



Medicaid Transformation Project

Implementation Plan

www.cpaawa.org



October 1, 2018

Meyers and Stauffer LC
9265 Counselors Row, Ste. 100
Indianapolis, IN 46240

RE: CPAA MTP Implementation Plan

Dear Implementation Plan Review Team Member:

Please find attached a copy of Cascade Pacific Action Alliance's Medicaid Transformation Project Implementation Plan. This plan provides a detailed roadmap of CPAA's project implementation activities in six project areas: Bi-Directional Integration of Care & Primary Care Transformation, Community-Based Care Coordination, Transitional Care, Addressing the Opioid Use Public Health Crisis, Reproductive and Maternal/Child Health, and Chronic Disease Prevention and Control.

As detailed in the plan, our region has made progress with advancing the Medicaid Transformation Project and achieving health care delivery system transformation through cross-sector collaboration. CPAA has selected a network of 44 traditional and non-traditional MTP Implementation Partners in addition to the region's seven federally recognized tribes and has a solid organizational infrastructure in place to support those partners during the planning and implementation of the Medicaid Transformation Project. Our region is excited to begin implementation approaches and activities with partnering providers and coordination with health systems and community capacity building and other initiatives across our portfolio of projects.

Please do not hesitate to contact us, should you have any questions regarding the enclosed report. We would be happy to provide you with further information.

Sincerely,



John Masterson, Interim CEO
Cascade Pacific Action Alliance

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**CPAA Project Work Plan is a Separate Document*

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Partnering Provider Project Roles

Cascade Pacific Action Alliance (CPAA) worked closely with Oregon Health Science University (OHSU) in the selection of Medicaid Transformation Project (MTP) Implementation Partners. Based on Request for Proposal (RFP) responses, 44 paid implementation partners were selected in addition to the seven federally recognized tribes in the region. The tribes did not participate in the RFP process because they were not required to compete for funding. CPAA announced this network of paid implementation partners on August 10, 2018, and have been in close communication with all 51 partners on next steps (Appendix A). We were deliberate with this selection process, working with the independent assessor to intentionally choose a mix of both traditional and non-traditional partners, including public health departments and community-based organizations (CBOs) that cover all six project areas and span the seven-county region, ensuring maximum transformative impact.

Table 1: MTP Implementation Partners by Organization Type

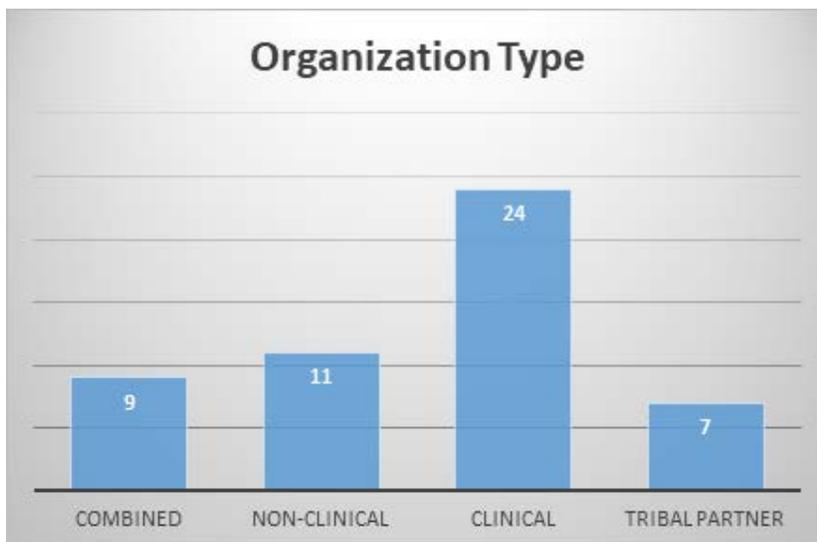
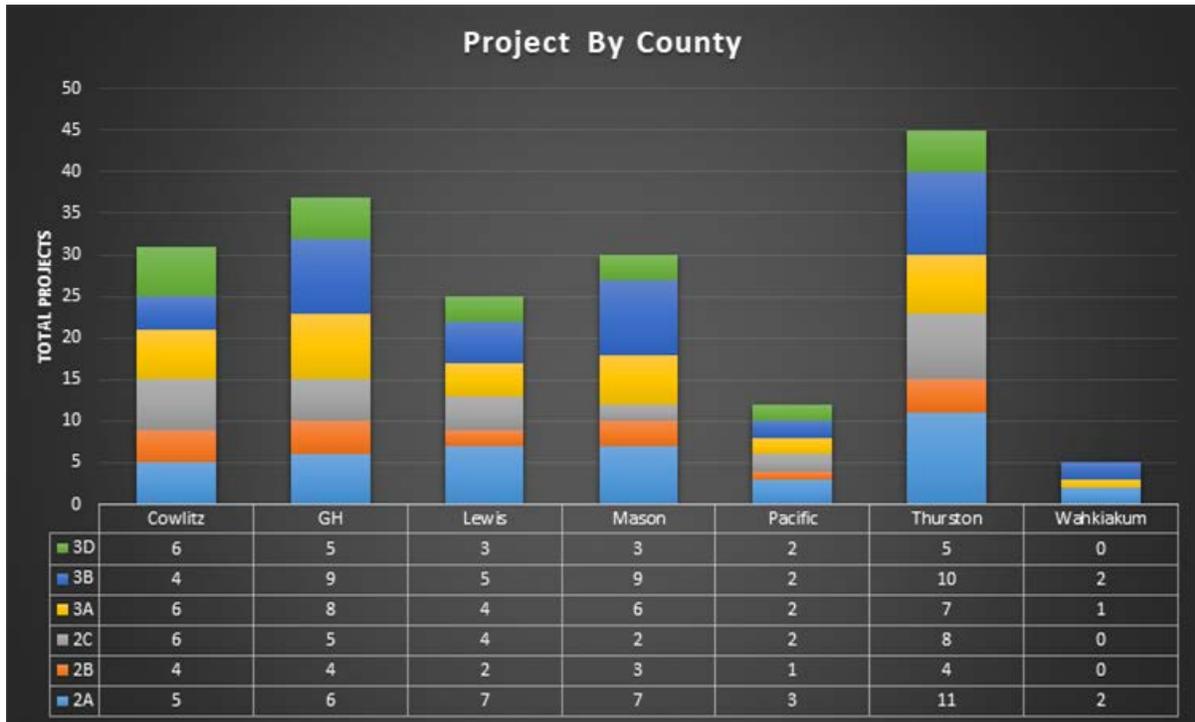


Table 2: MTP Implementation Partners by Project and County



The following section details partner provider project roles from DY2, Q3 through DY3, Q4. The section includes examples that represent all six project areas and all provider types including a tribal partner, a public health partner, a non-traditional CBO providing social services, and a traditional, clinical partner.

Name of Organization: Chehalis Tribal Wellness Center (CTWC)

Provider Type: Tribal Health Clinic

Project Area Involvement: 3A (Opioid Response)

Partnering Provider Roles and Responsibilities: In Washington State, Native Americans are at least twice as likely as the general population to experience substance use disorder (SUD) and three times as likely to die of an overdose.¹ The Confederated Tribes of the Chehalis aim to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports for tribal members experiencing opioid use disorder (OUD), as well as partner with CPAA to identify additional resources for non-tribal community members as necessary to treat tribal members.

¹ www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/12/06/fighting-opioid-abuse-in-indian-country

To accomplish this, CTWC will increase the number of patients who receive SUD screening, increase access to medication assisted treatment (MAT) and other evidence-based SUD treatment, and increase access to recovery supports including traditional healing practices.

CTWC is responsible for continuing to engage in MTP activities, including CPAA’s MTP Implementation Partner kick-off event, CPAA Council and Board meetings, the bi-monthly Tribal Health Directors meeting, and any trainings and shared learnings sponsored by CPAA. CTWC will also work with CPAA staff (directors, program managers, and Community and Tribal Liaison) as necessary to complete their Change Plan. CTWC will submit a narrative report quarterly, report on Change Plan Milestones quarterly, and metrics will be reported semi-annually.

Partnering Provider Key Steps Include:

- Engage tribal leaders and receive approvals
- Identify opioid response team
- Identify data collection or registry (EHR) and report on MAT patients
- Identify evidence-based model/s for project and training
- Determine type and services needed for MAT implementation
- Work with county or other outside entity to implement a syringe exchange program (SEP) on edge/border of reservation
- Identify any current tribal data on SUD-related mortality
- Attend harm reduction training
- Attend trauma-informed care training
- Develop a SUD/ODU prevention plan
- Develop a low-barrier buprenorphine model
- Provide or refer patients to counseling and/or psychotherapy
- Evaluate for service expansion
- Evaluate for additional staffing needs

Name of Organization: Thurston County Public Health and Social Services (TCPHSS)

Provider Type: Public Health

Project Area Involvement: 3A (Opioid Response), 3B (Reproductive/Maternal & Child Health), 3D (Chronic Disease Prevention & Control)

Partnering Provider Roles and Responsibilities: For all project areas, TCPHSS is responsible for continuing to engage in MTP activities, including CPAA’s MTP Implementation Partner kick-off event, CPAA Council and Board meetings, project area work group meetings, and any trainings and shared learnings sponsored by CPAA. TCPHSS will also work with CPAA staff (directors and program managers) as necessary to complete their Change Plan. TCPHSS will submit a narrative report quarterly, report on Change Plan Milestones quarterly, and metrics will be reported semi-annually.

Specific to Opioid Response, TCPHSS operates Thurston County Syringe Exchange Service Program (TCSSP), providing a range of services to people who use injection drugs: sterile syringes (they exchange

over 1 million syringes a year), education on safer injection practices, disposal of used syringes, naloxone training and distribution, and referrals to treatment services. Both a fixed and mobile locations serve Grays Harbor, Lewis, Mason, and Thurston counties. Many individuals who utilize TCSSP have complex needs, including lack of stable housing, food insecurity, justice system-related challenges, etc. 80% of their clients report being enrolled in Medicaid.

TCSSP operates its fixed location in Capital Recovery Center (CRC), another CPAA MTP Implementation Partner, to co-locate services for those with OUD and to complement CRC's clinic, educate TCSSP clients about MAT, and provide referrals to CRC. TCSSP's increased hours of operation will expand existing services and capacity. They aim to identify and develop referral sources and increase client referral to CRC's MAT program (including low-barrier buprenorphine), behavioral health services, recovery supports, and social service supports. Additionally, TCPHSS will increase naloxone education and distribution and enroll providers in the state's prescription drug monitoring program (PDMP).

Specific to Reproductive/Maternal & Child Health, TCPHSS will expand their existing Nurse Family Partnership (NFP) program currently serving families in Thurston, Lewis, and Mason counties. The NFP program starts working with families during pregnancy and continues home visits by a registered nurse (RN) until the child is two. Families partner with their nurse, who provides emotional support, guidance around the mother's health and wellbeing, and helps monitor the development of the child, ultimately impacting positive outcomes not only for the two and a half years of enrollment, but also for the rest of their lives. NFP home visitors also provide counseling around contraceptive care and help women identify contraceptive needs and models that most fit their reproductive intentions.

NFP staff provide mentoring and supportive supervision for newly hired home visitors, conduct outreach to enroll families into the program, support home visitors' charts, and collect data to capture outcomes for families. The NFP supervisor coordinates with other home visiting program managers to explore ways to improve collaboration and the referral process to include a central intake and accessibility for home visiting in our communities. This piece of work is ongoing and critical to ensuring they are offering evidenced-based home visiting to families who are eligible due to income or other risk factors. NFP would also like to learn more about the populations they are serving in the communities by collecting data specific to the tri-county region. This would further allow them to be strategic in utilizing caseloads to maximize the number of clients served and reduce the gaps in services.

Specific to Chronic Disease Prevention and Control, TCPHSS will develop a Chronic Disease Self-Management Program (CDSMP) in Thurston County. A Public Health Nutritionist will serve as the CDSMP Coordinator for the program, putting together the needed trainings and coordinate the actions of volunteers and supplies to deliver the program throughout the community. The CDSMP Coordinator role will hold workshops to meet regional needs, maintain leader capacity, and participate in regional discussions and work groups to help develop capacity for CDSMP in other areas of CPAA.

Partnering Provider Key Steps Include:

For Opioid Response:

- Recruit and hire staff to expand existing TCSSP services
- Train staff in harm reduction principles, trauma-informed care, motivational interviewing, etc.

- Continue building MAT provider network of prescribers for referrals
- Offer monthly harm reduction education/training to community partners and other counties in the CPAA region
- Identify health information exchange/health information technology (HIE/HIT) needs and customize data base to track participant enrollment, SUD screening, patients placed in treatment, housing needs, education needs, etc.
- Increase/enhance naloxone training and distribution
- Develop referral process, patient consent form, data collections
- Develop process for MAT referral – train staff, develop procedures and forms, develop follow-up loop
- Expand partnership network
- Assist/engage in the Thurston County Opioid Response Task Force and Task Force Plan

For Reproductive/Maternal & Child Health:

- Hire and train additional NFP home visitors
- Develop partnerships with other home visiting programs and other organizations like OBGYNs, WIC, and pediatric offices
- Develop a centralized intake for home visiting program in the region
- Convene the home visiting task force to develop warm hand offs and referrals between home visiting programs
- Convene shared learning opportunities like the Mother to Baby Coalition
- Work with the NFP National Service Office on quality improvement efforts and capturing client outcomes
- Participate in CPAA contraceptive counseling training opportunities

For Chronic Disease Prevention and Control:

- Submit request for CDSMP license from Self-Management Resource Center
- Assess CDSMP interest from other organizations in Thurston County
- Conduct outreach that contributes to development of a local network and begins to build regional capacity
- Develop application and evaluation materials for Master/Leader Trainings and workshops
- Recruit for a Master Training in Thurston County (if a minimum of 12 interested Master Trainers are identified)
- Conduct Master Training in Thurston County (minimum 12, maximum 20 participants); if a minimum of 12 Master Trainers are not identified, send one TCPHSS staff and one lay person to Palo Alto, California, for Master Training
- Purchase supplies for CDSMP workshops/leader trainings
- Recruit for Leader Training (if Master Training not conducted)
- Interview potential Leaders for Leader Training and conduct Leader Training
- Recruit for workshops
- Partner with Medicaid providers to refer patients to CDSMP workshops
- Coordinate Leaders for workshops; coordinator to co-lead workshops
- Evaluate Leader Trainings and workshops

- Participate in CPAA project work group to share best practices and encourage development of CDSMP in other neighboring communities
- Complete reporting requirements

Name of Organization: Gather Church

Provider Type: Community-Based Organization (CBO)

Project Area Involvement: 2B (Care Coordination), 3A (Opioid Response),

Partnering Provider Roles and Responsibilities: For all project areas, Gather Church is responsible for continuing to engage in MTP activities, including CPAA’s MTP Implementation Partner kick-off event, CPAA Council and Board meetings, project area work group meetings, and any trainings and shared learnings sponsored by CPAA. Gather Church will also work with CPAA staff (directors and program managers) as necessary to complete their Change Plan. Gather Church will submit a narrative report quarterly, report on Change Plan Milestone quarterly, and metrics will be reported semi-annually.

Gather Church currently has an extensive community outreach in Lewis County. In a community faced with high rates of homelessness and untreated mental illness, Gather Church provides integral social services, meeting people where they are at and guiding them through a sometimes daunting process, persisting as necessary to access the resources and care they need. Their community center is a kitchen, food bank, clothing bank, and helps families procure school supplies. They also have a six-bed transitional living facility, coordinate care, and provide limited transportation assistance. Through these programs, Gather Church is able to connect with young families, individuals in need, homeless, those living in poverty or on the brink of poverty, and people experiencing SUD/OD. Many other local agencies refer people in need to Gather Church because they are known for their ability to coordinate resources.

Specific to Care Coordination, Gather Church will serve their local communities as the Care Coordinating Agency (CCA) using the Pathways Community HUB Model. Although Gather Church is a CBO, they will implement Pathways services in the same way a clinical provider will. As a CCA, Gather Church will provide care coordination services, document their work and the progress of clients in the HUB’s software platform, generate measurable outcomes that the HUB will market to payers, and earn sustainable funding for their care coordination services through an outcome-based payment system managed by the HUB.

In addition to the CCA work of specific CPAA partners, such as Gather Church, all CPAA partners will have the opportunity to participate in the CPAA HUB. Active HUB members will use the Care Coordination Systems (CCS) software platform to increase secure exchange of client information between providers, improve the referral process between organizations, and to identify quality improvement opportunities related to their agency’s MTP CPAA Change Plan. The HUB will provide a venue for all partners to focus on and use data to inform planning and decision-making regarding priority populations. The HUB will also provide members who are payers a mechanism to invest in specific populations within the CPAA

region that makes care outcomes transparent and prevents downstream costs to local systems by identifying, engaging, and activating clients who are at risk.

Specific to Opioid Response, Gather Church is one of only a few Lewis County organizations that intersects with injection drug users and individuals experiencing SUD/ODU. Gather Church has partnered with University of Washington to receive free naloxone to distribute to prevent overdose deaths. CPAA has provided Opioid Response TA including assisting Gather Church in their development of policies and procedures and aligning them with syringe exchange services. Beyond merely handing out naloxone kits, Gather Church has trained their staff in how to use naloxone. They will also provide training for those who are receiving naloxone. Their outreach efforts extend to community education, training, and distribution.

Partnering Provider Key Steps Include:

For Care Coordination:

- Identify Pathways clients from their own clients and connect them to the HUB, as well as receive referrals from the HUB from other referral partners
- Serve the target population identified by the HUB, specializing somewhat based on their agency's expertise (i.e. specialize with clients experiencing substance use disorder and/or homeless/housing concerns)
- Hire care coordinators who have the characteristics of the Community Health Worker (CHW) workforce, such as Peer Counselors, Client Advocates, and others who share lived experiences with the people they serve
- All coordinators and supervisors from CCAs will receive standardized training on CHW care coordinator professional skills, how the Pathways model works, and the CCS software platform utilized by the CPAA HUB
- Work closely with the HUB on continuous quality improvement by reviewing data provided by the HUB's software platform, attending monthly trainings or work sessions with other CCAs and HUB staff, and aligning their own agency operations to produce outcomes for clients through the HUB structure and Pathways model
- New Pathways clients served by Gather Church will:
 - Be assigned by the HUB to ensure care coordination services are not being duplicated
 - Sign a release of information facilitating secure communication about the client between all appropriate providers that are within the CPAA HUB network
 - Receive a standardized assessment to determine all appropriate Pathways based on the client's needs
 - Be scored using the Patient Activation Measure tool to ensure client goals are set based on their readiness to engage in their own care
- Care coordinators at Gather Church will work with clients to achieve outcomes, progressively removing barriers for the client to access care and increasing the client's activation and engagement in their own care:
 - Meet with clients through home visits or in other community settings where the client is most comfortable, at least once a month

- Continue to add Pathways to the client’s care plan as trust deepens and outcomes lead to increased confidence and engagement
- Identify what motivates clients and help to break goals into smaller, actionable steps the client can take
- Support the client with coaching and education
- Advocate for the client to reduce barriers for themselves
- Empower the client to become activated in their own care
- Document all activities including barriers to completing outcomes
- Use the CCS platform to make secure, confirmable referrals for services to participating agencies
- Refer own clients to the HUB for care coordination services
- Receive referrals for services from CCAs
- Use community health record information from the CCS platform in care planning for HUB clients; records are pushed securely to providers automatically when they are documented as a member of the HUB client’s care team
- Contribute to HUB planning on target populations and expansion of HUB services

For Opioid Response:

- Hire and train new staff
- Provide on-going training for staff as needed
- Grow partnerships for referral network with additional behavioral health agencies
- Provide community education and training to coincide with naloxone distribution
- Expand current services into other facilities
- Maintain self-care for staff
- Develop and utilize HIE/HIT for outcomes tracking, client tracking

Name of Organization: Mason General Hospital & Family of Clinics (Mason General)

Provider Type: Public Hospital

Project Area Involvement: 2A (Care Integration), 2B (Care Coordination), 2C (Transitional Care) 3A (Opioid Response), 3B (Reproductive/Maternal & Child Health), 3D (Chronic Disease Prevention & Control)

Partnering Provider Roles and Responsibilities: For all project areas, Mason General is responsible for continuing to engage in MTP activities, including CPAA’s MTP Implementation Partner kick-off event, CPAA Council and Board meetings, project area work group meetings, and any trainings and shared learnings sponsored by CPAA. Mason General will also work with CPAA staff (directors and program managers) as necessary to complete their Change Plan. Mason General will submit a narrative report quarterly, report on Change Plan Milestone quarterly, and metrics will be reported semi-annually.

Specific to Care Integration, Mason General will develop a multi-disciplinary patient-centered care team, including licensed independent clinical social worker’s located in primary care clinics, licensed mental health provider in pediatrics, tele-psychiatry services available for both primary care and women’s

services, a pharmacist, interventional pain management program, nutrition services, diabetes educators, rehabilitation services, and integrated RN case management. Mason General’s behavioral health providers will collaborate with primary care providers through daily patient huddles, standardized process for referrals, integrated workflows, and a shared patient treatment plan. To accomplish this, Mason General will hire and train staff, modify electronic health record (EHR) capabilities, establish new billing lines with managed care organizations (MCOs) for behavioral health integration, and provide adequate space for mental health professionals.

Specific to Care Coordination, Mason General will serve their local communities as the Care Coordinating Agency (CCA) using the Pathways Community HUB Model. As a CCA, Mason General will provide care coordination services, document their work and the progress of clients in the HUB’s software platform, generate measurable outcomes that the HUB will market to payers, and earn sustainable funding for their care coordination services through an outcome-based payment system managed by the HUB.

In addition to the CCA work of specific CPAA partners, such as Mason General, all CPAA partners will have the opportunity to participate in the CPAA HUB. Active HUB members will use the Care Coordination Systems (CCS) software platform to increase secure exchange of client information between providers, improve the referral process between organizations, and to identify quality improvement opportunities related to their agency’s MTP CPAA Change Plan. The HUB will provide a venue for all partners to focus on and use data to inform planning and decision-making regarding priority populations. The HUB will also provide members who are payers a mechanism to invest in specific populations within the CPAA region that makes care outcomes transparent and prevents downstream costs to local systems by identifying, engaging, and activating clients that are at risk.

Specific to Transitional Care, Mason General will be implementing the Transitional Care model with high risk patients being discharged from the hospital to a less intensive care environment. Implementation of this evidence-based model will include pre-discharge patient education, care record transition to primary care provider (PCP), and one-on-one transitional support for a 30-day transition period, which includes establishing access to relevant community resources. This work will be supported by the utilizing of an integrated EHR throughout the hospital and affiliated clinics. Through this integration, patient information is available to all team members, and all information sharing is bi-directional with providers, nursing, support staff, and the various service lines. Chart notes from outside specialists, prior hospitalizations, skilled nursing facilities, and community resources are uploaded into our EHR and shared across the organization. Patients have 24/7 access to their care team.

Specific to Opioid Response, in Mason County, patients with chronic and acute pain have few treatment options. Pain affects not only quality of life, but also family interactions and relationships and work and the ability to work. Mason General will target opioid response for individuals with inadequate control of their co-occurring disorders and/or chronic pain. Implementation of primary evidence-based interventions includes following state prescribing guidelines, identifying opioid alternative pain medication when appropriate, enrolling providers in the PDMP and creating transparency around PDMP data by monitoring/checking before dispensing opioids to identify patients already on opioids, building relationships with behavioral health providers to provide additional supports to individuals experiencing OUD, and prescribe naloxone with all high dose opioid prescriptions.

Specific to Reproductive/Maternal & Child Health, Mason General will embed reproductive health screening questions into their screenings and EHR system, provide contraceptive counseling and access to adolescent patients, foster a strong relationship with Nurse Family Partnership (NFP), and support school nurses who provide back-to-school immunizations. Mason General will leverage the support from their senior leadership to provide additional staff time and outreach to support these projects. In addition to education materials and advertising, Mason General will be designing workflows in advance that recognize the value of including time for patient education and outreach. Mason General also plans to put additional focus on those patients who are non-English speaking or low literacy, especially those whose primary language is a Guatemalan dialect.

Specific to Chronic Disease Prevention and Control, Mason General will be implementing Million Hearts Campaign and Diabetes Prevention Program as a component of their Care Coordination Program to target patients who have two or more chronic diseases, multiple emergency department (ED) visits, and a high no-show rate for clinic appointments. Patients who receive this service will sign or give verbal consent to participate in the program. Depending on their acuity, some patients will also receive monthly monitoring of their care plan, treatment goals, compliance, and disease progression and medication reconciliation.

Partnering Provider Key Steps Include:

For Care Integration:

- Further develop a multi-disciplinary team including mental health professionals, tele-psychiatry, pharmacists, RN case managers, and primary care providers
- Hire advanced registered nurse practitioner (ARNP) and behavioral health coordinator positions
- Develop an interventional pain management program as part of the multi-disciplinary team
- Train multi-disciplinary team on behavioral health integration
- Triage which patients will receive warm hand-offs and who receives tele-psychiatry
- Build partnerships to connect patients to community resources that includes a feedback loop
- Further develop patient registry capacity for depression and anxiety
- Screen patients for depression and anxiety using Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder (GAD-7) screening tools
- Use scorecards to meet treatment targets
- Provide evidence-based psychotherapy including cognitive behavioral therapy, eye movement desensitization and reprocessing, and dialectical behavior therapy

For Care Coordination:

- Identify Pathways clients from their own clients and connect them to the HUB, as well as receive referrals from the HUB from other referral partners
- Serve the target population identified by the HUB, specializing somewhat based on their agency's expertise (i.e. specialize with clients experiencing substance use disorder and/or homeless/housing concerns)

- Hire care coordinators who have the characteristics of the Community Health Worker (CHW) workforce, such as Peer Counselors, Client Advocates, and others who share lived experiences with the people they serve
- All coordinators and supervisors from CCAs will receive standardized training on CHW care coordinator professional skills, how the Pathways model works, and the CCS software platform utilized by the CPAA HUB
- Work closely with the HUB on continuous quality improvement by reviewing data provided by the HUB’s software platform, attending monthly trainings or work sessions with other CCAs and HUB staff, and aligning their own agency operations to produce outcomes for clients through the HUB structure and Pathways model
- New Pathways clients served by Mason General will:
 - Be assigned by the HUB to ensure care coordination services are not being duplicated
 - Sign a release of information facilitating secure communication about the client between all appropriate providers that are within the CPAA HUB network
 - Receive a standardized assessment to determine all appropriate Pathways, based on the client’s needs
 - Be scored using the Patient Activation Measure tool to ensure client goals are set based on their readiness to engage in their own care
- Care coordinators at Mason General will work with clients to achieve outcomes, progressively removing barriers for the client to access care and increasing the client’s activation and engagement in their own care:
 - Meet with clients through home visits or in other community settings where the client is most comfortable, at least once a month
 - Continue to add Pathways to the client’s care plan as trust deepens and outcomes lead to increased confidence and engagement
 - Identify what motivates clients and help to break goals into smaller, actionable steps the client can take
 - Support the client with coaching and education
 - Advocate for the client to reduce barriers for themselves
 - Empower the client to become activated in their own care
 - Document all activities including barriers to completing outcomes
 - Use the CCS platform to make secure, confirmable referrals for services to participating agencies
 - Refer own clients to the HUB for care coordination services
 - Receive referrals for services from CCAs
 - Use community health record information from the CCS platform in care planning for HUB clients; records are pushed securely to providers automatically when they are documented as a member of the HUB client’s care team
 - Contribute to HUB planning on target populations and expansion of HUB services

For Transitional Care:

- Hire and train staff on Transitional Care Model
- Implement required policies and procedures

- Establish notification systems so clinic is notified within 48 hours when one of their patients has an ED visit
- Implement protocols to follow up with patients who had an ED visit within 48 hours of notification of the ED visit
- Establish a process to identify high-risk populations to enroll in evidence-based transitional care practice to reduce readmission
- Examine clinical outcomes, quality of care, patient satisfaction, and use of quality improvement (QI) around established transitional care tool
- Develop workflow for providers to review registry and do active follow-up based on a set of parameters
- Develop a process for connectivity between assigned primary care physician and case manager as applicable; ideally this will include real time notifications
- Establish an EHR with the ability to follow treatment targets clinical outcomes, dates of contact, and to include measures to track unstable housing and transportation
- Develop workflow to assist patients with avoidable ED utilization to make immediate appointments with a primary care physician/behavioral health practitioner with whom they can establish a care relationship
- Establish a workflow to assess and follow up on hospital readmission within 30 days

For Opioid Response:

- Integrate the state's prescription drug monitoring program (PDMP) into EHR
- Develop and implement workflows around "chart scrubbing" before patient appointment
- Develop protocol, provider data transparency, and adherence to state prescribing guidelines
- Report PDMP data to Quality Improvement Council and set priorities for Quality Improvement (QI)
- Put into place Comprehensive Pain Program (CPP): integrated, full-service pain management program with focus on rehabilitation and restoration
- Develop and implement an integrated approach to pain, including referrals to physical and occupational therapy, diet counseling, and other lifestyle choice counseling
- Educate providers and patients on new insights and approaches to non-narcotic pain management
- Evaluate program using individual patient pain scores
- Post signage in ED to inform patients that opioids will only be given for acute pain and cancer-related pain
- Integrate ED EHR/Emergency Department Information Exchange (EDIE) into primary care
- Naloxone prescriptions and resource pamphlets given as needed
- Build stronger alliances with community partners for referrals

For Reproductive/Maternal & Child Health:

- Engage hospital leadership in process for reproductive health screening
- Train clinical staff on appropriate actions related to the patient responses to reproductive health screening question
- Institute consistent documentation of use of the One Key Question (OKQ) for the target population at all appropriate visits

- Increase the outreach of community education about the availability, benefits, side-effects, and the range of contraceptive choices available at Mason General
- Mason General is in the process of working with the local School District to offer education and support around reproductive health for (primarily) teenage girls
- Maintaining and increasing enrollees in the NFP from Mason General patients
- Working with the local school district and their school-based nurses to provide back-to-school vaccinations

For Chronic Disease Prevention and Control:

Million Hearts® Campaign:

- Use standardized treatment protocols for hypertension treatment, tobacco cessation, and cholesterol management
- Leverage EHR systems to excel in the ABCs:
 - Appropriate Aspirin
 - Blood pressure control
 - Smoking cessation
- Implement self-measured blood pressure monitoring (SMBP) interventions with clinical support
- Develop an internal work plan to improve performance on Million Hearts® clinical quality measures on aspirin use, blood pressure control, cholesterol management, smoking cessation, and cardiac rehab
- Utilize one or more action guides (<https://millionhearts.hhs.gov/tools-protocols/action-guides.html>) to inform organization's quality improvement process as it relates to Million Hearts® Campaign
- Become a Million Hearts® Partner through a formal commitment to the initiative

Diabetes Prevention Program

- Choose to either use CDC curriculum or develop their own curriculum and have it approved by CDC
- Obtain Diabetes Prevention Recognition by submitting a Diabetes Prevention Recognition Program (DPRP) Application Form
- Designate and develop workflow for a program coordinator and data preparer
- Hire and train staff in Diabetes Prevention Program
- Hold a sufficient number of class cohorts each year to maintain minimum requirements of program
- Develop and implement marketing strategy to advertise and promote participation in classes

Partnering Provider Engagement

Training and/or technical assistance resources provided by the ACH:

CPAA plans to support partnering providers in project implementation in a myriad of ways. We developed an initial list of potential Domain 1 investments, including partnering provider technical assistance (TA) and training, as seen in the table below. This list is a living document that is updated regularly as needs are identified by CPAA staff and partners. While CPAA is open to providing and/or facilitating any training or TA our partners request, we have only just selected MTP Implementation Partners, so specific areas of need have not yet been identified.

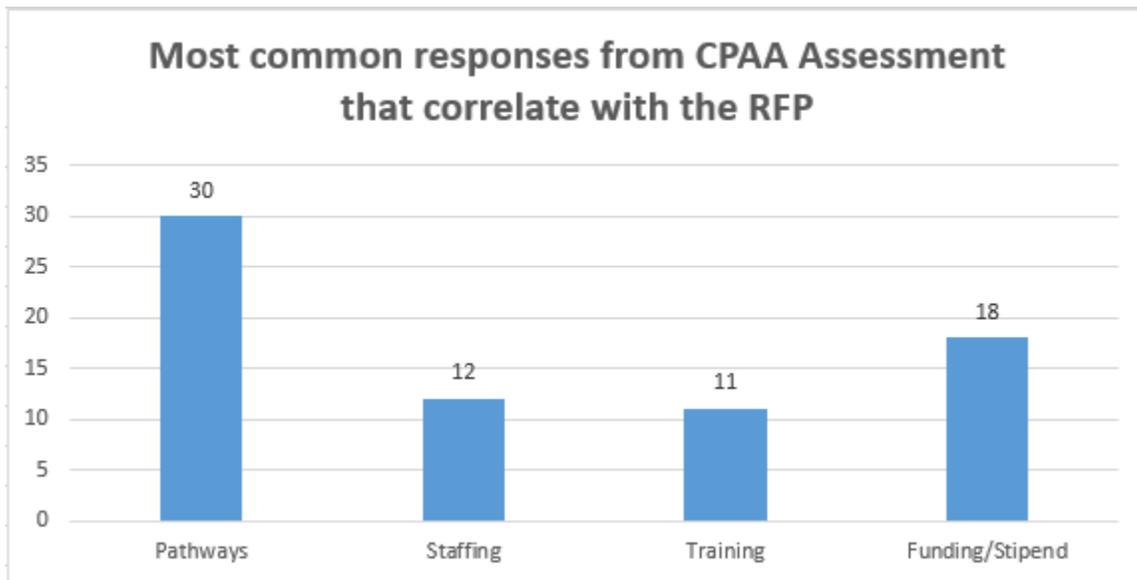
Table 3: Domain 1 Investment Ideas

CPAA Domain I Development Ideas

Topic	Development Ideas	Cross-project examples	Project specific elements
Data & Analytics	<ul style="list-style-type: none"> ➤ Purchase/develop software platform(s) that increase interoperability between organizations and sectors ➤ Partner with Public Health to develop “chief health strategist” capability and workflows ➤ Partner with Providence CORE to increase research and evaluation capabilities ➤ Develop or customize data dashboards that integrate multiple data sets 	<ul style="list-style-type: none"> • Patient risk stratification • Coordination of services • EMR linkage to other systems • Population health surveillance • Data analysis • Evaluation & research 	<ul style="list-style-type: none"> • Patient registries which includes measures to track specific conditions and SDOH • Pathways software • EDIE & Pre-manage • HMIS • One Health Port • Population Health data • Claims data • Evaluation of projects • ROI calculation
Learning Communities	<ul style="list-style-type: none"> ➤ Develop specific training and/or coaching that CPAA staff will offer ➤ Contract with trainers to make various trainings available to partners ➤ Develop an online learning portal ➤ Develop specific communities of practice that support partners learning from each other 	<ul style="list-style-type: none"> • Clinical practice transformation • Trauma informed • Cross-sector integration • Skill building (training & coaching) 	<ul style="list-style-type: none"> • Specific models (e.g. coleman, chronic care, etc.) • Grouping of partners (e.g. geographic, provider type, population served, etc.)
Planning & Policy	<ul style="list-style-type: none"> ➤ Make the RHIP a living document that partners integrate into own planning processes ➤ Identify regional needs, barriers, or gaps that require legislative advocacy ➤ Support the planning work initiated by multiple partners working as a collaborative ➤ Provide data & analysis products to inform the planning of others 	<ul style="list-style-type: none"> • RHIP • Gap analysis • Change management • Legislative agenda • Regional policy agenda 	<ul style="list-style-type: none"> • Project implementation • Program policies & procedures
Administrative Services	<ul style="list-style-type: none"> ➤ Create a suite of back-office support services that increases the ability of smaller organizations and non-traditional Medicaid partners to participate in MTD 	<ul style="list-style-type: none"> • ACH Staffing • Contracting • Back-office support 	<ul style="list-style-type: none"> • Project management • Braided funding • Shared services

CPAA included requests for TA and training in the Change Plan template (Appendix B) distributed to MTP Implementation Partners on September 21, 2018. Although we will not have a list of finalized training requests until November 2018, when we receive completed Change Plans from our partners, because of responses to the State Capacity Assessment, Request for Qualifications (RFQ), and Request for Proposals (RFP), CPAA anticipates some generalized, region-wide trainings requested across all project areas and service providers.

Table 4: Common Domain 1 Requests from MTP Partners



CPAA is planning to provide various training opportunities to partners in our region that are not specific to any one project area. These include, but are not limited to, value-based readiness, quality improvement (QI) resources, motivational interviewing, trauma-informed care and adverse childhood experiences (ACEs), harm reduction principles, bias mitigation, and health equity.

Trauma-informed care/healing-centered engagement is a cornerstone of CPAA’s portfolio of MTP program areas, particularly Opioid Response and Reproductive/Maternal & Child Health, but CPAA is committed to providing training for not only paid MTP Implementation Partners, but also for any provider of services in the region who is interested in learning more about applying trauma-informed care practices. CPAA is working to develop regional trauma-informed care trainings. This includes training for direct service providers as well as training for organizations around policy, including educators, community health workers, dentists, hygienists, law enforcement, community-based and social service organizations that provide outreach, etc.

Similarly, CPAA is pursuing region-wide training on harm reduction principles, which can also be broadly applied to transformative efforts across all project areas throughout the region. Additionally, we are exploring training for recognition and mitigation of bias, as well as cultural humility and linguistically appropriate communications, particularly for our work with the seven federally recognized tribes in the region and with the Medicaid beneficiaries receiving services. Overcoming historical trauma and building trust with affected populations takes time, and CPAA is committed to the process. These trainings would be beneficial not only for CPAA staff and partners, but also for anyone working in outreach or providing direct services to residents in our communities.

CPAA is working closely with Olympic Community of Health and Qualis Health to host a Value-Based Payment and Integrated Managed Care (IMC) two-day conference in October 2018, similar to the

conference held on the east side of the state early this year. Behavioral health providers from across the regions are invited to attend this conference to discuss how to successfully transition to value-based contracts and how to prepare for IMC in 2020 as an on-time adopter.

Specific to Bi-Directional Care Integration, CPAA is offering integrated care training for partners. We identified the University of Washington AIMS Center as a valuable technical assistance partner. They conducted a summer webinar series for our region on whole-person care, and CPAA has contracted to offer the AIMS Center Bi-Directional Care Integration training program to our region in October 2018 and January 2019. After completing an enrollment packet containing a commitment letter, partners will begin the training program as a cohort. CPAA has also found Qualis Health to be helpful by conducting Maine Health Access Foundation Site Self-Assessment (MeHAF) and Patient-Centered Medicaid Home (PCMH) assessments throughout our region and sharing data with us. CPAA is also considering how contracting with Qualis Health through 2019 would be most helpful to all our project areas.

Specific to Pathways, CPAA invested in the Care Coordination Systems (CCS) software platform for all Care Coordinating Agencies (CCAs) in the CPAA region. All Pathways partners, including non-traditional community-based organizations (CBOs) and smaller agencies, receive the same TA and training for care coordination staff in all necessary skills and the use of this technology platform. This TA training is provided by CCS and is hosted at a central location in the CPAA region. CCS training includes two full weeks of instruction and four additional weeks of practicum at CCA sites. After this intense onboarding process, CPAA will continue to facilitate monthly TA and training through structured meetings with CCAs and HUB staff. Additionally, there will be access to HUB staff during business hours for trouble-shooting and TA with the software platform. The HUB staff are able to provide one-on-one support as needed to ensure successful implementation of the Pathways program.

Specific to Reproductive/Maternal & Child Health, CPAA is exploring a relationship with Upstream USA, a nonprofit that provides assistance around implementation, provider training, data tracking, stocking, and workflow development for same day long-acting reversible contraception (LARC) insertions. Upstream USA is also available in a more limited capacity to work with our partners who are doing a LARC access project. Additionally, this project area is also considering working with Power to Decide, a consulting agency that provides training and workflow development to implement One Key Question. CPAA also had a discussion with the national Nurse Family Partnership office, which offered targeted TA for our partners working to expand or partner with NFP services. A follow-up meeting is scheduled for later this fall. Another potential TA resource for Reproductive/Maternal & Child Health is Within Reach, which develops immunization and well-child outreach materials.

Specific to Chronic Disease Prevention and Control, CPAA is looking to contract with a consultant to provide targeted technical support relating to project-specific interventions and quality improvement activities. CPAA is anticipating paying for training and licensing of partners engaging in the Chronic Disease Self-Management invention. CPAA is coordinating a regional training with the California Health Care Foundation to ensure partners are prepared to offer CDSM to people in their region.

How is training and/or technical assistance resources being delivered within that timeframe?

CPAA released the Change Plan template on September 21, 2018, requiring partners submit completed Change Plans to CPAA no later than November 15, 2018. Although CPAA has a high-level understanding of training and technical assistance resources needed based on the Current State Capacity Assessment and RFP responses, partners will finalize specific technical assistance resources needed on the Change Plan. CPAA is prepared to assist with training or technical assistance, delivered in a timely fashion.

Table 5: Training and TA Resources

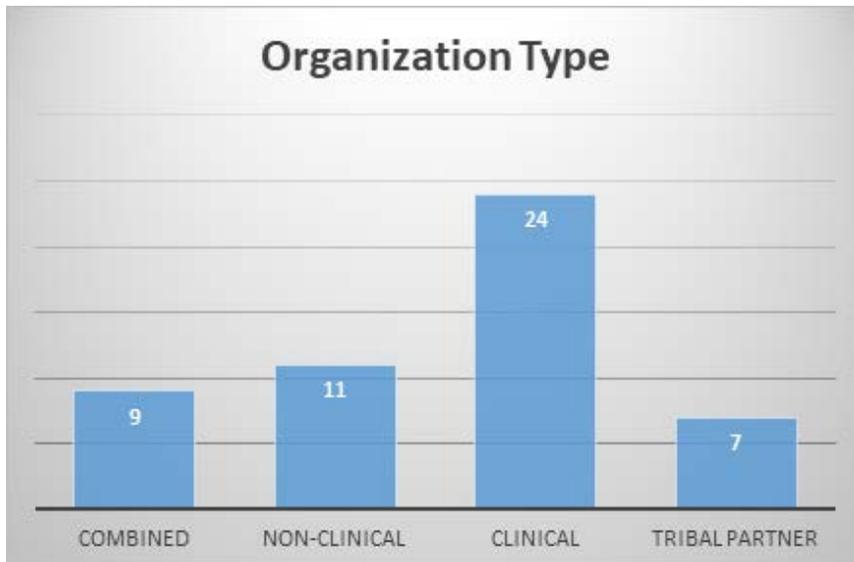
MTP Transformation Activities

External Supports Needed (CPAA Staff, Technical Assistance, Training)		
Supports Needed	Related Intervention	Justification
Potential Implementation Risks (What could go wrong? How could the risk be mitigated?)		
Potential Risk	Related Intervention	Mitigation Plan
Health Equity Activities (How do you use health equity to inform decision making and provide services?)		
Milestone(s)	Related Intervention(s)	Expected Outcome

How is the ACH engaging smaller partnering providers and community-based organizations with limited capacity?

While CPAA cannot anticipate all implementation challenges for all six MTP project areas, CPAA will continue monthly work group meetings and conference calls as needed with MTP Implementation Partners, including clinical providers, smaller, non-traditional, community-based organizations, public health departments, and tribes, to assess and work through those inevitable challenges as they arise together.

Table 6: CPAA MTP Implementation Partners by Organization Type



Although all MTP Implementation Partners are encouraged to take advantage of available resources, we anticipate our 11 smaller, non-clinical, community-based organizations with limited capacity may need more assistance. For example, smaller providers are eligible for training programs and to receive technical assistance from Qualis Health. Additionally, program managers will make themselves available and conduct regular check-ins and outreach calls, particularly to engage smaller providers and non-clinical community-based organizations and ensure their MTP success. CPAA will facilitate local community coalitions, forums, and shared learning opportunities and encourage partner participation. CPAA will also provide targeted technical support based on analysis of data trajectory, including site visits as needed and requested.

Additionally, CPAA offered the opportunity for a one-time payment up to \$15,000 from the Capacity Development Fund (Appendix C). These funds support a broad cross-sector of smaller, regional partners, including community-based organizations and clinical providers who play a critical role in improving community health but were not selected as paid MTP Implementation Partners. These organizations' responses to the RFP proposed innovative ideas and specialty services on a smaller scale, and the funds will support discrete projects, with project proposals due in November 2018.

CPAA also has set aside \$940,715 for the Regional Wellness Fund, which is a pool of funds available to support investments in smaller, community-based organizations that address social determinants of health. These funds will be used to make targeted upstream investments in community-clinical linkages such as affordable housing, economic security, safe neighborhoods, transportation, and access to adequate and healthy foods that complement MTP goals and investments. The fact that many of our partners already routinely assess for needs, barriers, and services demonstrates that they are very aware of the importance of foundational community supports and better communication and care coordination between providers, CBOs, and social service organizations. Moving forward, CPAA intends to encourage partners to scale up both assessing for social support needs and facilitate linkages and referrals to the CBOs and social service organizations that address social determinants of health. CPAA believes the availability of viable solutions and connections to community-based supports will encourage more clinical providers to assess for social support needs in their most vulnerable patients. The target population for this fund is the most economically disadvantaged and vulnerable residents who experience the greatest health disparities. CPAA plans to use Community Forums to identify local needs to make the most impact with these investments.

The seven federally recognized tribes in the CPAA region have a long history of generational trauma and have suffered grievances from both the state and federal government, which has resulted in a general mistrust when working with non-tribal organizations. CPAA is committed to working with tribes in a humble and culturally respectful way to help meet their and the larger region's health care goals and priorities. CPAA understands that building trust with seven different sovereign nations, each with their own priorities, takes time. To support this process, CPAA hired a full-time Community and Tribal Liaison, who has been meeting one-on-one with each tribe in addition to supporting a bi-monthly meeting of the tribal health directors with CPAA. This engagement process allows for strategizing with each tribe how to best support the MTP goals while meeting the tribes' health improvement goals, as well as finding alignment among the seven tribes.

What activities and processes are coordinated/streamlined by the ACHs to minimize administrative burden on partnering providers (e.g., coordination of partnering provider contracts/MOUs)?

To reduce administrative burdens on our partnering providers, CPAA has been intentionally deliberate with the streamlined design of the Change Plan template for MTP Implementation Partners. As each organization's completed Change Plan will act not only as a foundation for MTP health care delivery systems change but also as a tool to map out planning and implementation activities throughout the MTP, a strong, useful Change Plan is critical to MTP success. After working internally to draft a concise Change Plan template that sufficiently captured all the necessary implementation information without being overly burdensome for organizations to complete, CPAA solicited the advice of the Clinical Advisory Committee and a focus group of beta-testers (including a clinical provider, a small, non-clinical community-based organization, a tribal partner, and a public health department) to ensure the Change Plan template was satisfactory for each provider setting. After receiving feedback from the different types of organizations and partners, CPAA made the requested adjustments to the Change Plan template before widely distributing it to the network of Implementation Partners on September 21, 2018.

Additionally, CPAA worked with Providence CORE (CORE) to determine exactly what metrics (Appendix D) to be reported for each evidence-based intervention. By carefully choosing exactly what information needs to be captured and not asking for more, CPAA aims to ensure milestone achievement and alignment with state MTP goal while minimizing our partnering providers' administrative efforts and expenses throughout the entire MTP period. CPAA Operations reviewed the metrics, milestones, and Change Plan templates and intentionally kept contracting with implementation partners as simple as possible, with minimal administrative burdens. Metrics were released to partners in conjunction with the Change Plan on September 21, 2018.

Specifically aiming to further reduce administrative burdens and to assist implementation partners, the Change Plan form for all partners (clinical, CBOs, public health, and tribes) was prepopulated as much as possible, and CPAA encouraged partners to pull information and activities directly from their organization's response to the RFP. To assist in filling out the template and to minimize write-backs, CPAA provided each partner a Change Plan Development Form (Appendix E), which included specific feedback and recommendations to strengthen their organization's Change Plan based on their response to CPAA's RFP. CPAA required some organizations to consult with program managers before completing their Change Plan, and directors and managers are also available to any organization to assist in filling out the Change Plan if requested. CPAA's Community and Tribal Liaison is working with each of the seven tribes individually to assist in filling out their Change Plans.

Additionally, CPAA participates in a five-ACH collaborative managed by the Center for Evidence-Based Policy at OHSU to coordinate and streamline activities and processes across ACHs. The OHSU-ACH collective team convenes regular calls and in-person meetings with the participating ACHs. Agendas are developed collaboratively, and the focus of the collaborative is on identifying and sharing best practices,

pooling resources, providing mutual feedback, developing cooperative strategies, and coordinating efforts and activities wherever possible.

Coordinated and streamlines activities and processes with the OHSU-ACH collective have included:

- Joint engagement with vendors to pursue economies of scale and increase effectiveness or impact through coordination
- A report and crosswalk that distill the funds flow and financial management approaches adopted by all ACHs; the information was derived from Center-led interviews with each of the nine ACHs
- Compiling and sharing best practices; topics have included social determinants of health, consumer/beneficiary engagement, bi-directional integration, contracting with behavioral health providers, internal staffing, evaluation and metrics, investing in the community, and health equity
- A planned workshop dedicated to better understanding ACH successes and challenges pertaining to stakeholder outreach and engagement, provider payments, target populations, and evaluation; this sharing of information has already been critical in informing the ACHs on best approaches to for managing pace, scope, and scaling
- A planned sustainability work group that will bring together the participating ACHs and their regions' Managed Care Organizations (MCO), as well as other potential payers; the goal is to coordinate how the ACHs can establish a shared pathway to future MCO payments based on the identification and performance of key, agreed-upon metrics
- Development of a shared decision tree for vetting and responding to vendor inquiries, with the goal of coordinating between ACHs whenever there is an advantage to doing so

How is the ACH coordinating with other ACHs in engaging partnering providers that are participating in project activities in more than one ACH?

All nine Accountable Communities of Health recognize the importance of collaboration to maximize impact while reducing confusion for partnering providers participating in projects in more than one ACH. ACH Executive Directors and staff communicate on a regular basis not only with each other, but also with Washington State Health Care Authority, Department of Health, and other organizations that are critical to the success of the MTP. This includes weekly group phone calls among the ACHs and monthly in-person meetings of the ACH directors.

While CPAA is committed to coordinating with other ACHs to minimize the burden on partnering providers participating in projects in multiple regions, this presents multiple challenges. Although ACHs across the state share some basic goals and aim to provide uniformity of access and services regardless of location, ACHs are nine different legal entities with very different organizational structures, funds flow models (and thus different contracting), and methods of transformation. Each ACH is at different stages of implementation and doing different work in very different ways; this presents major challenges at both the ACH-level and for partners working with multiple ACHs, especially since, at present, there is not a state-wide mechanism in place for successful cross-ACH collaboration.

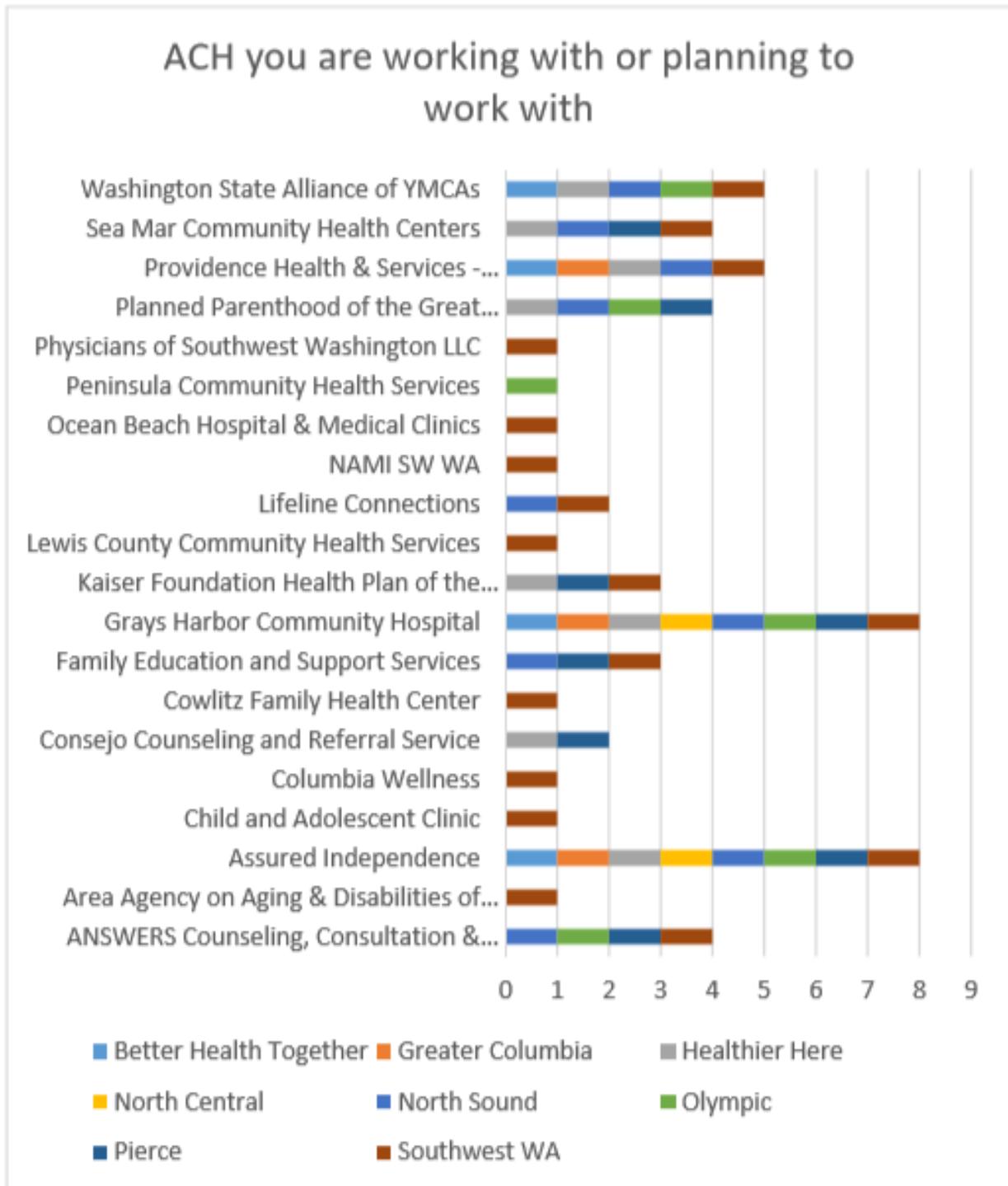
Additionally, specific to Pathways, regardless of whether Care Coordinating Agencies (CCAs) work with multiple ACHs in multiple regions, each HUB is geographically-bound and will have its own contracts with payers and CCAs.

Despite these many challenges, ideally, through the MTP process, ACHs aim to design systems collaboratively and build up infrastructure and resources to ensure a continuum of care throughout the state. One way to move towards that larger, synergistic goal is to begin coordinating meetings and trainings between ACHs to leverage assets and ensure broader participation. For instance, CPAA participates in cross-ACH meetings related to Pathways, including trainings and a monthly call for shared learning and strategic alignment. Cross-ACH collaboration has directly resulted in building common ground among ACHs working on Pathways by identifying shared investment strategies, which are still in early development. We anticipate the individual contracts ACHs have or are entering into with CCS will be transitioned into shared services during the MTP period, creating economies of scale and savings for CPAA and the other participating ACHs.

Already ACHs have created a template to cross-walk partnering providers to identify which ACHs have common partners. Additionally, CPAA has reached out to neighboring ACHs to align transformation efforts, specifically working to identify partnering providers that span ACH service areas. For example, Opioid Response is working with Olympic Community of Health and Peninsula Family Health to increase MAT access in Mason County. There is also discussion with both SWACH and Pierce County ACH to develop a cross-ACH opioid response with the goal of a consistent, base-line level of access and services, particularly along the I-5 corridor, because of the saturation of opioids and the transiency of the OUD population. CPAA aims to model this type of alignment and collaboration for the rest of the project areas and other ACHs.

Another state-wide goal would be to coordinate and streamline reporting tools to reduce burdens on providers working with multiple ACHs. CPAA collected data on those partnering providers working with multiple ACHs in the RFP. Now that MTP Implementation Partners have been selected, CPAA knows 20 of 44 MTP Implementation Partners are working with other ACHs in addition to CPAA. With this knowledge, CPAA can assess individual partner's challenges and work on how best to overcome them.

Table 7: CPAA MTP Implementation Partners Working with Other ACHs



Partnering Provider Management

What are the ACH's project implementation expectations for its partnering providers from DY 2, Q3 through DY 3, Q4?

CPAA will ensure partnering providers are driving forward project implementation. Traditional, non-traditional, and tribal partners all have the same requirements and implementation expectations during this reporting period.

CPAA conducted a Request for Proposals (RFP) from May 30 – June 16, 2018. CPAA partnered with Oregon Health Science University (OHSU) to score the RFP and select up to 45 partners encompassing all seven counties, six project areas, and a combination of clinical and community-based organizations. CPAA announced the 44 selected MTP Implementation Partners, in addition to the seven federally recognized tribes in the region, on August 10, 2018.

CPAA secured contracts with the selected implementation partners, traditional, non-traditional, and tribal, in October 2018. Contracts with partnering providers specified the required scope of work for each implementation partner, reporting requirements, and payment arrangements. CPAA will monitor these commitments by tracking semi-annual progress on project implementation and outcomes for performance metrics per agreed upon contracts with partnering providers.

CPAA gathered critical partner information during the Current State Capacity Assessment, responses to CPAA's RFP, and by requiring all implementation partners, including tribes and community-based organizations, to complete a Change Plan detailing their work. CPAA distributed Change Plan templates to partners on September 21, 2018, with a due date of November 15, 2018. CPAA is keenly aware a well-developed Change Plan with clearly articulated expectations is critical to project success, ensures partner understanding of broader regional transformation goals, and is necessary to monitor progress in upcoming years. Thus, to ensure robust engagement and partner success, CPAA provided each organization feedback specific to their response to the RFP. Additionally, CPAA will host a "virtual town hall" webinar on October 8, 2018, to publicly answer Change Plan questions and walk partners through the process, and program managers and directors are available as needed on an individual basis to organizations requesting assistance completing their Change Plans.

Each organization's Change Plan will be used throughout the entire MTP by both the organization and CPAA. It will outline all reporting requirements and help develop MTP organizational goals specific to project area/s and measure implementation successes: the activities listed in each Change Plan will detail the logical sequence of transformative events over the next four years that will result in each organization achieving MTP goals and vision of improved healthcare. Each Change Plan will define critical paths and key dependencies. The Change Plans are intended to be useable, working documents, and they can be updated as necessary throughout the MTP.

As detailed in the CPAA Project Work Plans, attached as a separate Excel document, CPAA expects all partnering providers, traditional, non-traditional, and tribal, to complete their organization's MTP

project planning during DY2 Q3 and Q4 (October 2018 – December 2018). As contracts with organizations detail, during that time, each partnering provider will:

- Organizational Change Plan
 1. Identify selected interventions/evidence-based approaches for each project area approved during the RFP
 2. Review metrics and report on data source, baseline data, and continuous improvement goals
 3. Update Change Plan
- Pay for Reporting Metrics
 1. Submit quarterly reports to CPAA
 2. Submit semi-annual reports for projects 2A and 3A, as required by HCA, to CPAA
- Contract
 1. Review, sign, and submit contract and scope of work to CPAA
 2. Finalize registration in Financial Executor portal
- Request and Engage in Technical Assistance and/or Trainings
 1. Pathways training
 2. AIMS care integration training series
 3. Webinars
 4. Training forums
 5. Shared learnings
 6. Harm reduction/trauma informed care/equity/culture awareness

Additionally, CPAA encourages all partnering providers, traditional, non-traditional, and tribal, to continue their engagement in working towards regional health improvement for the remainder of DY2. This includes active participation in CPAA's MTP kick-off event (Appendix F); project area work groups, planning committees, webinars, and conference calls, CPAA Board and Council meetings, local forums, and collaboration with other organizations within the CPAA region.

CPAA expects partnering providers, traditional, non-traditional, and tribal, to begin implementing their organization's MTP project during DY3 Q1 through Q4 (January 2019 – December 2019). During that time, each partnering provider will do the following:

Implementation January 2019 – December 2019:

- Begin implementation of approved Change Plan
- Develop infrastructure needed to support Change Plan

- Commit to practice change and quality improvement
- Organizations should provide evidence of improvement either through progress on metrics or on milestones
- Organization should show evidence for expansion or deepening of partnerships, as this will be essential for the "scale up" in DSRIP years
- Meet all implementation timelines submitted on the Change Plans:
 - Report data quarterly to CPAA using the form/tool provided
 - Participate in all scheduled trainings
 - Participate in work groups.
 - Improve clinical and CBO linkages
 - MOUs
 - Meeting summaries
 - Committees/work groups
 - Work plans
 - Participation in forums

Additionally, all CPAA partners will be encouraged and have the opportunity to participate in the CPAA Pathways HUB. Active HUB members will use the Care Coordination Systems (CCS) software platform to increase secure exchange of client information between providers, improve the referral process between organizations, and to identify quality improvement opportunities related to their agency's MTP CPAA Change Plan. The HUB will provide a venue for all partners to focus on and use data to inform planning and decision-making regarding priority populations. The HUB will also provide members who are payers a mechanism to invest in specific populations within the CPAA region that makes care outcomes transparent and prevents downstream costs to local systems by identifying, engaging, and activating clients that are at risk.

What are the key indicators used by the ACH to measure implementation progress by partnering providers within that timeframe?

CPAA will implement a rigorous project monitoring approach to measure partnering provider implementation of the MTP. The same approach will be employed across the entire portfolio of projects. This includes entering into contracts that clearly spell out partnering providers' responsibilities, including reporting requirements, and supports CPAA can offer as well as employing project planning software and tools to lay out required deadlines, key tasks, subordinate tasks, and milestones.

CPAA will use the following key indicators to measure partnering provider implementation progress:

- Change Plan completion
- Utilization of data reporting form/tool
- Partner engagement in trainings and shared learnings
- Partner engagement in committees and work groups

- Partners will be required to report against implementation timeline developed during the Change Plans

As outlined in the contracts, implementation partners are required to report on Change Plan milestones quarterly and pay for reporting metrics semi-annually. Pay for reporting requirements are a combination of HCA measures (for projects 2A and 3A), CPAA measures, and proxy measures developed by partners and approved by CPAA based on implementation plan and data available to partners. Metrics were released to implementation partners in conjunction with the Change Plan on September 21, 2018.

CPAA will combine all measures into a web-based reporting tool, currently still under development, which providers must submit by the end of the first month following every quarter. The reporting tool will feed directly into Tableau, which will be administered by CPAA. CPAA will issue performance dashboards to partners no later than the last day of the second month following every quarter. The set measures will detect when implementation challenges are encountered. This will allow partners to make timely, informed decisions for improving outcomes and meeting project metrics.

Table 8: Quarterly Reporting

Quarter 1 (Jan-Mar)	*Quarter 2 (Apr-Jun)	Quarter 3 (Jul-Sep)	*Quarter 4 (Oct-Dec)
1. Change Plan Progress Report	1. Change Plan Progress Report 2. Intervention Metrics	1. Change Plan Progress Report	1. Change Plan Progress Report 2. Intervention Metrics 3. Change Plan Update
April 30, 2019	July 31, 2019	October 31, 2019	January 31, 2020
April 30, 2020	July 31, 2020	October 31, 2020	January 31, 2021
April 30, 2021	July 31, 2021	October 31, 2021	January 31, 2022
April 30, 2022	July 31, 2022	October 31, 2022	January 31, 2023

What specific processes and tools (e.g., reports, site visits) does the ACH use to assess partners against these key implementation progress indicators?

CPAA will assess partners against these key implementation progress indicators with the following processes and tools:

- What did partners report on their Change Plan
- Pay for reporting measures
 - CPAA will develop a form which will feed directly into Tableau
 - Partners will be required to submit reports quarterly and will have access to all data generated by Tableau that reports on progress
- Pathways CCAs will provide extensive documentation through the CCS software platform – the software will be used to pull regular reports to track progress
- Pathways CCAs are required to attend monthly QI meetings hosted by CPAA Staff
- Quality Improvement tool
- Contract for technical assistance (Qualis Health)
- Site visits as needed and as requested

Access to timely and relevant data will be critical to our ability to monitor project implementation and support continuous improvement; measurement is an integral part of quality improvement. In order to assure alignment with the state MTP goals, CPAA will enter into a contract with each partnering provider based on the projects they were selected for. The contract details the responsibilities of both parties and include key components such as: compliance with the terms of the contract, conditions for and distribution of DSRIP funds, and adherence to product request as stated in the contract Scope of Work such as implementation criteria, participation in collaborative endeavors, reporting requirements, performance elements, and project milestones.

Our goal is to place minimal reporting burdens on our partnering providers while providing CPAA with an effective performance monitoring tool that provides us with timely performance data so that we can actively monitor and track partnering provider performance.

How will the ACH support its partnering providers (e.g., provide technical assistance) if implementation progress to meet required project milestones is delayed?

CPAA will support its partnering providers (e.g., provide technical assistance) if implementation progress to meet required project milestones is delayed with the following:

- Technical assistance from CORE, Qualis Health, AIMS Center, CCS, etc.
- Develop and put in place a Performance Improvement Plan; closely monitor Performance Improvement Plan to ensure improvement
- Facilitate peer mentoring – connect partnering provider with organizations that are doing well
- Conduct partner site visits
- Specific to Pathways:
 - Provide additional training during regular QI meetings
 - Use Pathways HUB Advisory Committee to develop solutions or identify additional resources (if appropriate)

CPAA partners, such as CORE and the AIMS Center, will provide quarterly reports to implementation partners. These reports will serve two purposes: 1) inform providers on where to target their efforts, and 2) advise providers on progress toward meeting required objectives. For example, if a provider is working to reduce readmissions, CPAA will need to advise practices on clients with high hospital admission rates and clients with conditions that put them at high risk for readmission. This will enable provider practices to proactively engage these clients and provide care and patient education interventions to reduce the incidence of readmissions.

When a partner is not making adequate progress on meeting key milestones and metrics, CPAA will reach out and develop a plan of action with the organization to remedy identified gaps or barriers. For example, CPAA and the provider might agree to additional workforce training to assure best practices are fully employed in working with the target population.

If the reports indicate one or more strategies within the project area are not working, CPAA will convene key stakeholders to assess the reasons for the lack in effectiveness. This may include partnering

providers, Clinical Advisory Committee, subject matter experts (e.g., technical assistance providers), and other ACHs that work in a similar project area and are achieving success. Based on this analysis, a recommendation will be made whether to continue the strategy in question with a revised approach or whether to discontinue the strategy in favor of a different one. The decision to change the approach or pursue a different strategy altogether rests with the CPAA Board based on discussion and recommendation by the CPAA Council. However, given their key implementation role, any decision to change elements of a strategy or switch out an entire strategy will require the consent of our partnering providers. It may also require the approval of the state. If the CPAA Board authorizes a different approach or strategy, the project implementation plan will be revised accordingly, and CPAA will enter into a new or revised contract with partnering providers as the case may be.

CPAA will set up a progressive implementation and performance monitoring structure with tiered interventions up to termination of partnering provider contracts. This will include regular meetings with our partnering providers to assess implementation progress and challenges. If project implementation progress becomes questionable or is delayed, the program manager will inform his or her immediate supervisor (Clinical Programs Director or Care Coordination & Educational Programs Director) of the concern. The senior project management team will assess the severity of the situation. When possible, we will seek to mitigate the risk or delay by providing technical assistance to help the partnering provider/s to get back on track. This will include seeking advice from clinical experts, including the Clinical Advisory Committee. The partnering provider and CPAA will agree on an action plan (Performance Improvement Plan) to resolve the issue or renegotiate the contract deliverables, if necessary. In severe cases or if the technical assistance does not correct the problem, the committee may identify additional problem solution strategies, help access additional external technical assistance resources, or engage other key stakeholders in addition to affected providers to remedy the cause of delays. If the problem cannot be resolved, is of a major magnitude, or involves key partners that serve large numbers of Medicaid beneficiaries, the CPAA Council and Board will be informed. The board will make the final decision about modifying or terminating contracts with partnering providers.

Alignment with Other Programs

Project 2A: What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other bi-directional integration efforts in the state?

CPAA is taking great care to facilitate alignment with our region’s collective work to improve bi-directional care integration and avoid duplicative efforts and capacity for this project. This is in keeping with one of CPAA’s foundational principles, namely to build upon existing assets in the region and strengthen existing infrastructure and care systems to the greatest extent possible.

CPAA is actively working to align activities with the following organizations, programs, and services to avoid duplicative bi-directional care integration efforts across the state:

- Pediatric-Transforming Clinical Practice Initiative (P-TCPI) – CPAA regularly coordinates 2A project activities with program staff managing the P-TCPI, including participating in monthly Medical Home Neighborhood webinars, ad hoc check-ins, conference calls, and meetings with P-TCPI leadership and care integration work groups. As P-TCPI has been active in enrolling pediatric clinics and behavioral health agencies in practice transformation, CPAA has identified a crosswalk of clinical metrics and plans to align P-TCPI metrics with the MTP reporting requirements. We strongly believe that partner efforts underway in P-TCPI are laying the ground work to be successful in the MTP.
- University of Washington AIMS Center – CPAA is contracting with the AIMS Center to offer technical assistance to partners in the form of a summer webinar series and bi-directional care integration training program. Both CPAA and the AIMS Center are working collaboratively to achieve a common goal of implementing whole-person care throughout our region. CPAA has supported AIMS Center comments regarding HCA policy changes and regularly disseminates the AIMS Center’s educational/training tools to partners on collaborative care.
- Mental Health Integration Program (MHIP) – CPAA has actively worked with the AIMS Center and Community Health Plan of WA to better understand how clinical metrics required in MHIP can also be built into CPAA’s Change Plan and data reporting requirements. Using information gained through these activities will allow us to limit the data reporting burden on our partners while allowing partners to align important clinical metrics common in VBP contracts.
- Washington Council for Behavioral Health (WCBH) – CPAA’s Care Integration Program Manager attended the annual WCBH conference this year to learn more about priorities and programs across the state involving behavioral health.
- Qualis Health – CPAA regularly collaborates with our region’s Practice Transformation Coach to help connect organizations to coaching, to review PCMH-A and MeHAF data, and to contract for technical assistance. Qualis Health has been a valuable partner in conducting PCMH-A and MeHAF assessments with our partners, which is building the foundation for conducting MeHAF assessment as part of the MTP Pay for Reporting metrics.
- IMC Summit – CPAA was present at the Behavioral Health Forum hosted by the Community Asset Building Coalition for Thurston and Mason counties that focused on preparing behavioral

health agencies for integrated managed care in 2020. Additionally, we are aware of next steps following the Great Rivers BHO Summit on IMC. We are planning to align with the next steps identified from both events by convening any necessary stakeholder meetings and making investments to ease the financial burden on our behavioral health partners.

Project 3A: What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports?

Improving opioid response depends on establishing a coordinated approach for prevention, treatment, and recovery supports across currently fragmented care systems. CPAA is taking great care to align with services and build upon our region’s collective work to ensure the Opioid Response project does not duplicate existing efforts and capacity. One way we are accomplishing this is through the establishment and support of the Opioid Response Work Group, composed of individuals experienced working with the region’s population most affected by the opioid crisis.

There is a great deal of alignment between Opioid Response, Care Coordination, and Reproductive/Maternal & Child Health. A concrete, tangible end-goal to live beyond the MTP is collective guidelines and protocols for dealing with pregnant and parenting drug users for home-visiting programs and care coordinators, a strategy that targets prevention, treatments, and recovery supports and impacts not only mothers, but also mitigates adverse childhood experiences (ACEs) and trauma for the children of those mothers. CPAA aims to facilitate a standardized training, policy, and approach across provider types first throughout the region, and then in alignment with other ACHs across the state, for harm-reduction guidelines like the Yale Method (currently used at Providence, one of CPAA’s MTP partners), which is a trauma-informed and cost-effective way of supporting mothers experiencing SUD/ODU.

Two of our partners will be targeting treatment and recovery support strategies by providing low-barrier buprenorphine access to people using syringe exchange programs: Capitol Recovery Center in Thurston County and Cowlitz Family Health Centers. Additionally, three federally qualified health centers and all of the major health centers in the CPAA are increasing access to MAT. Thurston County Public Health Department will be expanding their syringe exchange services and increasing their referral network into MAT and recovery supports.

Project 2B: How does the ACH align referral mechanisms and provider engagement strategies with the Health Homes and First Steps Maternity Support Services program?

Although care coordination is not new to the CPAA region, the Pathways Community HUB model is a new model of care coordination for our providers. There can only be one certified HUB per service area, and there are no existing HUBs or organizations pursuing certification in our region. Through the CPAA Council, local forums, and the Care Coordination Work Group, CPAA has ensured there is widespread awareness that we are undertaking this project, with CPAA serving as the HUB Administrator. CPAA

created an open RFP process to solicit project ideas from providers for this and other Medicaid Transformation project areas. The RFP process allowed CPAA to identify the initial six Care Coordinating Agencies (CCAs), ensuring all seven counties of the region were covered but not duplicated. These six agencies represent Cohort One, with seven additional organizations preparing to begin implementation in 2019 as Cohort Two.

In early meetings of the Care Coordination Work Group, we identified a need for the Pathways project to align referral mechanisms and engagement strategies while avoiding duplication with the Health Homes model of care coordination that is already implemented across Washington State. Health Homes providers participate in the Care Coordination Work Group, and CPAA will continue to work with these agencies to ensure we target different populations and develop a bi-directional referral process between Health Homes and Pathways.

CPAA and its project partners are well aware of the need to eliminate duplication of care coordination services, and the Pathways Community HUB model is well suited to this effort. Health Homes and Maternity Support Services (MSS) are the first care coordination services the CPAA HUB will target with our referral process and HIT platform capabilities to prevent duplication of services. Our initial six CCAs implementing the Pathways HUB model include organizations that already provide Health Homes and/or MSS, which will give us specific insight into appropriate workflows and technology solutions. We also have support in developing these workflows and technical solutions from senior leadership at Molina, the largest Medicaid Health Plan in our region by patient population size.

We are reviewing example workflows for Health Homes/Pathways referrals, provided by Molina and North Sound ACH, as a key document in developing our protocols for evaluating referrals to the CPAA HUB and ensuring that clients are not enrolled or eligible for other care coordination services. For technological solutions, we are working with the software vendor for our Pathways HIT platform, Care Coordination Systems (CCS), to explore how the platform could be provided to Health Homes and MSS providers in our region, which would integrate these services through a single platform. Alternatively, we could develop data sharing strategies that would allow us to confirm that clients are not eligible or enrolled in these programs prior to enrolling them in Pathways.

What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve care coordination?

Our target population is likely to be eligible and possibly enrolled in a wide variety of care coordination services beyond Health Homes and MSS. Pathways will facilitate alignment with Nurse Family Partnership, Parents as Teachers, Housing and Essential Needs case management, Employment Support Services, clinic-based care coordination, and many other similar services, which can be incorporated into our strategies to prevent duplication of services. We will likely need to explore data sharing agreements with key partners to integrate information from regional or statewide data systems, such as WIN 211, EDIE, HMIS, and others.

How is the ACH's approach aligned with MCO care coordination contract requirements?

Pathways is aligned with MCO care coordination contract requirements, as effective care coordination is critical to MCOs for meeting their contractual obligations and for the health of their business, providing the costliest clients with increased access to the services they need and increasing their engagement in their own care. Multiple MCOs in our region have been active participants in our work groups and planning efforts, ensuring that our target populations are in alignment and to keep open lines of communication. We are designing our Pathways HUB implementation to be mutually beneficial to all agencies in our region providing care coordination services, including those contracted to provide Health Homes.

Project 2C: How does the project align with or enhance related initiatives such as Health Homes or other care/case management services, including those provided through the Department of Corrections?

Improving transitional care vitally depends on establishing a coordinated approach across currently fragmented care systems. Thus, the transitional care strategy is linked closely with behavioral and physical health integration and care coordination between multiple delivery systems. The CPAA partners who have been involved in project planning acknowledged this interdependence repeatedly. CPAA is taking great care to align with our region’s collective work to improve transitions of care and avoid duplicating existing efforts and capacity. This is in keeping with one of CPAA’s foundational principles, namely to build upon existing assets and capacities in the region and strengthen existing infrastructure and care systems to the greatest extent possible.

Transitional Care directly aligns with many Health Homes and case management services in that the interventions of each target the most at-risk populations for adverse health outcomes to prevent negative health events in the most cost-effective way. While the transitional care evidence-based practices that CPAA will be coordinating implementation of use a variety of decision support tools to support care management interventions, Health Homes utilize the Predictive Risk Intelligence System (PRISM) score of 1.5 or greater to identify high risk patients. CPAA enhances and does not duplicate the efforts of Health Homes as our interventions will target populations who are at risk of adverse health events but may not be eligible to receive Health Home services. In this way, we can coordinate activities to further the reach of the prevention efforts in the region and ensure that the individuals who need the most care are able to access that care at the right time.

In a similar way, CPAA aims to support partnering organizations in the adoption of the evidence-based transitional care practice that most aligns with the needs of their organization and populations served. While each of the four evidence-based practices CPAA are supporting screen and provide intervention in a unique way, they are mutually reinforcing; they extend the prevention efforts in the region by detecting and providing tailored care management to diverse high-risk populations.

CPAA does not currently have any specific interactions with Department of Corrections but through our portfolio approach, we aim to incorporate alignment with transitional care evidence-based practices

into the practices of local Department of Corrections and sheriff's departments through targeted technical assistance and distribution of money from CPAA's Wellness Fund.

What additional programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve transitional care services?

CPAA aims to build further community connections and collaborate with local organization to facilitate alignment when possible. We are in the process of compiling an interactive data map of the evidence-based practices of partnering organizations in the region. This will be a valuable tool when evaluating and promoting further alignment of transformation of work in our region. As our work progresses, we hope this will also be a tool to expand the partnerships of partnering providers to further support their work.

Project 3B: How do the ACH's partnering providers align with and avoid duplication of Maternal Support Services? How will the project strengthen or expand current implementation of Home Visiting Models?

CPAA is supporting the expansion of Nurse Family Partnership and Parents as Teachers to hire additional home visitors, with special attention to bilingual home visitors to reach more diverse families. CPAA will not be directly funding expansion or operations of Maternity Support Services (MSS) in the region. For partnering providers in the CPAA network who offer MSS services, CPAA will encourage engagement and facilitate alignment on how they could better partner with other home visiting services. Currently, Nurse Family Partnership and Parents as Teachers do not have a working relationship with MSS. One of CPAA's goals for the transformation project is alignment between the various home visiting programs active in the region so that families are referred to the home visiting program that most suits their needs. Additionally, CPAA will encourage partners who do have a MSS program will work with families to improve outcomes for HCA identified metrics such as immunization, well-child visits, and sexually transmitted infection screening rates for their patients.

What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve access to high quality reproductive and maternal/child health care?

CPAA will ensure that their home visiting activities align with a regional home visiting coalition that brings Nurse Family Partnership (NFP), Family Education Support Services (FESS), and Parent-Child Assistance Program (PCAP) together.

CPAA will also be funding a project with Planned Parenthood to provide telemedicine for patients in Nurse Family Partnership. This app-based health service will support family planning services and access to birth control.

CPAA is working with Upstream USA to support provider training on long acting reversible contraceptive (LARC) insertion for women of reproductive age. Currently, LARC accessibility and demand is very limited

in many of the CPAA counties. Working with Upstream USA, CPAA hopes to improve both community awareness of the LARC method, as well as provider capacity to provide LARC services.

CPAA is also working with the Pediatric-Transforming Clinical Practices Initiative (P-TCPI) to continue the momentum of the quality improvement projects aimed at increasing well-child visit and immunization rates. These were priorities of P-TCPI, and many providers have had success implementing patient recall systems, patient text reminders, and provider reminders that have improved the uptake of their well-child visits and immunizations. Building on the success of these programs, CPAA will be able to support additional providers implement quality improvement projects through peer learning, as well as more targeted quality improvement projects to reach more difficult populations.

Supporting school-based health centers doing family planning will help engage difficult to reach populations. CPAA hopes to facilitate shared learning between school-based health centers in the region, with support from statewide school-based health center services.

Project 3D: What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve chronic disease management and control?

CPAA aims to build further community connections and collaborate with local organization to facilitate alignment when possible. We are in the process of compiling an interactive data map of the evidence-based practices of partnering organizations in the region. This will be a valuable tool when evaluating and promoting further alignment of transformation of work in our region. As our work progresses, we aim to also use this as a tool to expand the partnerships of partnering organizations to further support their work. We will also be taking a coordinated approach with our partnering organizations in the implementation of chronic disease education programs (Chronic Disease Self-Management Program, Diabetes Prevention Program, and Million Hearts Campaign). Currently, the delivery and coordination of these programs is disjointed, classes are difficult for consumers to find, and the classes that are available often have subpar graduation rates and are being delivered below recommended class capacity. CPAA aims to provide targeted technical assistance to promote efficient delivery, increased availability, improved convenience of classes for consumers, and build effective community connections to link consumers to valuable resources in the community.

Regional Readiness for Transition to Value-Based Care

What actionable steps are partnering providers taking from DY 2, Q3 through DY 3, Q4 to move along the VBP continuum? Provide three examples.

CPAA has facilitated and encouraged partnering providers taking actionable steps to move along the VBP continuum. CPAA promoted HCA's VBP survey in project work groups, multiple newsletters, and in an email to our broad stakeholder group. As part of a broader educational piece, CPAA has informed partners of VBP readiness tools and linked providers to VBP resources. CPAA is working with Olympic Community of Health and Qualis Health to host a VBP conference in October 2018, similar to what was held on the east side of the state in August 2018. Several MCOs have agreed to help sponsor this highly-anticipated event.

Additionally, CPAA has taken care to align MTP project design with VBP incentives and incorporate value and sustainability. CPAA also collaborates with MCOs to ensure we are promoting coordinated approach/strategies to VBP and facilitates communication between MCOs and providers to learn more about what it will look like with MTP is over and health care delivery systems transformation is achieved.

Three examples of actionable steps taken by partnering providers include:

1. One organization is in the terminal year of their accountable care organization (ACO) and discussing with the Centers for Medicare & Medicaid (CMS) on how to make the ACO more effective if given a six-month extension. At the end of this ACO agreement, this organization will start assuming some downside risk in a VBP arrangement. Additionally, they are discussing with CMS the possibility of starting their own ACO.
2. Another actionable step is related to participating in a model in which both the health care organization and MCOs have mutually shared risk. This is a result of successful partnerships over the last three years and discussion how to improve the next round of contracts involving healthcare effectiveness data and information set (HEDIS) measures.
3. Partners will focus a growing number of VBP contracts on behavioral health metrics such as early engagement and depression response or remission. Rather than a pass/fail metric, there is an increasing goal to move into contracts with downside risk and shared risk.

What is the role of the region's provider/practice champions as it relates to providing guidance to regional partners in support of value-based care goals?

The VBP provider champion will focus on supporting regional partners in a number of topics related to quality improvement, provider engagement, and interfacing with MCOs. Some of the challenge in moving to value-based care result from a lack of readiness, mostly on the part of smaller health care organizations. The champion will serve to share lessons learned through contracting, discuss successful improvement on specific HEDIS metrics or care models, educate partners on how to approach MCOs, and help facilitate necessary connections to MCOs or other relevant organizations. As the VBP provider

champion is well versed in ACO memberships, CMS requirements, VBP best practices, this is a crucial asset for CPAA to employ across our region.

Regional Readiness for Health Information Technology (HIT) / Health Information Exchange (HIE)

Based on Request for Proposal (RFP) responses, 44 paid implementation partners (a combination of provider types including clinical and CBOs) were selected in addition to the seven federally recognized tribes in the region. Program managers, directors, and the Community and Tribal Liaison are currently assisting these partners in the development of their organization's Change Plan, which includes milestones that directly address bi-directional communication, referral, and data sharing strategies. Completed Change Plans are due in November 2018. CPAA will collect this information and catalogue HIT/HIE, communication, and data sharing strategies. We can then review, discuss, and assess individual partner's HIT/HIE needs, as well as regional needs, and do a cross-analysis of potential technology platforms to determine what would be most effective for our region as a whole. After assembling a "menu" of in-house TA skills and expertise, CPAA will coordinate outside contracts with subject area experts as needed. Moving forward, to facilitate information sharing between integral partnerships that address essential gaps in care, CPAA will simultaneously be strengthening key partnerships and, once established, will be providing targeted technical assistance to strengthen information sharing within these partnerships.

What actionable steps are the ACH taking to facilitate information exchange between providers at points of care? Provide three examples.

1. Care Coordination Systems (CCS)

Early development of our Care Coordination project identified specific Domain I needs for successful implementation, including the ability to share care plans between providers (both clinical and community-based organizations providing social services and supports) through Health Information Technology (HIT). Initially, CPAA contracted for TA from experts in the Pathways model to help us understand the requirements within the model for workforce supports and HIT. One of our TA partners, Foundation for Healthy Generations, is currently in the process of becoming a certified master trainer in a curriculum specifically designed for the Pathways model. CPAA plans to utilize this resource to provide training, free of charge, to the Care Coordination Agencies partnering with us to implement the Pathways model.

Part of the HIT functionality desired in our region includes the ability to better share client information across providers and to improve the coordination of referrals for services outside of the Pathways program. After careful consideration of several software platforms that would support the Pathways project, CPAA elected to contract with Care Coordination Systems (CCS) for their software designed for Pathways. The CCS platform was purchased in May 2018 for both implementation of the Pathways model and for its capability to add additional HIT functionality desired by our broad set of partners.

CCS provides a "community health record" in alignment with a patient's clinical health record. Health is more than health care, and with CCS, the entire care team is able to access the patient's entire health record to facilitate whole-person care. CCS captures and reinvests the value we are generating through the MTP; selling outcomes is how Pathways will become sustainable.

Currently, CPAA is implementing CCS with Pathways community-based care coordinators, but we are exploring the potential to bring other care coordinating systems and models (such as Health Homes and Nurse Family Partnership, which is piloting CCS this fall in North Central ACH) into the CPAA-administered HUB under CCS. Other state-wide ACHs implementing Pathways have confirmed state-wide connectivity is the MTP end-goal, and while each region is busy getting their own system up and running, CCS is a willing partner to integrate the platform state-wide when ACHs are ready.

2. HealthBridge

HealthBridge is a universally accessible online portal anyone with internet access can use. Our partners asked for a system to help with follow-up and “closing the loop” and mitigating barriers with referrals, and HealthBridge makes referral resources CCAs use visible and useful to everyone in the region, adding another layer of functionality we are working to create. Providers and patients can track and catalogue referrals in real-time, request appointments, track how long it takes to get an appointment, record whether or not the appointment is kept, etc. HealthBridge is also a potential future method of referring a patient into the Pathways program. HealthBridge benefits the entire region, not just MTP partners, because the more users accessing the platform, the most useful it becomes: it generates regionally-specific information to identify gaps and resources and can increase patient satisfaction by offering after-hours communication with providers.

CPAA has already invested in this platform, there is no cost to users (both providers and patients), and we are currently exploring the possibility of incentivizing usage. Pathways referral coordinators will be keeping the information up-to-date. While HealthBridge is currently under development, regional 211 information is already uploaded into the platform.

3. Collective Medical Technologies (CMT) - Emergency Department Information Exchange (EDIE)/Pre-Manage

EDIE and Pre-Manage collects and shares, in real time, actionable information and data from hospitals, clinics, payers, behavioral health, long-term care, and care management. Most of the hospitals in the state already use EDIE, increasing the regional reach and improving state-wide HIE goals and acting as a catalyst for community and regional collaboration. Because Pre-Manage is directly integrated with the hospital EHR, no additional data entry or work steps are required; patient information is immediately and automatically sent to Pre-Manage, providing a “snapshot” at the time of care. Pre-Manage automatically cross-references patients with prior ED and inpatient visits, independent of location. If a visit triggers a pre-set criterion (i.e. an opioid prescription alert), Pre-Manage notifies, usually within seconds, the hospital, the patient’s primary care provider, and health plan. Notifications contain visit history, diagnoses, prescriptions, guidelines, and other clinical meta data. This means the ED provider has the critical information in hand before they see patient, and health plan and other care providers are aware of the patient’s location and potential needs; providers better able to make informed care decisions.

The CMT network exists to ensure providers are better able to make informed care decisions and connect all parts of our complex healthcare system to solve specific needs: addressing avoidable ED utilization, addressing our nation’s opiate epidemic, enhancing care coordination and care management to get patients the services they need, and to assist with administrative simplification and efficiency of healthcare operations. While the current platform does not allow CBOs to access a patient’s care plan, CMT is exploring expansion of their system to incorporate the entire care team, including social services and foundational community supports.

How is the ACH leveraging Transformation incentives, resources, and activities to support statewide information exchange systems?

CPAA strongly believes it is not the ACHs’ role to increase administrative work for providers, and we continue to actively look to the state for HIT/HIE guidance and priorities. ACHs cannot accomplish MTP HIT/HIE goals alone; HIT/HIE must be sustainable over time.

CPAA is exploring potential incentives for partnering providers who participate in statewide information exchange systems. The current funds flow model has not budgeted specifically for such incentives, and any changes to the model must go through the CPAA Finance Committee, and then to the council and board for approval.

CPAA supports the use of the State Prescription Drug Monitoring Program (PDMP) in the Change Plans. We are exploring providing the “patch” for providers wanting to use their existing EHR system with PDMP. CPAA is also promoting the state’s MyIR immunization data system that can be used by providers in different settings (schools, day care, head start, etc.) as well as parents. The Reproductive/Maternal & Child Health Work Group is developing an educational awareness and outreach piece to let parents know this information is available to them.

Part of CPAA's strategy for HIE/HIT investments related to Pathways has been to explore potential partnerships with other ACHs that are implementing this program. CPAA helped to convene initial cross-ACH conference calls on this topic and remains an active participant in these discussions. Albeit still in early development, cross-ACH collaboration has directly resulted in building common ground among ACHs working with Pathways by identifying shared investment strategies. We anticipate the individual contracts ACHs have or are entering into with CCS will be transitioned into a shared services agreement during the MTP period, creating economies of scale and savings for our ACH and other participating ACHs around the state.

CPAA also continues to contract with CORE to provide TA and data support. CORE recently applied for and was approved as the recipient of one of a few no-cost licenses on behalf of several ACHs, including CPAA, for the new Washington State All-Payer Claims Database (APCD) Analytic Enclave. As the data use cases and data products from the APCD Enclave are developed over coming months, CPAA will continue to look for opportunities to inform Domain 1 strategies, particularly related to understanding the transition to value-based payment (VBP) occurring across the region. CPAA will combine learnings from the APCD data products provided by CORE with information provided in the state’s VBP survey and its own assessment to better understand provider barriers and needs related to VBP.

CPAA supports transmission of information to OneHealthPort (OHP) and the Clinical Data Repository (CDR). Now that we have selected our MTP Implementation Partners, CPAA is conducting an assessment of who is using OHP and who is not, in addition to learning which providers are participants and which are actively exchanging information. After this data is collected, we will reach out to those providers who do not use OHP or who do not actively exchange information and discuss barriers to their involvement. This may include a training/education piece, connection with providers who are using the system to share their experiences, and providing a roadmap for robust participation.

Technical Assistance Resources and Support

What technical assistance or resources have the ACH identified to be helpful? How has the ACH secured technical assistance or resources?

CPAA has received technical assistance from numerous providers. We are coordinating activities and TA with our colleagues at Qualis Health and the Pediatric Transforming Clinical Practice Initiative to ensure partners are receiving clinic-based TA. We are also in discussions with both organizations to understand how investments in their TA services could further support our implementation partners throughout the MTP.

CPAA also continues to contract with CORE to provide TA and data support. CORE recently applied for and was approved as the recipient of one of a few no-cost licenses on behalf of several ACHs, including CPAA, for the new Washington State All-Payer Claims Database (APCD) Analytic Enclave. As the data use cases and data products from the APCD Enclave are developed over coming months, CPAA will continue to look for opportunities to inform Domain 1 strategies, particularly related to understanding the transition to value-based payment (VBP) occurring across the region. CPAA will combine learnings from the APCD data products provided by CORE with information provided in the state's VBP survey and its own assessment to better understand provider barriers and needs related to VBP.

Specific to Bi-Directional Care Integration, CPAA identified the University of Washington AIMS Center as a valuable technical assistance partner. They conducted a summer webinar series for our region on whole-person care, and CPAA is in contract negotiations to offer the AIMS Center Bi-Directional Care Integration training program to our region later in 2018. CPAA has also found Qualis Health to be helpful by conducting MeHAF and PCMH assessments throughout our region and sharing data with us. CPAA is also considering how contracting with Qualis Health through 2019 would be most helpful to all our project areas.

Currently, the Chronic Disease project area does not offer TA, but CPAA is exploring having exemplary partners take on a leadership and training role for assistance when required. Additionally, CPAA continues to meet with local subject matter experts to provide targeted technical assistance as necessary. For example, CPAA works with Providence CORE for data and metrics support. CPAA continues to seek out organizations that can provide insight into best practices when implementing tool kit interventions.

Reproductive/Maternal & Child Health is exploring a relationship with Upstream USA, a nonprofit that provides assistance around implementation, provider training, data tracking, stocking, and workflow development for same day long-acting reversible contraception (LARC) insertions. They are available in a more limited capacity to work with our partners who are doing a LARC access project. Additionally, this project area is also considering working with Power to Decide, a consulting agency that provides training and workflow development to implement One Key Question. CPAA also had a discussion with the National Nurse Family Partnership Office, which offered targeted technical assistance for our partners working to expand or partner with NFP services. A follow-up meeting is scheduled for later this fall.

Another technical assistance possibility is Within Reach, which develops immunization and well child outreach materials.

CPAA invested in the Care Coordination Systems software platform for all CCAs in the CPAA region. All Pathways partners, including non-traditional community-based organizations (CBOs) and smaller agencies, receive the same TA and training for care coordination staff in all necessary skills and use of technology platform. This TA training is provided by Care Coordination Systems and is hosted at a central location in the CPAA region. Care Coordination Systems training includes two full weeks of instruction and four additional weeks of practicum at CCA sites. After this intense onboarding process, CPAA will continue to facilitate monthly TA and training through structured meetings with CCAs and HUB staff. Additionally, there will be access to HUB staff during business hours for trouble-shooting and TA with the software platform. Additionally, the HUB staff are able to provide one-on-one support as needed to ensure successful implementation of the Pathways program.

How has the ACH secured technical assistance or resources?

CPAA secured technical assistance or resources through contracting, primarily funded by Domain 1 funds. CPAA collaborated with other ACHs, DOH, and HCA to identify possible resources. Vendors were also given the opportunity to respond to CPAA's RFP, illustrating how they can engage in specific project areas. CPAA is working closely with other ACHs in an effort to align technical assistance not only for cost savings, but also to avoid confusion with shared partnering providers.

What technical assistance or resources does the ACH require from HCA and other state agencies?

The burden of sustainability lies heavily on the state, with HCA and legislatures providing clarity and sustainable contracts. First and foremost, if the MTP is to indeed become sustainable, funding must come from patient outcomes. There are many value-based payment concerns that require clarity between state agencies regarding what MCOs will pay for and what they will not. Moving forward, there are also concerns requiring state-wide clarity about who will pay for the services the BHOs currently pay for. There is also a need for state advocacy for increased Medicaid reimbursement rates, and providing adequate financial incentives for quality of care, not quantity, is key to supporting sustainability of the MTP.

Workforce shortages continue to be a concern for CPAA. Multiple organizations have current openings they are unable to fill due to a lack of qualified applicants. CPAA anticipates this problem will not only persist but continue to grow as all nine ACHs across the state seek to expand the often specialized workforce necessary to implement MTP programs. Regional workforce shortages are compounded by the fact that Medicaid traditionally reimburses at a lower rate than commercial health plans or Medicare. Because of this, fewer providers, in a region already suffering from provider shortages, are accepting Medicaid patients compared to commercial plans. As a consumer on our Consumer Advisory Committee stated, being on Medicaid is, in itself, a barrier to care and a health equity concern. Providers

are uncertain on how to best engage this population while moving forward with value-based care, knowing Medicaid beneficiaries are most vulnerable, have some of the worst health outcomes, and will be difficult to engage in preventative care.

One solution to regional workforce shortages and the resulting lack of access to care is support at the state level for expanding the scope of practice for current providers and allowing for reimbursement on additional billing codes. This would allow providers to increase capacity immediately, without relying on additional hires, which may not be available. For example, behavioral health licensing and policy barriers are one of the biggest threats to successful physical and behavioral health care integration. Approving general behavioral health integration codes would significantly impact long-term sustainability of integrated care, alleviate initial financial costs to develop an integrated care program, and allow organizations more flexibility to adapt core principles of collaborative care to their specific practice settings. In addition, it would be helpful to streamline the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, dental health aide therapists, community health workers, Peers, and behavioral health care coordination, to lessen the costs of hiring, and increase the frequency of recovery coach and Peer training. We cannot transform rural areas without telehealth, and CHWs being billable/reimbursable for their integration into care teams is necessary for whole-person health and health care systems change. Support at the state level for stronger recruitment and tuition support would also help address the workforce shortages.

There is a vital need for consistent use of evidence-based guidelines and common standards of practice, especially for opioid response interventions. Standardized process for naloxone distribution, such as how to identify, screen, and prescribe; MAT also needs a standardized protocol for initiation of treatment in EDs. Opioid response needs statewide support for state-level advocacy for standardized response to pregnant and parenting women with OUD.

To successfully implement the MTP project areas, we need interoperability between electronic health records (EHRs), not only within our region but across the state. However, ACHs do not have the expertise or funding needed to bring about this statewide change. ACHs, in collaboration with Health Care Authority, are working to identify potential funding sources that could be used for the 10% state match under HITECH and MMIS funding.

HCA and ACHs, in collaboration with stakeholders and partners including the Washington State Association of Public Hospital Districts, the Washington Hospital Association, and Systems for Population Health Management will identify topics for an on-going Educational/TA series on HIT/HIE. HCA currently hosts a monthly Health IT Operational Plan meeting to develop and expand health information technology and health information sharing. During this monthly meeting, CPAA is able to share concerns and ask for additional assistance with Domain 1 resources related to HIT/HIE.

CPAA continues to look to Health Care Authority for guidance on the ACHs' role in moving towards whole-person care and value-based payment, especially regarding guidance for rural health providers. CPAA has sought guidance from providers, BHOs, MCOs, and HCA on how we can best support this transition. CPAA can act as a convener to enhance the collaboration of cross-sector agencies to reach

the region's VBP goals. As an ACH, CPAA would benefit from additional training on VBP readiness and to fully understand our role in supporting VBP contracts between HCA, MCOs, and provider organizations and how best to provide VBP support, incentives, and resources to our partnering providers.

CPAA would benefit from HCA lessening the narrative reporting burden, which currently necessitates an unsustainable amount of ACH resources to accomplish. CPAA would also benefit from a HCA-sponsored summit or conference on MTP to share lessons learned across the state, collaboration on the metrics HCA is having partnering providers report on currently so we can promote alignment, regions that have successfully implemented school-based health centers, and policies and procedures that support services that address social determinants of health. State agencies that could support this effort include Vaccines for Children, Office of Child Profile, First Steps, and the Department of Children, Youth, and Families.

What project(s)/area(s) of implementation would the ACH be interested in lessons learned or implementation experience from other ACHs?

CPAA would benefit from a HCA-sponsored summit/conference on the MTP to share lessons learned across the state including making plans for implementation. CPAA is interested in learning more from other ACHs and state agencies about VBP preparedness, alignment strategies with MCOs, supporting continuous improvement initiatives with partnering providers, measuring effectiveness of community-based organizations offering services that address social determinants of health, and how we can best develop reporting tools to coordinate and reduce administrative burden of partners, especially those working with multiple ACHs. CPAA could benefit from lessons learned about best practices around collaboration between Maternity Support Services and other home visiting programs, best practices around school-based health centers in regions that have school-based health centers, contracting with care coordinating agencies, and sustainability planning. CPAA is interested in learning more from other ACHs about VBP readiness resources, especially for smaller and/or community-based organizations, developing and implementing successful low-barrier MAT programs, and using collaborative care to better serve patients with SUD/OD. CPAA would be interested in learning about other ACHs' TA to their partners and what has been most effective: webinars, one-on-one meetings, large meetings, etc. Additionally, CPAA would be interested in developing and coordinating alignment between the other ACHs and MCOs, as well as a shared Pathways contract.

Appendixes



CPAA Announces Medicaid Transformation Project Implementation Partners

CPAA, through an independent assessor, has selected 44 organizations, in addition to the 7 federally recognized tribes, to be part of CPAA's network of paid MTP Implementation Partners. We are looking forward to this new phase of health care delivery system transformation work. Congratulations to the following partners:

ANSWERS Counseling, Consultation, and CM
Area Agency on Aging & Disabilities of SW Washington
Behavioral Health Resources
Capital Recovery Center
Cascade Mental Health Care
Catholic Community Services Family Behavioral Health
Child and Adolescent Clinic
Child Care Action Council
Coastal Community Action Program
Columbia Wellness
Community Action Council
Community Youth Services
Confederated Tribes of the Chehalis
Consejo Counseling and Referral Services
CORE Health
Cowlitz Family Health Center
Cowlitz Indian Tribe
ESD 113
Gather Church
Grays Harbor Community Hospital
Kaiser Foundation Health Plan of the Northwest
Lewis County Community Health Services (Valley View)
Lewis County Sheriff's Department
Lifeline Connections
Longview Fire Department

Lower Columbia CAPS
Mason County Public Health
Mason General Hospital and Family of Clinics
Morton General Hospital
Nisqually Indian Tribe
Northwest Pediatric Center
Ocean Beach Hospital and Medical Clinics
Olympia Pediatrics
Pacific County Public Health
PeaceHealth
Pediatric Associates
Peninsula Community Health Services
Physicians of Southwest Washington
Planned Parenthood
Providence Health & Services
Quinault Indian Nation
Sea Mar Community Health Centers
Shoalwater Bay Tribe
Skokomish Indian Tribe
Squaxin Island Tribe
Summit Pacific Medical Center
Thurston County Public Health
Wahkiakum Health and Human Services
Willapa Behavioral Health
Youth and Family Link
YWCA of Olympia

In the coming weeks, selected partners will receive an invitation to a CPAA MTP Implementation Partners kick-off event. This will be a casual event to celebrate the work they have done and provide an opportunity for partnering providers across the region to come together.

Additionally, due to Health Care Authority's (HCA) MTP implementation timeline, there will soon be multiple communications and required deliverables from CPAA to the Implementation Partners, including more information about CPAA's MTP Implementation Plan (submitted to HCA by October 1, 2018), memorandums of understanding/contracts for partners to sign, and a Change Plan template. CPAA leadership and staff are working to finalize pay for performance measures, reporting tools, and the Change Plan template, which we will send out in September.

Cascade Pacific Action Alliance

Organization	Org Type	2A	2B	2C	3A	3B	3D	Cowlitz	Grays Harbor	Lewis	Mason	Pacific	Thurston	Wahkiakum
ANSWERS Counseling, Consolation, and CM	Combined	x				x			x	x	x		x	
Area Agency on Aging & Disabilities of SW Washington	Non-Clinical		C2	x			x	x						x
Behavioral Health Resources	Clinical	x			x	x			x		x		x	
Capital Recovery Center	Combined			x	x						x		x	
Cascade Mental Health Care	Clinical	x								x				
Catholic Community Services Family Behavioral Health	Clinical	x			x				x		x		x	
Child and Adolescent Clinic	Clinical	x				x	x	x						x
Child Care Action Council	Non-Clinical					x			x		x		x	
Coastal Community Action Program	Pathways		C1	x					x			x		
Columbia Wellness	Clinical				x			x	x					
Community Action Council	Pathways		C1							x	x		x	
Community Youth Services	Combined	x									x		x	
Consejo Counseling and Referral Services	Clinical	x			x									
CORE Health	Clinical	x		x	x			x		x				
Cowlitz Family Health Center	Clinical	x			x			x				x		x
Capital Region - ESD 113	Combined					x			x	x	x	x	x	
Gather Church	Non-Clinical		C2		x					x	x		x	
Grays Harbor Community Hospital	Clinical			x	x	x	x		x					
Kaiser Foundation Health Plan of the Northwest	Clinical	x			x			x						
Lewis County Community Health Services (Valley View)	Clinical	x		x			x			x		x	x	
Lewis County Sherriff Department	Non-Clinical				x					x				
Lifeline Connections	Clinical		C2		x				x	x		x		
Longview Fire Department	Non-Clinical						x	x						
Lower Columbia CAPS	Pathways		C1	x			x	x						x
Mason County Public Health	Combined				x						x			
Mason General Hospital & Family of Clinics	Clinical	x	C2	x	x	x	x				x			
Morton General Hospital	Clinical	x								x				
Northwest Pediatric Center	Clinical	x		x		x		x	x	x	x	x	x	
Ocean Beach Hospital & Medical Clinics	Clinical						x					x		
Olympia Pediatrics	Clinical	x							x	x	x		x	
Pacific County Public Health	Non-Clinical				x							x		
PeaceHealth	Clinical			x	x		x	x						x
Pediatric Associates	Clinical	x		x	x	x	x						x	
Peninsula Community Health Services	Pathways	x	C1	x	x	x	x				x			
Physicians of Southwest WA	Combined		C2	x									x	
Planned Parenthood of the Great NW and the Hawaiian Islands	Clinical					x				x	x		x	
Providence Health & Services	Clinical	x		x	x		x			x			x	
Sea Mar Community Health Centers	Pathways	x	C1	x	x	x	x	x	x				x	
Summit Pacific Medical Center	Clinical	x	C2	x	x	x	x		x		x			
Thurston County Public Health and Social Services	Combined				x	x	x		x	x	x		x	
Wahkiakum Health and Human Services	Combined	x				x								x

Cascade Pacific Action Alliance

Organization	Org Type	2A	2B	2C	3A	3B	3D	Cowlitz	Grays Harbor	Lewis	Mason	Pacific	Thurston	Wahkiakum
Willapa Behavioral Health	Combined	x										x		
Youth and Family Link	Pathways		C1	x		x		x						
YWCA of Olympia	Non-Clinical				x	x							x	
The Confederated Tribes of the Chehalis	Tribal Partner													
Cowlitz Indian Tribe	Tribal Partner													
Nisqually Indian Tribes	Tribal Partner													
Quinault Indian Nation	Tribal Partner													
Shoalwater Bay Tribe	Tribal Partner													
Skokomish Indian Tribe	Tribal Partner													
Squaxin Island Tribe	Tribal Partner													
		19	20	16	22	15	15	12	14	15	17	8	18	6
		2A	2B	2C	3A	3B	3D	Cowlitz	GH	Lewis	Mason	Pacific	Thurston	Wahkiakum
		51	22	7	9	6	7							
	Total Partners	Clinical	Non-Clinical	Combined	Pathways	Tribes								

C1 = Cohort 1 for Pathways

C2 = Cohort 2 for Pathways



Medicaid Transformation Change Plan

This Change Plan is a required document that will function as a tool for your organization to map out Medicaid Transformation Project (MTP) planning and implementation activities.

Your Change Plan will be used throughout the entire MTP by both your organization and CPAA. It will help develop MTP goals and measure implementation successes: the activities listed in your Change Plan will detail the logical sequence of transformative events over the next four years that will result in your organization achieving your MTP goal and vision of improved healthcare. Although you only have to fill it out once, your Change Plan is intended to be a useable, working document and will be updated annually throughout the MTP.

CPAA provided you with a Change Plan Development Form with recommendations based on your RFP response. These recommendations are based on future pay for performance (P4P) measures outlined by Health Care Authority. P4P measures are directly related to future funding for the region.

CPAA directors and program managers are available to answer questions and provide technical assistance in completing your Change Plan.

This Change Plan will be a public facing document to increase transparency, collaboration, and shared learning.

Medicaid Transformation Change Plan

Organization Information

Organization Name	
Employer Identification Number (EIN)	
CEO/Executive Director	
Transformation Lead Name	
Lead Contact Information (email, phone, address)	

Summary of Interventions

PROJECT AREA	INTERVENTION	METRIC SELECTION
2A: Bi-Directional Integration of Care	<i>CPAA staff will prepopulate based on selected RFP responses.</i>	
2B: Pathways		
2C: Transitional Care		
3A: Opioid Response		
3B: Reproductive Maternal Child Health		
3D: Chronic Disease Prevention and Management		

Program Manager Contacts

2A: Bi-Directional Integration of Care Kyle Roesler Program Manager roeslerk@crhn.org	2B: Pathways Michael O’Neill Program Manager oneillm@crhn.org	2C: Transitional Care Alexandra Toney Program Manager toneya@crhn.org
3A: Opioid Response Sara Rainer Program Manager rainers@crhn.org	3B: Reproductive – Maternal and Child Health Caroline Sedano Program Manager sedanoc@crhn.org	3D: Chronic Disease Prevention & Management Alexandra Toney Program Manager toneya@crhn.org

Reporting

Organizations are required to report on Change Plan progress quarterly, while intervention-specific metrics are reported semi-annually during Quarter 2 and 4 to CPAA. The Change Plan is due November 15, 2018, and updated annually during Quarter 4.

Quarter 1 (Jan-Mar)	*Quarter 2 (Apr-Jun)	Quarter 3 (Jul-Sep)	*Quarter 4 (Oct-Dec)
1. Change Plan Progress Report	1. Change Plan Progress Report 2. Intervention Metrics	1. Change Plan Progress Report	1. Change Plan Progress Report 2. Intervention Metrics 3. Change Plan Update
April 30, 2019	July 31, 2019	October 31, 2019	January 31, 2020
April 30, 2020	July 31, 2020	October 31, 2020	January 31, 2021
April 30, 2021	July 31, 2021	October 31, 2021	January 31, 2022
April 30, 2022	July 31, 2022	October 31, 2022	January 31, 2023

*Intervention specific

Instructions

1. CPAA pre-populated your Change Plan with project area(s), corresponding interventions, and intervention-specific metrics. Metrics will allow you to monitor your progress for each SMART goal.
2. Review the Change Plan Development Form, which provides feedback based on your RFP response. Please use this feedback as a first step in identifying your own milestones.
3. In the Change Plan, identify one SMART (specific, measurable, achievable, relevant, and time-bound) goal per evidence-based intervention.
 - a. *SMART goal example: By 2021, increase the annual capacity from 1000 non-emergency transport services of Medicaid beneficiaries to 5700.*
4. CPAA has identified the metrics for each intervention, which are prepopulated into your organization's Change Plan template. For a limited number of interventions, please contact the program manager regarding metrics as indicated. Enter information for data source, data frequency, baseline data, and yearly targets.
 - a. Data Source: *Where will you collect the data?*
 - b. 2017 Baseline: *HCA is using 2017 data as a baseline for P4P measures in future years. Baseline is based off end of calendar year. If data is not available, describe the process in which you will collect data.*
 - c. 2019 – 2021 Targets: *What is your yearly attainable target for improvement over baseline?*
 - d. Reference supplemental document for additional metric information.
5. Under each SMART goal, write out the timeline of milestones to meet that goal with target dates and lead person(s). We understand activities may change over time; updates can be made to the Change Plan on an ongoing basis.
 - a. *Example: Schedule and conduct Long Acting Reversal Contraceptive (LARC) with 80% of providers*
 - b. *Example: Target Date: June 2018*
6. Once you have identified goals and milestones, complete the following sections:
 - a. Describe external supports or technical assistance needed to be successful in the project areas and interventions.
 - i. *Example: LARC Training: Justification – Providers are not trained in LARC insertion and removal.*
 - b. Describe potential risk and mitigation strategies as they apply to project areas and interventions.
 - i. *Example: Provider capacity is limited: Plan – Block schedules and plan training in advance to minimize revenue loss.*
 - c. Describe how you plan to use health equity to inform decision-making or provide service.
 - i. *Example: Create workflow to provide same day access.*
7. Submit the draft Change Plan to reporting@cpaawa.org no later than **October 15, 2018**, for initial feedback and recommendations.

Cascade Pacific Action Alliance

8. Sign Change Plan attesting to the required elements of the Change Plan. Person signing must be CEO, equivalent, or delegated authority.
9. Submit final Change Plan to reporting@cpaawa.org no later than **November 15, 2018**.

PROJECT AREA:					
EVIDENCE-BASED INTERVENTION:					
SMART Goal:					
Metric(s)	Data Source	2017 Baseline ¹	2019 Target	2020 Target	2021 Target
1.					
2.					
Notes:					
Planning (October 2018-December 2018)					
Milestones	Target Date	Lead Person			
Implementation (January - December 2019)					
Milestones	Target Date	Lead Person			

¹ If data is not available, describe the process in which you will collect data.

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Scale and Sustain (Jan 2020-2021)		
Milestones	Target Date	Lead Person

MTP Transformation Activities

External Supports Needed (CPAA Staff, Technical Assistance, Training)		
Supports Needed	Related Intervention	Justification
Potential Implementation Risks (What could go wrong? How could the risk be mitigated?)		
Potential Risk	Related Intervention	Mitigation Plan
Health Equity Activities (How do you use health equity to inform decision making and provide services?)		
Milestone(s)	Related Intervention(s)	Expected Outcome

Date Updated/Reviewed: __/__/__

Attestations:

1. We are registered and active in the Financial Executor Portal.

Yes	No

If "No," what steps have you taken to register in the portal?

2. A quality improvement/assurance plan is in place and ready for review upon request.

Yes	No

If "Yes," what quality improvement tools do you use or who are you currently working with to improve quality in your organization?

3. The information in this change plan is true and complete to the best of my knowledge.

Yes	No

Partner Organization Authorizing Authority

Printed Name: _____

Title: _____

Cascade Pacific Action Alliance

Signature _____

Date: _____

Dear [Insert Non-Selected Partner Name],

We regret to inform you that your organization was not chosen at this time to be one of Cascade Pacific Action Alliance's (CPAA) Medicaid Transformation Project (MTP) implementation partners. We greatly appreciate the time and effort you put into responding to CPAA's Request for Proposals (RFP), as well as your commitment to transform the region's health care delivery system. Thank you for your hard work.

Although [insert organization name] is not a paid MTP partner, your RFP response has merit and will help advance regional health care delivery system transformation. There is an opportunity for your organization to receive a one-time, up to \$15,000 payment through CPAA's Capacity Development Fund. This fund supports organizations with innovative ideas and specialty services. To be eligible for these funds, please submit a brief proposal of improvement of population health. (One-page; you are encouraged to pull directly from your RFP response.) Please focus on the biggest impact your organization can make in your community to improve population health. In one year, CPAA would like you to report on the outcomes of your choice for your project, which may include numbers served or impacted, etc. Please send your proposal to reporting@cpaawa.org by November 15, 2018.

Registration in the Financial Executor Portal and executed contracts are required to receive MTP payments. We anticipate disbursing the first partner engagement payments this fall. If you are not already registered in the portal, contact our Operations Director, Samantha Tatum at tatums@crhn.org as soon as possible.

Additionally, in the coming months, there will be more information about how to apply for the Regional Wellness Fund, which is a pool of funding available to support investments that address social determinants of health. These funds will be used to make targeted investments in community-clinical linkages that complement MTP goals such as affordable housing, economic security, safe neighborhoods, transportation, and access to adequate and healthy foods.

In addition to these funding opportunities, we encourage you to continue to stay engaged in health transformation work by participating in CPAA work groups and council meetings, and we invite you to attend any future regional training. As CPAA scales up MTP implementation, there will be additional opportunities, and perhaps the possibility of partnering in the future.

Again, thank you for all your work.

Sincerely,

John Masterson

John Masterson, Interim Executive Director

Change Plan Metrics Definitions

Below you find the detail documentation related to MTP measurements. The purpose of this document is to describe, in detail, the set of measures attached to your project/s and intervention/s. CPAA has identified the metrics for each intervention, which are prepopulated into your organization's Change Plan template. For a limited number of interventions as indicated, please contact the program manager regarding metrics.

[Related Worksheet: \[Interventions\]](#)

Worksheet [MTP Metrics]

Column heading	Column Description
Column A	<p>Project ID, According to the MEDICAID TRANSFORMATION PROJECT TOOLKIT:</p> <p>Domain 2: Care Delivery Redesign: Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes.</p> <p>Domain 3: Prevention and Health Promotion: Transformation projects within this domain focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations.</p> <p>CPAA Projects:</p> <p>2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation</p> <p>2B: Community-Based Care Coordination</p> <p>2C: Transitional Care</p> <p>3A: Addressing the Opioid Use Public Health Crisis</p> <p>3B: Reproductive and Maternal and Child Health</p> <p>3D: Chronic Disease Prevention and Control</p> <p>More details: https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf</p>
Column B (hidden)	MetricID , Unduplicated metric code for CPAA internal use. First two digits corresponds to the Project ID, third and fourth digits is an autonumeric by project.
Column C	Sub Category / Intervention
Column D	Short Description [Metric ID] : Measurement description as pre-populated in your Change Plan.
Column E	Measure Description : Detailed description of each measurement.
Column F	Numerator : The upper part of a fraction. The metric which has been counted. (e.g. # of people developed the disease of interest)
Column G	Denominator : The lower part of a fraction, used to calculate a rate or ratio. The population from which the numerator was derived. (e.g. total # of people in the population at risk)
Column H	Initial reporting date: Initial date that the data should be submitted to CPAA using the tool provided.
Column I	Set of data, "From - To", specific set of data to be reported.

Explanation of Metrics Definitions Supplemental Document

Instructions

1. CPAA pre-populated your Change Plan with project area(s), corresponding interventions, and intervention-specific metrics. This document provides a more detailed description of each metric than the Change Plan template, including how the metrics are calculated (the numerator and the denominator).
2. This document also captures the reporting period for each metric.
3. This document is a supplemental reference guide, not a reporting tool. The reporting tool is still under development and will be released at a later date.
4. Submit the draft Change Plan to reporting@cpaawa.org no later than **October 15, 2018**, for initial feedback and recommendations. CPAA will respond with any necessary write-backs by November 1, 2018.
5. Submit final Change Plan to reporting@cpaawa.org no later than **November 15, 2018**.

Intervention by Project	Total
2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation	4
Behavioral health integration in primary care settings	2
Physical health integration in behavioral health settings	2
2B: Community-Based Care Coordination	3
Pathways	3
2C: Transitional Care	10
Develop co-located primary care service and Emergency Department with case management protocol for triage and referral	3
Implement evidence-based transitional care tool	1
Other	1
Provide non-emergency medical transport services	3
Provide Services that address social determinants of health	1
Utilize a patient navigator to improve health outcomes	1
3A: Addressing the Opioid Use Public Health Crisis	10
Opioid Response - CBO	5
Opioid Response - Clinic	4
Opioid Response - Emergency Department	1
3B: Reproductive and Maternal and Child Health	12
Home visiting	5
Immunization (Bright Future or Enriched Medical Home)	1
Long-acting reversible contraception (LARCs)	2
One Key Question (OKQ)	3
School-based health center	1
3D: Chronic Disease Prevention and Control	19
Adopt medical home or team-based care models	1
Adopt policy systems and environmental change	1
Establish linkages and provide services that address the social determinants of health	1
Implement Chronic Disease Self-Management Program	3
Implement Diabetes Prevention Program	3
Implement Mobile Integrated Healthcare / Paramedicine Model	2
Implement Wagner's Chronic Care Model	4
Million Hearts Campaign	3
Other	1
Total measures in this document	58

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting	Set of data
2A	Behavioral Health Integration in Primary Care Settings	% Depression screening [2A01]	Depression Utilization of the PHQ-9 Tool (eCQM 2018) Measure Description: The percentage of patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying visit. *For pediatrics, age range is 12-18.	Patients who have a PHQ-9 tool administered at least once during the four-month period.	Patients age 18 and older with an office visit and the diagnosis of major depression or dysthymia during the four month period. *For pediatrics, age range is 12-18. **Exclusions: patients who died, patients who received hospice or palliative care services, patients who were permanent nursing home residents, patients with a diagnosis of bipolar disease, patients with a diagnosis of personality disorder	7/31/2019	Jan 2019 - Jun 2019
2A	Behavioral Health Integration in Primary Care Settings	% Depression remission [2A02]	Depression Remission at Twelve Months (eCQM 2018) Measure Description: The percentage of patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 30 days) after an index visit.	Patients who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.	Patients age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during the index visit. *For pediatrics, age range is 12-18. **Exclusions: patients who died, patients who received hospice or palliative care services, patients who were permanent nursing home residents, patients with a diagnosis of bipolar disease, patients with a diagnosis of personality disorder.	7/31/2019	Jan 2019 - Jun 2019
2A	Physical Health Integration in Behavioral Health Settings	% Universal BMI [2A03]	Percentage of Patients with Body Mass Index (BMI) Recorded in EHR Measure Description: The percentage of Medicaid beneficiaries with a BMI documented in an EHR during the reporting period	All members who had a documented BMI in during the reporting period	All Medicaid beneficiaries who had an encounter during the reporting period	7/31/2019	Jan 2019 - Jun 2019
2A	Physical Health Integration in Behavioral Health Settings	% Universal blood pressure screening [2A04]	Percentage of Patients with Blood Pressure (BP) Recorded in EHR Measure Description: The percentage of Medicaid beneficiaries with a BP documented in an EHR during the reporting period.	All members who had a documented BP during the reporting period	All Medicaid beneficiaries who had an encounter during the reporting period	7/31/2019	Jan 2019 - Jun 2019
2B	Pathways	# of active clients during the performance period. [2B01]	number of active clients during the performance period.	number of active clients during the performance period.	# of eligible clients referred to CCA from HUB	7/31/2019	Jan 2019 - Jun 2019
2B	Pathways	AVG # of completed Pathways per client [2B02]	Average # of completed Pathways per Care Coordination Agency client			7/31/2019	Jan 2019 - Jun 2019
2B	Pathways	AVG # of months per client [2B03]	Average # of months Care Coordination Agency client			7/31/2019	Jan 2019 - Jun 2019
2C	Utilize a patient navigator to improve health outcomes	# Clients in Patient Navigator Service [2C01]	Number of clients/patients engaged with patient navigator within the reporting period			7/31/2019	Jan 2019 - Jun 2019
2C	Develop co-located primary care service and Emergency Department with case management protocol for triage and referral	% of No Show [2C02]	Percent of scheduled appointment in which the beneficiary was not present for service delivery (reported as ratio)	number of scheduled appointment with Medicaid beneficiaries in which the beneficiary was not present for service delivery	total number of scheduled appointment during reporting period)	7/31/2019	Jan 2019 - Jun 2019

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting	Set of data
2C	Develop co-located primary care service and Emergency Department with case management protocol for triage and referral	% of First App Completed [2C03]	Percent of scheduled appointments with patients, who were referred to the co-located primary care service and attended first scheduled appointment. (reported as ratio)	Number of scheduled appointments with patients, who were referred to the co-located primary care service and attended first scheduled appointment	Total number of scheduled first appointments with patients, who were referred to the co-located primary care service)	7/31/2019	Jan 2019 - Jun 2019
2C	Develop co-located primary care service and Emergency Department with case management protocol for triage and referral	% patients received services within 7 days [2C04]	Percent of patients who received service within 7 days of contact (reported as ratio)	Number of service request in which patients received service within 7 days of contact	Total number of service requests of patients	7/31/2019	Jan 2019 - Jun 2019
2C	Implement Evidence-Based Transitional Care Tool	% Patients enrolled in a Transitional Care program [2C05]	Percent of patients identified as high risk patients who are enrolled in a Transitional Care program within your health system. *	Patients identified as high risk patients who are enrolled in transitional care services	Total number of Patients identified as high risk patients	7/31/2019	Jan 2019 - Jun 2019
2C	Provide Non-Emergency Medical Transport Services	# of transports to healthcare [2C06]	Number of transports to a healthcare appointment provided during reporting period (a ride is defined as a one way or round trip ride provided to a single health service destination)			7/31/2019	Jan 2019 - Jun 2019
2C	Provide Non-Emergency Medical Transport Services	% consumers who rebook [2C07]	Percent of consumers who rebook a services within the reporting period	Number of consumers who rebooks a service within the reporting period	Total number of consumers during reporting period	7/31/2019	Jan 2019 - Jun 2019
2C	Provide Non-Emergency Medical Transport Services	% of transportation service within 7 days [2C08]	Percent of transportation request in which consumers received service within 7 days of contact	Number of transportation request in which consumers received service within 7 days of contact	Total number of transportation requests of consumers	7/31/2019	Jan 2019 - Jun 2019
2C	Provide Services that Address Social Determents of Health	Eligible to Contact Program Manager to get specific metrics approved [2C09]	Eligible to Contact Program Manager to get organization specific metrics approved			7/31/2019	Jan 2019 - Jun 2019
2C	Other	Eligible to Contact Program Manager to get specific metrics approved [2C10]	Eligible to Contact Program Manager to get organization specific metrics approved			7/31/2019	Jan 2019 - Jun 2019
3A	Opioid Response - Emergency Depart	ED protocols MAT & Naloxone distribution [3A01]	Does the ED site have protocols in place to initiate Medication Assisted Treatment (MAT) and offer take-home naloxone for individuals seen for opioid overdose?	Drop Down Box <input type="text"/>	<ul style="list-style-type: none"> •MAT initiation •Take-home naloxone •Our ED does not offer these services •Not applicable. Our site is not an ED. 	7/31/2019	N/A
3A	Opioid Response - Emergency Depart	Follow opioid prescribing guidelines? [3A02]		Drop Down Box <input type="text"/>	<ul style="list-style-type: none"> •AMDG guidelines / Washington State prescribing guidelines •Bree Collaborative guidelines •CDC guidelines 	7/31/2019	N/A
3A	Opioid Response - Clinical	Clinical decision support for opioid prescribing [3A03]	Do providers follow [specific] opioid prescribing guidelines?	Drop Down Box <input type="text"/>	<ul style="list-style-type: none"> •None of the above •IntegratedMED calculator •Links to opioid prescribing registries or PDMPs •Automatic flags for co-prescriptions of benzos •None of the above 	7/31/2019	N/A
3A	Opioid Response - Clinical		What features does the site's clinical decision support for opioid prescribing include? (EHR or another support system)				

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting	Set of data
3A	Opioid Response - Clinical	Protocol for BH intervention [3A04]	What protocols are in place to provide a pathway for patients with opioid use disorder to be evaluated for behavioral health interventions?	Drop Down Box	<ul style="list-style-type: none"> Screening and treatment for depression/anxiety occurs on site Screening for depression/anxiety occur on site, patients referred to treatment Contracting with providers who offer these services Formalized referral relationship with providers who offer these services (MOUs or similar arrangement) Informal referral relationship with providers who offer these services None of the above 	7/31/2019	N/A
3A	Opioid Response - Clinical	Protocols for MAT [3A05]	What protocols are in place to provide a pathway for all patients with opioid use disorder to be evaluated for medication-assisted treatment (MAT)?	Drop Down Box	<ul style="list-style-type: none"> Medications are provided on site Contracting with providers who offer these services Formalized referral relationship with providers who offer these services (MOUs or similar arrangement) Informal referral relationship with providers who offer these services None of the above 	7/31/2019	N/A
3A	Opioid Response - CBO	CBO refer to MAT [3A06]	Does the CBO site have protocols in place to refer people with opioid use disorders to providers of medication-assisted treatment?	Drop Down Box	<ul style="list-style-type: none"> Yes No 	7/31/2019	N/A
3A	Opioid Response - CBO	CBO refer to psychosocial care? [3A07]	Does the CBO site refer people with opioid use disorders for psychosocial care?	Drop Down Box	<ul style="list-style-type: none"> Yes No 	7/31/2019	N/A
3A	Opioid Response - CBO	CBO refer to Hub & Spoke [3A08]	Does your site actively refer patients with opioid use disorder to a Hub & Spoke network or Opioid Treatment Network, where both medication and behavioral health treatments are available?	Drop Down Box	<ul style="list-style-type: none"> Yes, via warm handoff Yes, via providing information No, we provide these services on site No, we do not refer for another reason 	7/31/2019	N/A
3A	Opioid Response - CBO	CBO syringe exchange [3A09]	Does your CBO receive technical assistance to organize or expand a syringe exchange program, or to learn about locally available access to clean syringes?	Drop Down Box	<ul style="list-style-type: none"> Yes, to organize and expand Yes, to learn about access No, we did not receive technical assistance 	7/31/2019	N/A
3A	Opioid Response - CBO	CBO refer Hep C & HIV [3A10]	Does your CBO provide referral information for clients interested in testing or treatment for Hepatitis C and HIV?	Drop Down Box	<ul style="list-style-type: none"> Yes, via warm handoff Yes, via providing information No, we provide these services on site No, we do not refer for another reason 	7/31/2019	N/A
3B	One Key Question	# women screened for pregnancy intentions [3B01]	# of women of reproductive age (15-44) were screened for their pregnancy intentions	# of women of reproductive age (TBD) who had an office visit who were screened for pregnancy intentions during the measurement period	# of women of reproductive age (TBD) who had an office visit	7/31/2019	Jan 2019 - Jun 2019

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting	Set of data
3B	One Key Question	% women with response to pregnancy intention screening [3B02]	% of women of reproductive age (15-44) who have a documented response to the pregnancy intention screening	# women of reproductive age (TBD) who had an office visit with documented response to pregnancy intention screening during the reporting period	# women of reproductive age (TBD) with an office visit	7/31/2019	Jan 2019 - Jun 2019
3B	One Key Question	% chlamydia screening [3B03]	% of women age (15-44) identified as sexually active who had an office visit having at least one test for chlamydia during the reporting year	# women of reproductive age (TBD) identified as sexually active with an office visit and a documented STI test	# women of reproductive age (TBD) identified as sexually active with an office visit	7/31/2019	Jan 2019 - Jun 2019
3B	LARCs	% trained in insertion/removal of IUDs, implants [3B04]	% Clinicians trained in routine insertion and removal of IUDs and implants	# Clinicians trained in routine insertion and removal of IUDs and implants	# clinicians in site	7/31/2019	Jan 2019 - Jun 2019
3B	LARCs	% trained in complicated insertion/removal of IUDs, implants [3B05]	% Clinicians trained in complicated insertion and removal of IUDs and implants	# Clinicians trained in complicated insertion and removal of IUDs and implants	# clinicians in site	7/31/2019	Jan 2019 - Jun 2019
3B	Home visiting	% of eligible families enrolled [3B06]	% of eligible families enrolled into services	# of families enrolled in services	# of those that qualify	7/31/2019	Jan 2019 - Jun 2019
3B	Home visiting	% of families lost to care [3B07]	% of families lost to care	# of families enrolled in services	# of those that qualify	7/31/2019	Jan 2019 - Jun 2019
3B	Home visiting	% of families transitioned out of the program [3B08]	% of families transitioned out of the program	families who opt out of the program due to moving, positive life transition etc)	# of families in the program	7/31/2019	Jan 2019 - Jun 2019
3B	Home visiting	# graduated [3B09]	# graduated	families successfully completing the full range of services of the program and marked as graduated by home visitor	# of families in the program	7/31/2019	Jan 2019 - Jun 2019
3B	Home visiting	% of enrolled families with 6 visits [3B10]	% of enrolled families with 6 visits during the measurement period	families with 6 visits during the measurement period	# of families in the program	7/31/2019	Jan 2019 - Jun 2019
3B	School-based health center	% students who received services at the School Based health Center [3B11]	% students in the school who accessed services at the School Based health Center at least once during the measurement period	students in the school who accessed services at the SBHC at least once during the measurement period	all students in the school	7/31/2019	Jan 2019 - Jun 2019
3B	Immunization (Bright Future or Enriched Medical Home)	% children with 6 or more well child visits at 15 months [3B12]	% of children who turn 15 months of age during the measurement period with 6 or more well child visits	# of children who turn 15 months of age during the measurement period with 6 or more well child visits	# of children who turn 15 months of age during the measurement period	7/31/2019	Jan 2019 - Jun 2019
3D	Implement Chronic Disease Self-Management Program	# of clients/patients who are enrolled [3D01]	Number of clients/patients who are enrolled			7/31/2019	Jan 2019 - Jun 2019
3D	Implement Chronic Disease Self-Management Program	# of clients/patients who complete 1st class [3D02]	Number of clients/patients who complete the first class of the series			7/31/2019	Jan 2019 - Jun 2019
3D	Implement Chronic Disease Self-Management Program	# of clients/patients who completed course [3D03]	Number of clients/patients who completed course			7/31/2019	Jan 2019 - Jun 2019
3D	Implement Diabetes Prevention Program	# of clients/patients who are enrolled [3D04]	Number of clients/patients who are enrolled			7/31/2019	Jan 2019 - Jun 2019
3D	Implement Diabetes Prevention Program	# of clients/patients who complete 1st class [3D05]	Number of clients/patients who complete the first class of the series			7/31/2019	Jan 2019 - Jun 2019
3D	Implement Diabetes Prevention Program	# of clients/patients who completed course [3D06]	Number of clients/patients who completed course			7/31/2019	Jan 2019 - Jun 2019
3D	Million Hearts Campaign	% Blood Pressure Control [3D07]	Blood Pressure Control: Percentage of Patients 18-85 YO, who had a diagnosis of HTN and whose blood pressure was adequately controlled (<140/90) during the measurement period (reported as ratio)	Number of Patients 18-85 with a diagnosis of HTN whose blood pressure was adequately controlled	Total population of Patients 18-85 with a diagnosis of HTN	7/31/2019	Jan 2019 - Jun 2019

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting	Set of data
3D	Million Hearts Campaign	% Statin Therapy [3D08]	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease: Percentage patients considered at high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement period (reported as a ratio)	Number of patients considered at high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement period	Total number of patients considered high risk of cardiovascular event during reporting period	7/31/2019	Jan 2019 - Jun 2019
3D	Million Hearts Campaign	% Smoking Assessment and Treatment [3D09]	Smoking Assessment and Treatment: Preventive Care and Screening: Tobacco Use Percentage of Patients 18 + who were screened about tobacco use one or more times within the reporting period and who received cessation counseling intervention if identified as a tobacco user	Number of Patients 18 + who were screened about tobacco use one or more times within the reporting period and who received cessation counseling intervention if identified as a tobacco user	Number of Patients 18 + who were screened about tobacco use	7/31/2019	Jan 2019 - Jun 2019
3D	Establish linkages and provide services that address the social determinants of health	TBD [3D10]	Eligible to Contact Program Manager to get organization specific metrics approved			7/31/2019	Jan 2019 - Jun 2019
3D	Implement Mobile Integrated Healthcare / Paramedicine Model	Number of Patients on caseload [3D11]	Number of Patients who are active and on (received service within the last 60 days) caseload.			7/31/2019	Jan 2019 - Jun 2019
3D	Implement Mobile Integrated Healthcare / Paramedicine Model	% reduction in non-emergency 911 [3D12]	% reduction in non-emergency 911 utilization of contracted clients	Total number non-emergency 911 utilization of contracted clients during reporting period	Total number non-emergency 911 utilization of contracted clients before intervention	7/31/2019	Jan 2019 - Jun 2019
3D	Implement Wagner's Chronic Care Model	Diabetes Care : HbA1c Testing [3D13]	Percentage of patients with diabetes who had hemoglobin A1c > 9.0% during the measurement period	Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%	Patients with diabetes with a visit during the measurement period	7/31/2019	Jan 2019 - Jun 2019
3D	Implement Wagner's Chronic Care Model	Med Management People with Asthma (5-64) [3D14]	Percent of patients 5-85 years of age who were identified as having persistent asthma and were dispensed appropriate asthma-controlled medications that they remained on for at least 75% of their treatment period	Total number of Patients 5-85 years of age who were identified as having persistent asthma and were dispensed appropriate asthma-controlled medications that they remained on for at least 75% of their treatment period	Total number of patients 5-85 who were identified as having persistent asthma and were dispensed appropriate asthma-controlled medications	7/31/2019	Jan 2019 - Jun 2019
3D	Implement Wagner's Chronic Care Model	Statin therapy for patients with CVD [3D15]	Percent of patients who have clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy.	Number of patients who have clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy.	Number of patients who have clinical atherosclerotic cardiovascular disease (ASCVD).	7/31/2019	Jan 2019 - Jun 2019
3D	Implement Wagner's Chronic Care Model	% Patients enrolled in Clinical Case Management [3D16]	Percent of patients identified as high risk patients who are currently enrolled in a Clinical Case Management Service for Chronic Disease within your health system.	Patients identified as high risk patients who are currently enrolled in a Clinical Case Management Service for Chronic Disease within your health system	Total number of Patients identified as high risk patients within your health system	7/31/2019	Jan 2019 - Jun 2019
3D	Adopt medical home or team-based care models	# patients receiving care under team-based model [3D17]	Number of patients receiving care under team-based model			7/31/2019	Jan 2019 - Jun 2019
3D	Adopt Policy Systems and Environmental change	Eligible to Contact Program Manager to get organization specific metrics approved [3D18]	Eligible to Contact Program Manager to get organization specific metrics approved			7/31/2019	Jan 2019 - Jun 2019
3D	Other	Eligible to Contact Program Manager to get organization specific metrics approved [3D19]	Eligible to Contact Program Manager to get organization specific metrics approved			7/31/2019	Jan 2019 - Jun 2019



Change Plan Development Form

Partner Name:

Approved Project Areas:

Development Form Overview:

- CPAA reviewed all successful Request for Proposals (RFP) responses and provided recommendations to ensure all Change Plans are in alignment with the overall Medicaid Transformation Project (MTP) goals and program approaches as developed by CPAA. A successful implementation of all interventions is important for regional pay for performance measures and is directly tied to future funding.
- This form was pre-populated by CPAA for your organization’s approved projects areas.
- Partners should use the RFP feedback included in this form as guidance when completing their organization’s Change Plan.
- CPAA may not have provided feedback for all project areas or interventions if response to the RFP aligned closely with MTP goals.
- CPAA will retain a copy of each partner’s response to the RFP, Change Plan Development Form, and document progress towards Change Plan completion.

Work Steps:

Change Plan Development Steps	No Later Than Date
CPAA provides feedback on RFP responses for consideration when completing the Change Plan	September 15, 2018
Consult with appropriate CPAA Program Manager(s) for feedback and technical assistance as recommended	October 1, 2018
Submit draft Change Plan to reporting@cpaawa.org for review and recommendations	October 15, 2018
CPAA reviews draft Change Plan and provides feedback	November 1, 2018
Submit final Change Plan to reporting@cpaawa.org	November 15, 2018
CPAA reviews and accepts Change Plan, or returns to partner for write-back	November 28, 2018
Partners provide additional information as requested by CPAA	December 7, 2018
Partner receives formal acceptance of Change Plan and reporting requirements from CPAA	December 15, 2018



Change Plan Development Form

To ensure the best possible outcomes and largest impact for our region, listed below are CPAA’s specific recommendations for your organization’s Change Plan based on your RFP response. Each organization’s Change Plan will be used to measure progress during the MTP. As a tool that will act as a foundation for MTP health care delivery systems change and be utilized by each organization to map out planning and implementation activities throughout the MTP, a strong Change Plan is critical to MTP success.

Change Plan Recommendations

[] **If this box is checked, partner should consult with CPAA staff regarding Change Plan recommendations.** Please schedule a call with the following CPAA Program Managers: [List names of PMs]

PROJECT AREA	INTERVENTION	INTERVENTION FEEDBACK
2A: Bi-Directional Care Integration	Integrating Primary Care into Behavioral Health: Off-Site-Enhanced Collaboration Co-located-Enhanced Collaboration	<u>Areas that lacked sufficient detail:</u> <u>Recommended elements:</u> <u>Required adjustments to fit evidence-based model:</u>
	Integrating Behavioral Health into Primary Care: Collaborative Care Model	<u>Areas that lacked sufficient detail:</u> <u>Recommended elements:</u> <u>Required adjustments to fit evidence-based model:</u>
3B: Reproductive Maternal Child Health	One Key Question	<u>Areas that lacked sufficient detail:</u> <u>Recommended elements:</u> <u>Required adjustments to fit evidence-based model:</u>
	Enriched Medical Home Intervention Screening	<u>Areas that lacked sufficient detail:</u> <u>Recommended elements:</u> <u>Required adjustments to fit evidence-based model:</u>

*Each project area used the same format for intervention feedback



Join Us

Medicaid Transformation Kick-Off Party

October

11

Interact with fellow Medicaid Transformation Partners, learn about the different program areas, and enjoy great food! The CPAA Council & Board meeting will follow.