Whole Person Care Change Plans

Introduction

In 2015, the North Central Accountable Community of Health (NCACH) Governing Board selected whole person care as the primary project under a State Innovation Model (SIM) grant program. The Medicaid Demonstration presents an opportunity to build on this project and incorporate whole person care into six health improvement projects selected by the NCACH Governing Board. Because many purposes of the Medicaid Demonstration Projects cannot be addressed without changes in the care of patients, clinical provider organizations have a major role to play.

Whole Person Care Vision

Our region's vision of whole person care is for a patient to reach a state of complete physical, mental, and social well-being by creating healthcare systems that will:

1. Improve the patient experience of care
2. Improve population health, and
3. Reduce the per capita cost of health care

Patients will receive care that integrates behavioral and physical care and will be effectively connected to resources that can help mitigate the negative effects of social determinants of health. The goal is to promote Whole Person Care in a way that is financially sustainable for provider organizations.

Overview of Change Plan

The Change Plan template is intended to document what you, as a clinical provider, can accomplish to support whole person care in our region. It includes eight core topics, representing opportunities to support the NCACH projects (see ***Appendix A***) or an area felt to be important to meet the overall ACH goals which are to:

- Promote health equity throughout the state.
- Create, support and collaborate on local health improvement plans.
- Support local and statewide initiatives such as the Medicaid Transformation Demonstration, practice transformation and value-based purchasing.
- Align resources and activities that improve whole person health and wellness.

Each organization will make improvements and thus contribute to the overall goals of the ACH. The success of NCACH depends on robust changes at the practice level that roll up to collective success for the North Central region. For each topic, think about changes that would benefit your practice and the patients or clients that you serve. Your scores on the PCMH-A or MeHAF should guide you toward opportunities for improvement. This Change Plan will detail what you hope to change within your organization and also the commitment you make to support the ACH.

Completion of this template can be a roadmap for your work. You should refer to the descriptions in the appendix of this document to understand more about each topic (see ***Appendix B***), including resources to help you think through some evidence-based changes that will facilitate your progress. Subsequent funding decisions will involve how effectively you meet the milestones and aims outlined in your Change Plan.

Organization Name:
Health services offered (*check all that apply*): ☐ Primary Care ☐ Mental Health ☐ Chemical Dependency

I. Context

A. BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION

Briefly describe where you currently fall in the six levels of collaboration outlined in the Standard Framework for Integrated Care. Given your resources and patient population, which level do you hope to move to? (see https://www.integration.samhsa.gov/integrated-care-models/CIHS_Framework_Final_charts.pdf)

Current Level:
Desired Integration Level by 2021:

B. CURRENT STATE ASSESSMENT

Record your recently completed PCMH-A or MeHAF assessment here. Briefly discuss your results and what seem to be the next steps and opportunities to focus on during the demonstration project. Summarize your thoughts in the last column of the appropriate assessment.

PCMH-A		
PCMH-A Scoring Summary		
Change Concept	***Average Subscale***	***Improvement Opportunities to Target***
1. Engaged Leadership		
2. Quality Improvement Strategy		
3. Empanelment		
4. Continuous and Team-Based Healing Relationships		
5. Organized, Evidence-Based Care		
6. Patient-Centered Interactions		
7. Enhanced Access		
8. Care Coordination		

OR

MeHAF		
Characteristic *(edited for brevity)*	***Level***	***Improvement Opportunities to Target***
I. Integrated Services and Patient and Family-Centeredness		
1. Level of integration		
2. Screening and assessment for medical care needs		
3. Treatment plans for primary care **and** behavioral/mental health care		
4. Patient care based on best practice evidence		
5. Patient/family involvement in care plan		
6. Communication with patients about integrated care		
7. Follow-up of assessments, tests, treatment, referrals and other services		
8. Social support (for patients to implement recommended treatment)		
9. Linking to Community Resources		
II. Practice/Organization		
1. Organizational leadership for integrated care		
2. Patient care team for implementing integrated care		
3. Providers' engagement with integrated care		
4. Continuity of care between primary care and behavioral/mental health		

5. Coordination of referrals and specialists		
6. Data systems/patient records		
7. Patient/family input to integration management		
8. Physician, team and staff education and training for integrated care		
9. Funding sources/resources		

Add any additional background or context you feel will help ground your Change Plan (*optional*):

C. CRAFT YOUR VISION

As you work towards a whole-person approach to care (one that allows for pro-active, population-based, and coordinated care across a continuum of sites and providers), describe your vision for your future practice. How would envision your practice in 2022? *Please attach a letter of support from your organization's leadership demonstrating commitment to achieving this vision (required).*

II. Change Plan

This Change Plan is based on where you are today and will evolve as you progress. Remember to refer to the descriptions in ***Appendix B*** of this document to understand more about each topic (blue shaded rows). The numbers 1 – 7 refer to the columns in the table below. Add additional rows as needed.

Tip: *There is a sample completed Change Plan Template for a primary care practice and one for a behavioral health center in the appendices to assist you.*

Instructions

1. Choose an aim(s) for each of the topics in the Change Plan Template. What do you hope to accomplish within each topic? What changes will help you fulfill your vision by 2022? Integrate your improvement opportunities from your assessment tool to guide you. Choose at least one aim per topic. Consider at least one utilization aim for each topic as well.
2. Choose a measure(s) that will allow you to monitor your progress for each aim. Choose measures that are aligned with the Healthier Washington accountability measures whenever possible (see ***Appendix C***), but practice-specific measures are welcomed as well.
3. If you are currently collecting data for that measure, enter your baseline (calendar year 2017).
4. Enter a goal – if you succeed, what will be your level of performance? Quantitative goals such as numbers or percentages are preferred.
5. How will you realize your aim? Enter some action steps you will take initially. Your strategy may evolve, so just some general thoughts would be sufficient.
6. When do you anticipate starting to work on that aim?
7. For each aim, when would you anticipate reaching your goal?

Aim	Measure	Baseline	Goal	Action Steps	Start Date	Target Date for Goal
Bi-directional integration of Physical and Behavioral Health						
Community-Based Care Coordination						

Aim	Measure	Baseline	Goal	Action Steps	Start Date	Target Date for Goal
Addressing the opioid epidemic						
Addressing the social determinants of health and health disparities						
Diversion Interventions						
Transitional Care						
Chronic Disease Prevention and Control						
Improve Access to Care						

III. FINANCIAL SUSTAINABILITY

The Medicaid Demonstration can provide change management support and short-term investments in innovative approaches to care. However, organizations must have a longer term strategy to leverage these innovations in the value-based payment environment. Answer the following questions as comprehensively as possible.

Tip: *You may want to want to consult with financial experts in your agency to answer these questions.*

A. ESTIMATED COST

What is the estimated cost of implementing your proposed Change Plan between now and 2021? Describe types of staff needed for your project team and the level of commitment (FTE) required to implement your change plan and participate in Learning Community activities.

B. VALUE-BASED PAYMENT

Describe how your changes will be sustained through value-based payment arrangements beyond the Demonstration period. What technical assistance or support might you need from the Learning Community and/or ACH to help you get there?

EXAMPLE

Primary Care: From PCMH – A to Change Plan

A. *Current level of integration:* 2
Desired level of integration by 2021: 4

B.

PCMH-A Scoring Summary		
Change Concept	***Average Subscale***	***Opportunities to Target***
9. Engaged Leadership	5.2	Clinical leadership time for QI, time and resources for QI
10. Quality Improvement Strategy	7.0	Performance measures by provider and team, align QI with care teams
11. Empanelment	7.4	Improve panel management, transparent data by practice team
12. Continuous and Team-Based Healing Relationships	5.3	Evaluate care provision by MA, nurses; train to optimize roles
13. Organized, Evidence-Based Care	6.7	Pre-visit planning to improve preventive care and depression screening, use reports for outreach for patients with chronic illness
14. Patient-Centered Interactions	4.1	Incorporate self-management goal setting for selected patients
15. Enhanced Access	4.5	After-hours access, improve same day access
16. Care Coordination	5.8	Improve linkage with BH, work on care transitions from ED and hospital, improve sharing of test results with patients

Additional Background: Our practice has a lot of patients with diabetes and many in the catchment area struggle with affordable housing and housing insecurity. We recognize that we can do more to help our patients with chronic disease management and we will work to get actionable data into the hands of our care teams. By adding pre-visit planning, strengthening the contributions of staff in direct patient care, and engaging patients in their own care, we believe we will see overall outcomes improve. We also think that we need to partner with others to support MH care and to address homelessness to make a meaningful impact. We have the vision of being a great place to work but are experiencing high

turnover. We feel stable staffing is requisite to transform our practice so have included it. We hope that by making the work more meaningful, staff will be more satisfied overall. Finally, this opportunity will give us the resources we need to improve in making QI more systematic and in finding a way to improve our access for patients, especially after hours.

C. Vision: XXXXX is committed to providing the highest quality of care to our patients and values team-based care. We will position ourselves for value-based care by adopting data-driven practices and by being a great place to work.

Aim	Metrics	Baseline	Goal	Action Steps	Start Date	Target Date
Bi-directional integration of Physical and Behavioral Health						
Provide annual screenings of patients aged 18 – 65 for depression with the PHQ 9	% of patients screened	~4 %. No systematic screening	70%	• Introduce PHQ 9 and train staff. • Develop administration pathways, workflows and documentation templates • Develop reports to monitor implementation	2/2018	8/2018
Manage depression toward therapeutic target	Antidepressant Medication Management	0% Ad hoc; follows up at clinician discretion.	90% of patients treated with antidepressant medications follow evidence-based protocols	• Develop a report to monitor serial PHQ 9 results and including medications prescribed • Evaluate patients with inadequate therapeutic response	6/2018	11/2019

				and coach toward evidence based care.		
Decrease ED visits for those with mental illness	Outpatient ED visits per 1000 Member months	Not currently measuring	Decrease 10% from baseline	• Identify patients in the practice with existing mental health diagnoses • Ensure all patients with existing MH diagnosis are offered link to MH care • Strengthen our existing BH interventions by improving crisis services • Communicate crisis services broadly • Incorporate crisis intervention services into after-hours protocols, staff training, practice services descriptions	6/2018	1/2020
Community-Based Care Coordination						
Decrease ED visits for our homeless population	Outpatient ED visits per 1000 Member months	Not currently measuring. Anecdotally, homeless frequently visit ER	Decrease 20% from baseline	• Incorporate standardized screening tool for homelessness • Identify individuals who are homeless or	1/2018	6/2019

				at high risk for homelessness • Partner with community agencies to link homeless to CMs		
Addresses the opioid epidemic						
Decrease the number of patients with medication regimens that place them at risk	Number of patients that have prescriptions that exceed 100 MET or have opioid and benzodiazepine prescriptions Number of patients that receive more than 3 day supply of opioids for acute pain syndrome	Not known Unknown	None for those with non-cancer pain 0 once fully implemented	• Identify patients with non-cancer pain that meet criteria for at-risk opioid prescription • Work with patients to taper to safer dosage or wean benzodiazepine • Adopt standardized policy for opioid prescriptions for acute pain • Explore standardized clinical pathways for pain management	6/2018 8/2018 8/2018 10/2018	6/2020 6/2018 6/2020
Addresses the social determinants of health and health disparities						

Understand and address social determinants of health that impact patients with diabetes	% of diabetic patients that screen positive for social determinants and have linked to resources.	unknown	90%	• Diabetes is a common diagnosis in our practice but we do not understand the impact of SD on care • Screen all patients with DM with the PRAPARE tool • Use the PRAPARE toolkit to implement improvements and linkages to care	2/2019	2/2020
Diversion Interventions						
Decrease ED visits for homeless and those with mental illness	Outpatient ED visits per 1000 Member months	Not currently measuring	See above	• Increase same day access • Improve after hours protocols to offer other options in addition to ED • Develop communication pathways with ED and EMS to learn about inappropriate utilization • Consider addition of SW services	2/2018	11/2019
Transitional Care						

Improve transitions of care process	Outpatient ED visits per 1000 Member months Plan All-Cause Readmission Rate (30 days) Patient experience with transitions of care MU measure: Transitions of care summary	Not currently measuring Not currently measuring Not currently measuring 30%	Decrease overall by 20% from baseline Decrease 20% from baseline Percent of patients that agree or strongly agree 90%	• Create role description and accountability for transitions or care • Monitor follow up after hospitalization and ED visit with appropriate and complete transition of care summary • Measure patient experience of transitions of care • Work with behavioral health to ensure patients with MH-comorbidities are linked to MH care	4/2018	3/2019
Chronic Disease Prevention and Control						
Improve care for patients with diabetes mellitus	Comprehensive diabetes care: HbA1c testing Inpatient Hospital Utilization for patients with diabetes	80% annually, 60% every 6 months Not currently measuring	95% annually, 75%every 6 months Decrease 20% from baseline	• Develop more robust and systematic population management strategy utilizing existing diabetes registry • Create panel level registries with roles, workflows and	In process	11/2018

				accountability to monitor monthly • Develop outreach strategy and reminders for diabetes care • Standardize sharing of test results with patients • Implement self-management goal setting with patients who have diabetes • Consider addition of CM or CHW as part of outreach strategy		
Improve Access to Care						
Improve after hours coverage	Expansion of coverage to 24/7	NA	Offer 24/7 telephonic coverage to our established patients	• Explore partnership opportunities to establish a protocol-driven nurse line that would be available when our sites are not open	2/2018	2/2020
Improve same day access to care	3rd next available appointment Cycle time	Not currently measuring 1.5 hours Not currently measuring	< 2 weeks 45 – 90 minutes	• Request practice coaching • Evaluate current supply and demand for services	2/2018	2/2020

	Outpatient ED visits per 1000 Member months		Decrease overall by 20% from baseline	• Adjust schedule to improve same-day acess		

EXAMPLE

Behavioral/Mental Health: From MeHAF to Change Plan

A. *Current level of integration:* 1
Desired level of integration by 2021: 3

B.

MeHAF		
Characteristic *(edited for brevity)*	***Level***	***Improvement Opportunities to Target***
I. Integrated Services and Patient and Family-Centeredness		
1. Level of integration	1	Explore co-location
2. Screening and assessment for medical care needs	3	Pilot for clients with SMI and diabetes
3. Treatment plans for primary care **and** behavioral/mental health care	1	Standardize collection of medical care needs for those clients with SMI
4. Patient care based on best practice evidence	6	Clinicians committed to high quality care but opportunities to standardize tools and treatment protocols
5. Patient/family involvement in care plan	6	Most clinicians do this but there is variation in practice and documentation
6. Communication with patients about integrated care	4	Culturally sensitive and client-centered care yet opportunities to better integrate medical aspects of the care into overall care plan

7. Follow-up of assessments, tests, treatment, referrals and other services	5	Good follow-up for those who show for appointments
8. Social support (for patients to implement recommended treatment)	8	Strong partnerships with CBOs that support our clients in their treatment plan
9. Linking to Community Resources	7	Strong partnerships but follow-up could be improved
II. Practice/Organization		
1. Organizational leadership for integrated care	5	Desired but competing priorities has created barriers
2. Patient care team for implementing integrated care	3	"Teams" vary according to client needs. Could be more structured.
3. Providers' engagement with integrated care	4	Want to do this but hard to see a path forward.
4. Continuity of care between primary care and behavioral/mental health	5	Hope to expand care management services for clients with SMI especially
5. Coordination of referrals and specialists	3	Good follow-up with one PCP not others. Could expand.
6. Data systems/patient records	5	Client-centered record and includes all behavioral health programs. Data regarding medical care is not systemically collected.
7. Patient/family input to integration management	5	Recently started satisfaction survey and using to plan changes
8. Physician, team and staff education and training for integrated care	3	Need to learn more from other MH centers
9. Funding sources/resources	1	Exploring options to co-locate and share costs

Additional Background: We are just beginning our journey with data collection and analysis but know that our clients struggle with coordination of care. Many of our clients with serious mental illness lack routine primary care and our caseloads limit access for urgent issues. This in turn impacts the numbers of our clients that seek care in the emergency department. We are also trying to increase resources for providing care for substance use disorder to meet the demand although finding qualified staff has been challenging. It is worth exploring options to provide MAT with our PCPs in the community as a part of our integration strategy.

C. **Vision:** XXXXX is committed to providing the highest quality of care to our clients. We aspire to provide safe, timely and evidence-based care to all that suffer mental health issues and to treat every individual with dignity and respect.

Aim	Metrics	Baseline	Goal	Action Steps	Start Date	Target Date
Bi-directional integration of Physical and Behavioral Health						
Improve primary care for clients with SMI	% of clients with SMI who have a PCP % of clients with SMI who have seen their PCP within the last year	Unknown	80%	• Create a report of clients with SMI and their PCP (asked at intake) • Outreach to clients without a PCP • Create partnership agreements with local PCPs include ROI to share records.	2/1/2018	8/30/2020

				• Consider on-site primary care services.		
Support BH needs in primary care	Successful integration of a BH specialist into XYZ Health Clinic	NA	0.5 – 1.0 FTE	• Work with XYZ Health Clinic center toward a Collaborative Care Model • Consider shared services for SUD	4/2018	8/2020
Decrease ED visits for our clients	Outpatient ED visits per 1000 Member months	Not currently measuring	Decrease 10% from baseline	• Evaluate ED utilization for our clients • Partner with primary care sites that serve most of our clients • Improve collaborative case management services by creating linkages to ensure BH resources are readily available	6/2018	1/15/2020
Community-Based Care Coordination						
Improve follow up after discharge from the ED for mental health, alcohol or other drug dependencies	% clients with follow up within 72 hours of ED visit	Not currently measuring	90%	• Partner with the ED at JKL Hospital • Design notification system to let us know that a client	1/2/2018	6/1/2019

				was seen at the ED • Design roles, accountabilities and workflows to contact clients • Develop monitoring and reporting system		
Addresses the opioid epidemic						
Decrease the number of clients with medication regimens that place them at risk	Number of clients that have prescriptions have opioid and benzodiazepine prescriptions	Not known	None for those with non-cancer pain	• Routinely screen clients for opioid use before starting a benzodiazepine • Require psychiatry consult and consultation with prescriber of opioid to manage if benzodiazepines are felt to be essential for client care	6/2018 8/2018	6/2020 6/2018 6/2020
Addresses the social determinants of health and health disparities						
Understand and address social determinants of health that impact clients with SMI	% of clients with SMI that screen positive for social	unknown	90%	• understand the impact of SD on care for those with SMI	2/2019	2/2020

	determinants and have linked to resources.			• Screen all patients with SMI with the PRAPARE tool • Use the PRAPARE toolkit to implement improvements and linkages to care		
Diversion Interventions						
Decrease ED visits for those with mental illness or SUD	Outpatient ED visits per 1000 Member months	Not currently measuring	Completed linkages between first responders and crisis team	• Increase same day access • Develop communication pathways with ED and EMS to include linkage to our crisis infrastructure • Consider addition of CM services for those at high risk • Work with PCP to expand services for SUD	2/2018	11/30/2019
Transitional Care						
Improve transitions of care process	Outpatient ED visits per 1000 Member months	Not currently measuring	Decrease overall by 20% from baseline	• Create role description and	4/2018	3/15/2019

	Plan All-Cause Readmission Rate (30 days) Patient experience with transitions of care MU measure: Transitions of care summary	Not currently measuring Not currently measuring 30%	Decrease 20% from baseline Percent of patients that agree or strongly agree 90%	accountability for transitions or care • Monitor follow up after hospitalization and ED visit with appropriate and complete transition of care summary • Measure patient experience of transitions of care • Work with primary care to ensure clients with comorbidities are linked to PCP		
Chronic Disease Prevention and Control						
Improve care for clients with diabetes mellitus	Clients with PCP visit within the last 6 months Inpatient Hospital Utilization for patients with diabetes	Not currently measuring Not currently measuring	75% Decrease 20% from baseline	• Develop more robust and systematic population management strategy utilizing a diabetes registry • Include questions about recent primary care in all	In process	11/30/2018

	Percentage of clients with HbA1c >9.0	Not currently measuring	< 20%	follow up encounters • Explore feasibility of Treat to Target strategy		
Improve Access to Care						
Improve access to services for those who live more than 90 minutes from one of our sites	Geocoding service provision	NA	90% have documentation of offering virtual services	• Offer virtual services including telehealth, portal services and encrypted email	2/2018	2/2020
Improve same day access to care	3rd next available appointment Outpatient ED visits per 1000 Member months	Not currently measuring Not currently measuring	< 2 weeks Decrease overall by 20% from baseline	• Request practice coaching • Evaluate current supply and demand for services • Adjust schedule to improve same-day access	2/2018	2/2020