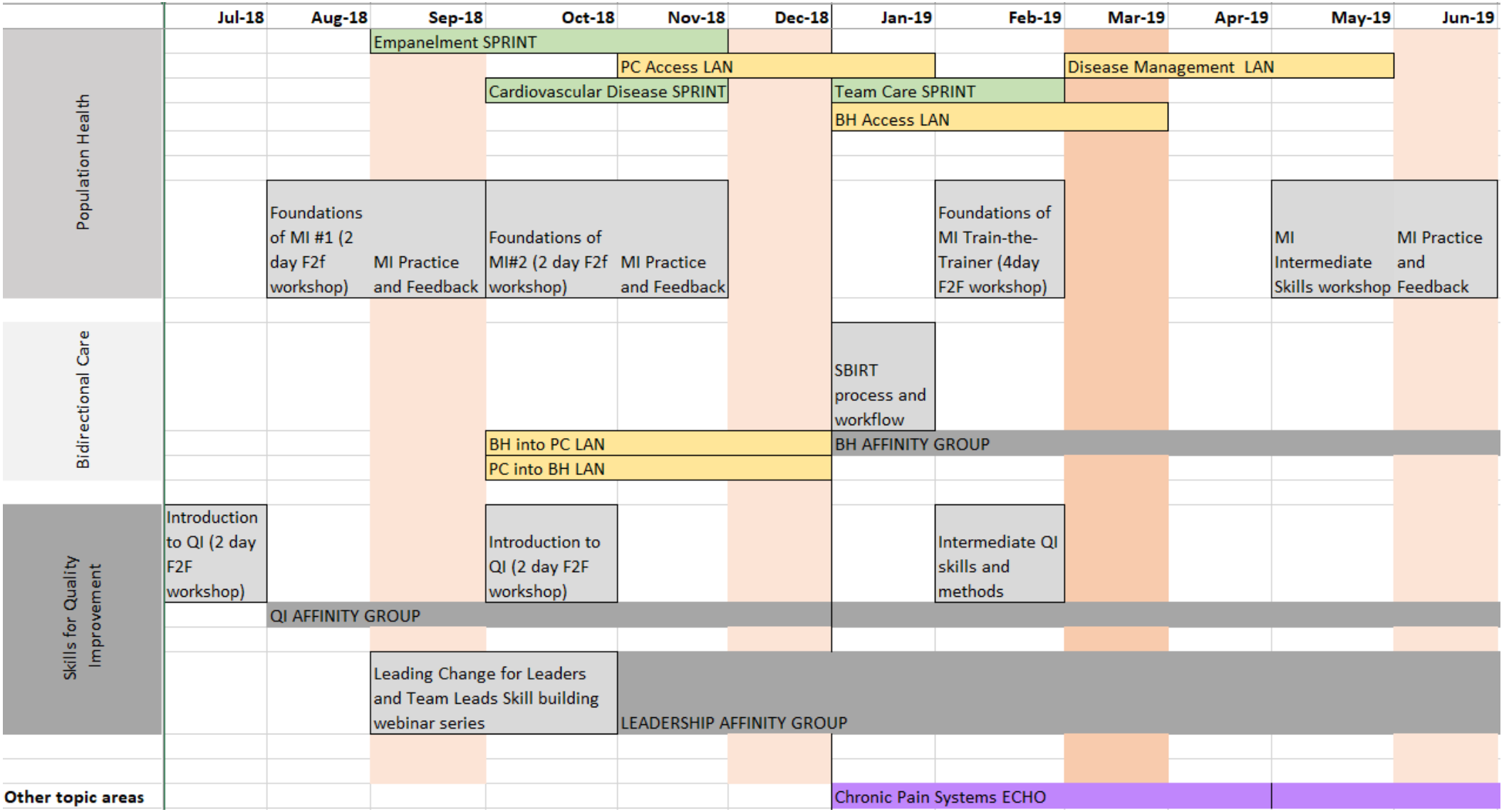
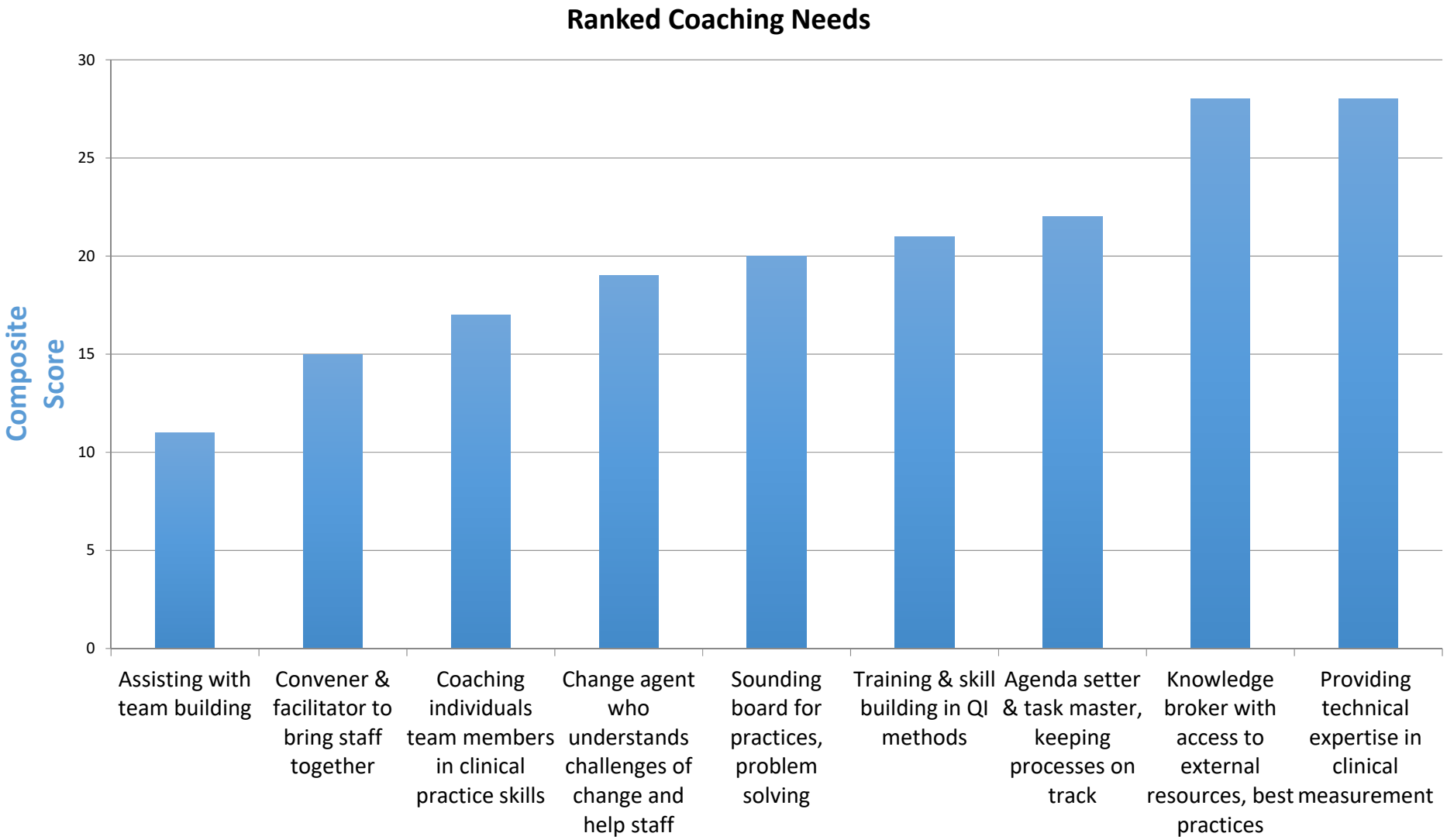
North Central Accountable Community of Health

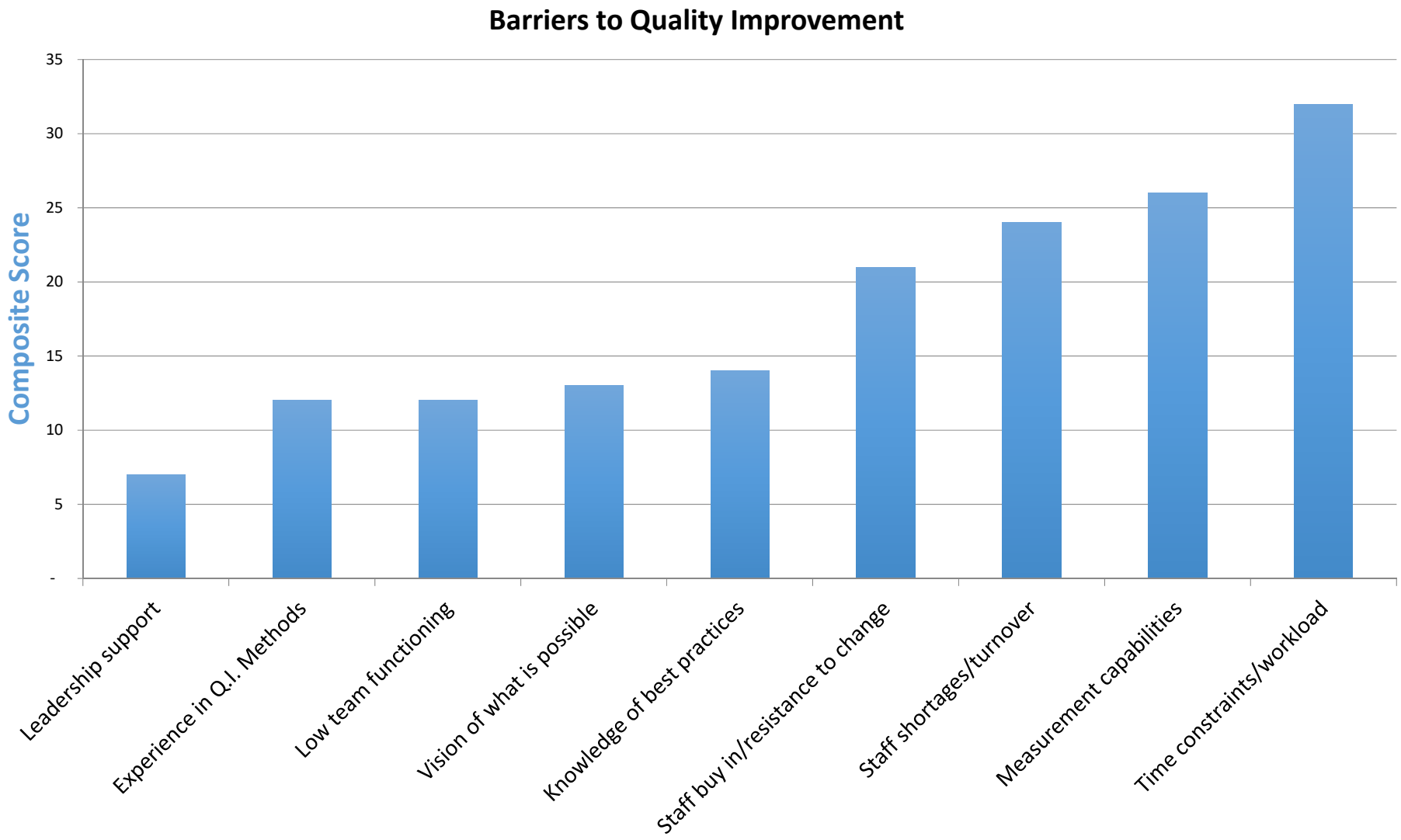
WPCC Workgroup

8/9/2018 Meeting

Learning Activities and Coaching


Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Population Health
Empanelment SPRINT
PC Access LAN
Disease Management LAN
Cardiovascular Disease SPRINT
Team Care SPRINT
BH Access LAN
Foundations of MI #1 (2 day F2f workshop)
MI Practice and Feedback
Foundations of MI#2 (2 day F2f workshop)
MI Practice and Feedback
Foundations of MI Train-the-Trainer (4day F2F workshop)
MI Intermediate Skills workshop
MI Practice and Feedback
Bidirectional Care
SBIRT process and workflow
BH into PC LAN
BH AFFINITY GROUP
PC into BH LAN
Skills for Quality Improvement
Introduction to QI (2 day F2F workshop)
Introduction to QI (2 day F2F workshop)
Intermediate QI skills and methods
QI AFFINITY GROUP
Leading Change for Leaders and Team Leads Skill building webinar series
LEADERSHIP AFFINITY GROUP
Other topic areas
Chronic Pain Systems ECHO


Ranked Coaching Needs
Composite Score
30
25
20
15
10
5
0
Assisting with team building
Convener & facilitator to bring staff together
Coaching individuals team members in clinical practice skills
Change agent who understands challenges of change and help staff
Sounding board for practices, problem solving
Training & skill building in QI methods
Agenda setter & task master, keeping processes on track
Knowledge broker with access to external resources, best practices
Providing technical expertise in clinical measurement

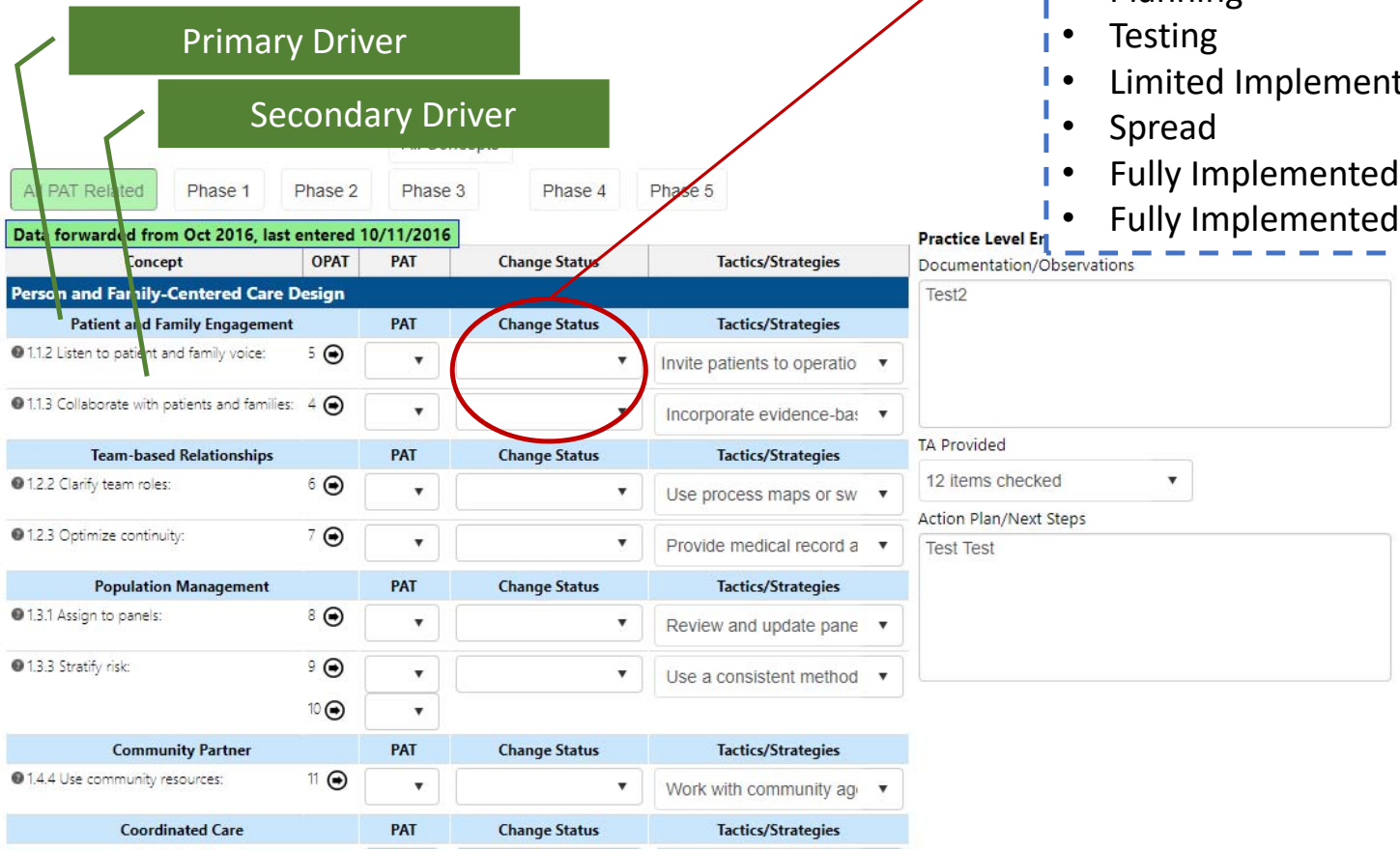

Barriers to Quality Improvement
Composite Score
35
30
25
20
15
10
5
-
Leadership support
Experience in Q.I. Methods
Low team functioning
Vision of what is possible
Knowledge of best practices
Staff buy in/resistance to change
Staff shortages/turnover
Measurement capabilities
Time constraints/workload

Reporting Process

Reporting Expectations

- First progress report will be due by 12/31/2018
  - Paired with an opportunity to fine-tune change plans and submit an updated version by 12/31/2018 in order to improve score.
- Quarterly quantitative and qualitative reports will mirror the submitted change plan
  - indicate change status on the secondary drivers in their organizational change plan (e.g. Planning, Testing, Limited Implementation, Spread, etc)
  - short narrative summary for each of the 8 topics
  - Measure reporting

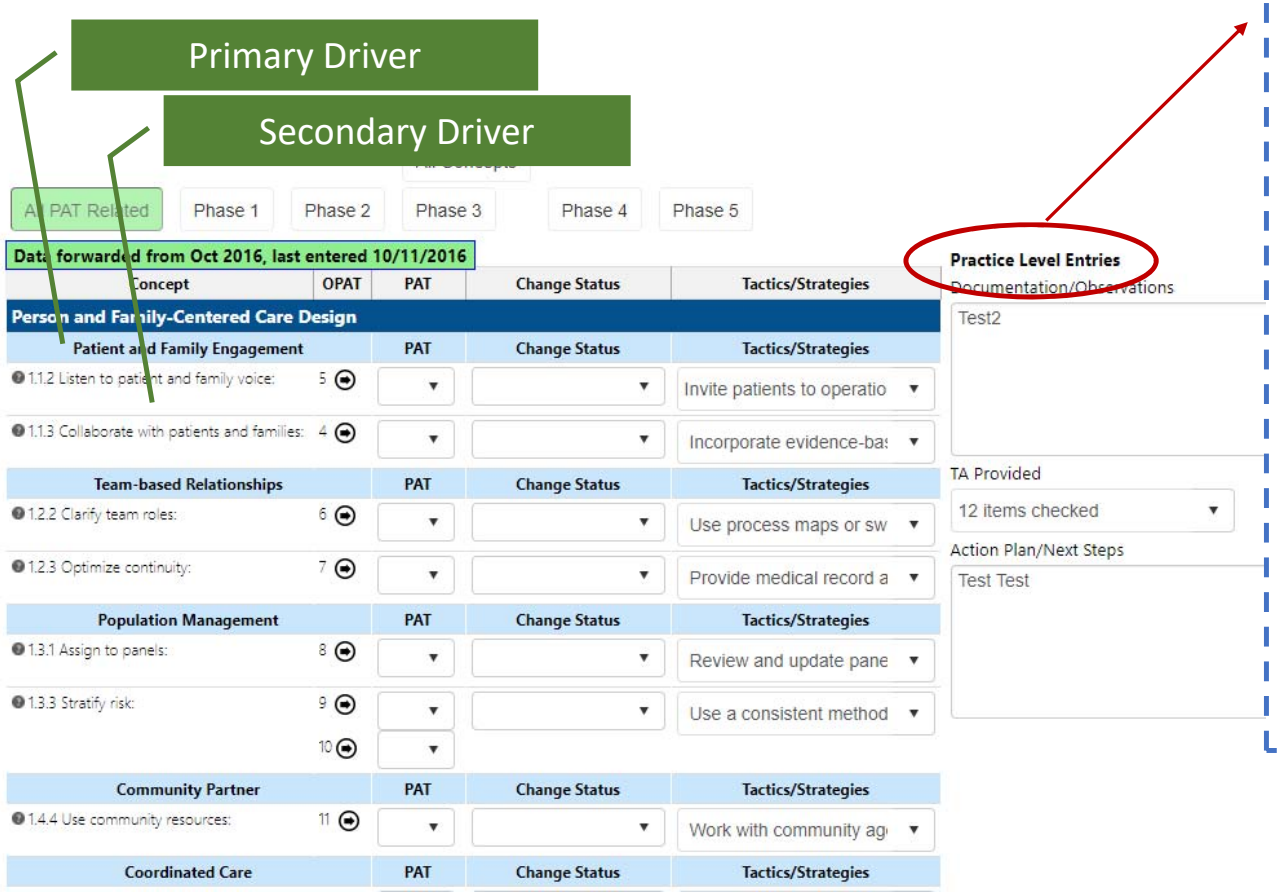
Reporting Mock Up



Change Status Drop-Down Options

- Not Started
- Planning
- Testing
- Limited Implementation
- Spread
- Fully Implemented
- Fully Implemented But With Gaps

Reporting Mock Up



Practice Status – Summary of Successes

- "What are you most proud of? What driver/strategy had the most impact this quarter?"

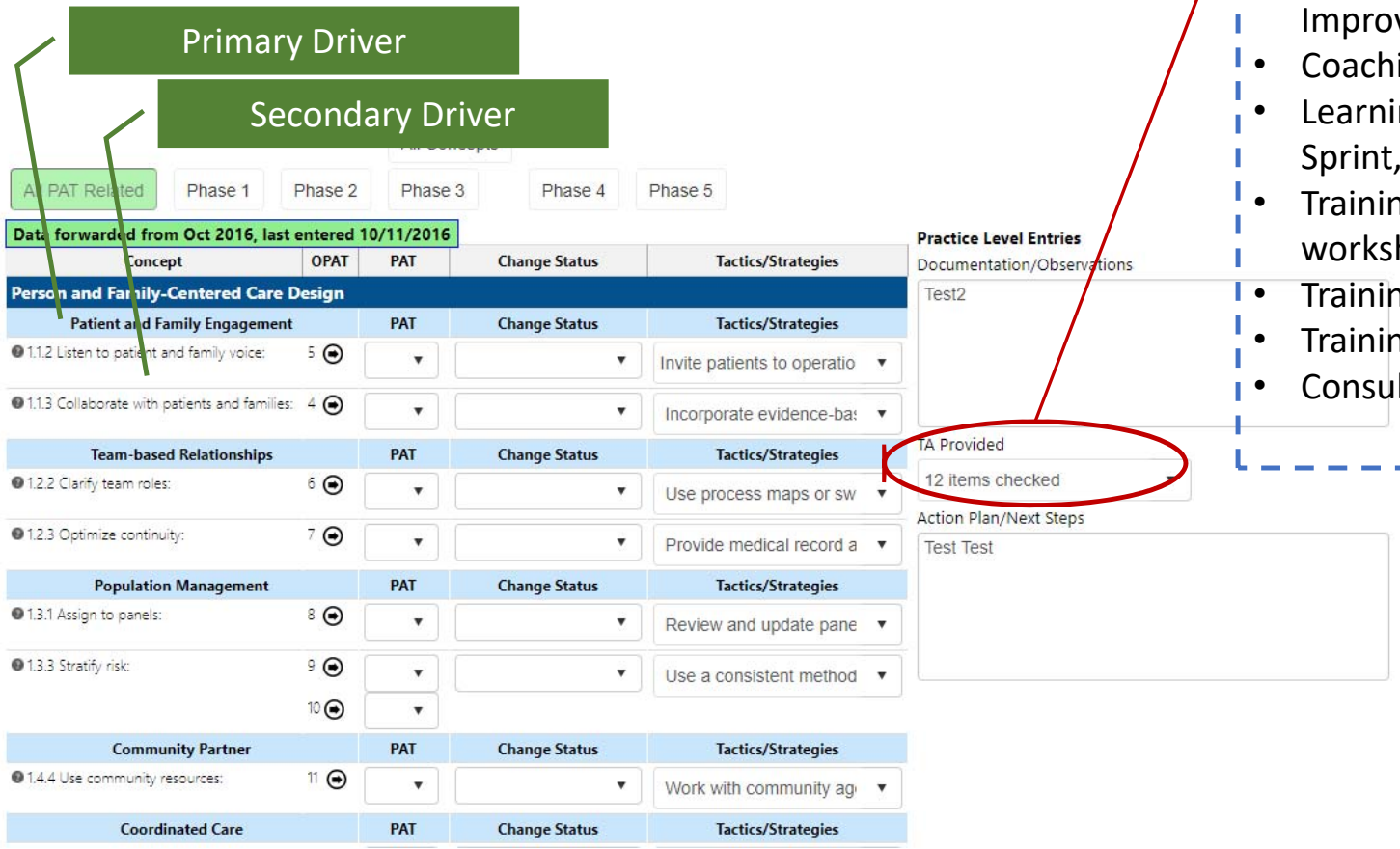
Practice Status – Summary of Challenges

- "How were certain drivers/strategies challenging? What held you back this quarter?"

Next Steps

- "What will you focus on in the near future to build on your work? What kind of assistance/resources could help you break down existing barriers?"

Reporting Mock Up



TA Provided

- Coaching by Quality Improvement Advisor
- Coaching by Faculty
- Learning Activity (e.g. LAN, Sprint, etc)
- Training – In Person (e.g. skills workshops, etc)
- Training – Webinar
- Training – Self-Paced Module
- Consult with peer/mentor/clinic

Measure Reporting

- The CSI Lumen system is designed to accept entry of numerators and denominators for measures that a practice wants to improve.
- The system calculates the actual measure based on the numerator and denominator and then allows the practice to view graphs of the measure over time so that progress toward improvement can be monitored.
- Measures need to be specified by mid-September
  - Name of Measure
  - Description
  - Numerators
  - Denominators

Recommended Measures

Recommended Measure	# of times selected
Follow up after ED discharge for mental health: 7 day	14
Child access to PCP	13
Depression screen and follow-up	13
% SDOH Screening	12
Follow up after ED discharge for alcohol or drug dependence: 7 day	12
Hospital all-cause follow-up	12
Practice experience with Pathways HUB	12
Diabetes: HbA1c testing	11
Follow-up after hospitalization for Mental Illness: 7 day	11
Outpatient ED Visits per 1000 Member months	10
Follow-up after hospitalization for Mental Illness: 30 day	9
Percent of providers trained on guidelines for prescribing opioids for pain	9
SDOH referred Pathways Hub	9
Diabetes: Eye Exam	8
Follow up after ED discharge for mental health: 30 day	8
Diabetes: Nephropathy screen	7
Follow up after ED discharge for alcohol or drug dependence: 30 day	7
Number of MDs, ARNPs, and PAs who are approved to prescribe buprenorphine	7
Patients with concurrent sedatives prescriptions	7

Recommended Measures

Recommended Measure	# of times selected
Patient/client experience with Pathways HUB	6
Patients on high-dose chronic opioid therapy by varying thresholds	6
Asthma Med Management	5
SDOH referred	5
% homeless	4
3rd Next	4
Antidepressant Med Management: Acute Phase	4
Antidepressant Med Management: Continuation Phase	4
Empaneled	4
Number of patient/client overdoses	4
Number of patients currently being prescribed buprenorphine.	4
# SDOH screened	3
Mental Health Service Penetration	3
Number of mental health and SUD providers delivering acute care and recovery services for people with OUDs	3
SDOH linked to services	3
CAHPS: appointment soon as needed	2
Continuity	2
Number of patient/client deaths due to overdose	2
Substance Use Penetration	2
CAHPS: after hours care	1
CAHPS: wait for appointment	1
Patients with concurrent sedatives prescriptions	1
Statins for CVD	1

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

Optional Measures

- 299 optional “measures” submitted via 17 change plans, including:
  - # of non-compliant opioid scripts provided to patients
  - # of patients enrolled in the portal
  - Report exists for mental health and SUD related hospital/ED discharge follow up for CC clients
  - Average PAM score increases by 1 point for identified clients (measure 1) within a year of first administration, signifying 2% decrease in hospitalization and 2% increase in medication adherence by 12/31/2021.
  - Provide integrated care for clients identified by PCP to have uncontrolled asthma.
  - All Behavioral and Medical services using single EHR (athenahealth)
  - Standard screening tool for social determinants developed and deployed by 1/1/19.
  - Develop Leadership programs in partnership with school districts
  - Appointment scheduling enhancement
  - Identify and develop process and procedure for diabetic screenings
  - Track attendance of referred diabetic clients to education
  - % of patients with BMI > 40
  - % of readmissions occuring within first 7 days
  - 7 day PCP follow-up visit rate
  - Patient registries will be used for management of chronic diseases, risks, pre-visit planning, and outreach.

Synchronizing Workgroup Strategies

TCDI Workgroup Update

NCACH Approach	Evidence Based Approach	Target Population	Implementation Partners
ED Diversion	Projects that support the ER is for Emergencies Seven Best Practices	Medicaid beneficiaries presenting at the ED for non-acute condition with 3+ visits in one year	Emergency Departments
	Community Paramedicine*	Medicaid beneficiaries who access the EMS system for a non-emergent conditions	EMS Providers
Transitional Care Services	Local Transitional Care Model (CH – TCM)	Medicaid beneficiaries discharged from acute care to home or to supportive housing	Inpatient Hospitals

TCDI Metrics

Transitional Care Model

- Increase in follow-up post hospitalization physician/mid-level visits for all patients
- Decrease in unnecessary inpatient hospital utilization
- Decrease in unnecessary outpatient Emergency Department visits
- Decrease in all-cause hospital readmission rate (30 Days)

ED Diversion

- Decrease outpatient Emergency Department Visits
- Increase follow-up After Discharge from ED for Mental Health
- Increase follow-up After Discharge from ED for Alcohol or Other Drug Dependence

Opioid Workgroup Update

Applicant	Project
Catholic Charities	Opioid Intervention Service
Chelan Douglas Community Action Council	Medication Lock Boxes and Education
Family Health Centers	Creating Resilience Against Opioids
Grant County Health District	Syringe Service Program
Grant County Health District	North Central Washington Opioid Communication Plan
Methow School District	Methow Valley School District Substance Abuse Prevention Program Pilot
Mid Valley Clinic	Mid-Valley Community Opioid Treatment Plan
North Valley Hospital	Drug Disposal Kiosk
Samaritan Healthcare	Narcan Take Home and Opioid Overdose Education
The Center for Alcohol and Drug Treatment	Establish Drug Court in Chelan County
WIN 2-1-1	Rapid Response To Resources (Text "OPIOID" to 898211)

Pathways HUB Update

Target Population

- Medicaid or Medicaid eligible, and;
- ≥ 3 visits to the Emergency Department in the past 12 months

Implementation

- Beginning with people residing in Zip Code 98837 (Moses Lake)

TIMING	10-1-18	4-1-19	10-1-20
SIZE (total)	200	400	800
LOCATION	Grant	Chelan-Douglas	Okanogan
TARGET POPULATION	≥ 3 ED Visits	≥ 3 ED Visits	≥ 3 ED Visits

North Central Accountable Community of Health

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