DRAFT TRANFORMATION PROJECT PLANNING SECTION for WPCC

This is a DRAFT version of one section in NCACH's Phase II Certification Proposal. It addresses the way Demonstration projects were selected, and how they fit together in a mutually reinforcing manner. Although this section will get further editing, we thought it might be useful at this point to WPCC members to see our thinking on how the WPCC effort fits into the rest of the Demonstration. (The numbers you'll see before each section are from the proposal template, which we'll use in the final submission.)

1

NCACH implemented a multi-faceted approach to ensure project selection aligned with regional needs.

The December 2016 Community Health Needs Assessment (CHNA) completed in our region revealed several regional priorities including: Access to care, particularly for mental health; substance abuse; diabetes; obesity; education; affordable housing; and healthy foods.

NCACH then held 6 widely publicized community forums in April 2017 and electronically distributed surveys and recorded presentations to 550 stakeholders to gain community input including Medicaid beneficiaries, providers, and other community partners. Based on the needs assessment and gathered input, the board at an open meeting on May 8th selected Care Coordination, Transitional Care, Diversion Intervention, and Chronic Care in addition to the two mandatory projects.

Six key considerations were articulated and applied during the Governing Board's project selection process:

1. Project selection should be shaped by patient and community needs, not by the institutional needs of any sector or organizations.
2. The Board agreed it would be better to do fewer projects well than to take on more projects than could be delivered effectively, notwithstanding the financial incentive to select all eight projects.
3. The projects are interrelated, and the portfolio of selected projects, if implemented well, would to some extent address the purposes of projects not selected.
4. It is crucial to select (and then implement) projects in a way that emphasized not the payment of service costs with Demonstration funds (except perhaps in a start-up phase), but the creation of a sustainable approach through which Demonstration dollars would no longer be needed after 2021 to deliver the services and innovative care models involved.
5. The Whole Person Care Collaborative (WPCC), organized over a year before, provided a powerful framework though which to apply demonstration resources in support of care transformation. The fact that WPCC already existed helped the Board envision the way projects could interact in the actual care of patients.

6. Changing the practice patterns of providers and the organization of delivery systems is a very difficult and slow process. A very well organized and focused effort involving mutually-reinforcing initiatives will be needed to meet Demonstration objectives in the time available.

The projects selected by the Governing Board reflect these considerations and make up a set of mutually-reinforcing initiatives:

- The Whole Person Care Collaborative, which brings together medical and BH provider organizations region-wide, provides a framework through which to create many of the care transformations on which the Demonstration is based. WPCC will use Demonstration funds to support the development and implementation of Change Plans by each member organization. Initial planning funds and consulting services will enable provider organizations to develop plans (with required milestones and metrics) for the many changes – ranging from IT systems to the makeup of care teams and the configuration of office space – needed to provide care in a sustainable manner under the new incentives created by VBP and other payment changes. Further awards of Demonstration funds to WPCC members will be used to implement these Change Plans during the Demonstration. WPCC will also serve as a learning collaborative for member providers as they work to implement care transformation.
- Through the WPCC initiative, NCACH's Demonstration efforts will directly address not only BH integration but also important aspects of the projects on Transitions and Diversions, the Opioid crisis and Chronic Disease Prevention and Control. For each of these projects, better whole-person care that integrates behavioral and physical health, while connecting patients with community resources to help mitigate health-related social issues, will directly improve the performance of the care system. This will be relevant whenever those patients are involved in Transitions (such as discharge from a psychiatric hospital or nursing home), have problems that could result in a need for Diversion options (such as alcoholism, bipolar disease or homelessness), are at risk of developing (or already have) opioid problems related to chronic pain, or have Chronic Disease risks or symptoms (such as obesity or hypertension). For our patients, these are not separate projects but various aspects of life and health care.
- WPCC Change Plans will address care coordination, and participation in the Pathways HUB as it builds out to cover the region. More effective care coordination directly addresses important aspects of BH integration, Transitions and Diversion, the Opioid crisis and Chronic Disease Prevention and Control.
- NCACH plans to use care coordination systems – current systems and, when available, the Pathways HUB – as a mechanism for funding the access of Medicaid beneficiaries to community-based services addressing the social determinants of health. The point here is to make services addressing the social determinants an integral part of the health care system, not a disconnected silo.
- WPCC is important, but it is not the whole story for NCACH. Additional workgroups will be created to address the important aspects of the projects not addressed by WPCC. For example, the Opioid and Transitions/Diversion effort will involve interfaces with law enforcement, jails, emergency

departments and EMS that would probably not be part of WPCC efforts. Workgroups will be created for:

- Creation of the Pathways HUB
- Diversion/Transitions Project
- Opioid Crisis Project
- Chronic Disease Prevention and Control Project

The two projects not selected were omitted for different reasons. Project 3B on Reproductive and Maternal/Child Health was not selected because the Governing Board believes that, to the extent services in this section of the Toolkit are sustainable, effective implementation of the selected projects will help address these needs. Project 3C on Access to Oral Health Services was not selected for two reasons. The first is that FQHCs in the region already have some capacity to address this need and plan to develop more. The second is that the primary barrier to additional progress is the persistent unwillingness of almost every dentist in the region (outside the FQHCs) to accept Medicaid reimbursement for adult dental care. Some of this unwillingness is no doubt based on misinformation, but it is very persistent and the Governing Board believes it makes sense to focus on areas where more results are likely – areas which are already a very heavy lift.

2

NCACH is committed to participating fully in Domain 1 initiatives as HCA further defines those initiatives and the roles of ACHs. We expect (and hope) that this work will involve considerable collaboration among ACHs.

Another important area of collaboration among ACHs involves the Pathways HUB. There are opportunities for shared learning and also the possibility of shared purchasing of HUB information systems. ACHs implementing the HUB may be able to share the cost of creating interfaces between the HUB information system and provider EMRs. NCACH is also aware that some of our MCO partners have considerable expertise regarding Pathways HUBs. We have already been in touch with other ACHs interested in the HUB and look forward to the time when all the ACHs have made their project selections and we can get down to work with those selecting the HUB.

NCACH has shared its plans for the Whole Person Care Collaborative with leaders of the state's ACHs and looks forward to opportunities to collaborate with them on any related initiatives they may adopt.

NCACH leaders are active in statewide conference calls of ACH leaders – those convened by HCA and those convened separately by the ACH leaders – and is committed to taking advantage of any opportunities arising from those discussions to collaborate with other ACHs on projects.

3

MCOs have been an integral part of NCACH's formation from the beginning and hold a voting seat on the ACH Governing Board. We view MCOs as critical partners in the design and implementation of Demonstration projects and one of the major advantages we see in being a Mid-Adopter region is that

we now know which MCOs will be active in the region and can get down to work with them. NCACH leadership has already had separate meetings with the three MCOs who are Apparently Successful Bidders for our region, and is in the process of scheduling as joint session for ACH leaders and all three MCOs. Our intention is to make this a regular meeting in order to assure that MCOs are fully engaged in NCACH's work, especially its Demonstration projects.

4

The biggest challenge in developing successful project plan submissions is that each project involves many partners, and a project that depends on many partners must include them in the planning process if it hopes to succeed. An effective project plan cannot emerge from a lone writer at a computer, but can only result from extensive discussions among many different people and organizations. That takes time. Although NCACH understands that DY2 is considered a planning and development year, we believe strongly that the sooner we begin implementation the more likely it is that difficult care transformations will occur in time to demonstrate an effect by the end of 2021. We hope to be ready for implementation well before the end of 2018. So we have a sense of urgency about this, to go along with our understanding that we must take the time necessary to adequately involve partners. We are addressing this need for collaboration in three main ways:

1. The Whole Person Care Collaborative already includes virtually every medical and BH provider in the region, and it was formed over a year ago because we knew their involvement would be critical in anything we attempted. WPCC will be an important venue through which project plans are developed.
2. Each local health jurisdiction in the region (Okanogan, Grant and Chelan-Douglas) organized a broad group of community partners and social service providers, called a Coalition for Health Improvement (CHI), in 2014 when the concept of ACHs was first introduced. Since then, CHIs have been instrumental in development of NCACH. The Governing Board recently decided to formalize the CHIs by providing a half FTE of staffing for each, to help organize and grow them, and by providing a voting seat on the board for each CHI. The CHIs will be an important avenue for partner involvement in the development of project plans.
3. We are in the process of forming workgroups for NCACH projects. Each workgroup will have a charter and will draw its members mainly from WPCC and the CHIs, though others (such as MCO representatives) will be recruited as needed.

NCACH is also very concerned about data issues. Perhaps most pressing is the need to develop solid baseline data on important project metrics, without which any subsequent data collection may be meaningless. We are not convinced that the state will be able to provide such data and are looking at options for developing this capacity within the region.

5

NCACH has made it a priority to reach out to every clinical facility in the region and we believe we are working with every Medicaid provider in the region through the Whole Person Care Collaborative. Our work as a Mid-Adopter region has facilitated our connection with behavioral health as well as physical health providers.

6

NCACH has developed a Whole Person Care Collaborative membership charter and membership agreement that was approved by the NCACH Board on August 7th, 2017. By signing the membership agreement, an organization becomes eligible for a Change Plan Development Award and, if the change plan is considered adequate, a Change Plan Implementation Award. We believe this funding, along with the opportunity to be part of an active learning collaborative, will incentivize provider organizations to commit to Demonstration project activities. Behavioral and physical health providers will be included in this process.

7

NCACH's Governing Board includes a wide variety of partners. NCACH's three Coalitions for Health Improvement (CHIs) are an important asset in assuring broad partner engagement. CHIs include a very wide range of partners. Clinical organizations, social service providers, local elected officials and community members are among the participants. Over 500 people in the region have been involved at some point since CHI's began meeting in 2014. More recently, CHIs were an integral part of project selection. The Governing Board recently provided funding for half an FTE at each CHI to further their development, and created a voting Board position for each CHI. CHIs are the primary mechanism through which NCACH assures that a very broad range of community partners are engaged in NCACH's work.

North Central's work to prepare for FIMC as a Mid-Adopter region has also involved an extensive series of Advisory Committee and related workgroup meetings. This has further engaged behavioral health providers, consumer representatives and other interested partners. We expect to fold these groups into the CHI effort after full contract integration occurs on January 1, 2018.

8

It is NCACH's firm policy not to fund service delivery costs or other operations costs for service providers, or for other project activities, except in the context of a project plan leading to sustainability in the absence of Demonstration funds after 2021. There will be startup costs in some projects – for example, the initial purchase of IT infrastructure and software for the Pathways HUB. But no such investments will be made until a practical sustainability plan, with commitments from funders, is developed. With regard to clinical transformation efforts funded through the Whole Person Care Collaborative, one of the requirements for Change Plans is a clear plan for sustainability. Implementation awards for providers' Change Plans will not be made in the absence of such plans. Those plans must demonstrate how the proposed changes will position the provider organization to

provide integrated Whole Person Care under new payment approaches such as VBP after 2021. The same emphasis on sustainability will occur in planning other aspects of the Demonstration. Sustainability is a core value of NCACH in all of its Demonstration efforts.