Supplemental Workbook – 3D Chronic Disease Prevention and Control Implementation Approach

Project Stage Milestones	Deadline (DY, Qtr)	ACH Approach for Accomplishing Milestones
Stage 1: Planning		
Assess current state capacity to effectively impact chronic disease	DY 2, Q2	Building on past regional capacities, CPAA will conduct an online survey of key clinical providers and public health departments in the region to gauge the current state capacity for implementing the Chronic Care Model and specific corresponding strategies outlined in the Project Toolkit by the end of DY2, Q2. Particular emphasis will be placed on potential partnering providers, i.e., key partners identified during the project design phase to date. We will augment this survey through a discussion of survey results with key partners, advisory committees, and work groups. In addition to understanding the impact of the Chronic Care Model, CPAA will identify how specific strategies, such as the Community Guide, Million Hearts Campaign, Stanford Chronic Disease Self-Management Program (CDSMP), and Community Paramedicine model, are being implemented to get a better understanding of alignment opportunities with other project areas and how current capacities can be expanded.
Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project	DY 2, Q2	By the end of DY2, Q2, CPAA will finalize the specific Domain 1 strategies which support the project. **1) Systems for Population Health Management:** Population health data analysis will continue to be used to refine target populations, including identifying sub-groups and sub-regions. Additionally, we will develop an inventory of our partnering providers' electronic health record (EHR) systems to develop strategies for information sharing. This will include push and pull notifications based on the level of system interoperability. CPAA will also explore opportunities for expanding the use of EPIC among partnering providers, given that approximately 40% of our region (especially hospital systems) is already using this technology platform. Connection of health information technology systems is integral to the Chronic Care Model and emphasizing the importance of producing better information on patient intake procedures will assist clinicians to better address the chronic disease aspects of a patient's care. Additionally, CPAA will explore the interoperability capabilities of EDIE, which is used by most emergency departments, and the different population health systems used by emergency medical services (EMS). **2) Workforce:** CPAA has solicited feedback from the Domain 2 Work Group to identify training needs to support the development of provider workforce capacity. One workforce enhancement strategy will be to increase the use of lay health advisors that have experienced chronic disease. CPAA will continue this assessment of provider workforce needs during implementation planning through an online survey of providers. Survey results will be discussed by the Clinical Provider Advisory Committee to interpret the results and ensure completeness. We will solicit the technical assistance and expertise of the HCA, DOH, and EMS personnel, among others, to provide additional support and training. We will bring together the expertise of training partners and the internal, in-depth knowledge of our providers to develop innovative workflows and new roles and responsibilities for

		health care personnel that will help mitigate unmet workforce needs. One strategy focuses on frontline clinical staff and developing increased skills in awareness of community resources and best referrals for patients with chronic health conditions. Another is training on how to effectively engage challenging clients with multiple conditions. CPAA will continue to explore provider workforce recruitment and retention support strategies that benefit all project areas, such as offering loan forgiveness and conditional scholarships. Additional workforce mitigation strategies CPAA will explore shared workforce strategies, such as expanding access to telehealth, changing overly burdensome licensing requirements for certain practitioners, developing internships for college students, and establishing a learning collaborative of partnering providers. As with investments in Systems of Population Health Management, our investments in Workforce training, recruitment, and retention will be coordinated across all project areas to develop synergies. **3) Value-based Purchasing:** Given the importance of MCOs in funding clinical care for Medicaid beneficiaries, CPAA has included MCO representatives in all stages of project selection and planning, including project work groups. This ensures that our project design and implementation aligns well with current and emerging VBP approaches. Since HCA contracts with MCOs, working closely with HCA will be crucial. CPAA will work with the statewide VBP Task Force to assess how VBP contracts can support chronic disease prevention and control efforts. This will allow partnering providers to assess VBP options and prepare their organizations for value-based care delivery. Again, CPAA's efforts to support provider movement to value-based care will not be specific to chronic disease prevention and control, but support all project areas.
Finalize specific target population(s), guided by disease burden and overall community needs, ACH will identify the population demographic and disease area(s) of focus, ensuring focus on population(s) experiencing the highest level of disease burden.	DY 2, Q2	By the end of DY2, Q2, CPAA will refine the selection of target populations. To date, CPAA determined it will target efforts in counties with the highest percentage of chronic disease diagnoses coupled with lower rates of required detection screenings. As a result of the analysis, we identified target populations and project areas that would address gaps and have the deepest impact for populations who would most benefit from needed interventions. As a proxy to identify areas where there are significant health disparities, CPAA looked at Medicaid claims data and mortality rates in counties by census tracts and the Healthier Washington Data Dashboard to identify specific target populations and sub-regions for our projects. Examples of such groups include: • Individuals with two or more chronic disease(s) • Individuals diagnosed with diabetes in Grays Harbor, Mason, and Pacific counties • Individuals diagnosed with heart disease in Lewis, Grays Harbor, Mason and Pacific counties • Individuals diagnosed with asthma in Grays Harbor, Lewis, and Wahkiakum counties • Individuals with a chronic condition and behavioral health disorder

Select evidence-based guidelines and best practices for chronic disease care and management using the Chronic Care Model approach to improve asthma, diabetes, and/or heart disease control, and address obesity in their region. -Region may pursue multiple target chronic conditions and/or population-specific strategies in their overall approach.		Addressing health disparities will help improve health equity in our community. Going forward, we will review the target population(s) prioritized by other project areas to determine whether there are shared population(s) across project areas with an emphasis on Care Coordination and Bi-Directional Integration of care. CPAA will perform a similar cross-analysis of sub-populations and sub-regions. Aligning our target populations and sub-regions across project areas to the greatest extent possible will generate maximum synergies and impact. In support of this analysis, we will continue to work with CORE to refine our data tools. As we progressively narrow down our target population(s) through these efforts, our work group and partnering providers will be able to make a final determination about the project's target population(s). The Domain 2 work group identified the Chronic Care Model as the evidence-based approach, along with several specific strategies, to address chronic disease prevention, treatment, and management. CPAA will work with partnering providers and advisory committees to establish best practices for implementing the Chronic Care Model approach, specifically to improve health of those living with asthma, diabetes, and heart disease. In response to regional health needs, CPAA will place an emphasis on implementing evidence-based guidelines for specific chronic conditions around the current practices at each provider. CPAA will work with the Clinical Provider Advisory Committee to identify additional strategies that may need to be included in order to reach the desired outcomes. With the support of CORE, the work group will vet these strategies as to likely impact and feasibility (cost, provider readiness, etc.) before a final determination about chosen evidence-based approaches will be made. This begins with ensuring the Chronic Care Model is in practice across the region's providers, then building outward to clinical-community collaborations and improving the supports available to patients in all aspects of their lives. The CPAA's Regional Health Improvement Plan already calls for action toward improving capacity for the CDSMP. To this, the CPAA will add Million Hearts campaign elements to create a health-promoting community environment.
Identify, recruit, and secure formal commitments for participation from all implementation partners, including health care providers (must include primary care providers) and relevant community-based service organizations. Form partnerships with community organizations to support and develop interventions that fill gaps in needed services (www.improvingchroniccare.org).	DY 2, Q2	CPAA identified key clinical partnering providers for this project using (1) the well-established network of partnerships with a broad range of clinical providers through CHOICE Regional Health Network's health improvement projects; (2) responses to a Request for Qualifications (RFQ) that was issued this summer; and (3) an analysis of the main Medicaid providers and community-based organizations in the CPAA region by our strategic data analytics partner, CORE. In the coming months, we will be systematically reaching out to those main Medicaid providers that have not yet engaged in project planning to introduce the project and encourage participation in project design and implementation planning. Concurrently, we will reach out to social service providers and community resources in our region whose support is crucial to fill gaps between needed chronic disease services. The recruitment of specific partnering providers - both clinical and community-based - will

		be guided by our final decision about the target population(s) and sub-regions for this project. Partnering organizations and providers will receive detailed technical support to ensure participants are well-versed on the Chronic Care Model and specific strategies to be implemented in conjunction with the Model. In order to secure formal commitments for participation from implementation partners, CPAA will define the specific scope of work for each partnering provider (what and where will investments be made); reporting requirements of partnering providers (what measures and how frequently will reports be made); and payment of partnering providers (how much and when payment occurs). Partnering providers will only commit to participating in the Transformation if they are clear on expectations and can assess the risks and rewards of their participation. CPAA will work with its Finance Committee and TA partners (e.g., Health Management Associates, Manatt, etc.) to establish the necessary payment framework. CPAA will work with its Clinical Provider Advisory Committee to clarify the scope of work of prospective partnering providers. CPAA will use its Support Team to assess partnering providers' scope of work across project areas. CPAA looks at the Transformation projects as an integrated project portfolio; hence, our partnering providers will be asked to engage in integrated project initiatives, rather than discreet, stand-alone projects. We anticipate partnering providers will make a firm commitment to participating in the Transformation once they have a full understanding of their implementation role across the entire project portfolio. These commitments will be memorialized in written agreements/contracts by the end of DY2, Q2.
Develop Implementation Plan that includes, at minimum: -Implementation timelines. -Description of the mode of service delivery, which may include home-based and/or telehealth options. -Roles and responsibilities of key organizational and provider participants, including community-based organizations. -Description of how project aligns with related initiatives and avoids duplication of efforts. -Specific change strategies to be implemented across elements of the Chronic Care Model: --Self-Management Support --Delivery System Design --Decision Support --Clinical Information Systems --Community-based Resources and Policy --Health Care Organization -Justification demonstrating that the selected strategies and the committed partner/providers are	DY 2, Q3	By the end of DY2, Q2, the project implementation plan will be developed by CPAA staff in close collaboration with the project work group and in consultation with the Support Team to ensure the project implementation plan integrates well with and supports the other Transformation projects pursued by CPAA. This includes alignment with Project 2A and 2B through the comprehensive review and coordination of target populations across different project areas detailed above (see Finalization of target population and evidence-based approaches). If feasible, CPAA will use Project 2B to help identify those affected with multiple chronic disease needing additional community resources using the Pathways model. CPAA will also work closely with Project 2A, focusing on those individuals with multiple chronic disease and behavioral health disorders. Additionally, our two advisory committees - the Clinical Provider and Consumer Advisory Committee - will review the project implementation plan to assess feasibility and impact from their respective perspectives and provide guidance on the final implementation plan. This will ensure that the implementation plan employs evidence-based approaches, is responsive to the needs of the region, and impacts high-need target populations. CPAA will work with partnering providers to establish timelines that meet the needs of our providers, first by focusing on large Medicaid providers and community-based social service providers, and then gradually building out to include smaller clinical and

culturally relevant and responsive to the specific population health needs in the region. -Strategies to identify and focus efforts in high risk neighborhoods or geographic locations within the region, with attention to addressing health care disparities related to selected diseases. -Describe strategies for ensuring long-term project sustainability		community-based providers. In finalizing commitment letters from partnering providers, CPAA will include final evidence-based approaches each provider will implement and ensure all implementation requirements are met. CPAA will ensure alignment across project areas is prioritized to serve specific target populations that cross the entire health care system. An assessment of current state capacities will be conducted to avoid duplicating efforts and instead build upon existing assets and resources to the greatest extent possible. This includes an assessment of existing care management and case management services and the reach of the Health Home program in our region. Again, this current state assessment will be reviewed across different project areas to develop maximum leverage and avoid duplication. In the implementation plan, the service delivery mode will be clearly articulated based on the selected target population/s and may include both home-based or telehealth options for chronic care management. CPAA will work with partnering providers to identify any assistance needed through training, infrastructure, or workforce to implement the Chronic Care Model to include self-management support, delivery systems design, decision support, clinical information systems, community-based resources and policy, and health care organization involvement. This includes the description of the service delivery mode. The program manager will ensure roles and responsibilities of implementing partners are clearly articulated in both the project implementation plan and our contracts with partnering providers. The program manager will monitor adherence to the implementation plan by all partners on an ongoing basis. CPAA will work closely with all partnering organizations, including MCOs and BHOs, to ensure that Domain 1 investments are leveraged to support the long-term sustainability of the project (see Domain 1 project support above for details). Additionally, CPAA anticipates working with other ACHs to maximize investments in Domain 1 activities through coordinated investments across the state, or at least those regions that are interested in developing shared capacity, especially around Systems of Population Health Management and workforce development.
Stage 2: Implementation		
Develop guidelines, policies, procedures and protocols	DY 3, Q1	By the end of DY3, Q1, CPAA will establish project-specific guidelines, policies, procedures, and protocols necessary to ensure consistent implementation of selected evidence-based strategies and models. In developing these documents, we will build to the greatest extent possible on already existing guidelines, policies, procedures and protocols that the proponents of the selected evidence-based strategies and models have already developed. For instance, there is a readily available set of guidelines and procedures associated with the Chronic Care Model. With guidance from the Clinical Director, the Program Manager will take the lead on developing any additional guidelines, policies, procedures and protocols necessary to customize the evidence-based strategies and models to our specific regional context, if appropriate. The

		Clinical Provider Advisory Committee will review the proposed project-specific guidelines, policies, procedures, and protocols and make changes as necessary. We will consult with this Committee as necessary, as well as with other technical assistance providers that have detailed knowledge of the Chronic Care Model and supporting evidence-based strategies. The Program Manager will ensure all partnering organizations have access to and understand the guidelines that will be implemented. The program manager is also responsible for monitoring adherence to these guidelines, policies and procedures and protocols through provider spot checks.
Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / approach	DY 3, Q2	By the end of DY3, Q2, CPAA will establish a progressive implementation and performance monitoring system. This will include regular meetings with partnering providers to assess implementation progress and challenges. These meetings will be augmented by regular provider and regional performance reports that demonstrate movement toward critical milestones and achievement of key outcome goals. If performance problems are identified, the Program Manager will take the lead on developing a QIP in consultation with the partnering provider who is underperforming. In developing the QIP, the program manager will be supported by the Clinical Director and senior agency leadership, as well as both the Clinical Provider Advisory Committee and the Consumer Advisory Committee. Whenever possible, the QIP will identify technical assistance resources that help the partnering provider to get back on track. CPAA will establish a common format for QIPs detailing strategies, measures, and targets along with timelines for required improvement to ensure accountability.
Implement disease/population-specific Chronic Care Implementation Plan for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/or improve: -Self-Management Support -Delivery System Design -Decision Support -Clinical Information Systems -Community-based Resources and Policy -Health Care Organization Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data sharing strategies.	DY 3, Q4	In implementing the project, we will follow the project implementation plan (see above), which details timelines, action steps and the specific roles and responsibilities of our partnering providers in their implementation of the selected evidence-based strategies. It will be the responsibility of the Program Manager to be in regular contact with our partnering providers to monitor adherence to the implementation plan and to ensure project-specific guidelines, policies and procedures and protocols are followed, so that implementation addresses the core components of the Chronic Care Model and specific change strategies associated with the model. The Program Manager is also responsible for ascertaining partnering providers' training and technical assistance needs, which are expected to surface through provider reports and regular meetings with providers, and to arrange for necessary trainings and technical assistance. Special emphasis will be placed on making sure care team members have access to shared care plans. We anticipate that establishing effective bi-directional communication strategies and systems between clinical and community-based organizations to ensure a smooth and timely integration focusing on communication, referrals processes, and data sharing strategies. In monitoring the performance of partnering providers, we will use a combination of quantitative and qualitative information provided by partnering providers through monthly reports and regular check-ins to ensure effective communication, referral, and data-sharing strategies are being implemented.

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Stage 3: Scale & Sustain		
Increase scale of approach, expand to serve additional high-risk populations, include additional providers and/or cover additional high needs geographic areas, to disseminate and increase adoption of change strategies that result in improved care processes and health outcomes	DY 4, Q4	During DY4, CPAA will do a gap analysis of target providers/organizations that have yet to implement the Chronic Care Model and/or any of the evidence-based strategies in the Project Toolkit. This gap analysis will allow us to target our outreach efforts and form partnerships with new providers. Additionally, CPAA will identify and engage providers already serving the target population, focusing on those offering primary care. In addition to the gap analysis, CPAA will work with our partnering providers and CORE to determine which high-risk populations and high-needs geographic areas are not seeing improvements in health outcomes and project metrics. This will allow CPAA to assess the best method to disseminate and increase adoption of change strategies.
Continue to employ continuous rapid cycle improvement processes/continuous quality improvement methods to refine change strategies and scale up implementation.	DY 4, Q4	Throughout the Transformation Project, CPAA will employ a dynamic quality improvement approach based on the real-life implementation experience of our partners. Our CQI approach will include: 1) monitoring performance against outcomes; 2) providing regular feedback to providers regarding performance; 3) intervening with providers when performance is not adequate and/or objectives are not met. Interventions may include consultation, training, or corrective action. As implementation challenges are encountered, we will consult with our partnering providers to assess the implementation issues and determine what technical assistance resources might help with resolving the challenges. CPAA will help partnering providers reflect on implementation challenges and develop solutions when partnering providers gather periodically (peer learning collaborative) to share lessons learned and problem-solve together. As a result, we anticipate that implementation of the Chronic Care Model and supporting evidence-based strategies will experience progressive refinement. Correspondingly, project-specific guidelines, policies, and procedures will need to be updated to capture learning. CPAA will incorporate discussion of how existing payment approaches may be modified or enhanced to transition to value-based payment. CPAA has included MCO representation on the Clinical Provider Advisory Committee to help assure the discussion is relevant to the prevailing method of provider reimbursement. At this stage of project implementation, we also anticipate partnering with other ACHs to compare the refinement of the model across ACH regions, further leveraging implementation experience.
Provide or support ongoing training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies.	DY 4, Q4	By DY4, CPAA will have identified training and technical assistance needs of major providers in the region and will continue assessing future needs on an ongoing basis. Ongoing support will be essential to achieving continuation and expansion of the Chronic Care Model and supporting evidence-based strategies. CPAA will use quarterly gatherings of its implementation partners (peer learning collaborative) to determine specific ongoing support needs as well as feedback from individual implementation partners. We anticipate that ongoing support needs will change in later years of the Transformation Project, emphasizing sustainability and shared learning. Thus, working even more closely with our MCO partners to provide opportunities for our implementation

		partners to learn with and from each other, as our region scales up the Transformation Project's scope and reach, will be essential. In providing these supports, CPAA will work with other ACHs that chose Chronic Disease Prevention and Control as a project area to the greatest extent possible in order to increase the spread of the project and maximize resource efficiencies through economies of scale (e.g., through shared training costs or technical assistance).
Engage and encourage Managed Care Plans to develop/refine model benefits aligned with evidence-based clinical guideline-concordant care and best practice recommendations.	DY 4, Q4	Throughout the Transformation and in partnership with MCOs, HCA, and our partnering providers, CPAA will monitor the degree to which value-based purchasing arrangements have been adopted in provider contracts to support chronic disease prevention, management and treatment in our region. With these partnerships, CPAA will be well-positioned to encourage MCOs to develop/refine model benefits to align with the evidence-based strategies being implemented across the region.
Identify and document the adoption by partnering providers of payment models that support Chronic Care Model approach and the transition to value based payment for services.	DY 4, Q4	By DY 4, Q4, CPAA will conduct a survey of its partnering providers and MCOs to determine VBP penetration for chronic disease care. Given the proprietary nature of provider contracts with health plans, CPAA will limit its inquiry to whether VBP arrangements are in place and, if so, what general type of VBP contract has been agreed upon (upside only, shared upside and downside risk, etc.). CPAA will also work with its partnering providers to scale activities such that all payers, not only MCOs, adopt payments models that support the Chronic Care Model. This is vital for the long-term sustainability of this effort. Lastly, CPAA will work with state policy makers to obtain a long-term commitment that rewards implementation partners, including MCOs, for efficiency gains achieved, rather than punishes MCOs and partnering providers through reduced reimbursements in subsequent years.