North Central Accountable Community of Health

WPCC Workgroup

2/20/2018 Meeting

Today's Agenda

1. Introductions
2. Medicaid Transformation Overview
3. WPCC in the Transformation
4. Change Plan Overview
5. Review of Supporting Data
6. Change Plan Deep Dive
   - Bi-Directional Integration Project
   - Chronic Disease Project
7. Input on Project Measures
8. Input on Driver Diagram Framework

Medicaid Transformation Overview

Medicaid Transformation Goals

- **Reduce avoidable use of intensive services and settings** — such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional long-term services and supports, and jails.
- **Improve population health** — prevention and management of diabetes, cardiovascular disease, mental illness, substance use disorders, and oral health.
- **Accelerate the transition to value-based payment** — using payment methods that take the quality of services and other measures of value into account.
- **Ensure that Medicaid cost growth is below national trends** — through services that improve health outcomes and reduce the rate of growth in the overall cost of care

Healthier WASHINGTON

5 Years from now

Current system

- Fragmented care delivery
- Disjointed care transitions
- Disengaged clients
- Capacity limits
- Impoverishment
- Inconsistent measurement
- Volume-based payment

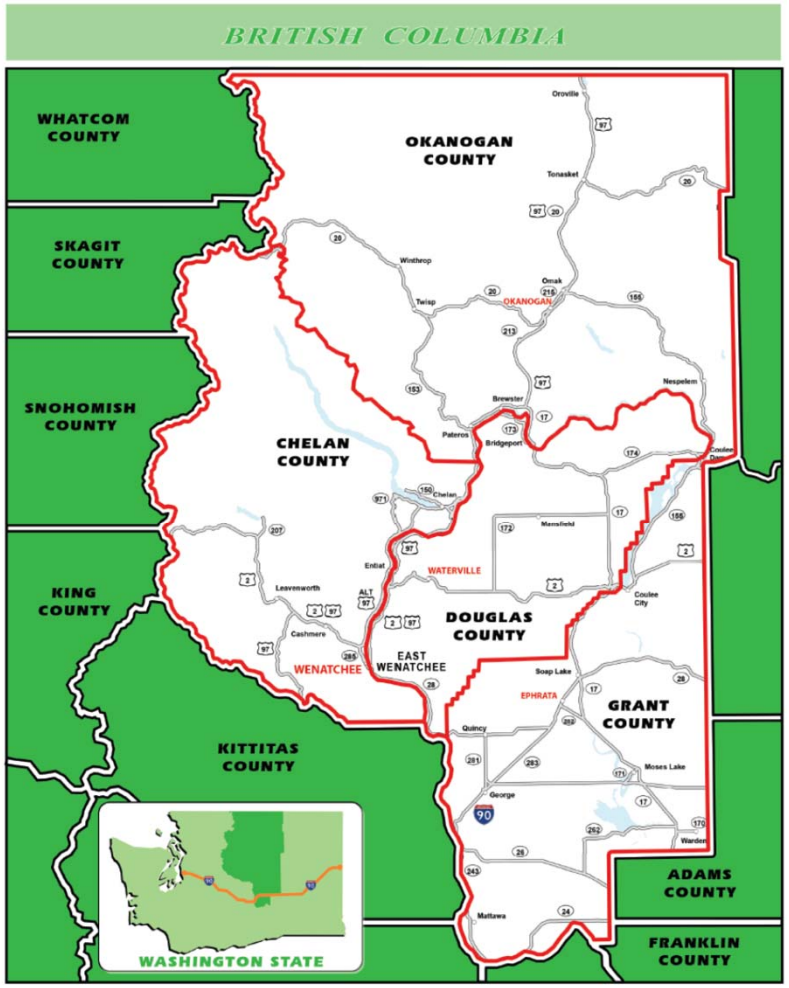
Transformed System

- Integrated, whole-person care
- Coordinated care
- Activated clients
- Access to appropriate services
- Timely supports
- Standardized measurement
- Value-based payment

Healthier WASHINGTON

A Regional Approach

- ACHs play a critical role:
  - **Coordinate** and **oversee** regional projects aimed at improving care for Medicaid beneficiaries.
  - **Apply** for transformation projects, and incentive payments, on behalf of partnering providers within the region.
  - **Solicit** community feedback in development of Project Plan applications.
  - **Decide** on distribution of incentive funds to providers for achievement of defined milestones.



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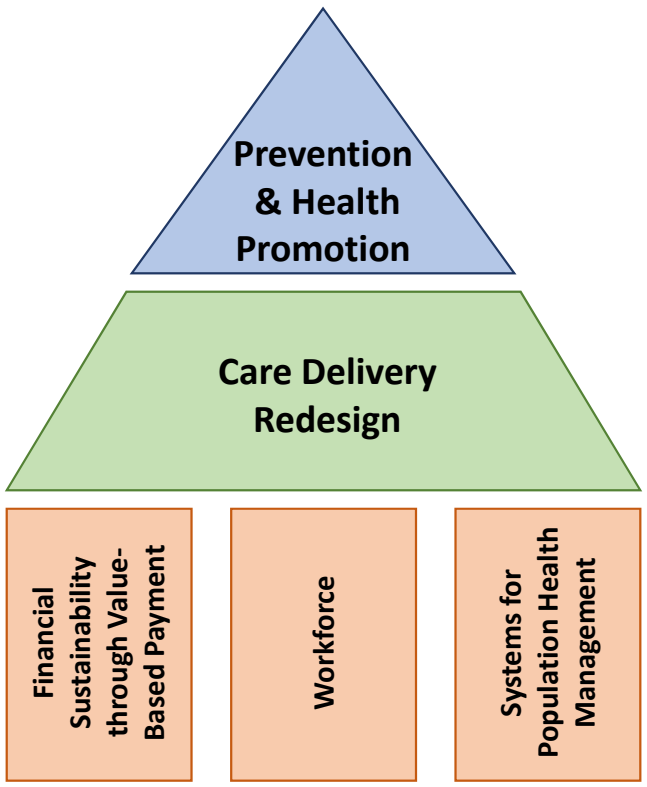
Initiative 1: Transformation through Accountable Communities of Health



Domain 3: Prevention and Health Promotion

- Addressing the opioid use public health crisis
- **Chronic disease prevention and control**

Domain 2: Care Delivery Redesign

- **Bi-directional integration of physical and behavioral health through care transformation**
- Community-Based care coordination
- Transitional Care
- Diversion interventions

Domain 1: Health Systems and Community Capacity Building

- Financial sustainability through value-based payment
- Workforce
- Systems for population health management

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WPCC in the Transformation

NCACH Structure

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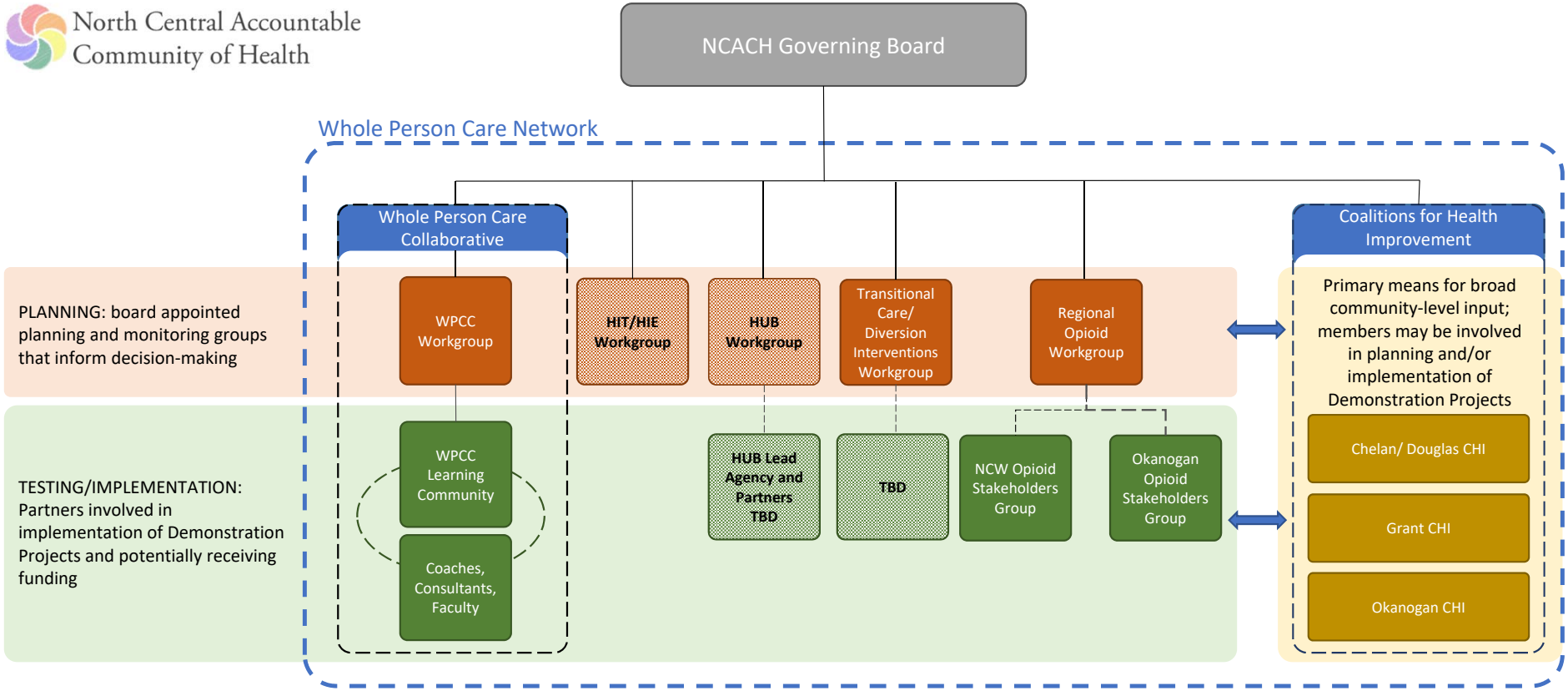
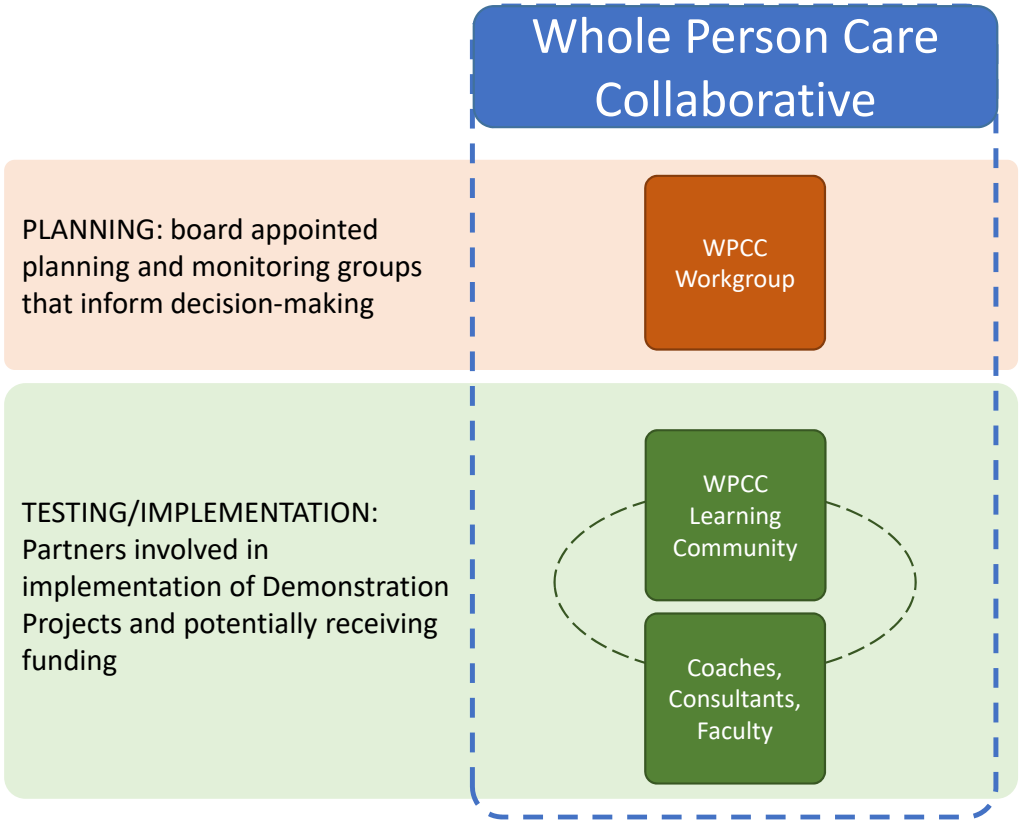


WPCC Workgroup

The Whole Person Care Collaborative (WPCC) was seen as a natural fit for the Bi-Directional Integration and Chronic Disease projects

Workgroup

- guides the planning and implementation of these two projects
- provide input into mechanisms that assist provider organizations in contributing to and supporting NCACH's four other projects



WPCC Workgroup Timeline

Jan-18

- WPCC Workgroup charter approved
- WPCC Workgroup members recruited

Feb-18

- Provide input and fine-tune change plan template
- Provide input into evidence-based approaches and target populations

Mar-18

- Provide input and help finalize change plan template
- Provide input into early portal development and set up

Apr-18

- Explore Stage 2 funding models based on partner feedback
- Consider Change Plan evaluation options (pass/fail, scoring?)

May-18

- Explore Stage 2 funding models based on partner feedback *cont.*
- Provide input into Domain I linkages

Jun-18

- Provide input into NCACH's outline for project implementation plans (for projects 2a and 3d)
- Provide input into Stage 2 reporting expectations for funded partners

Jul-18

- Continued input on Stage 2 process development (contracting, continuous monitoring/improvement)
  - Portal development around reporting tools

Aug-18

- Provide input into NCACH's draft project implementation plans (2a and 3d) *due to HCA in September*

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Change Plan Overview

- Purpose: to document what clinical partners (primary care and behavioral health) can accomplish to support whole person care in our region.
  - Articulate a vision for their future practice (what they hope to change within their organization and the commitment they will make to support the ACH's efforts)
- Change Plan is a deliverable for Stage 1 funding
  - It is not a static deliverable!
- Structured template will help providers build a roadmap of their work
  - Scores on the PCMH-A or MeHAF should guide them towards opportunities for improvement

Change Plan – After Submitted

- Change Plans due July 31st 2018 (submitted through portal)
- Subsequent learning activities will provide training and support as teams work to improve measures identified in change plan
- Reporting through the portal to capture progress on the approaches in the Change Plan
  - Narrative Report
  - Quantitative Measures
- WPCC Workgroup will provide input into the due dates and frequency of the reporting

Change Plan Evaluation Criteria

Aim	Measure	Baseline	Goal	Action Steps
Aim is: 1) well articulated 2) clearly associated with the Demonstration project goal 3) meaningful to staff and patients 4) supportable by measures and action steps	Measure(s) are: 1) included in the HCA targets related to this project and/or 2) can be demonstrated to support achievement of HCA measures	A clear baseline value has been established for each measure as a starting point for improvement activities.	1. Achievement of the goal will make a meaningful contribution to the ACH achieving targets. 2. The goal is sufficiently aggressive but achievable.	Action Steps are: 1. Directly related to PCMH-A, MeHAF, or other evidence based strategy 2. Selected based on Strategic the organization's priorities for improvement as identified in the Qualis Assessment 3. Described in a way that clearly indicates the organizations understanding of the work and its importance in achieving the Aim and hitting the goal 4. Supported by clearly articulated milestones to allow the organization to monitor progress and report it to the ACH

Change Plan Topics

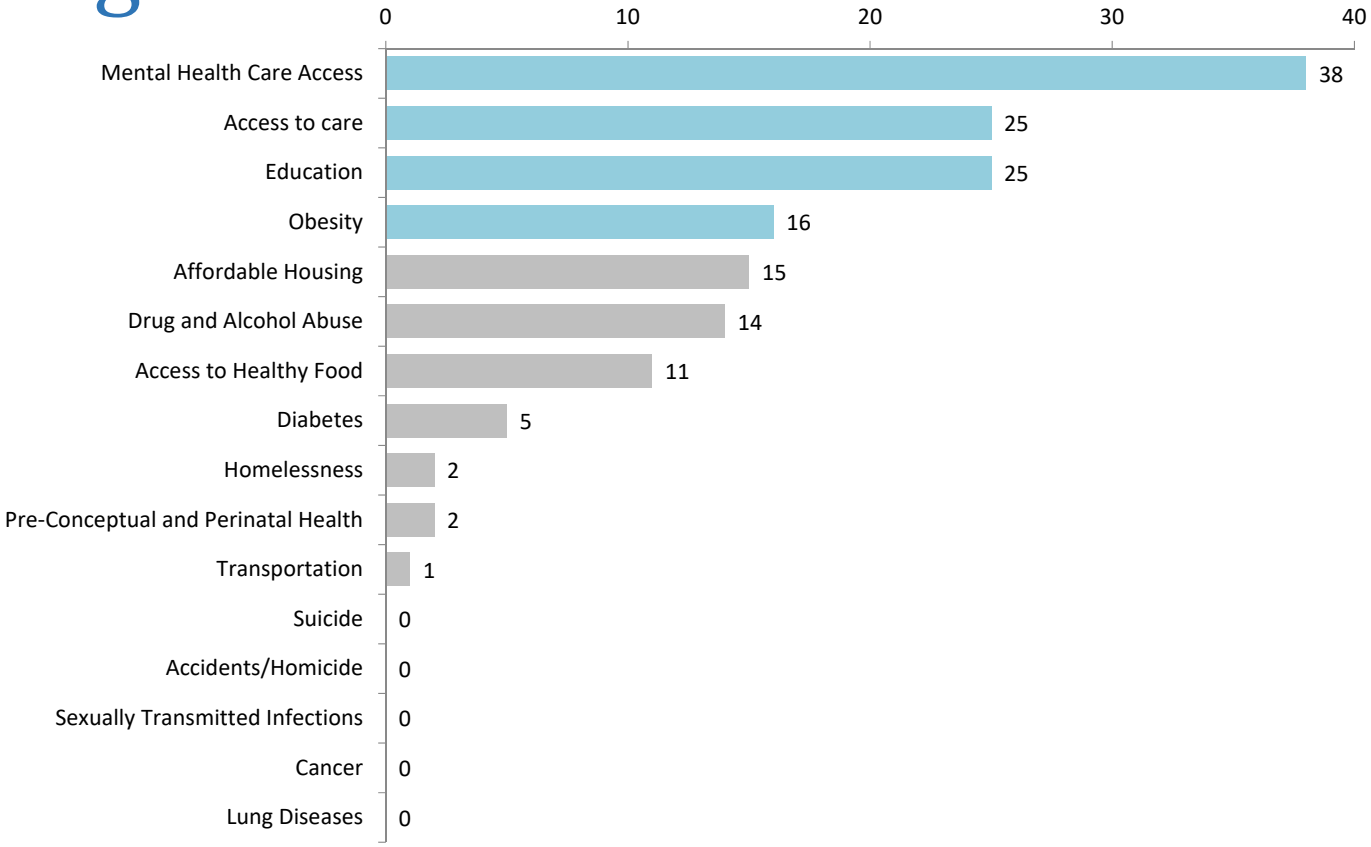
Bi-directional integration of Physical and Behavioral Health
Community-Based Care Coordination
Addresses the opioid epidemic
Addresses the social determinants of health
Diversion Interventions
Transitional Care
Chronic Disease Prevention and Control
Improve Access to Care

WPCC and Medicaid Transformation Projects

	Bi-Directional Integration (Project 2a)	Chronic Disease Prevention and Control (Project 3d)
Evidence-based approach *(as outlined in HCA Toolkit)*	For primary care providers, NCACH has preliminarily chosen to follow the **Bree Collaborative** evidence-based approach and incorporate additional principles of the **Collaborative Care Model** into the work in our region. For behavioral health providers, NCACH has preliminarily chosen to follow the integration practices outlined in the Milbank Memorial Fund report	**Chronic Care Model** (framework to guide practice redesign)
Target population	Focus on Medicaid beneficiaries with behavioral health conditions (SUD and MH)	Focus on Medicaid beneficiaries suffering from diabetes, respiratory issues, and heart disease

Preliminary thinking, as outlined in project plan applications that NCACH submitted at end of 2017

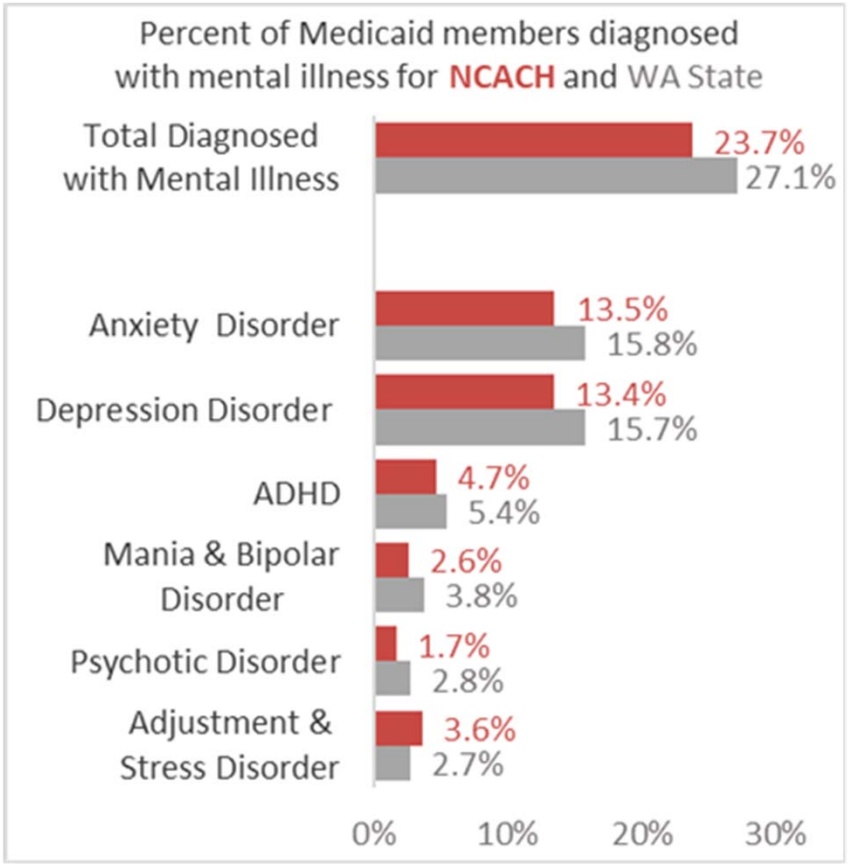
Regional Health Needs



Source: Community Health Needs Assessment

Supporting Data – Bi-Directional Integration

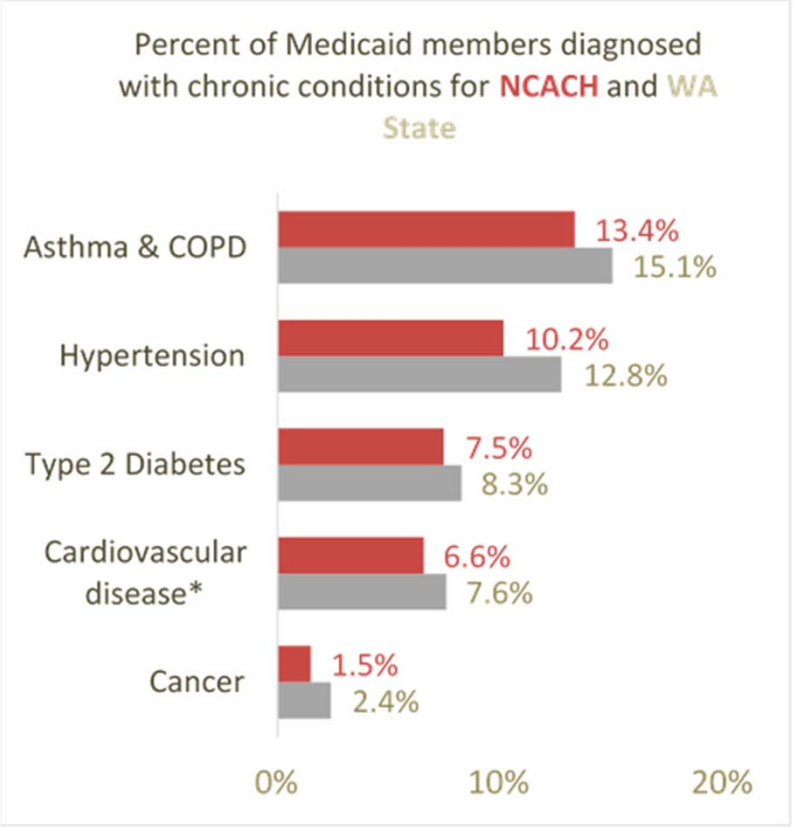
- Nearly 25% of the Medicaid members in the NCACH region have been diagnosed with mental illness.
- Anxiety disorders and depression are the most prevalent conditions.
- More than 5,000 Medicaid members have co-occurring mental illness and substance use disorder diagnoses.
- Mental and behavioral disorders are the second leading cause of acute hospitalizations.
- Mental and behavioral health disorders are the sixth leading cause of Outpatient ED utilization among Medicaid recipients.



***Source**: DSHS ACH Profiles produced by RDA, North Central Current State spreadsheet.*

Supporting Data – Chronic Disease

- Diabetes was one of the top ten most common causes of acute hospitalizations in our region, even though diabetes did not make it on the top ten list for Washington State.
- Nearly 10% of adults in the region reported having diabetes, the highest rate compared to other ACHs
- Respiratory infections were the fourth most common cause of acute hospitalizations for Medicaid recipients in our region (compared to 9th statewide)
- Diseases of the respiratory system third leading cause of Outpatient ED utilization among Medicaid recipients.



***Source**: DSHS ACH Profiles produced by RDA, North Central Current State spreadsheet.*

Top Ten Most Common Causes of Acute Hospitalizations Among Medicaid Recipients

Rank	Cause of Acute Hospitalization	Count	%	State Rank
1	Injury and Poisoning	266	12.1	2 *(9.4%)*
2	Mental and Behavioral Disorders	171	7.8	1 *(18.2%)*
3	Diseases of Heart	135	6.1	4 *(5.7%)*
4	Respiratory Infections	132	6.0	9 *(3.6%)*
5	Diseases of the Musculoskeletal System and Connective Tissue	115	5.2	5 *(4.5%)*
6	Substance Use Disorder	105	4.8	6 *(4.6%)*
7	Septicemia	105	4.8	3 *(7.4%)*
8	Cancer/Malignancies	102	4.6	8 *(3.6%)*
9	Diabetes	94	4.3	
10	Diseases of Liver, Biliary Tract, and Pancreas	84	3.8	7 *(3.7%)*

Data for North Central ACH, Excluding Pregnancy and Child Delivery Related Hospitalizations (Jan 1, 2015 - Oct 31,2015)
Source: Health Care Authority Starter Kit, determined by primary diagnosis field in HCA ProviderOne Medicaid Data System

Top Ten Most Common Causes of Outpatient ED Utilization Among Medicaid Recipients

Rank	Cause of Acute Hospitalization	Count	%
1	Symptoms, signs & abnormal clinical and lab findings	8,007	24
2	Injury, poisoning, and certain other consequences of external causes	7,822	23
3	Diseases of the respiratory system	3,860	11
4	Diseases of the digestive system	2,169	6
5	Diseases of the musculoskeletal system and connective tissue	1,635	5
6	Mental and behavioral disorders	1,554	5
7	Diseases of the skin and subcutaneous tissue	1,423	4
8	Diseases of the genitourinary system	1,352	4
9	Pregnancy, childbirth and the puerperium	1,195	4
10	Infectious and parasitic diseases	1,104	3

***Source**: Health Care Authority (ED utilization by Facility data set)*
Data for North Central ACH (Oct 1, 2015 - Sep 30, 2016)

Risk Factors for ED Utilization

Risk Factor	X times more likely to exhibit risk factor, if have 3+ ED visits		
Hematological	8.85 (extra high)	4.3 (medium)	4.3 (low)
Type 1 diabetes (high)	7.2		
Pulmonary	6.8 (very high)	4.7 (medium)	
Cardiovascular	6.6 (very high)	4.1 (medium)	
Renal (extra high)	6.0		
Co-occurring mental illness/substance use disorder	5.2		
Substance abuse (low)	4.8		

Source: DSHS Research and Data Analysis cross-system outcome measures
Date specific to Medicaid members in NCACH region

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Performance (P4P) Metrics	2A: Integration	2B: Pathways	2C: Transitional	2D: Diversion	3A: Opioid	3D: Chronic	Total
Outpatient Emergency Department Visits per 1000 Member Months	1	1	1	1	1	1	6
Inpatient Hospital Utilization	1	1	1		1	1	5
Follow-up After Discharge from ED for Mental Health	1	1	1				3
Follow-up After Discharge from ED for Alcohol or Other Drug Dependence	1	1	1				3
Follow-up After Hospitalization for Mental Illness	1	1	1				3
Percent Homeless (Narrow Definition)		1	1	1			3
Plan All-Cause Readmission Rate (30 Days)	1	1	1				3
Substance Use Disorder Treatment Penetration	1	1					2
Mental Health Treatment Penetration (Broad Version)	1	1					2
Child and Adolescents' Access to Primary Care Practitioners	1					1	2
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	1					1	2
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1					1	2
Comprehensive Diabetes Care: Medical Attention for Nephropathy	1					1	2
Medication Management for People with Asthma (5-64 years)	1					1	2
Substance Use Disorder Treatment Penetration (Opioid)					1		1
Antidepressant Medication Management	1						1
Patients on high-dose chronic opioid therapy by varying thresholds					1		1
Patients with concurrent sedatives prescriptions					1		1
Percent Arrested				1			1
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)						1	1

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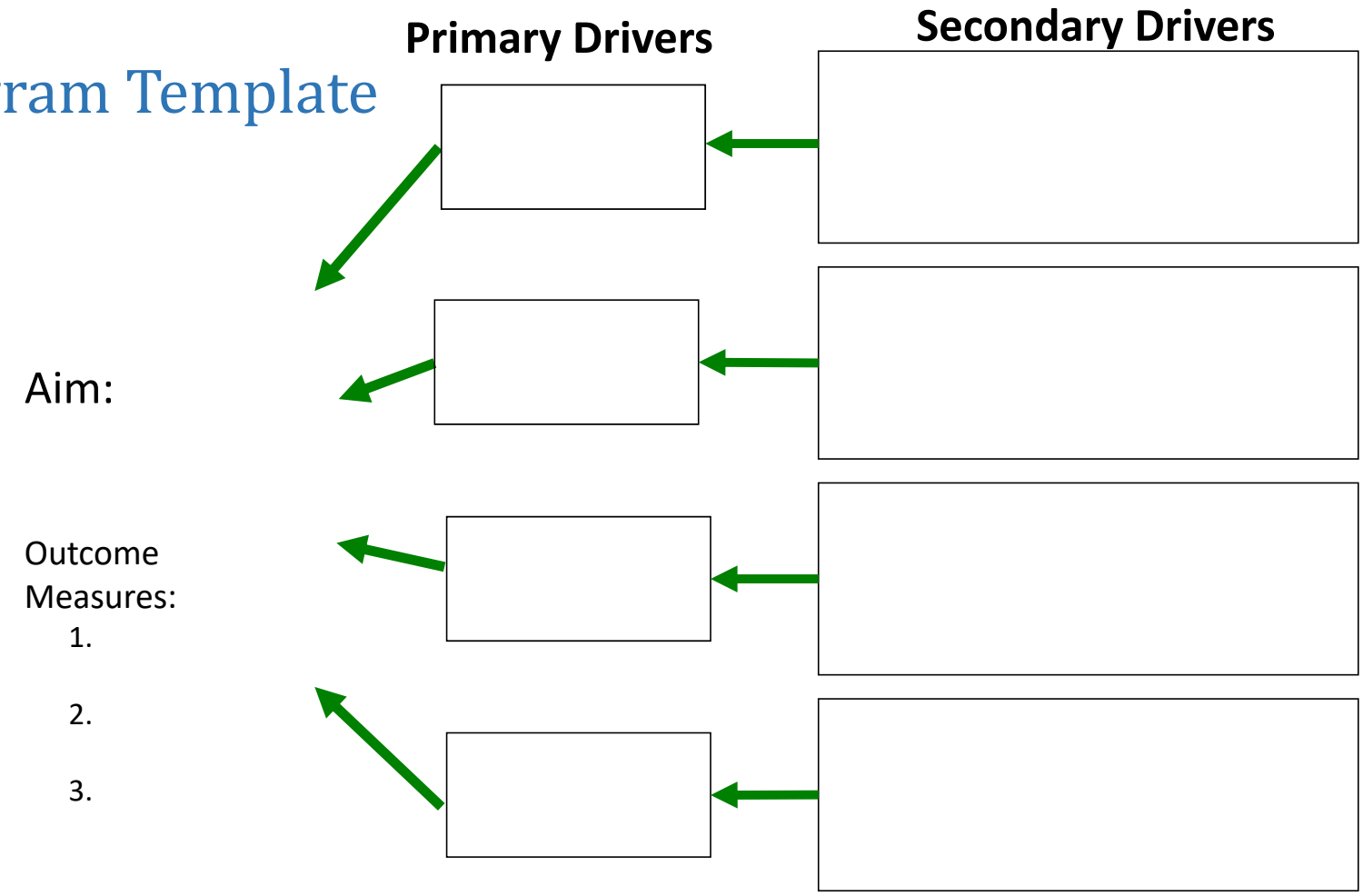
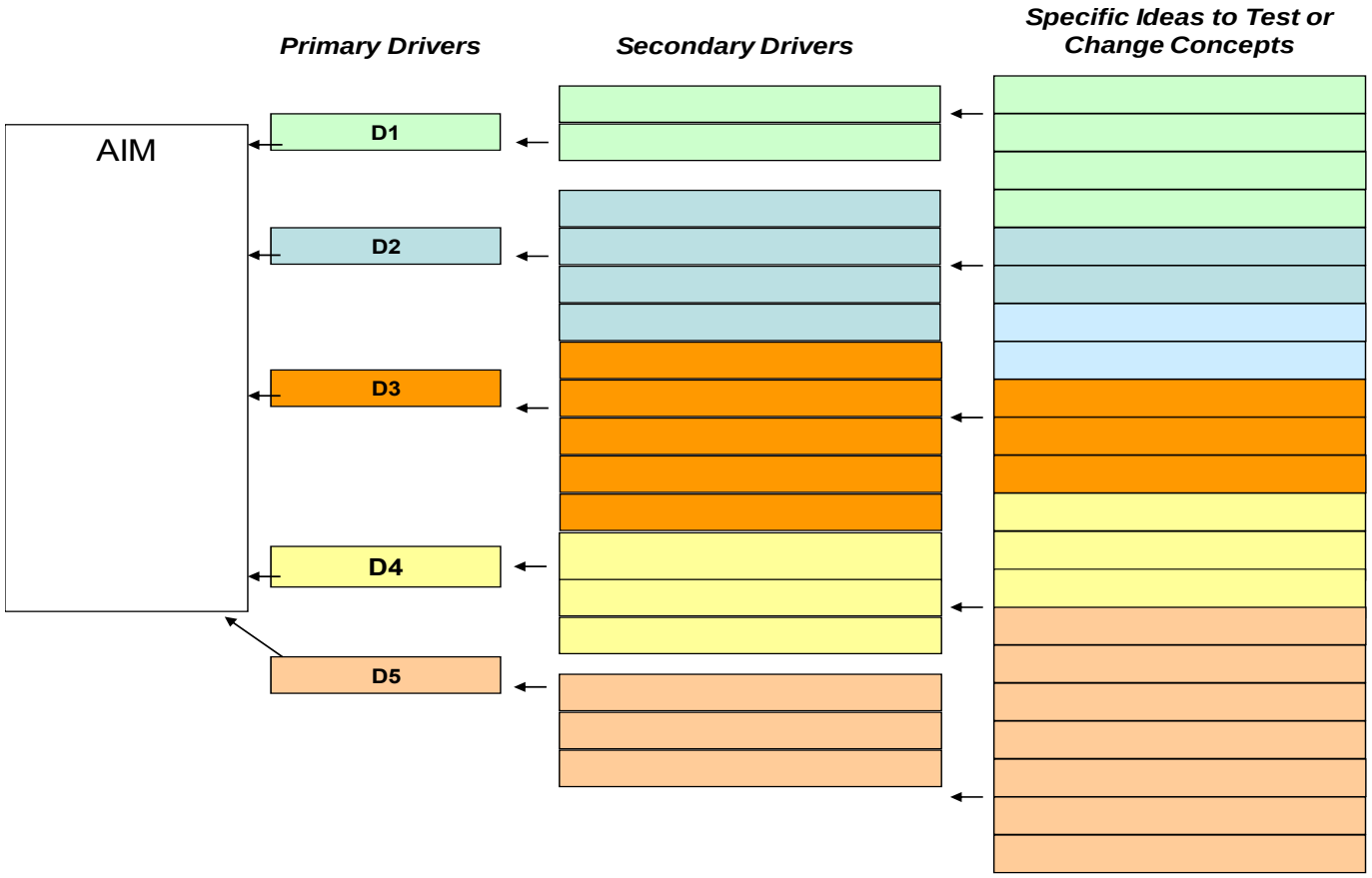
Driver Diagram Template



Source: Institute for Healthcare Improvement
http://www.ihi.org/education/IHIOpenSchool/Courses/Documents/DriverDiagramTemplates.pptx

Driver Diagram Template



Source: Institute for Healthcare Improvement
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Bi-Directional Integration

MINIMAL COLLABORATION	BASIC COLLABORATION FROM A DISTANCE	BASIC COLLABORATION ONSITE	CLOSE COLLABORATION/ PARTLY INTEGRATED	FULLY INTEGRATED
▸▸ Separate systems ▸▸ Separate facilities ▸▸ Communication is rare ▸▸ Little appreciation of each other's culture	▸▸ Separate systems ▸▸ Separate facilities ▸▸ Periodic focused communication; most written ▸▸ View each other as outside resources ▸▸ Little understanding of each other's culture or sharing of influence	▸▸ Separate systems ▸▸ Same facilities ▸▸ Regular communication, occasionally face-to-face ▸▸ Some appreciation of each other's role and general sense of large picture ▸▸ Mental health usually has more influence	▸▸ Some shared systems ▸▸ Same facilities ▸▸ Face-to-Face consultation; coordinated treatment plans ▸▸ Basic appreciation of each other's role and cultures ▸▸ Collaborative routines difficult; time and operation barriers ▸▸ Influence sharing	▸▸ Shared systems and facilities in seamless bio-psychosocial web ▸▸ Consumers and providers have same expectations of system(s) ▸▸ In-depth appreciation of roles and culture ▸▸ Collaborative routines are regular and smooth ▸▸ Conscious influence sharing based on situation and expertise
"Nobody knows my name. Who are you?"	*"I help your consumers."*	*"I am your consultant."*	*"We are a team in the care of consumers"*	*"Together, we teach others how to be a team in care of consumers and design a care system."*

NOTE: ACHs must be able to describe the level of integrated care model adoption among the target providers/organizations serving Medicaid beneficiaries (part of our current state assessment)

Source: "A Standard Framework for Levels of Integrated Healthcare". SAMHSA-HRSA, Center for Integrated Solutions.

Bi-Directional Integration Drivers

- Integrated Care Team
- Routine Access to Integrated Services
- Accessibility and Sharing of Patient Information
- Access to Psychiatry Services
- Operational Systems and Workflows Support Population-Based Care
- Evidence-based Treatments
- Patient Involvement in Care

Secondary Drivers
Each member of the integrated care team has clearly defined roles for both physical and behavioral health services
Team members, including clinicians and non-licensed staff, understand their roles and participate in typical practice activities in person or virtually such as team meetings, daily huddles, pre-visit planning, and quality improvement.

See: http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf

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- Patient Involvement in Care

Secondary Drivers
The integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care.
Clinicians work together via regularly scheduled consultation and coordination to jointly address the patient's shared care plan.

See: http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf

Chronic Disease

Elements of Chronic Care Model

- Self-Management Support
- Delivery System Design
- Decision Support
- Clinical Information Systems
- Community-based Resources and Policy
- Health Care Organizations

See: www.improvingchroniccare.org

Promote clinical care that is consistent with scientific evidence and patient preferences

Secondary Drivers
Embed evidence-based guidelines into daily clinical practice
Share evidence-based guidelines and information with patients to encourage their participation
Use proven provider education methods
Integrate specialist expertise and primary care

Chronic Disease

Elements of Chronic Care Model

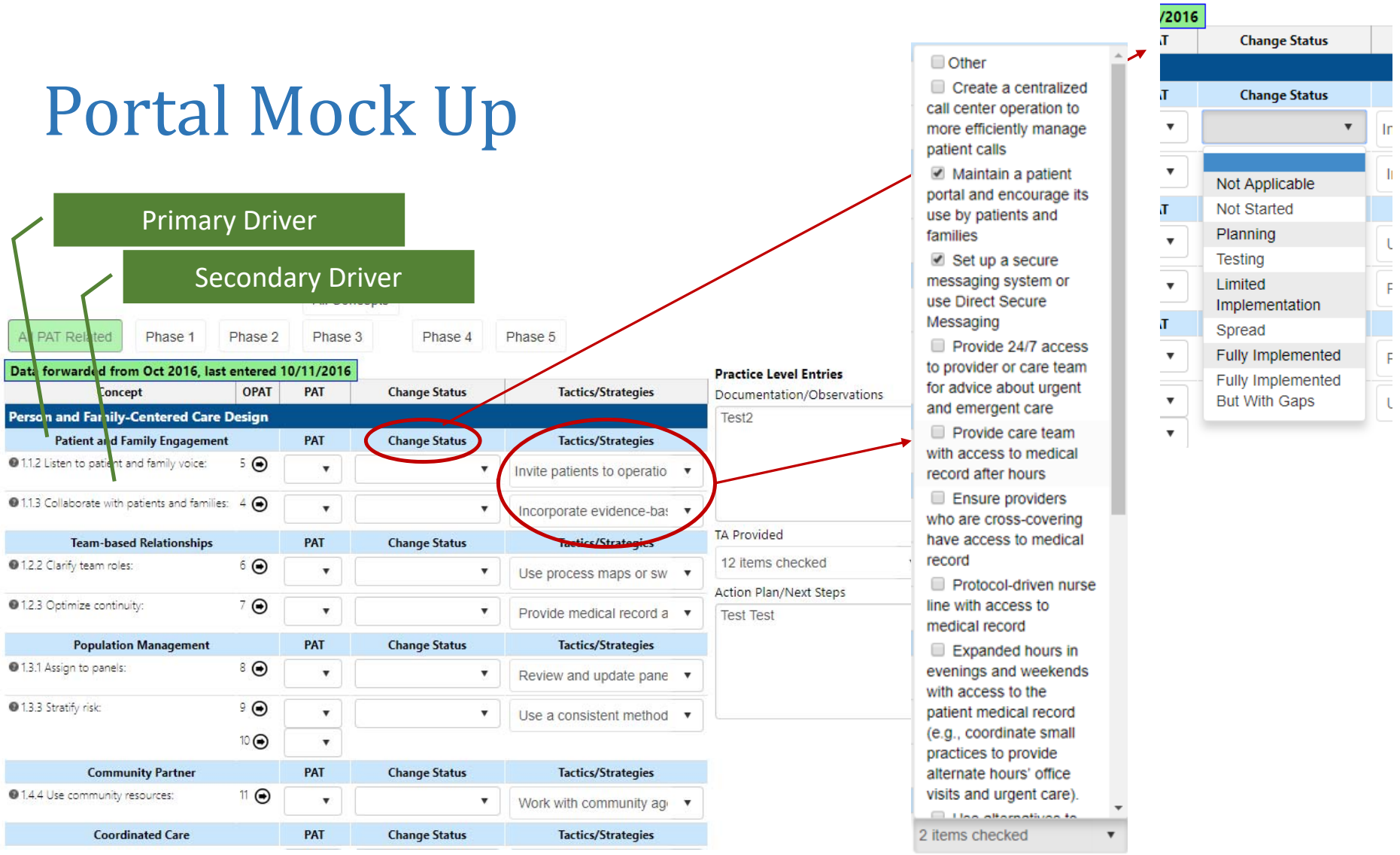
- Self-Management Support
- Delivery System Design
- Decision Support
- Clinical Information Systems
- Community-based Resources and Policy
- Health Care Organizations

See: www.improvingchroniccare.org

Organize patient and population data to facilitate efficient and effective care

Secondary Drivers
Identify relevant subpopulations for proactive care
Facilitate individual patient care planning
Share information with patients and providers to coordinate care *(2003 update)*
Monitor performance of practice team and care system

Portal Mock Up



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Contact

Caroline Tillier, Staff Support to WPCC Workgroup | caroline.tillier@cdhd.wa.gov

Peter Morgan, Director of Whole Person Care | peter.morgan@cdhd.wa.gov