



Quality Improvement Structure and Strategy

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I. Quality Improvement Structure and Strategy

A. Scope and Resources

The Elevate Health Quality Improvement Plan supports continuous quality improvement in both pay for performance (P4P) and pay for reporting (P4R) measures. The *Strategic Improvement Team* manages quality improvement and performance at Elevate Health with the Director of Population Health as the accountable executive, and efforts staffed by the ACH's Clinical Improvement Advisors. Strategic Improvement may be used interchangeably with 'quality improvement' throughout this plan.

The scope of the Strategic Improvement Team's work encompasses the administration, evaluation, tracking, and sharing of measures, as well as the technical assistance provided to improve upon said measures. The focus areas described in the QI Plan include:

B.

- i. **Administer Pay for Reporting (P4R) Survey and Compile and Share Results:**
 - a. Compile a regional directory of all service providers in Pierce County.
 - b. Work in partnership with Providence CORE to create an online survey platform for the administration of P4R questions.
 - c. Track the completion of P4R surveys.
 - d. Aggregate results of P4R to share with HCA, our councils, and governing board.
- ii. **Track and Publicize Pay for Performance (P4P) Measures:**
 - a. Establish a process for regularly tracking regional performance of the P4P measures.
 - b. Establish a process for socializing the P4P measures.
 - c. Fold P4P measures into our Binding Letters of agreement with direct partners.
- iii. **Deploy Technical Assistance to Support Performance Improvement:**
 - a. Hire and train a team of Clinical Improvement Advisors in the model for improvement science through the Institute for Healthcare Improvement (IHI).
 - b. Expand improvement capacity across the Pierce County workforce by sending Quality Improvement staff from partner organizations to Institute for Healthcare Improvement trainings.
 - c. Assign a Clinical Improvement Advisor to each direct partner organization to support workflow development, measurement adherence, and metrics tracking.
 - d. Lead Regional Learning Collaboratives for topical project areas.
 - e. Create a strategic improvement toolkit to standardize the region's approach to quality improvement.
- iv. **Semi-Annual Summary of Findings, Adjustments, and Lessons Learned:**
 - a. Support partnering providers in adjusting transformation approaches.
 - b. Identify best practices on transformation methods.

C. Accountability

Accountability to the strategies and measure sets outlined in this plan are managed through a two-pronged approach:

- i. **Semi-Annual Review of Regional Performance:** The Board of Trustees, Provider Integration Panel, and the Community Advisory Committee will review the regional performance dashboards (as published on the Washington Healthier Here website) for P4P and High-Performance Pool Measures. The three groups will review Pierce County’s performance against the state average and identify any regional trends or community characteristics that may be affecting performance.
- ii. **Performance Improvement Included in Binding Letters of Agreement:** Elevate Health is partnering with organizations who serve a majority of Medicaid lives, are committed to cross-sectional partnerships, and who have demonstrated a willingness to track and improve upon clinical performance measures. These “direct partners” enter a three-year binding letter of agreement requiring them to track performance on a subset of P4R and P4P measures, develop and deploy strategies to address improvement, and demonstrate improvement in those measures over time. Direct partners report their performance and strategies quarterly to the ACH via a quarterly workplan template (Attachment B). Beginning Q1 2020, funding to direct partners will be contingent upon performance improvement.

D. Reviewing Committee Structure and Composition:

As stated in Section B, three committees will review regional performance improvement dashboards:

- i. **Board of Trustees:** The Board of Trustees has ultimate decision-making authority for the ACH. It is currently comprised of representatives from all stakeholder groups in the region, including physical and behavioral health providers, health systems, County government, public health, managed care organizations, Tribal governments, and community-based organizations. There is also a seat on the Board for the Community Advisory Committee representative.
- ii. **Provider Integration Panel:** A cross-section of leaders from clinical and behavioral health organizations in the region, this group serves as the lens for the Pierce County provider community and weighs in on evidence-based best practices, changes to access and demand, and quality improvement strategies.
- iii. **Community Advisory Committee:** Individual representatives from across Pierce County comprise this group which is shaped to reflect the age, gender, racial, and ethnic demographics of Pierce County, and represents the individual’s experience across the health and social services in the community. The committee weighs in on trends that may be impacting the health of our community with a focus on the social determinants of health and health equity.

II. Technical Assistance and Strategic Improvement to Support Transformation

The Strategic Improvement Team (SIT): Elevate Health created the Strategic Improvement Department in 2017 in response to a clear need to provide quality improvement support to our partner organizations. Staffed with several full-time Clinical Improvement Advisors, the Strategic Improvement Team (SIT) provides partners with expertise in various models for workflow and performance improvement, including Six Sigma, Toyota Production Model, and the IHI Model for Improvement Science. The SIT is managed by the Director of Population Health, who works in partnership with the

Clinical Improvement Advisors to identify, facilitate, and proliferate best practices, ensure the inclusion of social determinants of health in performance measurement, and lead regional learning collaboratives.

The SIT supports regional transformation in four ways:

- i. **Deploying Expert Clinical Improvement Advisors:** Each direct contracted ACH partner is assigned a Clinical Improvement Advisor to support workflow development and measurement adherence, and metrics tracking. Clinical Improvement Advisors meet with the leadership team at the direct partner organization, at least monthly, to discuss performance, strategies, and review workplan goals. The Clinical Improvement Advisors operate under the direction of the direct partner leadership team to support frontline teams in workflow-redesign, plan-do-study-act cycles, or in measurement tracking. The Strategic Improvement Team also supports regional learning collaboratives designed to provide training and support for a broader set of regional partners.
- ii. **Expanding Workforce Capacity in Improvement Science:** In addition to providing its own expert Clinical Improvement Advisors, Elevate Health has sponsored seven (7) Quality Improvement staff members from partner organizations to attend the Institute for Healthcare Improvement Advisor Training, allowing partners to build their own internal capacity for quality improvement. This is an intensive 10-month course where an individual learns the core concepts of the model for improvement, identifies a project to improve upon, and learns foundational statistical concepts in order to track performance over time. After graduating this certificate program, staff can support their organizations in improvement around key transformation goals.
- iii. **Standardized Approach to Quality Improvement:** The Strategic Improvement Department has developed a standardized approach to addressing change and workflow redesign with its partners, compiling a toolkit drawing upon the best aspects of different disciplines. The SIT uses the toolkit to guide partners through a standard discipline for chartering, designing, implementing, testing, and improving a project. The toolkit is intended to be used by the Clinical Improvement Advisors as they work with partners, but it is also available to all partner organizations in the region for individual review and application.
- iv. **Leading Regional Learning Collaboratives:** In addition to individualized support, Elevate Health hosts two learning collaboratives annually to provide regional transformation support. The two most recent learning collaboratives focused on project 2B: Bi-Directional Behavioral Health Integration. The first, *Integrated Managed Care Learning Community (IMC) Learning Community*, is targeted at Behavioral Health Organizations transitioning to Fully Integrated Managed Care and brings together leaders from Behavioral Health organizations to discuss new billing practices, protocols, and claims processing in this new payment system. The evidence-based best practices used for this learning collaborative are the Qualis Billing and IT Survey and Toolkit and the MeHaF.

The second learning collaborative, *the Whole Person Care (WPC) Learning Collaborative*, is targeted at organizations seeking to integrate or co-locate primary care physicians and behavioral health providers in order to offer bi-directional services for patients. This collaborative is hosted in partnership with the University of Washington AIMS Center and leverages the evidence-based best practice toolkit used to lead workflow development and redesign from the AIMS Collaborative Care Model.

III. Summary of Findings – January 2020

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Project 2A: Bi-directional Integration of Physical and Behavioral Health	
<p>1. Summary of Support Provided for Transformation Project Area</p>	<p>The approaches employed for Project 2A come directly from the Elevate Health <i>Rules of Engagement</i>, a set of strategies and methods designed in collaboration with Elevate Health’s governance bodies and embedded within the Action Plans. The Rules of Engagement ask partners to set a goal for level of integration along a continuum of the SAMHSA scale, allowing for incremental transformation from minimal collaboration to full collaboration over the course of the Medicaid Transformation Project using the <i>Collaborative Care Model</i> as an evidence-based strategy.</p> <p>Specific activities for project area 2A include the following:</p> <p>Whole Person Care Learning Collaborative: Elevate Health, in partnership with the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center, offers the <i>Whole Person Care Collaborative</i> to support care teams from behavioral health and primary care clinics in the critical work of transitioning to an integrated and bi-directional health care delivery system. The Whole Person Care Collaborative concluded in December 2019 and will take on a new focus in 2020.</p> <p>Overview: Whole person care, in the scope of this collaborative, is defined as the right behavioral health and primary care services available to the right patient at the right time. The Collaborative is devoted to supporting the design of an integrated behavioral health and primary care delivery system throughout Pierce County. This collaborative will be dedicated to designing data-driven strategies and creating collaborative care teams to test integration and support the spread of change across the entire system. Multiple health systems will work together toward innovative solutions for how bi-directional care occurs in our region.</p> <p>In the 2019 Whole Person Care Collaborative, over 60 staff members from organizations from throughout Pierce County took part in the Collaborative.</p> <p>Participants included two hospital systems (MultiCare and CHI Franciscan); two primary care organizations (Northwest Physicians Network and Planned Parenthood); two community-based behavioral health providers (Comprehensive Life Resources and Consejo Family Treatment Centers); and two federally qualified health centers (Sea Mar Community Health Center and Community Health Care Tacoma). Two pediatric providers also worked toward whole person</p>

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care integration (Pediatrics Northwest and HopeSparks) for a total of 10 organizations working toward Behavioral Health integration in Pierce County.

There were 12 care teams operating across the aforementioned 10 organizations. Some organizations opted to focus on improving behavioral health integration and warm handoffs from PCP to behavioral health therapists within their system, such as CHI Franciscan. But a majority of care teams engaged in the whole person care collaborative were dynamic cross-organization partnerships such as CHC Tacoma partnership with Consejo, Pediatrics Northwest partnership with HopeSparks, and the partnership between MultiCare and Sea Mar.

As 2019 came to an end, there were trainings provided to cover hiring practices, co-planning for patient care, and billing practices for collaborative care. In addition, trainings were offered to cover workflow design and using a ‘creativity toolkit’ for shared problem solving.

2. Best Practices Identified to Date

Tracking & Managing Patients: Two of our partnerships have been particularly successful in establishing the collaborative care model: a collaboration between Pediatrics Northwest (Primary Care) and HopeSparks (Behavioral Health) and Northwest Physicians Network. At the end of 2019, both partnerships had successfully developed methods for using a registry to co-manage patients and were prepared to bill for collaborative care codes.

Active Tracking of Integration Levels: Elevate Health is used the MeHAF to identify whether sites involved in the Whole Person Care Collaborative can achieve improved MeHAF scores at an accelerated rate compared to the region as a whole. At the end of 2019, all 10 organizations participating experienced sustained scores on the MeHAF and many sites saw improvement in at least one or more areas of the MeHAF. Areas of growth were in provider and leadership engagement and executive support. Below is a breakdown of each site’s level of integration.

Practice Site	Registry?	Registry Used for MBC, T2T, and Early Engagement?	BH Provider Hired and Trained?	Psychiatric Provider Hired and Trained?	Systematic Caseload Review w/ Psych Consultant?	Billing CoCM Codes?
Tacoma CHC and Comprehensive Life Resources: Hilltop	Y	N	Y	Y	N	N
Tacoma CHC and Consejo: Parkland	Y	N	Y	Y	N	N
Sea Mar Tacoma	Y	N	Y	Y	N	N
Sea Mar and MultiCare: Tacoma Family Medicine	Y	N	Y	Y	Y	N
MultiCare: West Tacoma Family Medicine	Y	N	Y	Y	N	N
CHI Franciscan: Bonney Lake	N	N	N	Y	N	N
CHI Franciscan: Pearl Street	N	N	N	Y	N	N
Northwest Physicians Network	Y	Y	Y	Y	Y	Y

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<p>3. Summary of Findings, Adjustments, Lessons Learned</p>	<p>Throughout 2019, Bi-directional integration has been a challenge for multi-organization partnerships. The Clinical Improvement Advisors, using the strategic improvement toolkit, have assisted in the chartering of work across organizations so that expectations, team members, goals, and resources were explicitly agreed upon at the inception of the project.</p> <p>In 2019, we learned that in-person trainings were preferred to virtual trainings. In addition, we identified that in order to achieve bi-directional integration we would need to ensure that behavioral health sites also had access to primary care services. In 2020, the focus will be in ensuring there is primary care availability within behavioral health settings.</p>

Project 2B: Care Coordination

<p>1. Summary of Support Provided for Transformation Project Area</p>	<p>The specific tactics employed for Project 2B come directly from the Patient Centered Medical Home Model and the Elevate Health <i>Rules of Engagement</i>, a set of strategies and approaches designed in collaboration with Elevate Health’s governance bodies and embedded within the Action Plans. Partnering providers, both clinical and non-clinical, commit to the tactics they select and implement the Action Plan starting January 1, 2019, with updates in subsequent years.</p> <p>Key Strategies for Project 2B include:</p> <p>Care Coordination:</p> <ul style="list-style-type: none"> <i>i.</i> Develop/implement or improve follow-up with patients upon discharge from ED, urgent care, or hospital using PreManage. <i>ii.</i> Partner with CBOs for innovative care transitions (i.e. EMS, Community Paramedicine, Community Health Workers (CHWs)). <i>iii.</i> Partner with CBOs for innovative diversion strategies (i.e. criminal justice, jails, county, Crisis Triage Center, Mobile Community Intervention Response Team). <i>iv.</i> Participate in Health Information Exchange platforms that support information sharing across organizations. <i>v.</i> Develop document referral, care plan exchange, and follow-up processes with key “Medical Home Neighborhood” organizations, which may include specialty care, dental services, pharmacies, EMS, schools, criminal justice system, and CBOs. <i>vi.</i> Implement referrals to the Elevate Health Community HUB. <i>vii.</i> Become a Care Coordination Agency for the Elevate Health Community HUB.
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Care Traffic Control:

- i. Assess regional care coordination efforts, and identify and recruit partners and stakeholders for centralized care coordination referral network
- ii. Identify and develop technology platform to facilitate cross-system coordination and information sharing, and develop a process for data governance.
- iii. Develop community-wide processes and norms for care coordination.
- iv. Implement community HUB to facilitate Health Information Exchange with additional data streams.

Overview of Strategy: During the planning phase, Elevate Health and its governance bodies committed to deploy the *Pathways Community HUB model* as a first step to improve community-clinical linkages and better align community care coordination efforts in our region. In addition, by serving as the Care Continuum Network (CCN), Elevate Health functions as a centralized Care Traffic Control using a technology platform for care coordination documentation, health information exchange, and outcomes-based performance monitoring. In addition to Pathways, additional pilot programs will utilize the CCN to create an integrated “home” for care coordination that bridges clinical and community needs.

Progress of Pathways Pilot: The *Pathways Community HUB model* continues to grow. On November 29, 2020 the Elevate Health Pathways Community HUB received a Level-I certification from the Pathways Community HUB Institute. Achieving a Level-I certification means Elevate Health has demonstrated that it meets a majority of the national standards for quality community care coordination services and is committed to pursuing excellence. This certification decision represents the designation that can be awarded to a HUB that shows substantial conformance to the Pathways Community HUB certification standards. A HUB receiving a two-year term of certification has put itself through a rigorous peer review process and has demonstrated to the Pathways Community HUB Certification Program assessors during a certification review its commitment to offering programs and services that are measurable, accountable, and of the highest quality.

Any Medicaid and Medicaid-eligible individual with chronic disease, a behavioral health diagnosis, or who are pregnant may be referred to the CCN. The CCN Pathways Community HUB assesses client’s social risk and then refers them to the appropriate community-care coordinator. Five community partners who deploy the Pathways Community HUB are part of Elevate Health’s CCN.

Pathways Community HUB Care Coordination Agencies (CCAs) include:

- Community Health Care: A Federally qualified Health Center (FQHC) with operations throughout Pierce County.
- Hope Sparks: A partnering provider of pediatric behavioral health and other support services for children and families.
- Korean Women's Association: A CBO working with diverse communities across Pierce and neighboring counties.

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- Sea Mar Community Health Centers: An FQHC with operations throughout Pierce County and multiple counties in Western Washington.
- Tacoma-Pierce County Health Department: A CBO and healthcare providing, serving vulnerable populations via the methadone clinic (new partner in late 2018).

Elevate Health also contracts with community partners who may identify and refer clients directly to the CCN for screening to the Pathways Community HUB.

Referral partners contracted with Elevate Health include:

- Northwest Physicians Network
- MSS partners
 - First Steps
 - Answers
- CHI Franciscan
- MultiCare Health System, Tacoma Family Medicine
- Northwest Physicians Network

Addition of CCN Programs: Elevate Health onboarded new community partnerships in late 2018 to expand and sustain care coordination programming to address patient needs across the continuum of health. Expanding upon community partnerships allows a full spectrum of programs and services to be aligned and coordinated through the CCN and aligns with the regional goal to enhance cross-sector communications, centralize referrals, and ensure sustainability of programs.

Community agencies Elevate Health is actively in contract with to support project 2B include:

- Health Homes, Care Coordination Organizations:
 - Community Health Care
 - Sea Mar Community Health Center
- Community Health Action Team (CHAT):
 - MultiCare Health System
 - CHI Franciscan
 - Sea Mar Community Health Center
 - Pioneer Center for Human Services - Respite Center
- Community Paramedicine Collaborative:
 - Northwest Physicians Network
 - Central Pierce Fire & Rescue
 - East Pierce Fire & Rescue
 - Graham Fire & Rescue
 - Pierce County Fire District #18
 - Pierce County Fire District #5
 - West Pierce Fire & Rescue
 - Comprehensive Life Resources – MCIRT program

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	<ul style="list-style-type: none"> • Additional community partnerships and projects that aim to address care coordination that are forthcoming in 2019 include: • Health Homes <ul style="list-style-type: none"> ○ MultiCare Health System ○ CHI Franciscan • Jail Diversion: <ul style="list-style-type: none"> ○ Trueblood Diversion Program – project with Pierce County Jail • Fire District CARES: <ul style="list-style-type: none"> ○ City of Tacoma Fire & Rescue <p>Community Health Action Teams</p> <ul style="list-style-type: none"> • HopeSparks and Pediatrics Northwest
<p>2. Best Practices Identified to Date</p>	<p>A. Pathways Community Hub</p> <p>Overview: Elevate Health launched live operations as the Pathways Community HUB for Pierce County in March 2018. The Pathways Community HUB utilizes the cloud-based Care Coordination Systems software (CCS) platform. Elevate Health offers the CCS platform to referring partners and our five care coordination agencies employing seven CHWs and five supervisors. The CHWs continue to maintain a caseload maximum of 30 clients.</p> <p>Target Populations: The Pathways Community HUB continues to focus on the <i>Passage 2 Motherhood</i> program with the following population criteria:</p> <ol style="list-style-type: none"> i. Residing in Pierce County ii. Medicaid Or Medicaid Eligible iii. High Risk Factors iv. Previous Poor Birth Outcome v. Tobacco or Substance Use vi. Mental Health Concerns <p>In February 2019, the Pathways Community HUB expanded to serve chronic disease in our <i>Wellness First</i> program. Eligible criteria for this population include:</p> <ol style="list-style-type: none"> i. Residing in Pierce County ii. Medicaid or Medicaid Eligible iii. Birth - 65 years old iv. Diagnosis of two or more chronic diseases OR v. Diagnosis of one chronic disease with one mental health diagnosis / self-identified <p>Exclusion criteria includes cancer diagnoses and terminal illness.</p> <p>Trainings & Practices: All CHWs and their Supervisors are trained using a hybrid model including the use of the Pathways Community HUB Institute training and/or the Washington State Department of Heath CHW Training. Elevate Health provides the Pathways Community HUB model and technology platform training to new CHW staff. Monthly meetings remain as a best practice with the CHWs and</p>

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their supervisors to increase knowledge on resources in the community, review performance, conduct case reviews, and facilitate additional exercises where knowledge gaps are identified.

Certification: On November 29, 2019, Elevate Health received Level-I certification through the Pathways Community HUB Institute. Certification ensures fidelity to the model, ongoing quality assurance and a mechanism for ongoing process improvements. The model includes 20 standard Pathways to better address challenges and needs, particularly across known social determinants of health. Certification also requires the formation of a Pathways Advisory Workgroup (PAW). The first PAW, representing Pathways CHWs and supervisors, community members, local hospitals, and FQHCs, met in March 2019. The PAW identified outcomes performance monitoring, referrals to fill CHW capacity, and marketing as the three prime areas of its focus in 2019.

Payment: Elevate Health now provides payment to Care Coordination Agencies (CCAs) with 100% of earnings dependent on performance in closing Pathways to earn Outcome-based Payments (OBPs). Overall agency performance is reviewed with administrative staff and leadership on a periodic basis to assure fiscal monitoring and continued maximum performance. The goal for 2019 is to have at least one Managed Care Organization contract with Elevate Health to facilitate sustainable payment of OBPs to our CCAs. United Health Care is currently undergoing security assessment review with Elevate Health for this purpose.

Success Measures to Date: Successful launch and implementation of the Pathways Community HUB model is demonstrated by the number of clients engaged in the program. In 2018, 337 clients received care coordination from a Pathways Community HUB CCA (see Figure 1). Since the beginning of 2019, an additional 423 clients have received care coordination from a Pathways Community HUB CCA (see Figure 2).

Figure 1. Clients Engaged by Payer – March-December 2018

Medicaid Payer 2018	Number of Clients in Pathways
*Unknown	25
Amerigroup	42
CHPW	3
Coordinated Care	34
Molina	157
DSHS/ Provider One	25
United	51
Total Clients	337

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Figure 2. Clients Engaged by Payer - Jan. – Dec. 2019

Medicaid Payer 2019	Number of Clients in Pathways
*Unknown	30
Amerigroup	56
CHPW	3
Coordinated Care	46
Molina	202
DSHS/ Provider One	6
United	80
Total	423

More than 3,491 Pathways have been initiated with those under the Education Pathway being initiated more than 50% of the time. Other common Pathways to be initiated include those for medical referral and establishing a medical home.

Evaluation Plan: In 2020 Elevate Health will focus on cost-benefit analysis of the Pathways Community HUB programs: *Wellness First* and *Passage 2 Motherhood*. Data from this monitoring and evaluation system will support the expansion and scaling of our methods by helping identify challenges and allowing us to “smart-target” efforts required or resources available. These will take place at and with populations where implementation or proliferation is encountering challenges.

B. Health Homes

Overview: Elevate Health became a Health Homes lead for the state in late 2018 and went live with a roster of eligible clients in August 2019. Currently, Elevate Health’s CCN is focusing on the integration of Health Homes with other care coordination programs, including the Pathways Community HUB and Community Health Action Team (CHAT). In this way, Elevate Health may identify clients in the community who are referred for either the CHAT or Pathways who may be better served by the Health Homes program.

Tools & Technology: In May 2019, Elevate Health entered a contract with Innovaccer to support a cloud-based care coordination technology and facilitate documentation and referrals for Health Homes. The platform includes social vulnerability indexing and a community-referral platform to support a social service registry and referral system. The Health Homes protocol is launched, and training has begun with our Care Coordinators.

Training & Practice: Elevate Health hired staff to support the engagement of eligible individuals for Health Homes. A process workflow was developed June 2019 and is integrated with the Innovaccer platform. In addition, Elevate Health trained two staff members to become certified trainers. Our two trainers will be

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hosting their first supervised training with Community Health Care and Sea Mar early August of 2019. Trainers will also support deploying the training on Innovaccer for care coordinator and CCO staff.

C. Community Health Action Team (formerly Health Engagement Team)

Overview: Sea Mar Community Health Services and MultiCare Health Services, in coordination with Elevate Health's CCN, launched the first CHAT pilot in Pierce County in 2019, and additional partnerships with CHI Franciscan and Pioneer Center for Health Services Respite Center are in process. The CHAT care coordination team focuses on clients who need deep, community-based, and team-based care coordination. The CHAT model incorporates standards in clinical care management using a clinician (nurse or mental health practitioner) as well as use of the Pathways Community HUB model deploying a CHW. The clinical-CHW core team provides direct care and services to individuals, while ancillary team members provide wrap-around support. These team members include mobile psychiatric nurse practitioners, pharmacists, respite center staff, inpatient and ED care managers, hospitalists, primary care providers, needle exchange programs, and substance use treatment providers.

Tools & Technology: In Q1 2020, the Pathways & CHAT workflow is built into Innovaccer, Elevate Health's technology infrastructure, to support clinical documentation and referrals for the CHAT program. The protocol workflow incorporates elements of Health Homes and Pathways Community HUB care planning documentation with a heightened focus on engagement strategies to foster outcomes improvement. For more information, including population criteria, see Summary of Support Provided for Transformation Project Area, under Project 3A below.

D. Care Continuum Workgroup: The Community Paramedicine Collaborative

Overview: The Community Paramedicine Collaborative is an identified best practice in Pierce County to address the overuse of emergency medical services calls. This collaborative, initiated in 2014, has demonstrated outcomes improvement and better knowledge of care coordination services providers for EMS partners. This includes community partners, law enforcement, payers, behavioral health, and primary care providers.

The workgroup proposed a plan to sustain the paramedicine collaborative by December 31, 2019. In 2020 Elevate Health will work with the Care Continuum Workgroup which includes 7 Pierce County Fire Districts, to help track reduction in 9-1-1 calls as well as reduction in EMS transports.

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Target Population: The focus of the collaborative is on Medicare patients who utilize EMS frequently, or for whom Fire Department and other rescue teams have identified a safety concern in the client's home.

Success Measures to Date: Preliminary evaluation has examined several outcome measures by comparing 12-months prior to 12-months post services received. Results have shown a 44% decrease in EMS calls 12-months post services, as well as a 47% decrease in EMS transports.

The Care Continuum Workgroup: Elevate Health began working with the workgroup at the beginning of 2019 with the goal of assisting the Pierce County Fire Districts involved in the collaborative achieve a sustainability plan after December 31, 2019. During the year in 2019, Elevate Health held and helped to facilitate monthly meetings to work through the Care Continuum Workgroup. In addition, the group explored scaling up the population and developing sustainable payment models for this partnership. At the end of 2019, the collaborative's centralized referral coordinator, Northwest Physician's Network (NPN), will no longer act in that capacity. Elevate Health is currently working through the Care Continuum Workgroup, which meets monthly with all partners, to explore how Elevate Health may support the program as centralized referral coordinator as NPN transitions away from the role.

Elevate Health will continue to support the sustainability of the EMS Community Paramedicine work in 2020. Three additional EMS partners will be funded for this work include City of Tacoma, Key Peninsula, and Graham, Washington.

CHAT Best Practices: The CHAT team hired an additional Community Health Worker and Integration Specialist in Q4 2019. The full team now includes two CHWs, two Integration Specialists, and one supervisor. The team is also in the process of adding 0.25 FTE of an existing ARNP from Sea Mar. This transition should be complete in Q2 of 2020.

In Q4 2019, the CHAT team began transitioning to a new technology platform that will be completed in Q1 2020. The current technology platform is in the process of being phased out and replaced with a more efficient platform. All previous client information will be transferred to the new platform and users will receive training on the new platform at the end of January 2020. Although, the transition process from one system to another will be time-consuming; the new technology platform, Innovaccer, provides many benefits when compared against the data platform to be phased out. Innovaccer matches more closely with the ACH's overall data strategy and adds increased functionality and ease of use for our anticipated users (both front end for operational use and backend for data analytics).

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<p>3. Summary of Findings, Adjustments, Lessons Learned</p>	<p>Scaling the CCN: Planning to scale the Care Continuum Network to incorporate all community-based care coordination programs in the region is a major priority. Elevate Health is supporting this effort through the IMC learning Network, Community-Care Management Collaboration, and the CHW collaborative, as well as supporting the development and deployment of additional care coordination projects in the community.</p> <p>Community-Owned Solutions: Bi-directional communication and standardization of care management processes across sectors remains a challenge in the community. Elevate Health is supporting this effort through the development of shared technology solutions to address these needs while remaining a shared community asset rather than belonging to, or working for the sole benefit of, any single partner or stakeholder.</p> <p>Payment Reform: Elevate Health is actively pursuing strategies to build sustainable payment models within the community that can spread and scale programs. We continue to explore contracting with Managed Care Organizations in new ways to build toward long-term community sustainability.</p> <p>CHAT Summary of Findings: In 2019, the CHAT team learned that there were some barriers to accessing their services. Through staffing increasing and utilizing a standard documentation tool, the theory is that utilization of CHAT will increase. Additionally, CHAT has been a useful resource in supporting patients in the respite center transitioning from care back into the community. The CHAT team will be integral in preventing readmissions and ensuring patient’s social needs are met.</p> <p>Care Continuum Workgroup Summary of Findings: Data is essential as a guiding force. While working with the Care Continuum Workgroup for the 2019 year, it was discovered that Emergency Medical Services (EMS) would be best understood, tracked and captured if there were more data points to analyze. In 2020 the Care Continuum Workgroup will track emergency services calls and transport with the goal of referring patients to appropriate services in order to reduce avoidable 9-1-1 calls and EMS transports. Using reduction in calls and transports as proxy measures, it is expected that this will result in a reduction in avoidable emergency department utilization.</p>

Project 2C: Transitional Care

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1. Summary of Support Provided for Transformation Project Area	Not Applicable
2. Best Practices Identified to Date	Not Applicable
3. Summary of Findings, Adjustments, Lessons Learned	Not Applicable

Project 2D: Diversion Interventions

1. Summary of Support Provided for Transformation Project Area	Not Applicable
2. Best Practices Identified to Date	Not Applicable
3. Summary of Findings, Adjustments, Lessons Learned	Not Applicable

Project 3A: Addressing the Opioid Use Public Health Crisis

1. Summary of Support Provided for Transformation Project Area	<p>Overview of Approach: Elevate Health is implementing a portfolio approach to Project 3A, fusing all project areas together and incentivizing partnering providers to engage in transformational activities through the formation of Action Plans. The specific approaches employed for Project 3A come directly from the Elevate Health <i>Rules of Engagement</i>, a set of strategies and approaches designed in collaboration with Elevate Health’s governance bodies and embedded within the Action Plans. Partnering providers, both clinical and non-clinical, commit to the tactics they select and implement the Action Plan starting January 1, 2019. The following tactics are outlined for project area 3A.</p> <p>A. Community Health Action Teams (CHAT) as of Q4 2019: The ACH is working with Sea Mar and MultiCare to stand up CHAT teams targeted at deterring cost for high utilizing patients, especially those with complex health</p>
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challenges, such as opioid and other forms of substance abuse. Criteria for individuals to be eligible in the program include:

- i. Adult patients being served by Sea Mar and MultiCare, or patients being exclusively served by MultiCare;
- ii. Individuals covered by Medicaid;
- iii. Individuals identified as frequent utilizers of services as defined by having four or more emergency department (ED) or inpatient visits within the last six months; and
- iv. Individuals with admission complaints related to:
 - a. Infections or infectious disease;
 - b. Respiratory diagnoses or complications;
 - c. Cardiovascular diagnoses or complications; and/or
 - d. Individuals engaging in active drug use.

The CHAT, managed and employed by Sea Mar, provide intensive medical, mental health, and social service coordination for its clients with the aim of improving health outcomes and reducing high-cost hospital utilization. The general goals of the CHAT program are: 1) reduced use and costs of emergency and health care systems; 2) promotion of efficient and appropriate use of community resources; 3) improved health, independence, and well-being of individuals with complex needs.

Success Measures to Date: 46 referrals have been made from the participating hospital and through a respite project for the CHAT services. Thirty-four of those 46 clients have been engaged for services. A success story includes connecting a client to an adult family home. This has reduced a client's utilization of the emergency room and has opened the door for treatment services.

B. Community-Level Opioid Leadership Role as of Q4 2019:

Elevate Health serves as a regional leader and convener for opioid use disorder strategies, co-leading the *Pierce County Opioid Task Force*. The task force is comprised of local stakeholders including the county council, county Human Services, the Tacoma Pierce County Health Departments, MCOs, and providers across the physical, mental health, and substance-abuse settings. The task force comes together in a series of committees to address the opioid crisis, including:

- i. **Access to Treatment Committee**
 - a. *Priority:* Collaborative for providers in MAT services, policy change, and advocacy in guidelines for Naloxone availability.
 - b. *Tactics:* Explore the possibility of a collaborative comparable to Elevate Health's Whole Person Care Collaborative, but with a focus on MAT services. Naloxone's availability has been lacking, and the Access to Treatment committee is hoping to contact the Department of Health to advocate for availability of Naloxone.

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	<p>ii. Right Services, Right Time Committee</p> <ul style="list-style-type: none"> a. <i>Priority:</i> Develop a clear intake tool for first responders and law enforcement to assess readiness for opioid use disorder treatment and access areas in the community. b. <i>Tactics:</i> Increase awareness of the District Court’s Resource Center, and support Partners efforts to provide diversion programs. <p>iii. Prevention and Education Committee</p> <ul style="list-style-type: none"> a. <i>Priority:</i> Address the opioid epidemic upstream with children and youth and identify drivers for addiction. b. <i>Tactics:</i> Assess prevention curriculum in all 15 school districts, develop a screening and referral strategy, and research youth focused media campaigns. <p>C. National-Level Leadership Role:</p> <p>At the beginning of 2019, Elevate Health joined a national consortium of service providers and researchers, hosted by the Massachusetts Institute of Technology and our DSRIP Partners to the east, Staten Island Performing Provider System (PPS), to address the opioid crisis at the national level. At the end of 2019, Elevate Health determined it would hold on its participation in the national consortium and focus on efforts within Pierce County. Elevate Health still plans to stay abreast of national updates and progress on the Opioid Epidemic.</p>
<p>2. Best Practices Identified to Date</p>	<p>Community-Level Best Practices as of Q4 2019:</p> <ul style="list-style-type: none"> ▪ Utilizing the prescription monitoring program before writing prescriptions for opiates and other addiction medications. ▪ Promote awareness of, and access to, Naloxone (Narcan). ▪ Ensure safe space drop offs are available within the community. ▪ Understand reasons for provider’s reservation to prescribing MAT. ▪ Ensure that therapy is administered with medication assisted treatment. <p>National-Level Best Practices:</p> <ul style="list-style-type: none"> ▪ Utilize the Opioid Risk Tool to screen all patients before prescribing opioids. ▪ Follow CDC guidelines for initial chronic medication dosing. ▪ Obtain informed agreement from patients on the risks and benefits of opioids. ▪ Offer patients information on tamper-resistant caps and bottles. ▪ Promote return of unused controlled medications and establish safe drop off points. ▪ Establish cross-sector partnerships to transition from a punitive response

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to overdose to one that promotes restorative justice and ensures a patient is receiving proper clinical care and medication assisted treatment to deter addiction.

3. Summary of Findings, Adjustments, Lessons Learned

Data as a Foundational Asset: Reliable and timely data is critical to track the outcomes of best practices and tested strategies. With Opioid Use Disorder in particular, it has been difficult to track the outcomes of strategies in the absence of a data source to track clinical or claims data. In our Q4 2019 SAR, we asked an additional question regarding measuring the number of providers who are licensed to prescribe MAT, and the number of providers who are actively prescribing. We have also included a free-form text box to garner feedback on why organizations with licensed prescribers may be hesitant to providing MAT.

The goal of this additional data collection is to help us understand the pervasive access gap to MAT providers and understand the need for additional training or infrastructural supports which can lead to improved access.

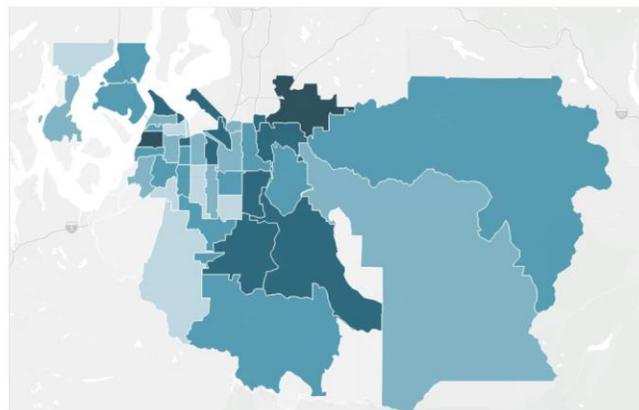
We also facilitate dialogue with our Provider Panel to understand trends in accessing MAT services in the community. We have created hot spot maps to understand access and demand needs impacting MAT services.

Substance Use Treatment Penetration

Rate (%)

- Suppressed
- 32 - 41
- 30 - 31
- 28 - 29
- 23 - 28
- 6 - 23

Substance Use Treatment Penetration includes Medicaid beneficiaries ages 12 and older with a substance use disorder treatment need. A higher rate (darker shade) corresponds with more members receiving substance use treatment services
Pierce rate: 28%



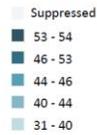
© 2019 Mapbox © OpenStreetMap

Data Source: Healthier Washington Dashboard; Measure Period: 10

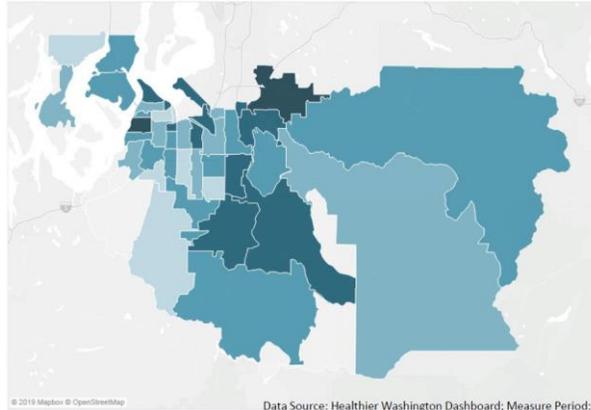
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Substance Use- Opioid- Treatment Penetration

Rate (%)



Opioid Treatment Penetration includes Medicaid beneficiaries ages 18 and older with a opioid use disorder treatment need. A higher rate (darker shade) corresponds with more members receiving medication-assisted or medication-only treatment services.
Pierce rate: 44%



© 2019 Mapbox © OpenStreetMap Data Source: Healthier Washington Dashboard; Measure Period: 10/1/17

Project 3B: Reproductive and Maternal/Child Health

<p>1. Summary of Support Provided for Transformation Project Area</p>	<p>Not Applicable</p>
<p>2. Best Practices Identified to Date</p>	<p>Not Applicable</p>
<p>3. Summary of Findings, Adjustments, Lessons Learned</p>	<p>Not Applicable</p>

Project 3C: Access to Oral Health Services

<p>1. Summary of Support Provided for Transformation Project Area</p>	<p>Not Applicable</p>
<p>2. Best Practices Identified to Date</p>	<p>Not Applicable</p>

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3. Summary of Findings, Adjustments, Lessons Learned

Not Applicable

Project 3D: Chronic Disease Prevention and Control

1. Summary of Support Provided for Transformation Project Area

Overview: The specific tactics employed for Project 3D come directly from the Patient Centered Medical Home Model and the Elevate Health *Rules of Engagement*, a set of strategies and approaches designed in collaboration with Elevate Health’s governance bodies and embedded within the Action Plans. Partnering providers, both clinical and non-clinical, commit to the tactics they select and implement the Action Plan starting January 1, 2019, with updates in subsequent years. Elevate Health is implementing a portfolio approach fusing all project areas using two primary tactics: 1) strategic improvement to facilitate transformation and outcomes improvement, and 2) care coordination. Both efforts aim to assess the needs of the population to target interventions that drive improved outcomes for chronic disease.

Elevate Health selected Wagner’s *Chronic Care Model* as the evidence-based approach for this program area. The project is centered on four key drivers of change:

- i. Adoption of Elevate Health’s Transformation Rules of Engagement, ensuring consistent guidelines across regional partners;
- ii. Implementation of Chronic Disease Self-management (CDSM) interventions;
- iii. Provision of support for effective complex care and disease management for targeted populations (scaling and spreading as interventions begin to work in the initial targeted populations); and
- iv. Utilization of the Community Advisory Committee and the Provider Integration Panel.

Change Concepts: Demonstration participants are incentivized through milestone payments to work with non-clinical partners for Chronic Disease Prevention and Mitigation. Clinical partners are held accountable to the following change concepts:

- i. Engaged leadership
- ii. Empanelment for population health management
- iii. Quality improvement strategy
- iv. Continuous and team-based healing relationships
- v. Organized, evidence-based care
- vi. Person-family engagement and experience
- vii. Enhanced access
- viii. Care coordination
- ix. Value-based payment
- x. Equity in the delivery of services and interventions

xi. Whole-person care

Activities required within these concepts are outlined below.

Transformation Activities Required for Clinical Partners:

Clinical partners are required to engage in activities within each of the change concepts outlined above. Specific activities include:

- i. **Partnership Accelerator Framework:**
 - a. Identify actions, policies and initiatives to advance along spectrum of partnerships continuum with financial incentives provided in funds flow framework.
- ii. **Health Equity Accelerator Framework:**
 - a. Identify actions, policies and initiatives to advance along spectrum of health equity continuum with financial incentives provided in funds flow framework.
- iii. **Engaged Leadership:**
 - a. Assign a Chronic Disease Management project to a multi-disciplinary team.
- iv. **Quality Improvement Strategy:**
 - a. Choose a formal model for quality improvement to drive systems changes for Chronic Disease Management (IHI Model for Improvement recommended).
- v. **Sustainable Business Operations:**
 - a. For Behavioral Health partnering providers, develop a plan to transition to IMC payment model.
 - b. Develop a plan to transition to VBP arrangements.
- vi. **Person/Family Engagement:**
 - a. Utilize the Elevate Health’s CAC for Phase 1 Action Plan feedback.
- vii. **Empanelment:**
 - a. Implement/improve a process for reviewing panel-level data for patients with chronic disease and/or who are at risk for chronic disease.
 - b. Use panel data and registries to proactively contact, educate and track patients with chronic disease.
- viii. **Continuous and Team Based Healing Relationships:**
 - a. Define team roles including those who support patients with diabetes either directly or indirectly and communicate roles to patients.
 - b. Assess training needs of care team and implement a training plan with emphasis on stigma and trauma reduction, trauma-informed care, cultural and language diversity, health literacy, motivational interviewing, and Opioid Misuse Disorder treatment and prevention.

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- c. Provide MAT training opportunities for providers and care team members.
- d. Consider integration of Community Health Workers or Peer Specialists in the care team.
- ix. **Organized, Evidence-Based Care:**
 - a. Implement Guidelines for Prescribing Opioids for Pain and Substance Use During Pregnancy (SAMHSA).
 - b. Implement Washington State Medical Director’s Group Interagency Guidelines on Prescribing Opioids for Pain.
 - c. Implement Washington Emergency Department Opioid Prescribing Guidelines for emergency departments.
 - d. Integrate Decision Support Tools in the EHR.
 - e. Implement validated, substance use screening such as Screening, Brief Intervention and Referral to Treatment (SBIRT), including evaluation for MAT.
 - f. Register providers with the PMP.
 - g. Integrate PMP with the her.
 - h. Evaluate appropriateness of co-prescribing Naloxone for pain patients.
- x. **Person/Family Engagement:**
 - a. Develop/implement or improve process for engaging patients in decision making in plan of care.
 - b. Provide self-management support at every visit through goal setting, action planning and follow-up.
 - c. Obtain feedback from patient/family about their healthcare experience and use this information for quality improvement.
 - d. Review how the organization communicates with patients for culturally appropriate and/or health literacy-level communication.
 - e. Integrate Community Health Workers for person/family engagement.
- xi. **Enhanced Access:**
 - a. Promote and expand access by assuring established patients have 24/7 access to their care team via phone, email telehealth, and/or in-person visits.
 - b. Provide scheduling options that are patient- and family-centered and accessible to all patients.
 - c. Integrate usage of Community Health Workers/Peer Support Specialists in the care team (i.e. ensuring appointments are kept)
 - d. Implement telehealth programs that enhance access.
- xii. **Care Coordination:**
 - a. Develop/implement or improve follow-up with patients upon discharge from emergency department, urgent care or hospital.
 - b. Partner with CBOs for innovative care transitions (i.e. EMS, Community Paramedicine, Community Health Workers).
 - c. Partner with CBOs for innovative diversion strategies (i.e. criminal

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- justice, jails, county, Crisis Triage Center, Mobile Community Intervention Response Team),
- d. Participate in Health Information Exchange platforms that support sharing across organizations.
 - e. Develop document referral, care plan exchange and follow-up processes with key “Medical Home Neighborhood” organizations, which may include specialty care, dental services, pharmacies, EMS, schools, criminal justice system, and CBOs.
 - f. Implement referrals to the Elevate Health Community HUB.
 - g. Become a CCA for the Elevate Health Community HUB. Determine target populations of interest.

Elevate Health & the Role of the CCN: In addition to these individual organizational change concepts, Elevate Health connects these efforts by acting as a centralized Care Traffic Control with a platform for Health Information Exchange, and a holds the process for implementing an outcomes-based approach to coordination of care supported by a robust software platform and detailed analytics. Below is a set of tactics specific to implementation of the Care Continuum Network.

i. Care Traffic Control

- a. Assess regional care coordination efforts and identify and recruit partners and stakeholders for CCN that includes CHAT (clinical care coordination, transitions, and diversion) linked with Pathways (Social Determinants of Health).
- b. Identify and develop technology platform to facilitate cross-system coordination and information sharing, as well as develop a process for data governance.
- c. Develop community-wide processes and norms for care coordination.
- d. Implement Care Continuum Network to facilitate Health Information Exchange with additional data streams.

ii. Community Health Action Team

- a. Pilot CHAT model for persons and families who need deep, community-based, team-based care coordination for priority populations outlined below.
- b. Identify CHAT pilot target population. Potentially to focus on opioid, chronic disease, dual diagnosis, and long-term care target populations.
- c. Conduct request for proposal (RFP) process to identify key health systems and community-based partners for CHAT pilot.
- d. Build technology infrastructure, such as adapting technology platform for CHAT pilot and connecting to provider EHR systems.

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	<p>Transformation Activities Required for Non-clinical ACH Partners: CBOs or other nonclinical partners are also required to engage in activities to support a transformed health system and improved care delivery by strengthening the link between community and clinical systems while reducing barriers to care. They are required to:</p> <ul style="list-style-type: none"> i. Identify target populations. ii. Identify how proposed project design aligns with the Elevate Health projects (e.g., prevention and management of behavioral health challenges, chronic conditions and/or opioid misuse) and connects with Health Systems. iii. Implement a process to engage clients and, where appropriate, family members in decision-making. iv. Reduce barriers to care. v. Partner with Health Systems who serve the identified target population. vi. Develop quality improvement and evaluation processes and metrics. vii. Develop and implement actions, policies, and initiatives to advance partnerships with health systems and promote health equity.
<p>2. Best Practices Identified to Date</p>	<p>Elevate Health has used a multi-phase process to identify target populations for this project. With the support of CORE and Elevate Health’s DLT Workgroup, council members were asked to identify populations according to need and potential impact. Based on the assessments and data, these sets of priority populations with multiple chronic care conditions were identified for Pierce County:</p> <ul style="list-style-type: none"> i. Adults with diabetes (particularly Type 2) ii. Children and adults with obesity iii. Children and adults with asthma/chronic obstructive pulmonary disease (COPD) iv. Adults with hypertension and cardiovascular disease <p>Targeted populations are selected by partnering providers and embedded in their workplans. Outcomes selections were assessed and collected Q3 of 2019. Additional populations will be considered in later years as interventions prove successful.</p>
<p>3. Summary of Findings, Adjustments, Lessons Learned</p>	<p>Strategic Improvement Teams: Elevate Health will help advance the communities’ work in chronic disease prevention and control through the deployment of Elevate Health’s <i>Strategic Improvement Team</i>, which utilizes the principles of improvement science to drive transformation by deploying trained advisors to support transformation initiatives and helping build transformation capacity within the community of partnering providers.</p>

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Workplan Monitoring & Fine Tuning: Partnering providers will update their workplans on an annual basis in consultation with Elevate Health, thus allowing for sustainability, spread, and ongoing process improvement of chronic disease management and mitigation.

Continuous Improvement: Elevate Health Pathways Community HUB pilot launch of chronic disease in 2019 is gaining ground. The PAW in Q4 2019 will be looking at P4P outcomes performance data to assess opportunities for improvement and steer direction for the CCN.

IV. Approval and Review Process:

Elevate Health will review its quality and strategic improvement strategies and benchmarks every 6 months and revise and update the Quality Improvement Plan annually, as necessary. The plan will be approved by the Executive Leadership and the Provider Integration Panel.