) as well as family and paid caregivers.

- **Lack of Provider Capacity:**
  - Hospital staff have no time to research who the high-risk patient's key care contacts are and struggle with making time for "warm handoffs".
  - If there is no established primary care provider for high-risk patients, follow-up care can be compromised because primary care providers may not accept new patients due to capacity limitations.
- **Workflows:**
  - Established workflows and quality improvement requirements of key care contact agencies result in uncoordinated follow-up calls to patients that result in patient confusion and reduced compliance.
  - Established workflows prevent high-risk patients to be seen for follow-up care by primary care providers within the first few days after discharge; there are no appointments available.
- **Information Sharing:**
  - Clinical information about the hospital stay (discharge summaries) is not available in time for follow-up care providers to consider in their care planning.
  - Social service providers, especially those assisting with patient care at home or in a skilled nursing facility, do not have visibility into clinical data sets and cannot support clinical care interventions and after care.
- **Patient Engagement:**
  - Patients do not understand their critical role in supporting effective transitions of care, e.g., through keeping scheduled follow-up appointments.

CPAA Strategy for Mitigating the Identified Risks and Overcoming Barriers

The following lists various mitigation strategies to address the identified challenges and barriers. Many of the project-specific mitigation strategies have been developed and agreed upon by a broad range of project partners that have come together under the CHOICE-led regional care transitions improvement project.

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
Lack of Information	• Long-term, community providers and care coordinators/case managers education and activate patients to know and list their key care contacts; share this info with their primary care providers (PCPs); and bring this info with them if they must go to the hospital. Emphasize simple, low-tech solutions. • Hospitals and PCPs ask and record key contact info for high-risk patients. • MCOs share info on PCP and care coordinators w/ hospital during hospitalization (concurrent review), and share info on care coordinators with PCP. • Implementation of the Pathways care coordination model will improve sharing of information across providers.
Lack of Provider Capacity	• Hospital staff are augmented with care coordination staff that are able to research high-risk patients' key care contacts and facilitate "warm handoffs". Includes care coordinators working through the Pathways project. • Proactively establish relationships with key clinical partners that can provide follow-up care for high-risk patients (e.g., community health centers).
Workflows	• Develop shared protocol for contacting high-risk patients after hospitalization; coordinate follow-up calls to patients. • PCPs reserve slots in their daily clinic schedule for unforeseen high-risk patient follow-up visits.
Information Sharing	• Agree on what data points and in what format care plan details will be shared. • Build automated hospitalization notification function into ED Info Exchange (EDIE/PreManage). • Hospitals and other key care contacts coach patients to bring hospital discharge info with them to PCP follow-up appointments. • Develop push/pull information sharing technology options with appropriate safeguards for PCPs and other care parties. • Community providers, care coordinators and hospitals develop standardized information release forms and practices that facilitate bi-directional info sharing.
Patient Engagement	• Coach patients on the importance of keeping scheduled follow-up appointments, bringing hospital discharge information to follow-up

	appointments with other members of the care team, and taking an active role in their recovery.

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

This project builds squarely on years of transitional care improvements in the region by health care providers and social service agencies. There is great interest in this project area in our region and key stakeholders have already made substantial investments to improve community transitions of care that

will be leveraged by this project. 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. Additionally, CHOICE Regional Health Network will be carrying forward this work with our partners beyond the Transformation period.

As previously detailed, 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. Additionally, systemic changes made through the Care Coordination project area to implement the Pathways model will reinforce the changes made in this project area.

Lastly, the development of value-based payment contracts is critical to the long-term sustainability of this and other Transformation projects. Our provider partners have consistently articulated that the absence of viable payment models to support good transitions of care are a key barrier to improvements in this area. Reliable funding streams to support transitional care tied to value-based care will be central to the long-term sustainability of our region's investments in this project area. We are hopeful that the increased value resulting from the project will be reflected in reimbursement rates and/or provider payments. CPAA will consider advocating for improved methods of funding in the Medicaid program to support efforts that demonstrate success.