SECTION II: PROJECT-LEVEL: Chronic Disease Prevention & Control

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
☐	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
X	3D: Chronic Disease Prevention and Control

Project Selection & Expected Outcomes (2,000 words)

Abstract

The management of chronic diseases, including asthma, heart disease, and diabetes, places a huge burden on our region's health system. Approximately 26% of Medicaid beneficiaries in the CPAA region (38,900 members) have at least one chronic condition based on diagnostic coding.[1] To improve chronic disease prevention and management, we are exploring the Chronic Care Model, The Community Guide, Community Paramedicine, Chronic Disease Self-Management, and Million Hearts interventions. These interventions address the community needs and provide the needed support and infrastructure to address the chronic disease burden in the community. By addressing the chronic disease burden in our communities, we aim for our community members to have the tools and resources to manage their chronic conditions successfully as well as have the policies and systems in place to effectively support chronic disease management.

Project Description and Justification

Justification for Selecting Project and How It Addresses Regional Priorities

An integrated health system, along with community approaches, will be crucial to improving chronic disease prevention, management, and control. Through health system improvements and taking a whole-person approach to care, providers have the opportunity to reduce chronic diseases and conditions that create an overwhelming burden on the health system in terms of costly, preventable health problems. In 2014, seven of the top 10 causes of death in the United States resulted from chronic

[1] HCA Category 1 Behavioral Health and Chronic Conditions Co-Occurring file, September 2017

diseases.[2] Research shows people who suffer from a chronic disease are more likely to suffer from depression, which highlights the need for an integrated health system as these co-morbidities result in health care costs two to three times higher than the general population.[3][4]

Locally, heart disease and cancer are the leading causes of death in Thurston, Lewis, and Mason counties, closely following statewide and national trends.[5] Approximately 26% of CPAA's Medicaid beneficiaries (38,900 members) have at least one chronic condition based on diagnostic coding.[6] Approximately 15,300 members (10.2%) have a substance use disorder (SUD) diagnosis and at least one chronic condition, and just under 30,000 members (19.9%) have a mental health diagnosis and at least one chronic condition.[7] On average, the majority of the CPAA region has a higher prevalence and rate of numerous health measures including overweight or obese adults, arthritis, diabetes, and heart disease than Washington State 3D-1.[8] The region's average diabetes rate exceeds the state rate of 9%.[9] CPAA also lags behind statewide performance in statin therapy for patients with cardiovascular disease (14% compared to 20% statewide, CPAA is the lowest performing ACH on this measure).[10]

Table 3D-1. Adult (Age 18+) Chronic Disease

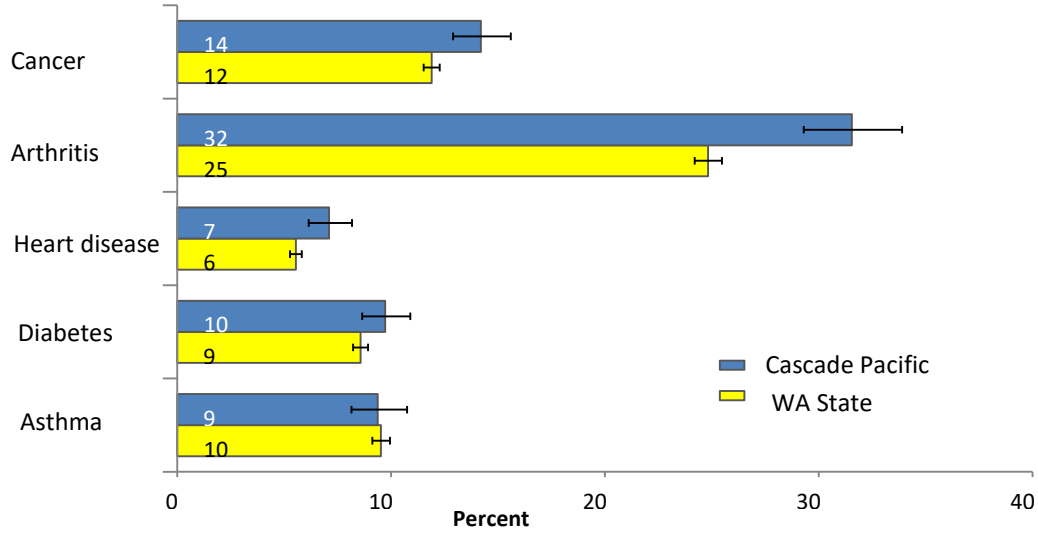

Table CD-1. Self-reported lifetime prevalence – Survey respondent answered "yes" to "have you ever been told by a healthcare professional that you have asthma / diabetes / heart attack, coronary

[2] Centers for Disease Control and Prevention. Chronic Disease Overview. https://www.cdc.gov/chronicdisease/overview/index.htm
[3] https://www.cdc.gov/workplacehealthpromotion/tools-resources/pdfs/issue-brief-no-2-mental-health-and-chronic-disease.pdf
[4] Bree Collaborative Behavioral Health Integration Report and Recommendations
[5] Washington State Department of Health, death data. Accessed via Providence Centralia and Providence St. Peter's Hospital 2016 Community Health Needs Assessment (CHNA) and Mason General Hospital's 2017-2019 CHNA. http://communitybenefit.providence.org/~/media/Files/CBR/CHNAs/2017/WA/2017%20CHNA%20Providence%20Centralia%20Hospital.pdf and https://www.masongeneral.com/media/forms/Community-Health-Needs-Assessment-2017-2019.pdf
[6] HCA Category 1 Behavioral Health and Chronic Conditions Co-Occurring file, September 2017
[7] Ibid.
[8] Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System. Accessed via Providence Centralia and Providence St. Peter's Hospital 2016 Community Health Needs Assessment (CHNA) and Mason General Hospital's 2017-2019 CHNA. http://communitybenefit.providence.org/~/media/Files/CBR/CHNAs/2017/WA/2017%20CHNA%20Providence%20Centralia%20Hospital.pdf
[9] Data Source: Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System, supported in part by Centers for Disease Control and Prevention, Cooperative Agreement U58/SO000047 -1 through 4 (2012-2015) and 3U58SO000047-SO14-1401. Analysis conducted by Thurston County Public Health & Social Services Department
[10] Washington Health Alliance, Community Checkup. 2016.

Led by CHOICE Regional Health Network, the organization providing administrative support to CPAA, our region has focused for several years on improving chronic disease prevention and control. An integrated health system, bolstered by community approaches to raise awareness and engage and activate patients, is crucial for improving chronic disease prevention, management, and control. Through health system improvements and taking a whole-person approach to care, providers have the opportunity to reduce the prevalence of and better manage chronic diseases, i.e. diabetes, heart disease and asthma, that create a high burden on the health care system and overall community well-being.

Providing whole-person care in the setting in which individuals are most likely to seek care is a key building block for CPAA to achieve its overarching goals of improved health, better quality, and lowered costs. Through local forums in the CPAA region and in collaboration with the managed care organizations (MCOs), five regional health priorities were identified to achieve these goals. The Chronic Disease Prevention and Control Project offers CPAA a strategy that aligns with three of these five regional priorities: improving access to health care (including primary care and behavioral health), improving care coordination & integration, and preventing & managing chronic disease.

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

This project supports sustainable health system transformation in two keys ways: through investing in efforts to transform the clinical delivery system in all health care settings (primary care and behavioral health), and by investing in efforts to support these clinical efforts through better coordination with community-based prevention efforts to raise awareness and better self-management of chronic disease. The success of this project rests on a close alignment with other project areas. For example, through the bi-directional care integration project, both primary care and behavioral health providers will work to better diagnose, treat, and manage behavioral health disorders and chronic disease. These efforts will be bolstered by this project, which will not only allocate resources to support providers to be better equipped to provide effective chronic disease prevention, diagnosis, and management in clinical settings, but also by community-based efforts to raise awareness and disease self-management through periphery systems such as public health and emergency medical services. The Chronic Care Model, coupled with chronic disease-specific strategies, is an ideal framework for CPAA to accomplish this because it encompasses both aspects of what is needed to make improvements in chronic disease prevention and management.

Managing patients with chronic disease is very costly and time consuming for both providers and patients. As the region transitions to value-based care, the prevention of chronic disease is key. The Chronic Care Model supports value-based care by reducing the number of admissions and readmissions, improving patient self-management, controlling costs, and working toward the overall goal of transitioning to value-based purchasing. The project brings together MCOs, providers, and community resources to ensure all entities are positioned for value-based purchasing after the Medicaid Transformation ends in 2021.

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

Improving chronic disease prevention and control depends vitally on establishing a coordinated approach across currently fragmented care systems. CPAA is taking great care to build upon our region's collective work to improve chronic disease prevention and control and avoid duplicative efforts and capacity for this project. This is in keeping with one of CPAA's foundational principles, namely to build

upon existing assets in the region and strengthen existing infrastructure and care systems to the greatest extent possible. Therefore, one of the first implementation steps in this project area will be an update of past assessments of our partnering providers' existing care systems and capabilities relating to chronic disease. Data from these assessments will assist with capacity building and be used to track, monitor, and coordinate implementation efforts.

CHOICE has led regional healthcare improvement planning and worked closely with leaders and the community for over 20 years and is thus familiar with both healthcare needs and existing services provided in the region. CPAA's governance and advisory structure bring to the table a wide-range of service providers, stakeholders, and organizational leaders in the region, including the two Behavioral Health Organizations and all five Managed Care Organizations that serve Medicaid beneficiaries. This broad range of partner relationships already in place enables us to hear real-time concerns about health issues, including common chronic conditions and diseases.

Building on this strong foundation in the community, during Transformation Project design, four work groups that initially met independently to address their respective project areas (bi-directional care integration, community-based care coordination, transitional care, and diversions), including 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's work group helped develop this project application, and there is a high level of understanding in the Domain 2 Work Group of the need for more streamlined, cross-system coordination without duplicating existing services, along with guidance on transforming individual organizations to meet standards outlined in the Project Toolkit.

CPAA began taking stock of project areas in which partnering providers are planning to implement interventions by opening a Request for Qualifications (RFQ) process that prompted providers to describe new project ideas, how new projects will avoid duplicating efforts, and which partners are working in collaboration. It has been well communicated through project work groups and correspondence with partners that Transformation funding can only be used for new projects and/or enhancing current projects. To date, we have received 38 RFQ responses, of which 15 pertain to the chronic disease prevention and control project area (see Appendix XXX).

Additionally, CPAA conducted a landscape analysis of major Medicaid providers and payers, as well as public health departments in the region (see Appendix XXX). For providers, this includes dental, primary care, FQHCs, hospitals, and major health systems. The purpose of this assessment is to better understand who the major stakeholders are in the CPAA region, who is already engaged in the Transformation projects, and who CPAA still needs to engage in the Transformation work. During a review of this tool by the CPAA Council and Domain 2 Work Group, a number of key providers were identified that needed to be added to the list. To populate this tool, we used Provider data supplied by HCA and included providers in the table 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 Chronic Disease Prevention and Control project has the potential to serve all Medicaid beneficiaries, both children and adults, with, or at-risk for, the most common chronic illnesses such as arthritis, cancer, asthma, diabetes, heart disease, obesity, and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region. Although not specified in the Toolkit, we are acutely aware that co-occurring behavioral health conditions add to the complexity of chronic disease treatment. Patients with a behavioral health diagnosis and a chronic disease will be a key overlapping sub-population served under the bi-directional care integration project.

Providence CORE conducted an analysis for CPAA that highlights sub-regions and subgroups with poorer health outcomes where the greatest impact could be made (see Appendix XX). CPAA reviewed these findings with the Domain 2 Work Group and asked members to identify additional subgroups and sub-regions for further consideration. Based on work group members' feedback, we identified the following qualitative list: patients diagnosed with diabetes have a much greater risk of heart disease, patients with numerous chronic conditions have a higher risk for hospital admission, ED utilization, and death, those without a PCP, those with transportation barriers in urban and rural settings, and people who are homeless.

Based on a review of available data, diagnostic coding indicates that approximately 38,900 members in the CPAA region have at least one chronic condition.[11] As more data becomes available, we will refine our target populations to include specific numbers for patients with three or more chronic diseases and patients with two or more chronic diseases because these are the broad populations experiencing the greatest burden of chronic diseases. The table below shows proposed target populations and an anticipated number of individuals that will be reached through this project. We estimate that, by the end of the Transformation, approximately 38,900 potential patients will be reached through chronic disease prevention and treatment activities of this project.

Table 3D-2. Proposed Target Populations

Proposed Target Population	**Estimated Number**
Medicaid enrollees in the CPAA region with one or more chronic diseases	38,900
Medicaid enrollees in the CPAA region with one or more chronic disease & a co-morbid behavioral health disorder	45,000
Medicaid enrollees in Mason, Thurston, and Grays Harbor counties and with Diabetes	4,771
Medicaid enrollees in Thurston, Lewis, and Mason counties with Heart Disease	12,179
Medicaid enrollees in Grays Harbor, Lewis, and Wahkiakum counties with Asthma	2,748
Note: Numbers may be duplicative, but give a general sense of the scope of the target populations	

The Domain 2 Work Group will make final determinations about the populations experiencing the greatest burden of chronic disease(s) in the CPAA region and will refine which populations should be added as we expand the capacity of our region to serve additional clients.

[11] HCA Category 1 Behavioral Health and Chronic Conditions Co-Occurring file, September 2017

Involvement of Partnering Providers

CPAA is keenly aware that we need to engage the right providers in order to meet our region's Transformation goals. With that in mind, CPAA has conducted three efforts to identify partnering providers: 1) a Request for Qualifications (RFQ) to identify and engage partnering providers; 2) a table that includes providers who served approximately 90% of Medicaid beneficiaries in 2016; and 3) a table that includes community-based organizations and social services in each county that have already been engaged (see Appendix XX), all of whom are vital partners for this project because they are able to facilitate essential community-clinical linkages without which the project cannot be successful.

Many of our clinical partners have been engaged with CPAA from the start and have specifically been involved in work groups to design this project application. This project promotes and supports specific changes in clinical delivery that have a strong evidence base for improving patient outcomes. Public health has also been a foundational sector participating in the CPAA. Their expertise in population health campaigns and policy change that improves overall health are critical for reinforcing changes within the clinical systems. Public health's long-term engagement with communities is a key part of developing supports for healthy behaviors and developing solutions for social determinants of health. Emergency Medical Services providers have come to the table more recently and bring a critical understanding of and interaction with populations that have fallen through the cracks of our clinical systems.

There is strong representation from most of the major Medicaid providers in the CPAA region around implementing chronic disease prevention and control. The clinical providers identified in the CORE analysis represent the main clinical access points for Medicaid beneficiaries. With strong involvement from our clinical partners across the region, we can expect to serve a large population of Medicaid beneficiaries, specifically the target populations detailed above, which is critical for the success of this project. Additionally, our clinical partners implementing this project will follow the evidence-based models outlined in the Project Toolkit, which are the proven strategies for achieving care delivery redesign. CPAA continues to engage non-clinical partners with the understanding that their involvement will play a key role in improving education and awareness of chronic disease risk factors. Future work will involve strengthening partnerships between our clinical and non-clinical partners.

Level of Impact

This project is unique in its scope in that it is predicated on a multi-pronged approach which encompasses both clinical redesign strategies to better diagnose, treat, and manage chronic disease, but also incorporates broad-based community efforts to raise awareness about preventing and self-managing chronic diseases. Effective treatment and management of chronic diseases require an ongoing productive relationship between providers and patients. Prevention or reduction of complications also requires engagement with community partners to create supportive conditions for healthy behaviors. By improving clinical practices and the supports that can help patients better engage in care, CPAA can make significant improvements for the Medicaid population.

To achieve the outcomes expected for the project in our target population/s, we know we must focus our efforts. We will leverage the work to redesign the clinical delivery system with the bi-directional care project in both primary care and behavioral health, a key place where we need a heightened focus on individuals with co-occurring behavioral health disorders and chronic disease(s). Similarly, our ongoing analysis of potential target populations for this project area is leading us to specific communities within our region with higher rates of specific diseases. For example, Lewis, Grays Harbor, Mason, and Pacific counties have a higher percentage of adults who are overweight or obese as well as adults who have

been diagnosed with arthritis, compared to the state average. Lewis and Grays Harbor counties have a higher percentage of adults who currently have asthma, compared to the state average. Additionally, Grays Harbor, Mason, and Pacific counties have higher percentages of adults diagnosed with diabetes.[12]

Patients with diabetes are more likely to have a range of other chronic disease conditions, including gastrointestinal, renal, eye, and pulmonary conditions. Outpatient emergency department utilization rates are significantly higher for people with diabetes than for those without diabetes. For example, non-disabled adults with diabetes experienced 126 outpatient visits per 1,000 members per month, compared to 73 visits per 1,000 members per month for non-disabled adults without diabetes. Diabetes costs an estimated $8 billion each year in Washington State. This includes $6 billion in direct medical expenses for diagnosed diabetes and $2 billion (in 2015 dollars) spent on indirect costs from lost productivity due to diabetes. The individual medical cost of having diabetes is approximately $14,000 per year. This is twice the cost of medical care for people without diabetes.[13] Building on these types of analyses will allow us to achieve maximum impact for the target populations.

While the data above points us toward certain target populations and sub-areas within the region, 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. Special emphasis will be placed on prevention and self-management strategies. This approach is one that is focused on improving community health outcomes, with an emphasis and focus on the population/s experiencing the greatest burden of chronic disease.

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

In review of the available data, our work groups explicitly considered health equity as a guiding principle, in keeping with the CPAA's broader values. 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[14]. By further analyzing this health outcome data with our clinical and non-clinical partners in the project work groups, we will focus our intervention efforts on reaching populations that have disparate geographic barriers and those who are underserved by the health care system. The process by which we have gathered local knowledge on subgroups and sub-regions speaks to our effort to better understand health disparities in our region, e.g. patients receiving treatment for a chronic disease may have an undiagnosed mental health condition, which, left untreated, can result in the increased use of emergency departments and admissions.

Additionally, 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 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.

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[12] Washington State Department of Health, death data. Accessed via Providence Centralia and Providence St. Peter's Hospital 2016 Community Health Needs Assessment (CHNA) and Mason General Hospital's 2017-2019 CHNA. http://communitybenefit.providence.org/~/media/Files/CBR/CHNAs/2017/WA/2017%20CHNA%20Providence%20Centralia%20Hospital.pdf and https://www.masongeneral.com/media/forms/Community-Health-Needs-Assessment-2017-2019.pdf

[13] Washington State Department of Health (2016). *Diabetes Epidemic and Action Report*. Retrieved from file:///C:/Users/mitchellc/Desktop/Data/345-349-DiabetesEpidemicActionReport.pdf ,

[14] In our view, elevated mortality is to be interpreted as the ultimate result of a host of health disparities experienced by sub-populations in a given geographic area.

Likewise, 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 chronic disease prevention and control 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. Targeted workforce investments will include specific training related to the Chronic Care Model and supporting strategies. One strategy will be to focus on training frontline clinical staff and developing increased skills in awareness of community resources and best referrals for patients with chronic illnesses. This will be especially useful for registered nurses and care coordinators.
2. **Changes at the Practice Level:** Similarly, we anticipate that 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.
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 that the state is going to make in Health Information Exchange systems, but it will result in a transformed clinical system that is better suited to managing chronic diseases and preventing costly complications and better integrated with community-based awareness and self-management efforts, including a mobile integrated health (MIH) system that identifies people relying on emergency medical services when their needs could be better met through other systems. Once these infrastructure investments have been made, they will provide benefits into perpetuity for our region to improve chronic disease care specifically and care integration 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 the benefits of our investments in improved chronic disease prevention and control 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 3D 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. From the beginning, CPAA has included a broad range of providers in its work across a seven-county region, including providers that collectively serve a significant portion of the Medicaid population. This has occurred at all levels of the collaborative venture, i.e., at both the local and regional levels and within our work groups.

For this project, we formed a work group to help address project development and to ensure that a significant portion of the Medicaid population will be served in this project area. A principal asset in this engagement process are the well-established provider relationships that 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.

With the help of CORE, we identified key providers collectively serving 90% of Medicaid clients in the CPAA region in 2016. Using this initial landscape analysis, CPAA worked with the work group to engage and connect stakeholders with the goal of creating new partnerships and coordinating intervention efforts. CPAA is well positioned to facilitate new partnerships between providers, keep track of individual provider initiatives, and create new tools to monitor existing project efforts.

We are now systematically reaching out to key Medicaid providers who have neither participated in the project planning so far, nor responded to our RFQ to ensure they are aware of this project and engage in the project planning and implementation moving forward. In instances where engagement from missing

key Medicaid providers should prove challenging, we will ask our Provider Champions, clinicians who have agreed to assume a leadership role in liaising with our provider community, to reach out to their peers at these key Medicaid provider organizations to begin the engagement process. We will then follow up with in-person visits to explain the project and answer any questions that the targeted key providers may have.

Process for Ensuring Partnering Providers Commit to Serving the Medicaid Population

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

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 now systematically reaching out to key Medicaid providers who 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. In instances where engagement from missing key Medicaid providers should prove challenging, we will ask our Provider Champions, clinicians who have agreed to assume a leadership role in liaising with our provider community, to reach out to their peers at these key Medicaid provider organizations to begin the engagement process. We will follow up with in-person visits to explain the project and answer any questions the targeted key providers may have.

Concurrently, with the help of our work group members, we are conducting an analysis of missing social service provider organizations that are essential to successful project planning and implementation. At work group meetings, we identify gaps in our partner participation by asking our members to identify 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 chronic disease prevention and control.

Finally, the CPAA Council consists of members throughout different health and social services organizations. CPAA does extensive outreach to organizations that need to be involved. CPAA's approach to governance and project management relies on strong provider engagement. All five work groups, the Support Team, and the Council include providers representing different practices and organizations. Appendix TK lists provider representatives and the organizations they represent.

As we continue working with clinical and social service providers, the diversity of organizations involved will help us to keep our perspective broad, yet focused on the patient experience and outcomes we are working to achieve. As we complete our current state assessment, the work group will identify engagement gaps of social service providers and additional Medicaid providers. The group will need to determine at that time whether to engage these providers during start-up or later on as the project scales up and expands.

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

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

Appendix TK lists MCO representatives and the organizations they represent.

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

Assets CPAA and Regional Partnering Providers Will Bring to the Project

One of the principal assets CPAA brings to the project is CHOICE's 22 years of experience working with the community to systematically identify health care needs, convene key stakeholders to understand and plan responses to those needs and develop collaborative action plans to address those needs. The value of these decades of experience is significant because the CPAA has established positive, collegial relationships with providers and other stakeholders and is a trusted partner in the community and region. Partnering providers throughout the CPAA region bring a wealth of knowledge from many different sectors of health care, urban and rural perspectives, and small clinics to large hospital systems. The amount of in-kind time contributed through work groups and advisory groups is a critical component of our efforts. These partners have shown consistent engagement in project work groups, advisory committees, and the council and board of directors. Additionally, the major Medicaid providers in the CPAA region continue to express their commitments to this ongoing collaborative effort.
One of the principal assets CPAA brings to this project is CHOICE's broad and well-established network

of positive, collegial relationships with clinical providers, community-based organizations, and health plans developed over more than two decades of community-led health improvement and collective action. In its project planning and implementation, CPAA can readily build on this strong, trusting foundation.

Partnering providers throughout the CPAA region bring a wealth of knowledge from many different sectors of health care, urban and rural perspectives, and small clinics to large hospital systems. The amount of in-kind time contributed through work groups and advisory groups is substantial and demonstrates the deep commitment of our partners. Our implementation partners have shown consistent engagement in project work groups, advisory committees, and the council and board of directors. Additionally, the major Medicaid providers in the CPAA region continue to express their commitment to this ongoing collaborative effort.

Several public health departments, clinical providers, and social services organizations have expressed interest in developing/expanding Mobile Integrated Health (MIH), community paramedicine, and Chronic Disease Self-Management programs. Some elements of MIH are already up and running in Thurston County, and other counties, notably Cowlitz and Wahkiakum, have begun to develop community paramedicine programs as well. Physicians of Southwest WA and health departments have past experience with and are interested in expanding or implementing new interventions from the Community Guide and Million Hearts campaign to help individuals make choices which can improve health and prevent disease. Providence Centralia Hospital and Providence St. Peter Hospital are interested in developing community paramedicine programs that connect with the Pathways HUB program. Local health jurisdictions have experience and capacity to run chronic disease prevention campaigns, including the CDSM program and interventions specified in the Community Guide. Table 3D-3 provides additional examples of chronic care programs being implemented across the CPAA region.

Table 3D-3. Examples of Chronic Care Programs Located in the CPAA Region

Agency	County	Intervention	Desired Outcome
Capital Region - Education Service District 113, Education Service District 112	All	Nurse Case Managers embedded in schools to manage students with chronic disease that is not well-managed	Improve health and reduce number of missed schools days
Ocean Beach Hospital	Pacific	Diabetes Education, Nutrition Counseling, and Support Group	Develop self-care plans to improve health
Washington State University	Grays Harbor	Community based diabetes prevention 16 week program with 6 month follow-up sessions	Prevention of Type 2 diabetes through education and prevention
Mason General Hospital	Mason	Diabetes Education, Nutrition Counseling, and Support Group	Develop self-care plans to improve health
Morton General Hospital	Lewis	Diabetes Wellness Program includes education, training, and support groups. Provides free support for the community.	Prevent and manage diabetes through screening and self-management
Providence Health & Services	Thurston and Lewis	Diabetes Education, Nutrition Counseling, and Support Group	Prevention and management of diabetes
Health Homes Programs	Thurston	Free home visiting to identify environment conditions which affect health	Prevention and management of asthma
PeaceHealth	Cowlitz	Diabetes assessment, prevention,	Prevent and manage

		education, screening, and support	diabetes through screening and self-management

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 principle 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 chronic disease prevention and control.

- Geographic challenges
  - The large geographical distance between people needing resources and the physical location of service providers, due in part to the rural nature of much of the region.

    - Transportation to multiple health care appointments to manage chronic diseases, especially in low income and rural areas
    - Reaching those affected with chronic disease in a large, medically underserved population
    - The CDSMP model depends on having a sufficient number of people in groups to hold a regular sequence of sessions, which may be difficult in rural areas with low population of Medicaid patients
- Lack of information
    - Lack of identified community resources
    - Inadequate referral processes
- Lack of Provider Capacity
    - Shortage of assigned primary care providers, registered nurses, and care coordinators
    - Lack of community health workers
    - Not enough patient follow-up activities
- Information sharing
    - Health outcomes depend on patient engagement, which is a difficult variable to control.
    - Mobile-integrated health needs enhanced data sharing between providers and EMS.
    - Benefits of community campaigns, such as those that are part of Million Hearts, are spread throughout a population, so impact on Medicaid patients may be diluted.
- Patient engagement for chronic disease management
    - Patients do not understand their critical role in managing their care
    - Treating multiple chronic diseases perceived as too difficult to manage

CPAA Strategy for Mitigating the Identified Risks and Overcoming Barriers

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

Barrier	Potential Solutions
Data	• Partner with CORE, state and providers to identify/refine target populations, partnering providers, and interventions (underway) • Partner with providers and MCOs to obtain close to real-time provider performance information; explore contracting with a third-party data aggregator with data analytics capabilities (underway).
Health Information Systems	• Partner with state, MCOs, providers, and other ACHs in developing interoperability between health information systems; expedite planning for and implementation of clinical integration of behavioral health.
Workforce	• Invest in training of partnering providers in evidence-based methods/models • Explore shared workforce options, e.g., through telehealth
Finances	• Funds Flows: Work with CPAA Finance Committee to clarify funds flows (underway) • Financial Sustainability: Work with payers (health plans and state) to support transition to value-based purchasing; state needs to adjust contracting w/ MCO who in turn modify provider payment approaches accordingly
Geographic Challenges	• Develop transportation assistance programs by leveraging transit systems and using gas vouchers

	• Improve telehealth capabilities for individuals in rural areas • Further expand mobile integrated health and community paramedicine programs
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. • MCOs share info on PCP and care coordinators w/ hospital during hospitalization (concurrent review), and share info on care coordinators with PCP.
Lack of Provider Capacity	• Proactively establish relationships with key clinical and community-based partners that can provide follow-up services to patients with multiple chronic conditions.
Information Sharing	• Hospitals and other key care contacts coach patients to bring hospital discharge info with them to PCP follow-up appointments. • Community providers, care coordinators and hospitals develop standardized information release forms and practices that facilitate bi-directional information sharing. • Develop an information sharing connection to the Pathways Community HUB. • Develop data sharing capabilities between ED and EMS services.
Patient Engagement	• Coach patients on the importance of keeping scheduled follow-up appointments and bringing hospital discharge information to follow-up appointments with other members of the care team • Access patient engagement information from the Pathways Community HUB

Monitoring and Continuous Improvement (500 words)

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

CPAA will implement a rigorous project planning and monitoring approach to implementation of each 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. 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
- 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. Final decision-making rests with the board. As with switching out a specific strategy or changing a project approach within a project area, any such change requires the consent of our partnering providers that will need to implement the revised set of strategies. State approval may also need to be obtained. Assuming everyone approves the revised strategies, a detailed revised implementation will be developed with clear milestones, performance metrics, etc.

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

Project Metrics and Reporting Requirements

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

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

YES	NO
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives*

currently in place.

- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

Project Sustainability (500 words)

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

CHOICE Regional Health Network and CPAA existed before the Medicaid Transformation and will continue to pursue their long-term goals after the Transformation project is completed. CPAA and CHOICE represent a tested framework for regional collaboration that will endure, which will be critical to the sustainability of this project. Both have proven track records of developing innovative projects with pilot funding and then developing ways to sustain these efforts into the future. Key to our success has been our ability to demonstrate to stakeholders, including hospitals and CBOs, that the project has enabled the stakeholders to achieve efficiencies, improve outcomes, or avert future costs. In the Youth Behavioral Health Coordination Project, CPAA worked with the school system, Behavioral Health Organizations, and medical clinics to help with project development, cost-share on program costs, and created last partnerships.

This project builds squarely on years of healthcare 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 chronic disease prevention and control 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 our key partners will continue their investments in this project area beyond the duration of the Medicaid Transformation.

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

CPAA anticipates the development of value-based payment (VBP) approaches will support the sustainability of the project. As we develop VBP methods, our focus will include changes that can be sustainable post-Transformation project. The model selected for this project, the Chronic Care Model is an outcome-based strategy and recently HCA has approved new billing codes to support it. Ideally,

partnering providers who elect to implement this strategy will have a greater opportunity to influence achieving the project outcomes. To that end, we may propose improved methods of funding in the Medicaid program to support efforts that have demonstrated success.

Applying and reinforcing the Chronic Care Model across the region will result in Medicaid and health care system improvements that save health care costs through improved patient health outcomes on chronic diseases. Additional interventions from The Community Guide, Community Paramedicine, CDSMP and Million Hearts will have accomplished changes in polices (reflecting community norms) and environments that are health-promoting, preventive supports designed to endure long after the duration of the Transformation without needing additional funds. In addition to being more attuned to chronic care and secondary prevention, the health care system will be better connected to community settings that offer enduring supports (policies and environments) for healthier living as a result of this project.