## 3D: Transformation Project Description: Chronic Disease Prevention and Control

### Introduction- Why the Project is Needed

In the North Sound region, asthma, diabetes, and hypertension are among the most common chronic diseases experienced by Medicaid enrollees, and are tied to high rates of admission to hospitals and emergency departments. The presence of chronic diseases such as pulmonary or cardiovascular disease were associated with a two to four times higher likelihood of three or more ED visits per year compared to the general Medicaid population.[1] While largely preventable—with early, identifiable disease precursor states such as prediabetes and prehypertension—if not diagnosed early and not managed effectively through medical and lifestyle interventions, they can lead to severe health challenges and high health care costs. For example, Type II Diabetes is a national epidemic, fastest growing in the pre-teen and adolescent population. Hypertension is a precursor to cardiovascular and cerebrovascular diseases and can impact or exacerbate existing chronic conditions like diabetes, congestive heart failure, or coronary artery disease.

Health is most impacted by factors that occur outside of the clinical setting, by where we live, work, learn and play. Environmental conditions that many Medicaid enrollees in our region experience have been shown to influence health outcomes negatively. For example, homes that low-income residents in Western Washington can afford tend to be older, with deferred maintenance issues, including water intrusion, mold growth, air leakage, and old carpets that can all exacerbate asthma symptoms. Living in non-walkable or unsafe neighborhoods can limit ability to exercise, and a lack of access to healthy, fresh food (because grocery stores are not available in a convenient location, or because fresh and healthy food tends to be more expensive) contributes to increased obesity and diabetes rates.

For low-income adults (incomes less than $25,000/year) in the North Sound region, 13.6% had an asthma diagnosis, and 12.8% had a diabetes diagnosis.[2] There is variability of chronic disease burden and risk for local populations in the North Sound. Overall, health disparities in chronic disease risk factors and disease burden were present in population segments by gender, race/ethnicity, age, education and income. Further, necessary chronic disease screening, prevention, and management processes show opportunity for improvement—with only 31% of qualified diabetics having received eye screening for diabetic retinal disease, 20% of adults with diagnosed cardiovascular disease prescribed a statin, and 27% of Medicaid enrollees (5-64 years) remaining on asthma medication[3]. Finally, four of the 9 leading causes of death for Medicaid enrollees in the North Sound region are directly associated with chronic disease, accounting for 28.5% of mortality among enrollees:[4]

- Major Cardiovascular Disease (15.1%)
- Chronic Liver Disease & Cirrhosis (7.1%)
- Diabetes (3.6%)
- Chronic Lower Respiratory Diseases (2.8%)

[1] Measure Decomposition Data, RDA/DSHS, released July 7, 2017.
[2] RHNI Starter Kit, HCA, released May 8, 2017.

[3] RHNI Starter Kit, HCA, released May 8, 2017
[4] RHNI Starter Kit, HCA, released May 8, 2017

**Table 1: Chronic Diseases, Risk Factors, & Health Disparities, North Sound & WA**

| Measure | WA | North Sound | Health Disparities by Population Segments | | | | |
|---|---|---|---|---|---|---|---|
| | | | Gender | Race & Ethnicity | Age | Education | Income |
| Poor Mental Health Status- Adults | 11% | 10% | Female | AI/AN<br>Hispanic<br>White | 18-24<br>25-34 | HS or Less<br>Some College | Less Than $25,000<br>$25,000 to $49.999 |
| Asthma- Adults | 10% | 9% | Female | AI/AN<br>White | 18-24<br>45-54<br>55-64 | HS or Less<br>Some College | Less Than $25,000<br>$25,000 to $49.999 |
| Diabetes- Adults | 8% | 8% | Male | Hispanic<br>Asian | 45-54<br>55-64<br>65+ | HS or Less | Less than $25,000 |
| Personal Health Care Provider- Adults | 74% | 75% | Male | AI/AN<br>Native*<br>Black*<br>Hispanic | 18-24<br>25-34<br>35-44 | HS or Less | Less Than $25,000<br>$25,000 to $49.999 |
| Obesity- Adults | 27% | 26% | Female | AI/AN<br>Black*<br>Hispanic<br>White* | 35+ | HS or Less<br>Some College | Less Than $25,000<br>$25,000 to $49.999 |
| Smoking- Adults | 16% | 16% | Male | AI/AN<br>White | 18-24<br>25-34<br>35-44<br>45-54 | HS or Less<br>Some College | Less than $25,000<br>$25,000-$49,000 |
| Washington State Department of Health, BRFSS. 2013-2015. CHAT, 2015. | | | | | | | |

Actual chronic disease diagnosis rates among Medicaid enrollees are relatively low as reflected in claims data, with 3% showing billing codes for with diabetes diagnosis, 3% with billing for asthma diagnosis and 10% with billing for major depression diagnosis.[5] However, diagnosis rates may not be the strongest measure to indicate the disease burden of chronic conditions, including behavioral health and substance abuse. Analyzing claims data through the lens of the UCSD Chronic Illness & Disability Payment system,[6] burden of chronic illness and/or disease can be seen in the association of claims and disease categories. Based on this, the top five chronic illness diagnoses in North Sound were:[7]

1. Depression
2. Pulmonary conditions like asthma, COPD
3. Hypertension
4. Gastro conditions like intestinal infections, ulcers and hernias.
5. Osteoporosis, musculoskeletal anomalies

Lastly, chronic conditions, mental illness and substance abuse can exacerbate one another, which is why it is a fundamental North Sound ACH priority to identify co-occurring illnesses while further defining target populations for this project area. In 2016, 40,626 of Medicaid enrollees were diagnosed with a Mental Illness and one or more chronic conditions, while 20,135 of Medicaid enrollees were diagnosed with a Substance Use Disorder (SUD) and one or more chronic conditions. Several other North Sound project areas will be implementing strategies designed to address the relationship between mental illness, SUD, and chronic

[5] Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2016

[6] Improving Health-Based Payment for Medicaid Beneficiaries: Chronic Illness & Disability Payment System, University of California- San Diego, 2000.

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

disease, including Bidirectional Integration of Physical and Behavioral Health, Diversion Interventions, Transitional Care, Addressing the Opioids Crisis, and Care Coordination.

### Target Population

The target population for Chronic Disease Prevention and Control strategies are Medicaid enrollees (adult and children) with, or at-risk for, chronic respiratory disease (asthma), diabetes, and hypertension, with a focus on those populations experiencing the greatest burden of chronic disease in the North Sound region. These three categories of disease were selected by the Chronic Disease project area workgroup due to the associated opportunities for primary and secondary prevention of disease development, their prevalence in the Medicaid population, the cost to treat these conditions if unmanaged, and their association with the pay for performance metrics identified in the Medicaid Transformation Project Toolkit.

During the 2018 planning period, the North Sound ACH will review the best data available for the region and identify the population segment with the most need, in which a strategic investment in system reform can likely move the performance metrics during the Medicaid Transformation Project period. A focused target population for this project area will be selected from this population segment. The North Sound ACH will use Targeted Universalism[8] as an approach 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 interventions.

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[9] 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.

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

[9] 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 3D: Chronic Disease Prevention and Control**

**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
- 32,100 diagnosed 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
- 22,390 diagnosed with Type 1 or 2 diabetes
  - 5,868 Disabled, 1,501 Non-Disabled Adults, 8,080 Newly Eligible Adults, 608 Non-Disabled Children, 6330 Elders
- 40,626 diagnosed with a Mental Illness and one or more chronic condition
  - 14,651 diagnosed MI and any cardiovascular condition
  - 14,238 diagnosed MI and any pulmonary condition
  - 4,330 diagnosed MI and Type 1 or Type 2 Diabetes
- 20,135 diagnosed with a Substance Use Disorder and one or more chronic condition
  - 8,335 diagnosed SUD and any cardiovascular condition
  - 7,410 diagnosed SUD and any pulmonary condition
  - 2,001 diagnosed SUD and Type 1 or Type 2 Diabetes

**Project Area Impact:**

**Performance Measures**

- 20% of Medicaid adults with cardiovascular disease were prescribed statins
- 27% of Medicaid enrollees (5-64 years) with asthma and medication managed
- 86% of Medicaid children ages 2-6 years who went to a PCP in the last year
- 31% of Medicaid enrollees with a diagnosis for diabetes received an eye exam screening for diabetic retinal disease.

**Geographic Disparities**

- All counties in the North Sound (39%-43%) have higher rates of adults with high cholesterol compared to the state.
- Snohomish County has the highest smoking rate among adults at 17%
- Snohomish County has the highest rate (6%) of enrollees with SUD and more than one chronic condition.
- In Whatcom and Island counties, 12% of enrollees with a mental illness have more than one chronic condition

**Demographic Disparities**

- Adult females are more likely to have poor mental health and asthma
- 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.
- Whites and American Indian/Alaskan Natives were more likely to have poor mental health, asthma, not have a personal health care provider and smoke.

**Co-morbid Disparities**

| | |
|---|---|
| | • Patients with chronic pulmonary or cardiovascular diseases or diabetes were between 2 and 4 times more likely to have 3 or more outpatient ED visits.<br>• 40,626 diagnosed with a Mental Illness and one or more chronic condition<br>• 20,135 diagnosed with a Substance Use Disorder and one or more chronic condition |
| 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. 6) Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. 7) Chronic Disease Profiles (North Sound) WADOH, April 2016. | |

In the North Sound ACH region, many challenges exist to effectively address chronic diseases in our current systems, and many Medicaid enrollees in our communities face significant barriers to health that put them at a higher risk for developing chronic diseases like asthma, diabetes, and hypertension. Many people and families lack funds to afford insurance or co-pays, medication, transportation, or healthy foods. Distance from clinics and services are a significant barrier to accessing care, and can lead to isolation in rural or remote areas (such as east Whatcom, Skagit, and Snohomish counties, or throughout Island or San Juan counties). The elevated costs of living in city centers where services and clinics are often located can prevent low-income families from having easy access to health care providers.

Many community members have complex care needs, and have a need for integrated services such as primary care and diabetic retinopathy screenings. Managing chronic diseases often requires environmental support, which many people do not have at home, at work, or at school. Knowledge and education is also essential to effective self-management of chronic diseases, such as the ability to use an inhaler, blood pressure cuff, insulin pen, as well as healthy lifestyle practices such as regular exercise and healthy cooking.

Primary care providers can vary considerably in the use and implementation of national clinical guidelines to guide their clinical practice. Opportunities for clinical improvement in this area include:

- regularly prescribe controller medications for asthma when warranted;
- help ensure patients use an inhaler correctly;
- inform their patients why they are prescribing medications like Metformin (used to control diabetes) and/or how best to take it in order to minimize side effects;
- counsel patients about the risks of being overweight or obese
- provide suggestions healthy eating and lifestyle changes.

Embedding evidence-based practices and prescribing policies around chronic disease prevention and management through practice transformation and population health management techniques as elements of the Chronic Care Model will be essential to address these clinical performance gaps.

### Alignment with Regional Priorities

This project area aligns with regional priorities as identified in the most recent Community Health Needs Assessments, Community Health Improvement Plans, and Community Health Assessments conducted by counties, hospital systems, and community-based organizations in our region - specifically around addressing food insecurity (especially for people with chronic diseases), nutrition, child and adult obesity, and promoting exercise. Asthma, diabetes, and hypertension are specifically called out in recent needs assessments and

improvement plans as priorities that need to be addressed in our region to promote better health, especially for low-income communities.

## Recommended Strategies

**PROJECT OBJECTIVE:** Integrate health system and evidenced-based community approaches to improve chronic disease management and control.

### Enhancement and Expansion of the Chronic Care Model in Primary Care Practices

The Chronic Care Model (CCM) of chronic disease prevention and management is an evidence-based and patient-centered methodology for reducing chronic disease burden through clinician-patient teams and community-based resource referral links.[10] Developed at the MacColl Center for Healthcare Innovation by Ed Wagner in 2004, the Chronic Care Model has been tested and expanded throughout the nation over the course of the last decade. The model has demonstrated success in clinical prevention and management for a range of chronic diseases, including:[11]

- Arthritis[12]
- Asthma[13]
- Depression[14]
- Diabetes[15]
- Hypertension[16]

Most clinical organizations in the region report successful implementation of the Chronic Care Model, in using clinician/medical assistant teams to identify, prevent, and manage chronic disease. Indeed, a regional primary care system, Family Care Network, was an initial pilot site of the CCM and counts national subject-matter experts on chronic disease management in their provider staff. Collaborating with partners on the Health Systems Advisory Coalition (primary care and hospital systems), this project will continue to build on existing chronic disease prevention and management systems in:

- training providers in the most current clinical guidelines on screening, diagnosing, and intervening to prevent and manage the chronic diseases in the scope of this project;
- educating providers on local community-based chronic disease prevention and management programs;
- implementing population health management techniques, including Health Information Technology (HIT) tools, to identify patients who are at risk of or diagnosed for the chronic diseases;
- recalling identified at-risk or diagnosed patients for prevention, intervention, and potential to community-based programs;
- use of available billing options and processes for referring or prescribing patients to home-based chronic disease management (such as at home blood pressure management) or community-based chronic disease prevention and management programs.

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[10] Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*. 1998

[11] Battersby MW. Health reform through coordinated care: SA HealthPlus. BMJ 2005; 330(7492):662-5.

[12] MacLean CH, Louie R, Leake B, McCaffrey DF, Paulus HE, Brook RH, Shekelle PG. Quality of Care for Patients with Rheumatoid Arthritis. JAMA 2000; 284(8): 948-992.

[13] Lozano P, Finkelstein JA, Carey VJ et al. A multisite randomized trial of the effects of physician education and organizational change in chronic-asthma care: health outcomes of the Pediatric Asthma Care Patient Outcomes Research Team II Study. Arch Pediatr Adolesc Med 2004; 158.(9):875-83

[14] Simon G, VonKorff M, Rutter C, Wagner E. Randomised trial of monitoring, feedback, and management of care by telephone to improve depression treatment in primary care. BMJ. 2000; 320:550-4.

[15] Piatt GA, Orchard TJ, Emerson S et al. Translating the chronic care model into the community: results from a randomized controlled trial of a multifaceted diabetes care intervention. Diabetes Care 2006; 29(4):811-7.

[16] Battersby MW. Health reform through coordinated care: SA HealthPlus. BMJ 2005; 330(7492):662-5.

In addition, specific work will be done to implement practice improvement and provider education activities around asthma, diabetes, and hypertension:

1. *Asthma*: Ensure clinics implement national clinical guidelines on diagnosis and treatment for asthma with home-based assessments and remediation, through trainings in:
    - effective asthma diagnosis through spirometry;
    - Stepwise approach to medication management;
    - patient education on use of inhalers with spacers;
    - asthma action plans.
2. *Diabetes*: Ensure clinics implement national clinical guidelines for diagnosing and treating both prediabetes and diabetes; and linking with other community-based programs like Chronic Disease Self-Management Education (CDSME) and other community- and school-based programs that will help promote healthy lifestyles (increase activity, healthy eating/portion control, etc.).
3. *Hypertension*: Implementing national clinical guidelines on diagnosis and treatment for hypertension through application of tools and protocols the Million Hearts initiative; refer patients to community-based programs that focus on healthy lifestyle, smoking cessation, etc.; prescriptions for home blood pressure monitoring equipment.

**Expand Regional Capacity for Community-based Chronic Disease Prevention and Management**

A key part of this work will be to expand regional capacity to provide evidence-based, community-based chronic disease prevention and management programs. A critical element of the Chronic Care Model is referral to community-based resources, which requires strong, available community programs where patients can receive support in self-management and lifestyle modification. Several evidence-based environmental, patient education, and self-management programs will be implemented where appropriate to address asthma, diabetes, and hypertension.

This work will build on current programs that exist in communities to prevent and manage chronic diseases, and look to examples of successful programs that are accessible and effective at improving health outcomes. A significant part of the 2018 planning phase will be identifying these community-based programs to ensure that all partners are engaged and that duplication of programs does not happen. Projects in this area will take care to not "reinvent the wheel" but build on or scale up the work that is already happening in communities.

During this planning phase, the North Sound ACH will collect and analyze sufficient data to identify target populations through review of existing chronic disease burden on communities, disparities in disease prevention and management, and existing chronic disease prevention and management resources. Implementation partners will collaborate with the North Sound ACH in a financial analysis of intervention cost compared to the impact on health outcomes and performance measures. Existing regional programs that are strong candidates for enhancement or expansion include:

1. *Asthma Home-Based Multi-trigger, Multicomponent Environmental Intervention (Healthy Homes)*: Healthy Homes targets persons with asthma or COPD and provides a holistic housing assessment coupled with environmental health education that includes: a home education visit to help families take action to create a healthier home; inventory to support households in improving indoor air quality; comprehensive home assessment to identify indoor air health and safety hazards; referral to weatherization and home repair programs to improve indoor air quality, reduce asthma triggers and increase energy efficiency; one year of follow up service, both in-home and via phone. Community health workers can become certified to conduct environmental assessments and refer to Healthy Homes.

2. *National Diabetes Prevention Programs (NDPP)*: The goals of NDPP are to increase healthy eating and activity and promote healthy weight loss. NDPP are based in community organizations like the YMCA (one-year program is comprised of 25 small group one-hour sessions), Washington State University (WSU Extension DPP consists of 16 weekly Core classes and followed by 6 monthly Post Core classes).
3. *Chronic Disease Self-Management Programs (CDSMP)* is an effective small group self-management education program for people with chronic health problems to help them control their symptoms and better manage their health problems. The program specifically addresses arthritis, diabetes, lung and heart disease, but teaches skills useful for managing a variety of chronic diseases.
4. *"Eating Smart, Being Active"*, an 8-week food and nutrition series;
5. *"ACT!"*, a partnership between Seattle Children's Hospital and the YMCA of Greater Seattle, that coaches overweight kids (8-11), and teens (12-14), and their families to lead healthy lifestyles.
6. *Fruit and Vegetable Prescription Program* - a partnership between local food banks and primary care providers, to prevent and treat food insecurity and chronic diet-related diseases (type 2 diabetes, hypertension). Participants are enrolled by a healthcare provider, screened for food insecurity, and work with a counselor to discuss nutrition goals and strategies each month. Participants are referred to WIC/SNAP if appropriate, and receive a Fruit and Vegetable Rx voucher that is redeemable at farmers' markets, mainstream grocers and corner stores.

**Toolkit Model Used**

The strategies in this project area are based in the Chronic Care Model, and implement several different evidence-based change strategies, such as Self-Management support, Delivery System design, Decision Support, Clinical Information Systems, Community-Based Resources and Policy, and Health Care Organization strategies.

**ACH Role and Supports for Partners**

The North Sound ACH will improve health in the region by supporting the strengthening of clinical and community-based prevention, treatment, and management of chronic diseases for Medicaid enrollees who are at-risk or have been diagnosed with asthma, hypertension, or diabetes. Partner organizations directly serving Medicaid enrollees who are at-risk or diagnosed with chronic diseases (including primary care providers, specialty providers, social service organizations, and community-based prevention and management programs) 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 (which will be finalized in 2018).

Examples of roles the ACH will play in strengthening the prevention and management of chronic diseases in the North Sound Region include:

- Working with partners to identify and address challenges in engaging the target populations;
- Acting as convener for regular cross-sector collaboration meetings during the planning and implementation phases;
- Working with leadership of partner organizations to:
    - increase protected time for trainings (including trainings in best practices for screenings and referrals to community-based programs, which the ACH would likely not lead, but can assist in connecting providers with trainers and potentially provide financial support)
    - 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 clinical providers and community-based services 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;
- Considering the needs of the entire North Sound Region to ensure that strategies are implemented which promote access to services for Medicaid enrollees in rural and remote areas as well as urban areas;
- Sharing learnings from other ACH regions with planning partners when developing implementation plans.

### Metrics

In order to be successful in meeting the reporting and performance metrics this area, a strong partnership and active collaboration between primary care providers and community-based programs is essential. The strategies in this project area are expected to improve the following measures of success:

I. Reporting or attestation measures:
   - Number of providers trained in appropriate blood pressure assessment practices;
   - Number of patients with automated blood pressure monitoring equipment;
   - Number of new or expanding community self-managed support programs, such as CDSMP and NDPP;
   - Number of home visits for asthma services and hypertension;
   - Number of completed, documented, and up to date Asthma Action Plans
   - Number of Medicaid enrollees in the North Sound region participating in chronic disease prevention or management programs.

II. Performance, HEDIS or clinical quality measures:
   - Percent of Medicaid enrollees with a diabetes diagnosis who have received comprehensive diabetes care including retinal exams, hemoglobin A1c testing, and medical attention for nephropathy;
   - percentage of Medicaid enrollees 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.
   - Percent of Medicaid enrollees with three or more ED visits
   - Percent of Medicaid enrollees with inpatient hospital utilization
   - Access to Primary Care for Adults and Adolescents,
   - Percent of Medicaid enrollees with a diagnosis of hypertension and whose blood pressure was adequately controlled
   - Percent of Medicaid enrollees with diagnosed cardiovascular disease who were proscribed statin therapy.

### 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 Chronic Disease 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

Historically, healthcare has been clinically driven, with limited links to outside-the-clinic, evidence-based interventions and resources that are proven to reduce risks or assist in managing chronic diseases. Clinical transformation can play a big part in preventing and managing chronic disease. However, true transformation will require a shift in relationships along the healthcare continuum to create strong, sustainable pathways and links for integrated care from clinic to community, and investment in building up both clinical interventions to prevent and manage chronic disease, and community-based programs to also help prevent and manage chronic disease.

Chronic Disease project strategies will benefit the Medicaid population as a whole beyond those diagnosed or at-risk for asthma, diabetes, and cardiovascular disease. Strengthening clinical and community-based systems that help prevent and manage chronic conditions and address the behaviors and environmental factors that can contribute to them, will benefit the entire community by reducing the burden of disease and cost of care while improving quality of life.

## 3D: 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 Chronic Disease project area, the North Sound ACH has been fortunate to receive high-levels of engagement from both community-based and clinical partnering providers whose participation will be essential to the project's success. Serving in the role of workgroup leads are representatives from a local community-based organization (Opportunity Council), a regional health system (Skagit Regional Medical Centers), and a Managed Care Organization partner (Molina Healthcare).

Upon news of a successful agreement for the Medicaid Transformation, the North Sound ACH began a process of moving from broader stakeholder engagement to targeting partnering providers based on those currently serving or interested in serving a greater proportion of the Medicaid population. This engagement began with the formation of eight workgroups in each of the Toolkit project areas. An open invitation was extended to providers and stakeholders with interest or focus in certain project areas. These included behavioral health and SUD providers, community-based organizations, county governments, primary care providers, health systems, Managed Care Organizations and health departments. Two or more volunteer subject matter experts from the community were invited to serve alongside staff in a lead role for each workgroup. As more information on the Medicaid Transformation project 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 leads then gathered these submissions and reflected back a compilation of content to produce the outlines of a regional approach in each area.

Workgroups further honed these ideas during dialogue at monthly face-to-face meetings with remote access capability. 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 across the region, while also aiming to move their respective pay-for-performance metrics. This dialogue on target populations, partnering providers already serving and committed to serve the Medicaid population and effective strategies honed the focus of the workgroups onto Medicaid enrollees, including the subpopulations indicated by 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 and remain a value for future engagement.

Concurrently, a coalition of health system primary care providers formed an advisory body to staff, wherein staff facilitate regular meetings, assist with scheduling, agendas and note-taking. The Health System Advisory Coalition includes members from the largest hospital systems providing primary care in the region, all the regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. Collectively, the group has self-reported coverage of over 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 those serving a significant majority of the Medicaid population. Plans to similarly convene partnering providers working in behavioral health and SUD settings will ensure a broad spectrum is represented for the purposes of Chronic Disease Prevention and Management.

The North Sound ACH recognizes the importance of Managed Care Organizations to the success of the Medicaid Transformation Project and efforts at systems transformation in our region. Managed Care Organization 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. 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.

## 3D: Regional Assets, Anticipated Challenges and Proposed Solutions

### Assets

The foundation of the regional assets that will support this project is the collaborative nature of the diverse partners working to improve health in the North Sound region. Since the inception of the ACH, organizations that have traditionally competed with each other have come together to collaboratively plan the transformation of our regional health system. Strategies in this project area will build on the many assets in our region, including strong commitments from diverse partners to improve environmental quality in homes, food access, healthy eating, physical activity, and other conditions that help prevent chronic disease, as well as effectively manage chronic diseases to help reduce health care costs and improve patient outcomes. Key assets include:

### Clinical Service Delivery and Expertise

Our region has many health care providers who are an asset to this work, including:

- Federally Qualified Health Centers (Sea Mar, Unity Care NW, Community Health Center of Snohomish County)
- Community Health Workers (Home health programs)
- Community Paramedics (Whatcom and Snohomish)
- Pediatricians and pediatric practices (such as Skagit Pediatrics)
- School based health (school nurses, and school based health centers under development)
- Military medical services (U.S. Naval Air Station Whidbey Island)
- Behavioral health providers (North Sound BHO, Compass Health, Sunrise Services, etc.)
- Hospital Systems (such as PeaceHealth, Skagit Regional, Providence, Island Hospital, etc.)
- Emergency Departments
- Managed Care Organizations
- Pharmacies

### Nonclinical Service Delivery and Expertise

In the North Sound region there are many nonclinical, government or community-based organizations focused on preventing and managing chronic diseases like asthma, diabetes, and heart disease, including:

- Community Action Agencies (e.g., Opportunity Council, Skagit Community Action, etc.)
- Local Health Jurisdictions
- Population Health Trust (Skagit County)
- Community Wellness Programs (YMCA, WSU Extension, etc.)
- Food systems, hunger relief and coalitions (Food Banks, etc.)
- Gyms and health clubs
- Grocery stores and Farmers Markets
- City and County-supported wellness and recreation programs
- Transportation partners (public transit, biking advocates, etc.)
- Tribal governments
- Faith communities
- K-12 schools
- Area Agency on Aging (NW Regional Council)
- Housing and social service providers (Lydia Place, YWCA, Catholic Community Services, Lutheran Community Services, etc.)
- Health promotion organizations (Verdant Health Commission, etc.)

### Workforce and Human Capital Assets

While there is opportunity for workforce expansion in this area, there is a robust existing clinical, and nonclinical workforce across the North Sound region, including:

- Community Health Workers
- Primary Care Providers
- Emergency Department providers
- Specialists (pulmonologists, nutritionists/dietitians, cardiologists, etc.)
- Pediatricians
- Nurses
- Home-visiting nurses
- Community wellness program leaders
- Social Workers and Case Managers
- Public Health Professionals

### Financial Resources

The ACH and implementation partners in the Chronic Disease project area intend to draw on existing funding sources external to Medicaid Transformation funds to cover all the costs for the recommended strategies, many of which are currently operating in some capacity. Funds will be leveraged from federal and state funding, philanthropy and other existing funding mechanisms to expand the limited scope, limited capacity, and pilot projects, with DSRIP funds used to build out capacity to unserved areas and to additional targeted populations. The North Sound ACH intends to establish a braided funding model to support the prevention and management of chronic disease, supplemented by Medicaid Transformation funding and including the following sources:

- Managed Care Organizations
- Philanthropic support from “angel investors”
- Potential city, county, state, and federal funding
- Community organizations

## 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 | Proposed Solutions |
|---|---|
| Project has difficulty meeting performance metric targets | • The ACH will engage implementation planning teams in embedding tracking mechanisms in their implementation plans, including surveys, regular automated or manual reports of metrics, and other means for tracking success. Quality Improvement Plans will be integrated into the implementation strategy using rapid-cycle process improvement strategies to identify points of failure and improvement early for quick response. Data & Learning Teams will also convene, based either in the implementation planning teams or the data and learning team, to regularly review metrics and assess areas of change or improvement.<br>• The ACH Data and Learning team will support the strategy through the development of a suite of monitoring and evaluation measures that provide an ongoing, actionable dashboard for project progress. Included in this will be ongoing survey-based assessments of training effectiveness and project implementation to partnering providers, regular review of clinical quality measures aligned with toolkit pay for performance measures, HCA reports on performance measure benchmarks, and other heuristic metrics for assessing project implementation success. Clinical quality measures will be pulled for tracking and quality improvement purposes, based on reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform or cloud-based registries.<br>• Modifications to project plans will occur after the data and learning teams or implementation planning teams identify and report gaps or areas of improvement to the Program Council. ACH staff 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. Managed Care Organizations could be engaged in this component, to assist ACH staff and partners in workflow redesign and lean process improvement activities.<br>• The ACH will identify potential sources of outside technical assistance to support this process, including Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations. |

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| | • Work with project partners to identify and understand barriers or limitations that contribute to the inability to meet these metrics<br>• Actively engage with partner providers to support additional training (with financial support) to adopt new practices (i.e. appropriate chronic disease screenings, referral to community programs, etc.)<br>• Outreach to other ACHs, as well as state and national experts, to learn successful strategies to address performance issues |
| Geographic barriers, resulting in limited provider capacity in more remote/rural areas, transportation barriers for Medicaid enrollees in these areas, as well as limited food access and access to safe places to exercise | • The North Sound ACH will prioritize flexibility when developing implementation plans, and ensure that mobile services (such as mobile dentistry, mobile needle exchange/substance use disorder treatment, etc.), telehealth, and home visiting services are possibilities for populations in particularly rural or remote areas (such as the San Juan Islands or east Whatcom, Skagit, and Snohomish counties).<br>• Allocate ACH resources to improve access to, use of, and reimbursement for Medicaid Transport services.<br>• Work closely with existing resources in these areas (not necessarily within the realm of health care) to think of non-traditional methods to promote access to food and exercise<br>• Utilize monitoring and continuous improvement processes to quickly identify when geographic barriers are impacting access to services. |
| Lack of affordable, available housing in the North Sound region resulting in inability to reduce homelessness, and unstable housing limits improvement in health outcomes | • Outreach to other ACHs, as well as state and national experts on reducing homelessness, to learn successful strategies to address performance issues<br>• Consider investing ACH resources (including staff time) in more upstream efforts to reduce homelessness rates (investing in housing, advocacy at the city, county, and state levels, etc.) |
| Challenges with reimbursement for services by Apple Health (services not covered/reimbursement rate is insufficient/lack of provider understanding around billing procedures) | • Exploring sustainability with the local Managed Care Organizations will be needed to continue integrated services.<br>• Work together with the HCA to increase the number of covered services that will support movement of performance metrics, including community-based services and prevention services<br>• Work together with the HCA to ensure that reimbursement rates for services are sufficient for providers to cover their costs and continue to provide services for Medicaid patients.<br>• Leveraging expertise from the UW-AIMS center and cross sector workgroup support can provide information on proper billing and coding. |

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| Health Information Technology/Exchange (HIT/HIE) challenges, including interoperability of multiple systems, implementation challenges with new systems (such as Pathways), barriers to data sharing between providers/systems (including protected health information), concerns around public disclosure and liability issues | • Utilize a mutually agreed-upon Release of Information (ROI) that can be used by partner providers in this project area, to ensure that patients' Protected Health Information (PHI) can be shared across agencies and agencies remain HIPAA-compliant.<br>• Set up regular data/HIT round tables with partner providers to identify concerns around HIE, data sharing, and challenges around implementing new systems.<br>• The ACH will work with partners to identify any legal or regulatory barriers to sharing data and health information across providers or systems (laws around Public Disclosure; criminal history sharing; 42 CFR Part 2, Confidentiality of Substance Use Disorder Patient Records, for example), and advocate where possible to remove these barriers.<br>• Engagement with partner providers for evaluation of current capacity and needs around Medicaid reimbursement and billing. Connect partner providers with the Healthier Washington Practice Transformation Support Hub and resources through the project plan could mitigate this barrier.<br>• 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 the North Sound ACH will describe this arrangement in contracts with the MCOs. The ACH can draw on the experience and expertise of other Pathways HUBs and Pathways experts in doing so.<br>• Work with leaders of the Pathways Community HUB to ensure that Pathways technology is able to integrate with existing HIT in use by partner providers.<br>• Potentially leverage ACH resources to pay for data migration costs and set up of new systems, as well as staff training on the new system. |
| Challenges identifying long-term funding outside the Medicaid Transformation Project | • Utilizing monitoring and continuous improvement processes, regularly evaluate project performance to be able to clearly communicate project impact to potential outside funders, as well as demonstrate a commitment to effectiveness.<br>• Collaborate with MCOs to identify opportunities that align long-term objectives and achieve total cost of care savings in line with needed investments<br>• Dedicate ACH resources to identify additional funding sources, including in-kind support, local community development foundations, philanthropic foundations, other state and federal programs and "angel investors."<br>• Partner with other ACHs to achieve economies of scale<br>• 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. |

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| | • Perform cost effectiveness calculations that demonstrate short and long-term savings for care settings due to transitional care planning.<br>• Advocate for city, county, state, and federal-level allocation of funds to promote access to chronic disease prevention and management<br>• Work together with the HCA to increase the number of covered services that will support movement of performance metrics, including community-based services |
| Limited partner capacity (for training, implementing new programs, willingness to take on new projects) | • Design distribution of project incentive funds to incent partner participation based on specific activities, adoption, and accomplishments; revise distribution as needed throughout the duration of the project to support ongoing partner engagement<br>• Coordinate with front-line staff to address barriers and correct the project implementation plan as needed<br>• Engage partnering providers in leading the project design and implementation as a way to activate their participation<br>• Subsidize training fees for partners, and/or reimburse providers for lost revenue due to clinic shut down for training.<br>• Work with clinical providers to revise internal work flow to eliminate steps causing excessive strain on workflows<br>• Provide technical assistance from the ACH and other external partners |
| Challenges reaching/recruiting patients to fill new/expanded programs | • Consider additional consumer and stakeholder engagement tactics to identify barriers to adoption and expand buy-in, including, but not limited to:<br>o Targeted focus groups<br>o Engage the North Sound ACH's Community Leadership Council to clarify community needs and understand challenges to adoption<br>o Leverage CHWs, social workers, care managers, patient navigators, and allied health professionals that can engage hard-to-reach consumers<br>o Leverage trusted community organization partners that can help expand buy-in<br>• Outreach to other ACHs to learn successful strategies to stimulate project adoption in early implementation<br>• Devote more resources to outreach, analyze what is working & shift in that direction<br>• Retool out-reach and in-reach processes; use analytics to identify promising demographics<br>• Incorporate marketing tools into referral mechanism; offer incentives when appropriate |

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| | • Use Motivational Interviewing techniques to overcome ambivalence |

## 3D: 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.

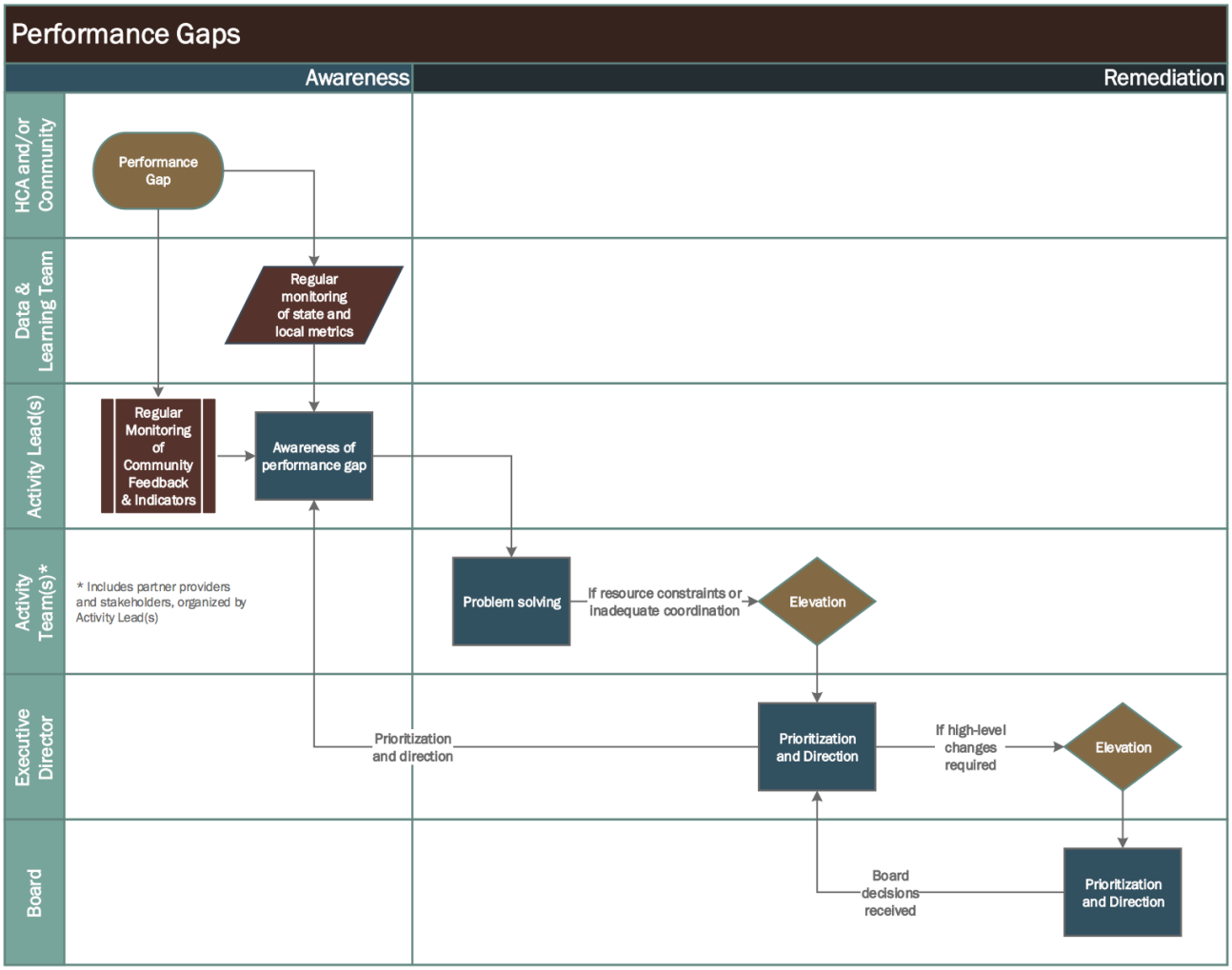

Figure 1: Performance Gaps Process Map

### 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.

## 3D: 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 | |

## 3D: 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 | |

## 3D: 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. 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 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 funds 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 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 assure 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 Chronic Disease, successful implementation of the Chronic Care Model will yield multiple opportunities for long-term project sustainability. By focusing on team-based care, patient engagement, connection with community-based resources and clinical training on evidence-based practice, clinical partners will improve performance on clinical quality measures for chronic conditions such as diabetes or asthma. This improved performance will generate revenues for these clinical partners and cost savings for Managed Care Organization partners and create opportunities for investment in community based organizations and services to address the social determinants of health.