2B: Community Based Care Coordination

Introduction

In 2015, data from the North Sound region's county and hospital community health assessments in Whatcom, San Juan, and Skagit Counties identified care coordination as a priority for regional health systems. There are numerous existing care coordination efforts in the region, serving different populations, through different systems, and focusing on different needs. Some of these organizations, such as Health Homes Leads, and their contracted Care Coordination Organizations (CCOs), already support care coordination for specific high-risk populations in each of the North Sound ACH counties. However, there is an opportunity across the region to better coordinate care for all Medicaid enrollees, and address disparities in the populations represented in care coordination programs.

Target Populations

The target population for Community-Based Care Coordination strategies are Medicaid enrollees (adults and children) with one or more chronic disease or conditions (such as arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke), or mental illness/depressive disorders, or moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization).

As required during the 2018 planning period, North Sound ACH staff will conduct further statistical analysis and facilitate planning processes necessary for final target population selection due in June 2018. The North Sound ACH will work with implementation planning teams, Community Leadership Council and the Data and Learning Team to use the best available research, regional data, and community input to identify a final high-need target population, with consideration for how strategic investments can impact performance metrics during the Medicaid Transformation Project period.

The ACH will finalize a target population that is appropriate for Pathways and for non-duplicative collaboration with Health Homes. To ensure success in Pathways and avoid duplication with Health Homes, North Sound ACH will choose a target population that:

- Experiences disparities in health outcomes
- Has risk factors that can be addressed via existing Pathways
- Is currently served by organizational partners who are relevant to the population (e.g. culturally, geographically)
- Is not currently served by Health Homes, either due to PRISM (Predictive Risk Intelligence System) scores <1.0, insufficient Health Home capacity, or individuals' choice to opt out of the Health Home program
- Has potential to achieve better health outcomes as a result of care coordination
- Can produce sufficient cost savings to demonstrate potential for return on investment to the payer partners
- Experiences disparities or low engagement with existing care coordination systems due to systemic, geographic, or institutional barriers; and shows a strong likelihood of improved engagement and outcomes through culturally appropriate, community-level care coordination through Pathways

Targeted Universalism[1] will be used throughout the planning phase as an approach and analysis framework for selecting target populations to ensure that health equity features strongly in this process. Targeted Universalism will be applied when measuring regional needs, identifying population segments experiencing

[1] Targeted Universalism is a different way—a powerful way—to make the transformational changes we need. Changes we need to improve life chances, promote inclusion, and enhance and sustain equitable policies and programs. Means setting universal goals that can be achieved through targeted approaches. Ultimately, this approach shows how a universal goal can be a good thing, but a one size fits all approach is not always the solution. John Powell, Haas Institute, 2017

health disparities, understanding root causes within population segments and selecting appropriately targeted strategies.

North Sound ACH staff will continue to collaborate with ACH's across the state and the Health Care Authority's AIM Team to identify shared data-driven processes and target population selection methodology. To maximize the reach and impact of the demonstration projects and increase the likelihood of region-wide success in moving the metrics, the North Sound ACH aims to align target populations across the project portfolio. Possibilities include first-time expectant mothers, individuals with frequent contacts with the criminal justice system, patients with at least one behavioral health service need and chronic disease, and people experiencing homelessness or unstable housing. Lastly, we will select a pilot target population for whom we can design a project that will produce learning we can apply as we scale Pathways to additional populations and payers.

The North Sound ACH used a common format for each project area to summarize the anticipated reach of target population(s) and identify performance metrics and health disparities project strategies aim to impact, as follows below.

<table>
<tr><th colspan="2">North Sound Project Area Reach & Impact
Project Area 2B: Community-Based Care Coordination</th></tr>
<tr><td colspan="2">Potential Target Population Reach:
• 37,279 diagnosed with asthma, COPD (Pulmonary, low)
  ○ 5,997 Disabled, 3,280 Non-Disabled Adults, 11,406 Newly Eligible Adults, 13,159 Non-Disabled Children, 3,437 Elders
• 46,893 diagnosed with major recurrent depression (Psychiatric, low)
  ○ 8,654 Disabled, 5,505 Non-Disabled Adults, 18,389 Newly Eligible Adults, 11,655 Non-Disabled Children, 2,690 Elders
• 32,100 diagnosed (including duals) with hypertension (Cardiovascular, extra low)
  ○ 6,727 Disabled, 2,620 Non-Disabled Adults, 11,406 Newly Eligible Adults, 461 Non-Disabled Children, 7,688 Elders
• 17,243 diagnosed with drug abuse, dependence or psychosis (Substance abuse, low)
  ○ 3,422 Disabled, 2,571 Non-Disabled Adults, 9,860 Newly Eligible Adults, 903 Non-Disabled Children, 487 Elders
• 11,336 diagnosed with alcohol abuse, dependence or psychosis (Substance abuse, very low)
  ○ 1,844 Disabled, 1,295 Non-Disabled Adults, 7,138 Newly Eligible Adults, 719 Non-Disabled Children, 340 Elders</td></tr>
<tr><td>Project Area Impact</td><td></td></tr>
<tr><td>Performance Measures
• Pulmonary related diagnosis is the leading diagnosis among children with Medicaid coverage. (i.e. Viral pneumonias, chronic bronchitis, asthma)
• 29% of those discharged from ED for Alcohol and Other Drug (AOD) dependence received follow up care within 30 days</td><td>Geographic Disparities
• Snohomish County has the highest percentage (6%) of Medicaid enrollees with SUD and more than one chronic condition in the North Sound ACH region.
• Whatcom and Island counties, have the highest percentage (12%) of Medicaid enrollees with a mental illness and have more than one chronic condition.</td></tr>
</table>

• 69% of those discharged from ED for mental illness received follow up care within 30 days • 907 of 5,952 patients discharged from hospitals were readmitted within 30 days (15%) • 5,847 Medicaid homeless adults, increased over the last three years • 59% of Medicaid adults had a follow-up visit after discharge from emergency department for Mental Illness within 7 days. • 15.3% of Medicaid enrollees discharged from hospital were readmitted within 30 days • 12.3% of patients discharged from psychiatric inpatient care were readmitted within 30 days.	• Readmission rate among Medicaid enrollees in Skagit County is 17%; 2% higher than regional average. • Island County's outpatient emergency department visits rate of 59 per 1,000 member months is the highest in the North Sound ACH region. **Demographic Disparities** • Adult females are more likely to have poor mental health and asthma, while adult males are more likely to have diabetes and smoke. • Adults with incomes under $25,000/year are more likely to experience higher rates of chronic conditions and risk factors. • American Indian/Alaskan Natives and Whites were more likely to have poor mental health, asthma, not have a personal health care provider and smoke. • Hispanic Medicaid enrollees 25% more likely to not follow up with PCP for care after hospitalization for mental illness within 30 days. • American Indian/Alaskan Native Medicaid enrollees were 2x more likely to not receive follow-up care after hospitalization for mental illness. **Co-morbid Disparities** • Medicaid adults with substance use disorders or co-occurring MI/SUD are more than 3 times more likely to be experiencing homelessness • Medicaid adults with chronic cardiovascular, pulmonary, or metabolic diseases between 2 and 3 times more likely to not have active employment
Data Sources: 1) RHNI Starter Kit, HCA, released May 8, 2017. 2) Measure Decomposition Data, RDA/DSHS, released July 7, 2017. 3) ACH Toolkit Historical Data, HCA, released August 17, 2017. 4) ACH Profiles Future, DSHS/RDA, released April 11, 2017. 5) BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017. 6) Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. 7) Chronic Disease Profiles (North Sound) WADOH, April 2016.	

Health Disparities

In the Medicaid claims data from the table above, we can see that indicators associated with the need for care coordination--such as medication management, readmission, and social determinants of health (e.g. lack of housing or employment) --show disparities across self-identified demographic groups, geographic regions,

or co-occurring diagnoses. Patients who identify as Hispanic or Black have an increased likelihood of not remaining on prescribed medication for mental health needs through the maintenance phase.[2] Snohomish county shows the highest rate of co-occurring substance use disorder and chronic disease while Whatcom and Island show high regional rates of co-occurring mental health treatment needs and chronic disease.[3] Patients with such co-morbidities show much higher rates of homelessness, unemployment and more than 3 ED visits per year.[4] The existence of these disparities demonstrates insufficient system capacity to serve specific patient populations and a need to address them through culturally appropriate, community-based, and patient-centered care coordination.

Strategies/Model

Guided by the Targeted Universalism[5] concept, North Sound ACH will pursue a Care Coordination project using the Pathways Community HUB model. Establishing a Pathways Community HUB in the North Sound region will ensure that patients in the target populations receive robust, patient-centered care coordination through community health workers who can help them navigate resources: in the Pathways model, community-based care coordinators go to where patients are and work with them and their families to overcome social and economic barriers to managing their health. The region's Pathways Community HUB will connect more Medicaid enrollees with coordinated, community-based services, thus improving outcomes and reducing costs. Pathways provides a blueprint for sustainable and scalable care coordination, which will help ensure these improvements last.

The Pathways model will provide North Sound ACH and our partners with a formal structure for reducing duplication of care coordination services, achieving better health outcomes, and addressing the social determinants of health. In the Pathways model, services are reimbursed by payers, thus providing sustainability beyond the funded Medicaid Transformation period. Throughout the planning process, North Sound ACH has collaborated with MCOs and other partners to ensure a design for the HUB and a system that has payer buy-in, and the transformation built through Pathways lasts beyond the Medicaid Demonstration project. Additionally, North Sound ACH sees opportunities to pursue other sources of Pathways funding (e.g. private insurance payers, foundations) as we scale the model after the initial pilot phase.

Metrics and Outcomes

North Sound ACH intends for Pathways to support improvement on all the Project 2B Performance measures, as well as appropriate measures within the other project areas. The metrics that will show the most improvement will depend on the selected pilot target population and overlap with other project areas, including: Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence; Follow-up After Hospitalization for Mental Illness; Inpatient Hospital Utilization; Mental Health Treatment Penetration (Broad Version); Outpatient Emergency Department Visits per 1000 member months; Percent Homeless (Narrow definition); Plan All-Cause Readmission Rate (30 Days); and Substance Use Disorder Treatment Penetration.

Additionally, we expect to see the community-based care coordination provided through Pathways improve long-term health, social, and economic outcomes for patients due to the patient-centered support for improving social determinants of health.

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[2] Measure Decomposition Data, RDA/DSHS, released July 7, 2017.

[3] ACH Profiles Future, DSHS/RDA, released April 11, 2017.

[4] Measure Decomposition Data, RDA/DSHS, released July 7, 2017

[5] John A. Powell, Haas Institute. Targeted Universalism. 2017. Retrieved from http://haasinstitute.berkeley.edu/targeteduniversalism

Types of Partners

The North Sound ACH will serve as the Pathways HUB for the region. Relationships with providers, care coordination agencies, and other partners will be formalized in the coming planning year. To date, the types of providers we have engaged are:

- Health Home partners: our MCO and other Health Home lead partners are critical to our Care Coordination project because of the wealth of experience they bring in managing care coordination, because we are designing a Pathways-Health Homes complementary system that avoids duplication, and because Pathways can provide additional care coordination capacity in our region when Health Homes cannot serve all eligible Medicaid enrollees due to capacity limitations.
- Hospital and healthcare delivery systems will serve as sources of referrals into Pathways as well as hosts for community-based care coordinators, in addition to delivering care to Pathways clients.
- EMS and Government Services will be engaged as both referral systems as well as partners for monitoring and evaluating project success. In some cases, they may also serve as Care Coordination Agencies.
- Community-based organizations are key partners as Care Coordination Agencies, as well as routes for service delivery to Pathways clients and families.

After the pilot target population has been determined, Care Coordination Agencies in the region currently serving that population will be identified and engaged in implementation planning, including identification of care coordinators and managers for training. We expect to train a cohort of at least 20 care coordinators for the pilot project. Based on Pathways certification requirements and the experience of other HUBs, we expect each full-time care coordinator will carry a caseload of 25 to 30 clients with a balanced range of complexity, for a total of approximately 500 to 625 Medicaid enrollees served by Pathways in the pilot period.[6,7]

Coordination and Avoiding Duplication

Our region's Health Homes Leads already provide care coordination services to high-risk individuals, with a total of 11,249 Medicaid patients enrolled in Health Home Care Coordination out of a total 13,591 patients eligible.[8] To date, North Sound ACH has met with MCO and other Health Home lead partners in four dedicated meetings to discuss and develop a regional care coordination model that avoids duplication of services. In the first conversations, the ACH and Health Homes partners approached this issue from the "Health Homes **vs**. Pathways" perspective--discussing and planning how to carve out space for each model to function independently of the other, with no overlap. By September 2017, the conversation evolved to "Health Homes **and** Pathways" with the ACH and Health Homes partners mapping processes and making plans for these two models to complement each other while avoiding duplication and creating a bi-directional referral system.

Planning conversations will continue, but so far North Sound ACH and Health Homes Leads have sketched out bi-directional referral relationships, and determined that Pathways can complement the work of Health Homes by targeting individuals who are in the Health Homes backlog (due to insufficient capacity); individuals who have opted out of Health Home enrollment, but may be receptive to another "door" to care coordination; and individuals who are not eligible for Health Home enrollment but would still benefit from care coordination (e.g., PRISM score below 1.5). Our goal is to design a model for Pathways/Health Home collaboration that successfully serves our region and that can be replicated in other ACH regions.

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[6] Rockville Institute. Pathways Community HUB Certification Pre-Requisites and Standards. Rev February 2017.

[7] Sartorious, P.J. Pathways Model Aligns Care, Population Health. Health Progress: Journal of the Catholic Health Association of the United States. May-June 2015.

[8] Data reported by HCA Health Home Contract Manager by email, October 2017.

Summary

The North Sound ACH is working with its partners to design, pilot, and eventually scale a Pathways HUB to improve the health of the North Sound population, touching lives beyond the pilot target population and engaging diverse payers and funders in this transformation. We will start small and pursue excellence, continual improvement, and solid foundational partnerships in a pilot, and then plan for expansion to other populations within and possibly beyond the Medicaid population. Although the pilot target population will be small, the partnerships, systems, and shift of perspective toward paying for outcomes developed for Pathways populations will serve to improve our region's care coordination system as a whole, thereby benefiting additional populations.

2B: Partnering Providers

The organizations and stakeholders listed in the Partnering Providers Tab of the Supplemental Workbook represent partners who have been substantively engaged in the project planning workgroups to date or that we expect will be engaged in the planning phase in 2018. Some, but not necessarily all of these partners will eventually be entered into the financial executor portal to receive payment.

In the Care Coordination project area, the North Sound ACH has a broad level of engagement from stakeholders across the region for the Pathways framework including Tribal Nations, community-based organizations and others able to leverage community health workers into the effort and the clinical and other partners able to serve as referral sources. Workgroup leads in this area include a representative of a local FQHC: Sea Mar Community Health Centers, as well as a large health system partner: PeaceHealth.

In Spring 2017, the North Sound ACH began moving from broad stakeholder engagement into workgroups comprised of potential partnering providers who serve or are interested in serving the Medicaid population. Eight workgroups were formed, with an open invitation extended to providers and stakeholders who wanted to engage. These included behavioral health and SUD providers, community-based organizations, county health and human services and public health leaders, physical health care providers, tribal partners, health systems, and Managed Care Organizations. Two or more subject matter experts were invited to serve in a lead role for each workgroup, which were supported by North Sound ACH staff. As information from HCA became available, the focus and process for workgroups evolved accordingly. An initial inquiry was made for workgroup members and coalitions to craft draft "Statements of Interest" highlighting their individual and organizational interest and ideas for project frameworks. Staff and workgroup leads compiled these submissions to produce the outlines of a regional approach in each area.

Workgroups further refined these ideas at monthly face-to-face meetings with remote access for those who could not join in person. North Sound ACH staff encouraged workgroups to focus on guidance from the Project Toolkit, including indicated target populations and seeking a strategy capable of incorporating participation from partnering providers, aiming to move the region's pay-for-performance metrics. This dialogue included the subpopulations indicated in the toolkit and the partnering providers necessary to reach them. Due to the open and inclusive nature of stakeholder engagement in the workgroups, a broad spectrum of partnering providers are represented in the Supplemental Workbook and remain a value for future engagement.

Concurrently, a self-formed group of health system primary care leaders agreed to become an advisory body to staff, wherein staff facilitate regular meetings, assist with scheduling, agendas and note-taking. This Health System Advisory Coalition includes leadership from the largest hospital systems providing primary care in the region, regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. The group has self-reported coverage of more than 205,000 Medicaid primary care

enrollees in the region. Staff are continuing with outreach to other partnering providers, including those located in more rural settings and smaller in size. These efforts form the foundation of the strategy to ensure inclusion of physical health providers serving a significant majority of the Medicaid population, similar to the reach that the North Sound BHO has with providers working in behavioral health and SUD settings.

The North Sound ACH recognizes the importance of Managed Care Organizations to the success of Medicaid transformation in our region. MCO partners are engaged on the Board of Directors, the Program Council and represented in each of the workgroups, including serving as leads in the areas of Care Transitions and Chronic Disease. MCO partners have thus provided significant expertise and guidance to the project planning to date and will continue to do so throughout the Medicaid Demonstration and beyond. In the case of Care Coordination, the North Sound ACH has participated in a series of meetings with MCO partners and representatives of the region's Health Home providers regarding coordination of these services in the development of the Pathways HUB. Through existing channels of governance and the workgroup format, the North Sound ACH will consult and leverage MCO expertise in project planning and eventual implementation, while simultaneously avoiding duplication of efforts.

2B: Regional Assets, Anticipated Challenges and Proposed Solutions

The foundation of the regional assets that will support Project 2B is the collaborative nature of the diverse partners working to improve health in the North Sound Region. Since the inception of the North Sound ACH, organizations that have traditionally competed with each other have come together to collaboratively plan the transformation of our regional health system. This is demonstrated in the developing partnership with MCOs and Health Homes leads, who want to see Pathways succeed in our region by working in a complementary fashion with Health Homes.

Clinical Service Delivery and Expertise

- Clinical delivery systems and physical health care settings in our region have extensive experience with clinical care coordination and care management for their patients and may be selected to serve as Care Coordination Agencies, especially where they are currently employing community health workers.

Nonclinical Service Delivery and Expertise

- In the North Sound region, there are community-based organizations with extensive experience in serving high-risk populations with culturally appropriate services, including care coordination and resource navigation. Many of these organizations have expressed interest in Pathways and could serve as Care Coordination Agencies, with existing community health worker certified employees. These organizations include Snohomish Community Services, Opportunity Council, Community Action of Skagit County, and others.

Data, Analytic Tools, and Infrastructure

- The data backbone of Pathways Community HUB is the Care Coordination Systems platform, accessible in the cloud by online interface or mobile tablet application. It is interoperable with most of the regionally implemented EHR systems used by hospitals and physical health care providers, as well as capable of sending patient dashboards via direct messaging.
- The existing integration of CMT's EDIE platform at hospital systems region wide and the expansion of the twin CMT product PreManage to physical health care and behavioral health clinics will support the ACH in achieving improvement on follow-up after discharge measures, hospitalization rates, and ED utilization.

Workforce and Human Capital

There is a robust existing workforce of community health workers and care coordinators based in the Community Service Organizations and Federally Qualified Health Centers across the North Sound region, including:

- Health Home Care Coordination Organizations (CCOs) that provide care coordination services to high-risk Medicaid Enrollees. MCO and CCO partners may be able to support cross-training of Health Home care coordinators to also serve as Pathways community-based care coordinators.
- Community health workers (CHW) who are employed throughout the region, at Community Based Organizations and at Federally Qualified Health Centers.
- Other community based organization staff who serve in CHW-like roles but have not yet completed CHW training. Capacity building through training opportunities is an essential component for individuals and organizations which play a key care coordination role, but are not currently reimbursed for playing that role. In the Pathways HUB model, community health workers serve as care coordinators, and the North Sound ACH intends to leverage this existing workforce capacity to successfully engage the target populations where possible, and expand the workforce, especially among communities experiencing disparities, where CHWs with lived experience play a critical role as community liaisons.

Financial Resources

The North Sound ACH intends to establish a braided funding model to support care coordination services in the North Sound region, supplemented by Medicaid Transformation project funding and including the following sources:

- Managed Care Organizations
- Philanthropic and community development foundations such as Verdant Health Commission, Arcora Foundation, United Way, Chuckanut Foundation, or the Skagit Community Foundation
- Health care delivery systems

CHALLENGES AND STRATEGIES TO OVERCOME THEM

Below are several of the challenges inherent in these strategies and an early assessment of ways to mitigate issues arising. All of these will depend on continuous performance monitoring and application of quality improvement techniques to resolve problems.

Potential challenge	How will ACHs mitigate those challenges?
Currently, levels of care coordination differ among counties in the North Sound region (e.g. experience, capacity, ability to measure impact).	• Seek region-wide solutions to data collection and analysis that reduces the burden of monitoring project performance on individual agencies. • Invest in capacity building technology and workforce development that puts all regional partners on an equal playing field.
Geographical barriers to services is also a major challenge for North Sound residents. Any projects serving populations in San Juan, Island, or other remote locations will have significant challenges accessing services that require trips on ferries, bridges, or mountain passes.	• The North Sound ACH will evaluate potential target populations based on ability to overcome geographic barriers. The home visiting component of Pathways may be both an asset and a challenge for geographical barriers. • Improve access to and use of Medicaid Transport services that pay transportation costs for physical health appointments where there are barriers to transit.

Insufficient service capacity to meet the need is a major challenge for any care coordination project. Coordination of care, referral to services, and payment for completed pathways will only be effective if services exist to be referred into. For example, housing and employment are identified by partners as major gaps in services region-wide. The housing and employment pathways will be very difficult to close, even when patients receive care coordination and have appointments with the relevant service providers.	• Partner with housing agencies to streamline housing access. • Participate in opportunities to grow affordable housing stock in the region through targeted investments or ACH role as regional convener. • Establish relationships with employment services and workforce training centers to assist Pathways clients in obtaining work. • Use data gathered through Medicaid Transformation project activities, including closed/unclosed Pathway ratios, as evidence to motivate policymakers.
There are already robust care coordination systems in place in our region (such as Health Homes) that provide substantial care coordination services to high-need Medicaid clients and in which our provider and MCO partners have already invested deeply. To avoid duplication, improve outcomes, and lower costs, we will need a target population that is not already served by Health Homes that still has potential to produce cost savings and improve health outcomes.	• Our strategy for avoiding duplication with Health Homes has been to engage our MCO and Health Home leads from the beginning of our planning process, and work with them to create a care coordination system in our region that leverages both Pathways and Health Homes in the most efficient and effective manner possible. • Our MCO partners are experts in the Health Homes model, and North Sound ACH has engaged experts from the Pathways Model and Foundation for Healthy Generations to assist us in planning, engaging partners, and problem solving around Pathways. • Once the Pathways HUB is implemented and staff are hired, North Sound ACH and Health Home partners will hold cross-training sessions on the two models for staff, to ensure they understand how Pathways and Health Homes function and fit together.
An additional challenge in designing a complementary Pathways-Health Homes regional care coordination system will be data exchange, including eligibility determination and assignment of individuals to Pathways or Health Homes. The ACH will coordinate between CCS-the HIT infrastructure for Pathways--and Health Home lead organizations to ensure that patients referred into care coordination through the Pathways Community HUB are screened for receiving services through Health Homes.	• Determining eligibility for Pathways versus Health Homes will likely require exchange of data between the HUB and MCO partners. In late 2017 and 2018, North Sound ACH (as the Pathways HUB) and the MCOs will design a data-sharing system that facilitates eligibility determinations and protects privacy, and we will describe this arrangement in our contracts with the MCOs. We can draw on the experience and expertise of other Pathways HUBs and Pathways experts in doing so.
To participate in Pathways, care coordinators will be required to undergo training on the Pathways model. This training is intensive and expensive, and	• The North Sound ACH recognizes the importance and community connections of our region's smaller community-based organizations. These partners will be essential to successfully implementing Pathways in the

will likely present a financial barrier to smaller community-based organizations with limited staff capacity and financial resources.	North Sound region, particularly in working with populations facing health disparities. • North Sound ACH is committed to removing barriers to the participation of these critical partners, and is exploring strategies for doing so. One possible strategy could be for the ACH to subsidize the Pathways training fees for CHWs working in small CBOs with limited budgets. We will continue to discuss improving feasibility with our partners as the pilot project plan takes shape.
HIT/HIE systems not compatible with EHRs used by delivery systems or not functional for care transitions purposes.	• Coordinate with vendors and systems to troubleshoot issues with interoperability/compatibility/functionality, including software updates and custom programming if no other solution available. • Explore contracts with other vendors who are able to provide more interoperable or functional solutions. • Train providers and clinical staff in use of HIT systems to improve functionality and engagement with population health management technologies.
Challenges in patient information sharing across organizations (confidentiality/HIPAA)	• Facilitate the development and spread of Release of Information agreements and Business Associate Agreements across delivery systems and community-based organizations to share patient information such as care plans and hospitalization status for better care coordination and patient management.

2B: Monitoring and Continuous Improvement

Summary

The North Sound ACH will implement a monitoring and continuous improvement plan, which will include quality improvement processes, that leverages existing infrastructure, such as internal clinical quality improvement (QI) teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data, as well as identifying gaps in information and explore opportunities for data collection systems with multiple ACH's. The identification and use of measures for monitoring and continuous improvement will emphasize pragmatic, real-time measurement data sources that track progress through automated systems without requiring a heavy burden of manual measurement and tracking. Methodologies used will include embedded evaluation tools and continuous quality improvement techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles, and run charts to track project success and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis in order to determine success of evidence-based approaches. When projects or approaches are identified as in need of improvement or modification by stakeholders through a deliberative process, ACH will consult with Program council and implementation planning teams to provide assistance and explore solutions before engaging with the Health Care Authority (HCA) engage in a project plan modification.

Information Management & Data Sources

Tracking measures for monitoring and continuous improvement will include data from ongoing survey-based assessments of training effectiveness and implementation milestones to partnering providers, regular review

of clinical quality measures aligned with toolkit pay-for-performance measures, HCA reports on performance measure benchmarks, and other proxy metrics for assessing implementation success. While some measures will require manual tracking, such as training enrollment forms, tally sheets for workflow revisions, and manual chart review, special consideration will be given to measures that can provide real-time, automated tracking of progress that have a low-impact on partner organizations' staff time.

Project Managers will serve as liaisons and primary contacts with implementation partners, ensuring that monitoring and continuous improvement measures are submitted or collected on a monthly or quarterly basis for review by the data and learning team. As stated in Section I, Sub-section Governance, Project Managers will be assigned specific projects and groups of providers to monitor. Functions performed by Project Managers will include site visits, meetings with providers to identify successes and challenges, and periodic surveys to measure progress toward contractual goals.

The North Sound ACH will collaborate with partners to identify and capture clinical quality measures and related proxy measures for tracking and quality improvement purposes, based on automated or custom-built reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform, syndromic surveillance systems, or cloud-based registries. Because these measures use data directly managed from HIT systems they provide a nearly real-time (within 24 hours) view of performance, the ACH Data and Learning team will be able to quickly identify and respond to delays in implementation or gaps in performance. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems. A full inventory of available data sources for monitoring of implementation progress will be developed as part of the ACH current state assessment process. Selection of measures within these data sources will be informed by the planning processes among the Implementation Teams and the North Sound ACH Current State Assessment.
As illustrated in Figure 1, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular monitoring of community feedback and indicators by the Project Managers in their capacity as Activity Leads. In the latter case, surfacing performance gaps will be a primary function of the Activity Teams. Independently and in cooperation with the team, Leads will routinely probe for indicators of lagging achievement, employing site visits, meetings with providers, and periodic surveys. When a performance gap is identified through either signal path, the Lead (i.e. the responsible project manager) will lead the Activity Team to develop a remediation plan.

In some cases, adequate remediation may be inhibited by resource constraints or sub-optimal coordination within the ACH or the community. If Leads are unable to resolve these impediments themselves (e.g. through cross-team problem solving), they will elevate unresolved issues to the Executive Director (ED). The ED will then make prioritization decisions and provide direction as necessary. When high-level or systemic obstacles are at play, the ED will request Board assistance to resolve them and then translate Board decisions into instructions for Leads to implement.

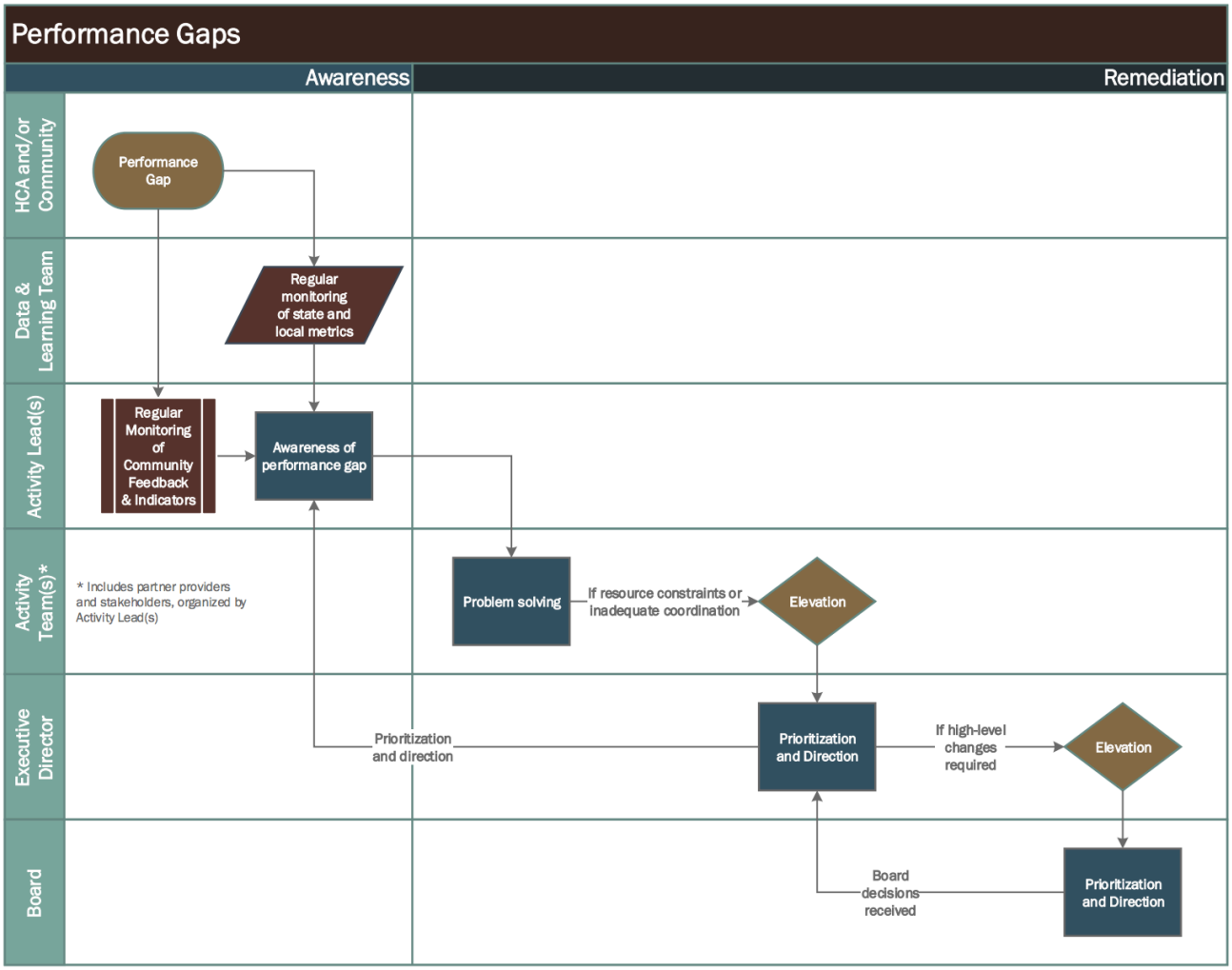

Figure 1: Performance Gaps Process Map

Quality Improvement Planning Process

Internal or embedded implementation teams will work with the most immediate data, based on quality improvement plans, internal quality improvement tracking mechanisms such as clinical quality measures, provider dashboards, and tally sheets. These will be reported to Project Managers and shared with the data and learning team for oversight. Additionally, the data and learning team will continuously identify and use HIT and HIE systems for tracking performance data such as hospital admission, ED utilization, and immunization status based on population health management technologies such as CMT's EDIE/PreManage platform, immunization registries, syndromic surveillance, and third party registries. These platforms can provide a picture of regional performance on some monitoring and continuous measures with a delay as small as 24 hours. When these systems identify performance gaps, the data and learning team will collaborate with implementation teams via the Project Managers to solve the challenges. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems, such as a performance management portal.

The North Sound ACH implementation planning teams will embed continuous tracking mechanisms in their implementation plans as part of their quality improvement planning process, to include surveys, regular automated or manual reports of metrics, and other means for tracking success. This quality improvement planning will emphasize rapid-cycle process improvement strategies that will identify points of failure and improvement for quick response through PDSAs or workflow redesign. The ACH will engage existing

quality improvement teams at clinical or community-based implementation partners to provide expertise and support ongoing, real-time review and improvement of evidence-based approach implementation. Where possible, implementation partners will be encouraged to use these internal quality improvement teams to track their performance and PDSA improvements as needed.

The North Sound ACH Data and Learning team will support this strategy through the development of a suite of monitoring and evaluation measures for each evidence-based approach that provide an ongoing, actionable dashboard for tracking progress. The Data and Learning team will convene to regularly review metrics and assess implementation delays or gaps in performance that require changes or improvements.

Process Improvement and Project Plan Modification

Implementation delays will be identified through regular monitoring and oversight of performance and tracking measures by internal implementation teams at partner organizations. When implementation is delayed or encounters a barrier, these teams will first attempt rapid cycle improvement processes including Plan-Do-Study-Act (PDSA) cycles to solve these challenges and report outcomes to Project Managers. If this method does not lead to improvement, Project Managers will collaborate with implementation partners, the data and learning team, program council, and technical assistance consultants to address implementation delays.

When changes or improvements are identified as necessary by the ACH Data and Learning Team, the North Sound ACH staff will first work to support project implementation teams through internal QI activities, workflow redesign, PDSA cycles, resource allocation, staff training, collaborative conversations across sectors and ACHs, and other forms of assistance to improve performance (Figure 2). Technical assistance, trainings, and other resources will be supplied as needed to partner organizations and individual providers for these additional supports based on data and a deliberative process between North Sound ACH staff, the Data and Learning team, and implementation partners, as well as with feedback from the program council.

Modifications to project plans will occur after the North Sound ACH staff and implementation planning team leads report to the Program Council that a project has gaps, delays, or areas of improvement that could not be solved through other forms of assistance, as described above. North Sound ACH staff, project partners, key stakeholders, and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Prior to applying for a project plan modification in these instances, the North Sound ACH will coordinate with the Health Care Authority to identify potential alternative solutions.

Technical Assistance

Potential sources of technical assistance in developing our quality improvement plans, training our teams in continuous improvement, and identifying tracking measures include Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations.

2B: 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
XX	

2B: 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
XX	

2B: Project Sustainability

The North Sound ACH is committed to working with partners in our region to develop strategies and initiatives that will move the metrics outlined in the Project Toolkit, and achieve long-term sustainability while impacting Washington's health system transformation beyond the Medicaid Transformation project period. With our partners, we will work toward achieving a "virtuous cycle," which occurs when clinical transformation improves provider performance on clinical quality measures in value-based contracts, payers such as Managed Care Organizations reap savings, and reinvestments can be made back into the community and community-based organizations to address upstream, social determinants of health. To ensure lasting impact, we will optimize project strategies that hold promise for additional financial earnings and substantial buy-in from both clinical and community-based partners. The implementation of projects will foster relationships among partnering providers, so implementation is realized on the regional level and when Medicaid Transformation project dollars are no longer available, the relationships and transformative changes will continue.

The North Sound ACH plans to leverage its unique position as a regional convener and facilitator to identify additional long-term supports for transformative changes to our health systems. Whenever possible, the North Sound ACH will seek to braid together DSRIP earnings with other sources, including Managed Care Organization partners. Additionally, philanthropic support and investment from foundations and community development organizations at the local, state, and federal level will be pursued and leveraged.

Within the clinical environment, the North Sound ACH will work with partnering providers to foster systems transformation, evidence-based practices, and team-based workflows to drive performance on clinical quality measures and thereby increase reimbursements for value-based contractual agreements, as the state moves toward HCA goals for increased VBP adoption. Improving utilization of non-clinical staff in the clinical environment can increase the ability to pursue payments for additional services billable to Medicaid, such as those supporting behavioral health practitioners performing assessments or other interventions. Finally, establishing improved linkages and care coordination between clinical settings and community-based resources can improve patient engagement and satisfaction, also bolstering clinical quality measure performance and subsequent reimbursements. Through the Pathways and other models incentivizing value-based or population health models over fee-for-service models ensures a more holistic approach to achieving health equity in the region.

The North Sound ACH plans to advocate at city, county, and state level for policies that will support this work, and reduce regulatory barriers to successful project implementation. This includes advocacy for policies that impact bi-directional integration and clinical transformation, social determinants of health, such as housing, access to transportation, childcare, employment, food access, environmental pollutants, etc. Additionally, the ACH will advocate for changes in programs and policies within partner organizations and systems, to support the implementation of services that support Medicaid Transformation and address health disparities.

Domain 1 areas of Workforce and Population Health Management offer substantial opportunities to ensure long-term sustainability and transformation. Training new members of the health workforce (or retraining current members) is an upfront and self-sustaining investment, particularly if partners are able to train staff in-house, building capacity for these providers in the long-term. Supporting implementation of systems for Health Information Technology or Exchange (HIT/HIE), is an up-front investment and will help defray costs over the long-term. Additionally, improved interoperability, communication and patient service resulting from improved technology and systems will reduce costs and improve patient satisfaction in the long-term, likewise driving increases in reimbursements for value based contractual agreements.

Specific to Care Coordination, the Pathways Community HUB Model is unique among other North Sound ACH Transformation projects with a built-in payment mechanism to support community-based care coordination. As the system stands up and shows value, long-term sustainability becomes possible through partnering with Managed Care Organizations, as well as other streams of funding (such as philanthropic supports) and other, non-Medicaid populations who would bring in other insurance payers and support the Pathways HUB infrastructure through additional reimbursement possibilities.