2C: Transformation Project Description: Transitional Care

Introduction: Current State

Transitioning between different care settings can be challenging for any patient, but high-risk patients are especially at risk for negative outcomes due to insufficient transitional care planning. While there is a relatively low population of Medicaid enrollees admitted to inpatient hospitals, mental health facilities, or incarcerated compared to target populations in other project areas, they are a significantly more expensive population for delivery systems, Managed Care Organizations, and county governments to manage and care for. Based on the Medicaid Transformation project toolkit, the high cost of care for patients receiving care in these settings, and priorities identified by partners, we have identified three areas of care transitions that the North Sound ACH will focus on: Transitions from Inpatient Hospitalization; Transitions from Inpatient Mental Health and Substance Use Disorder (SUD) Treatment Facilities; and Transitions from Incarceration. The strategies used to improve transitions in each of these areas will build upon and add to existing work to improve transitions of care in the North Sound region.

Target Population

The target population for Transitional Care strategies are Medicaid enrollees in the North Sound region transitioning from intensive settings of care or institutional settings, including enrollees discharged from acute care to home or to supportive housing, and enrollees with SMI discharged from inpatient care, or client returning to the community from prison or jail.

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.

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 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.

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.

[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

North Sound Project Area Reach & Impact Project Area 2C: Transitional Care	

Potential Target Populations Reach:
• 52,634 diagnosed with Serious Mental Illness (SMI)
  ○ 10,893 Disabled, 5,970 Non-Disabled Adults, 20,297 Newly Eligible Adults, 12,374 Non-Disabled Children, 3,100 Elders
• 15,029 diagnosed with both Substance Use Disorder Treatment Need and Serious Mental Illness
  ○ 3,565 Disabled, 2,123 Non-Disabled Adults, 7,822 Newly Eligible Adults, 1,154 Non-Disabled Children, 365 Elders
• 4,715 Adults (18+) who were incarcerated
• 76 Adults (18+) who were in acute inpatient psychiatric stays that followed by an acute psychiatric readmission within 30 days	

Project Area Impact:	
Performance Measures • 59% of Medicaid adults had a follow-up visit after discharge from emergency department for Mental Illness within 7 days. • 20% of Medicaid adults had a follow-up visit after discharge from emergency department for alcohol or other drug dependence 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.	**Geographic Disparities** • 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 1000 Member Months is the highest in the region. **Demographic Disparities** • Hispanic enrollees 25% more likely to not follow up with PCP for care after hospitalization for mental illness within 30 days. ○ 75% more likely to be readmitted within 30 days after discharge for psychiatric inpatient care. **Co-morbid Disparities** • Mental health service needs increase the likelihood of readmission by about half. • Medicaid enrollees with diagnosed chronic diseases such as CVD or Diabetes as much as doubled their likelihood of readmission.
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: ESA Profiles Program Participants, RDA/DSHS, released September 22, 2017. 5) BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017.	

Existing Work

Transitions from Inpatient Hospitalization

All hospitals in the North Sound ACH region have implemented various models of transitional care planning for successful discharge and readmission prevention. PeaceHealth St. Joseph Hospital in Bellingham implemented a successful early demonstration of the Care Transitions Intervention (CTI) model in 2008 with a pilot project called Stepping Stones – resulting in a 9% decrease in 30-day readmissions and improved

outcomes for patients after discharge. The Stepping Stones project provides a building block for care transitions work in the North Sound ACH region and the master trainers from this project are an asset that can be used to train future transition coaches.

Evaluations of previous implementations of the CTI model have identified a need for additional collaboration with home health services and enhanced family caregivers to improve outcomes and reduce barriers to hospital discharge and post-hospital success. Some of these barriers include the inability to maintain continuous care with primary care providers, lack of transportation, food and prescription needs, in-home caregiving and coordination, and other social barriers that potentially can prolong care and healing. Along these lines, Providence Health and Services in Everett has developed a transitional care pilot program in collaboration with Homage Senior Services and Northwest Justice Project, a publicly funded legal aid agency that provides medical-legal assistance. This program is designed to connect community members to necessary social supports and improve health outcomes, including connection to legal services and enhanced patient advocacy.

As the North Sound ACH coordinates with regional hospital partners to reduce inpatient hospitalization and readmission rates, these existing activities will serve as a strong foundation for identifying and piloting successful care transition strategies. These strategies will be targeted to specific Medicaid patient populations using data on inpatient hospital utilization and readmission rates for Medicaid patients as well as engagement from partners, to enhance and expand care transitions activities without duplicating existing work.

Transitions from Inpatient Mental Health and Substance Use Disorder (SUD) Treatment Facilities

The North Sound Behavioral Health Organization (BHO) currently contracts with Compass Health to provide staffing to ensure North Sound residents enrolled in Medicaid who are discharged from inpatient mental health settings are connected with services intended to prevent re-hospitalization. Compass Health currently utilizes a staffing model of two teams of clinicians and peer counselors at six facilities in Skagit, Snohomish, and Whatcom counties, serving residents of all five counties in the region.

North Sound BHO issues Compass Health a list of North Sound residents enrolled in Medicaid who have been admitted to one of these inpatient psychiatric facilities. A member of the team contacts the facility to determine if the individual is still there and the estimated discharge date. At least once prior to discharge, the clinician and Certified Peer Counselor meet with the client and the discharge planner in person to engage the client, discuss the discharge plan, and identify potential barriers to following through on the discharge plan.

Upon discharge, the team supports the client in following through on the discharge plan, connecting with resources and supports. Compass Health provides this support for approximately 30 days, until the client is connected with necessary supports to prevent re-hospitalization.

Transitions from Incarceration

There are currently jail transitions services (JTS) programs in place at facilities across the region. In Snohomish County, while incarcerated, inmates self-refer or are referred into the JTS program. Once eligibility is established, staff conduct a brief mental health assessment and a comprehensive needs assessment and enroll the individual into JTS. A clinician from an agency of the inmate's choice comes into the jail prior to release, meets with the individual and develops a plan for the days immediately post-release, often to include housing or shelter and accessing benefits.

Upon the inmate's release, contracted agencies have 90 days within which to provide supportive services. These services can include, but aren't limited to:

- assistance in accessing transportation and phone service,
- connections to employment service providers,
- SUD and MH assessments to determine eligibility for ongoing treatment,
- an appointment with a psychiatric medication prescriber,
- assistance in navigating benefits systems including ABD, SSI benefits and HEN
- assistance with connecting to potential housing resources
- connection to a primary care provider,
- coordination of behavioral health and physical health services.

Additional work includes ensuring they are enrolled in Medicaid, facilitating meetings with the MCOs and their members who are incarcerated to collaborate around healthcare needs, identifying high-utilizers with behavioral health issues and creating robust plans to help ensure services are in place at time of release, initiating Medication Assisted Treatment (MAT) in jail and facilitating MAT medication to begin the day of release, completing SUD assessments and facilitating classes for inmates in jail, as well as facilitating placement in residential treatment at release.

Strategies

Cross-cutting strategies for Care Transitions

Regardless of the target populations or the strategies employed, there are significant infrastructure gaps that will need to be addressed to allow traditional and non-traditional providers to better serve and coordinate care for patients/clients. Some of the cross-cutting strategies for improving transitions from all care settings include:

- Support widespread adoption and expansion of HIE tools such as PreManage for care management at physical health, behavioral, social service providers--including jail-based health providers. Access to these tools will help providers identify when shared clients have entered the ED and share care plans across clinical settings so care and services are coordinated and not duplicated.
- Build capacity to serve targeted populations: across all three strategies, we will need to expand capacity for services to be delivered to the identified target populations and to make sure we can sustain the workforce for the projects.
- Establishment of sustainable funding sources for transitional care planning, through value-based payment systems for health care providers or dedicated county funding for jail transition services.
- Integration of behavioral health screening in non-behavioral health provider settings through the collaborative care model, whether in inpatient physical health facilities or at booking in jails to identify which patients need behavioral health services. By standardizing and spreading this, we allow for quicker coordination with behavioral health providers to engage patients in services as well as reduction in stigma around behavioral health needs.
- Additionally, we expect that implementation of the Pathways Community HUB will positively impact most of the care coordination measures for Transitional Care, because of the importance of effective community-based care coordination for follow-ups after discharge, hospitalization, ED utilization, and readmission.

Jail Transitions: Reentry into the Community

During the planning phase, the North Sound ACH will convene partners from jail services and law enforcement in each of our five counties to share lessons and collaborate on collective activities to improve jail transitions for their systems. Partners have suggested additional strategies to improve transitions for the jail population, including:

- Business Associate Agreements between county services and the BHO and MCOs, which would allow jail-based physical health providers to better coordinate care. The current contract with the BHO provides reports on which inmates are enrolled with the BHO so that the jail can collaborate

with behavioral health providers on medication management. With the move toward Fully Integrated Managed Care, these same BAAs will need to be put in place with the MCOs.
- Use of criminogenic risk assessment tools to target inmates who are most likely to benefit from the services provided. Criminogenic screens help to determine which inmates are most likely to re-offend and most likely to benefit from the interventions provided.

Across all of the target population areas and strategies, the North Sound ACH will work closely with regional partners to ensure that projects enhance and do not duplicate existing efforts, gathering partners across the five counties to share successful strategies in their sectors. As plan implementation begins, these cross-county conversations will help identify areas of overlap and synergy to improve coordination and reduce redundancy of work.

Transitions from Inpatient Care

Through a deliberative process, review of evidence-based care transitions models, and evaluation of current care transitions activities in the region, our partners have identified the Care Transitions Intervention (CTI) model as the key strategy for reducing hospital length of stay and readmissions rates. This model, as outlined in the Medicaid Transformation Demonstration Toolkit, uses transition coaches, transition planning and enhanced care management to support patients discharging from acute inpatient care. This selection was based on the demonstrated regional success of CTI at reducing readmission rates and improving patient outcomes. Additionally, implementation can be supported by drawing on existing assets, including local CTI master trainers who can "train the trainer" at all settings which elect to integrate the CTI model--building a community of transition coaches out of an existing workforce. The North Sound ACH will coordinate with regional hospital partners to explore implementation of the CTI model in their systems. Past or current implementations of the CTI model, such as that at PeaceHealth St. Joseph's Hospital, will be drawn upon to establish best practices and spread experience in the model. Additionally, enhancements of the CTI model to integrate community services and in-home assistance for patients after discharge, such as at Providence Medical Center Everett, will be evaluated for feasibility of implementation at additional hospital settings or mental health facilities.

Medical Respite care for people experiencing homelessness is also a potential element of our post-acute transitions strategy. This model can serve patients with comorbid disorders who have been recently treated at medical facilities and ready for discharge but lack housing. The goal of the model is to provide short-term, medically assisted housing that allows the patient to stabilize medically and begin the process of engaging in behavioral health services and connecting with stable housing. Existing respite programs and pilot programs will be assessed for support and enhancement to build capacity.

ACH Role and Support for Partners

The North Sound ACH will improve health in the region by supporting the creation of a transitional care infrastructure and continuum that benefits Medicaid enrollees and providers in the highest-risk, highest-cost settings of care. Partner organizations directly serving Medicaid enrollees transitioning between care settings will implement the strategies selected for this project area, and the North Sound ACH's role will be to support them in doing so successfully and with maximum impact in the target populations.

Examples of roles the ACH will play in establishing the care transitions infrastructure include:
- working with partners to identify and address challenges in engaging the target populations;
- working with leadership of partner organizations to:
    - increase protected time for trainings and work flow modifications to support successful transitions,

    - identify opportunities for partners to see organizational budget savings based on improved efficiency
    - achieve buy-in to transformative change of front-line staff;
- developing and brokering relationships between service providers to expand the resources available to Medicaid enrollees;
- collaborating with MCOs and delivery system leadership to develop funding mechanisms that solve reimbursement challenges;
- facilitating the use of interoperable HIT and Release of Information agreements across partners;
- demonstrating the financial value of these interventions to funders, health systems, and other stakeholders who can potentially provide additional, sustainable financial support.

Metrics

Based on the application of the cross-cutting transitions strategies, jail population specific strategies, and implementation of the Care Transitions Intervention model we aim to achieve success in the following Toolkit metrics:

- Inpatient Hospital Utilization
- Outpatient Emergency Department Visits per 1000 member months
- Percent Homeless (Narrow Definition)
- Follow-up After Discharge from ED or Hospitalization for Mental Health, Alcohol or Other Drug Dependence
- Plan All-Cause Readmission Rate (30 Days)
- Percent Arrested

Health Equity

The North Sound ACH will use health equity as a lens for all our project areas. In order to be truly transformational and meet the needs of our community, disparities by race/ethnicity, socioeconomic status, geographic area, and other categories must be brought to the forefront. In the Transitional Care project area, strategies will be adapted when possible to each community to ensure that clinical and community interventions are both culturally appropriate and accessible (for example, hiring bilingual community health workers and clinic staff; hiring staff from the communities they will serve; requiring training on cultural humility, undoing institutional racism, implicit bias, and more).

Lasting Impacts

In an effort to produce long-term and sustainable results, efforts have focused on ensuring a wide variety of partners participate in this project area. Having the five counties involved in this effort will help to standardize processes, gain efficiencies where they are needed in our healthcare settings, and provide education and additional resources that have not been represented until now in all of the groups participating. It will enable partners to be proactive in the approaches, to successfully collect key data, and to measure the benefits for the larger population over the course of this project and beyond.

Additionally, it will be crucial to connect these transitions efforts into the processes built out in Project 2B: Community Care Coordination. The Pathways HUB could provide a sustainable platform for health workers to continue to connect patients to the social services and supports necessary for them to be successful upon leaving the hospital, jail, or mental health treatment facility.

With all of these strategies aligned, the critical focus must be on providing more standardized transitions for target populations, including ensuring access to any of the services of most immediate need for patients, whether they be behavioral health services or housing, food, employment, or others. The overarching goal is

to build a stronger and healthier community and provide ongoing education and resources to ensure sustainability in the North Sound counties.

2C: 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 Transitions project area, the North Sound ACH had high levels of engagement from clinical inpatient partners, community based organizations, tribal nations, and county governments, among others, which is essential to the project area's success. Workgroup Leads include representatives from a large regional health system: Providence Medical Center, and a Managed Care Organization partner: Amerigroup.

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 BH and SUD providers, Community Based Organizations, county health and human services and public health leaders, primary care providers, tribal partners, health systems, and Managed Care Organizations. Two or more subject matter experts were invited to serve in lead roles 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 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 honed these ideas at monthly face to face meetings with remote access for those who could not join in person (which was essential for this process to be accessible for more remote partners, especially those in San Juan county). North Sound ACH staff encouraged workgroups to focus on guidance from the Project Toolkit, including identifying target populations and strategies for 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 coalition of health system physical health care providers agreed to become an advisory body to staff, wherein staff convene regular meetings, assist with agenda setting, scheduling, 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 assignees in the region. Staff are continuing 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 BH and SUD settings.

The North Sound ACH recognizes the importance of Managed Care Organizations to the success of Medicaid Transformation in our region. Managed Care Organization partners are engaged at the Board of Directors, at 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. 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.

2C: Regional Assets, Anticipated Challenges and Proposed Solutions

While the Transitional Care Project Area concerns three separate, distinct target populations, there exists a wealth of shared resources for managing care transitions in those three areas across all five counties.

Clinical Service Delivery and Expertise

Physical and behavioral health providers are critical to supporting patients transitioning out of inpatient care and maintaining the stability of their conditions. Hospital systems such as PeaceHealth and Providence bring existing experience implementing Care Transitions Interventions model, including master trainers who can expand the transition coach workforce by training trainers. Jail physical health services and county governments provide all-encompassing physical health care to patients incarcerated at jails across the region.

Nonclinical Service Delivery and Expertise

Successful transitions of care – whether from inpatient physical and behavioral health settings or from incarceration – rely on access to robust community services and factors such as housing, nutrition, and social support. Each county in the North Sound ACH region has a robust network of county government services and community-based services that can be leveraged to support patients during care transitions.

An existing partnership between Homage Senior Services and Providence Regional Medical Center, Everett also represents a regional asset as a pilot demonstration of enhanced care transitions that could be spread to other hospital and health systems.

Data, Analytic Tools, and Infrastructure

A critical element in managing care transitions will be electronic communication of care plans and patient status across care delivery settings, including hospitals, inpatient behavioral health facilities, long-term care facilities, primary care providers, and behavioral health providers. Most of these settings have implemented EHRs or are in the process of implementing an EHR.

The expansion of CMT's EDIE/PreManage platform also presents an asset to the North Sound ACH region in achieving better transitions of care for patients, as it will notify outpatient providers in both primary care and behavioral health settings when patients are hospitalized or visit the ED.

In 2016 the Snohomish County Jail implemented an electronic medical health record system, CorEMR. This implementation and access to data by staff has allowed more efficient sharing of information and better collaboration between the county's Human Services staff and jail-based physical health staff. The success of this model will be examined and disseminated to encourage adoption of similar strategies in other counties in the North Sound ACH region where possible.

Workforce and Human Capital

The Care Transitions Intervention (CTI) model for inpatient care transitions relies on transition coaches with specialized training to support patients in developing care transition plans and maintaining their health stability. There is at least one master trainer in the CTI model who can support the training of additional

transition coaches across the region, reducing the overall cost of the training and improving sustainability of the strategy.

Financial Resources

The North Sound ACH intends to establish a braided funding model to support transitional 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, United Way, Chuckanut Foundation, or the Skagit Community Foundation; and
- 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.

Anticipated Challenges	Possible Solutions
Implementation of Care Transitions model not meeting performance measures, such as inpatient hospitalization rate or readmission rate for Medicaid Expansion population.	• Convene Quality Improvement team to review gaps in performance measures • Explore reasons for performance gaps and consider revisions or enhancements to improve rate for target population • Use population health management technologies to identify key target populations that are not responding to intervention. • Implement needed mid-course corrections, including integration of new partners or new strategies.
Limited partner capacity (for training, implementing new programs, willingness to take on new projects)	• Support the dedication of provider time to care transition trainings and workflow modification activities • Identify financial opportunity for participation in transformation project through improved efficiency and outcomes that supports organizational budgets beyond funding incentives. • Integrate and support front-line providers in planning and implementation process, so that projects are appropriate to provider needs and capacity.
Lack of resources such as housing or home health services for patients transitioning out of hospitalization	• Build relationships and connections with additional county services to assist patients in obtaining housing. • Explore opportunities to develop medical respite model.
Challenges with reimbursement for additional time or services associated with Care Transitions Intervention	• Collaborate with delivery system leadership and MCO partners to develop funding mechanisms that pay for performance on reducing hospital readmissions and length of inpatient stay. • Perform financial analytics that demonstrate value in transitional care improvement strategies.

	• Highlight benefits of improved care transitions services for reducing total cost of care and increasing shared savings reimbursements under value based payment contractual agreements.
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.
Inability to obtain funding for expanding/spreading successful strategies across regional partners.	• Facilitate site visits for stakeholders and decision makers with ability to provide needed funds, so that the value of the models can be experienced first-hand. • Perform cost effectiveness calculations that demonstrate short and long-term savings for care settings due to transitional care planning.

2C: 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.

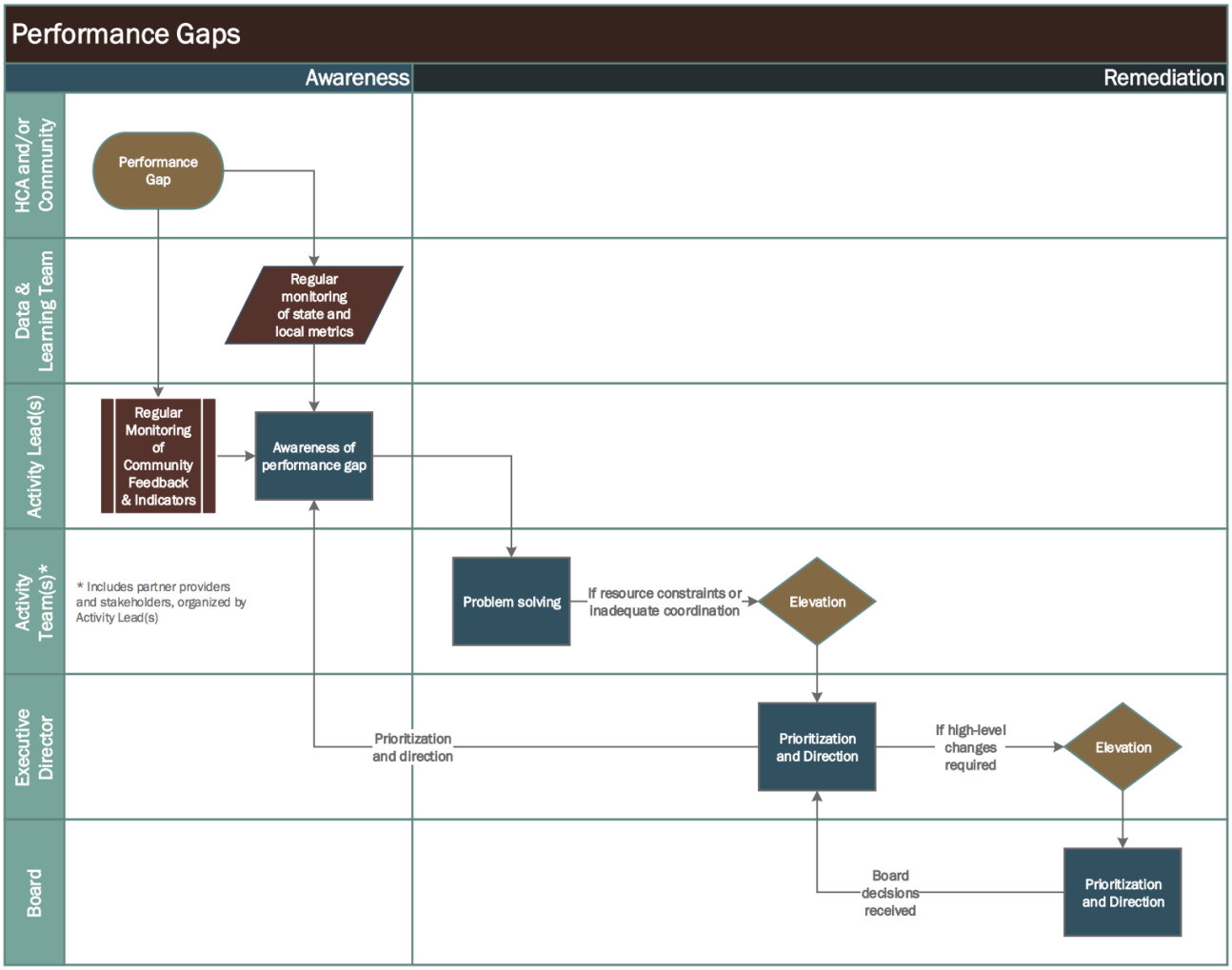

Figure 1: Performance Gaps Process Map

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.

2C: 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	

2C: 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	

2C: Project Sustainability

The North Sound ACH is committed to working with partners in the North Sound ACH 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. A virtuous cycle results 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 assure 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 wherever possible.

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, both current and future 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, child care, employment, food access, environmental pollutants, etc. Additionally, the North Sound 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 the Transitional Care, when strategies outlined in the Transitional Care project area are successful at reducing hospital readmissions, hospital systems will not only see a reduction in spending but will see a reduction in penalties through other contractual arrangements. These funds can be reinvested back into systems to expand Transitional Care support and to serve more Medicaid patients. Additionally, cost savings from reduced recidivism in jails can be reinvested in expansion of jail transitions programs.