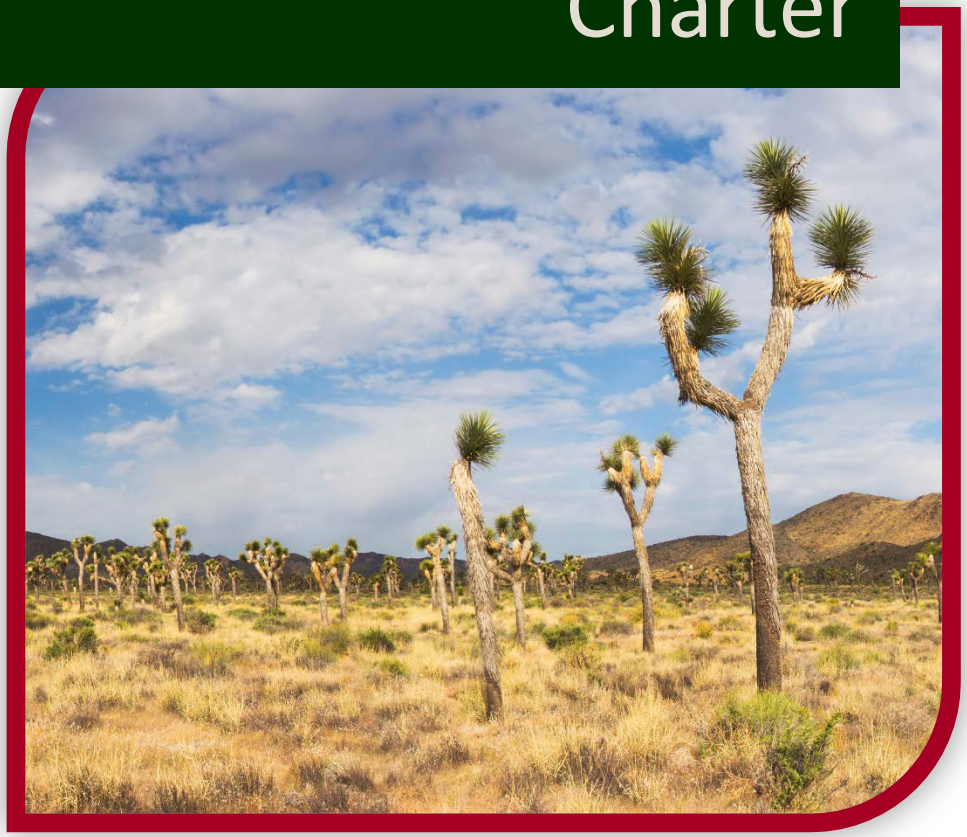
Inland Empire Health Plan

JEN CLANCY CONSULTING

Behavioral Health Integration Complex Care Initiative

Charter



Behavioral Health Integration Complex Care Initiative Charter
Clinical Transformation and Integration Department,
Inland Empire Health Plan
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Executive Summary

The health care system serving the Inland Empire has too few providers and isolated partners who are disconnected from the behavioral health system. This results in poor quality of care, poor health outcomes, and prohibitively high costs. The lack of technology infrastructure further compounds the problem. The Behavioral Health Integration Complex Care Initiative (BHICCI) aims to engage provider teams to test and implement fundamental practice changes—that is, to develop an array of "health homes" and integrated complex care management systems within local health organizations. During its Pilot phases, the BHICCI services will be focused on individuals who can benefit from care management and who have two or more chronic conditions: a chronic medical condition AND a mental health disorder and/or a substance use/addictive disorder (aligned with Section 2703 of the California Dept. of Health Care Services *Health Homes for Persons with Complex Needs*). The key commitments of this Initiative include:

- Improving both patient and health care team experience;
- Improving care coordination and integration of primary, specialty, addiction and mental health care across and between healthcare/treatment settings;
- Improving complex care management of individuals with chronic conditions;
- Improving population health management by using data analytics;
- Improving access; and,
- As a result of these fundamental changes improving population health outcomes and reducing overall health care costs in the Inland Empire safety net.

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Our Health-Care System

Few Providers - Isolated Partners – Disconnected Behavioral Health – Fragmented Care Leads to Poor Health Outcomes – Lack of Decision-Supports – Lack of IT Infrastructure – Very High Costs

Problem Statement

The current health care system is not adequately meeting the needs of the population in the Inland Empire. This is due to a number of factors. The provider supply within the Inland Empire is not sufficient to meet the current and future demand, particularly in adult and pediatric primary care, creating challenges to access.

This is compounded because demand for care in outpatient settings is increasing and Inland Empire safety net providers tend to work in siloed systems with insufficient care management and care coordination. Health care systems are frequently isolated from partner agencies that offer care and services that are critical to addressing the social determinants of health that impact health outcomes. Some of these agencies include, but are not limited to: housing agencies, social service and community based organizations, and corrections agencies.

Additionally, health outcomes and quality are further compromised because primary and behavioral health care are not integrated. There is limited use of clinical decision making supports and evidence-based medicine. Finally, there is a significant lack of the data infrastructure needed to support population health management and quality improvement at the behavioral and primary care provider clinics as well as at the hospitals. These problems in the Inland Empire health care system compromise not only the quality of care and health outcomes, but also drive up the cost of care to prohibitive levels that could be avoided by transforming fundamental clinical and systems processes, technology, and roles.

Improvement Aim

Over a period of twenty-four (24) months, the Inland Empire Health Plan (IEHP) will sponsor initiatives at 37 primary care, behavioral health, and hospital ambulatory clinics/programs to improve the whole health status of the safety net population through transforming clinical practices of the public health care delivery system. At each participating site, teams will be formed that include treatment providers from primary care, specialty care, mental health, substance use disorders, as well as other providers, working with the Inland Empire Health Plan (IEHP) and their key consulting agency, Jen Clancy Consulting (JCC) to test and implement fundamental practice changes. These changes will build:

- Developing complex care management systems for individuals with chronic health/behavioral conditions;
- Developing a more seamless experience of whole health care (inclusive of behavioral health) for all individuals that is person-centered, cost effective, and results in improved health and wellness.

JCC will support the development of an array of "health homes" and integrated complex care management systems within local health organizations, including: primary care clinics, adult and children's behavioral health clinics, a board and care center, an adult day health care center and local hospitals. Participating health care teams will receive individualized support to transform their clinical practices and ensure "integrated care". Core areas of practice transformation include: assessment processes; care planning; team-based care, integrating measurement into care processes to improve outcomes; complex care management; population health management; health promotion/self-management, and improved patient and health care team experiences.

These new processes and team structures will be designed, tested and implemented by partner institutions during the course of BHICCI in order to achieve predictable and reliable outcomes and ensure a consistent, high-quality experience for the IEHP member population. It is understood that there will be some local variation in how key practice changes are implemented to reflect variation and differences related to size, organizational complexity and available resources.
The system-wide implementation of integrated behavioral and physical health care, and complex care management will result in improved patient outcomes and reduction of unnecessary use of ED visits and hospitalizations. Specifically, better outcomes for persons with chronic medical and behavioral health conditions will create system- level cost savings that can be reinvested in improving the overall health and wellness of all residents in the Inland Empire.

Core BHICCI practice change areas include:

- Improving Patient Experience
- Improving Health Care Team Experience of Providing Care
- Using a Quality Improvement Framework for Implementing and Sustaining Change
- Multidisciplinary Team-Based Care
- Population Health Analytics, Information and Technology
- Complex Care Management/Care Coordination
- Health Promotion And Self-Management Support
- Organizational and Collaborative Leadership
- Behavioral Health Integration

Target Population*

The patient population of health care organizations involved in IEHP Clinical Transformation and Integration Initiatives will benefit from infrastructure development funding and coaching support for core practice change. However, the target population which is the initial focus of practice changes will be a finite number of individuals who demonstrate greater whole health needs and complexity. This target population is aligned with the eligible enrollees for the California Dept. of Health Care Services *Health Homes for Persons with Complex Needs* (Section 2703) and includes:

1. Individuals who have two or more chronic conditions: a chronic medical condition AND a mental health disorder and/or a substance use/addictive disorder.
2. Individuals who will benefit from care management
3. Individuals who are IEHP members[i]

Goals

Patient Level

1. **Improve Whole Person Care** (increase patient-centered care, reduce fragmented and siloed care, and improve patient experience)

2. **Increase Patient Self- Management** (increase patient/family education about their chronic conditions and treatment options, promote patient's ability to manage their chronic conditions and engage in healthy behaviors)

3. **Increase Shared Care Planning** (increase involvement of patients in selecting whole health goals, increase communication and sharing of these among key providers).

4. **Improve Coordination of Care** (increase the number of patients with an assigned Care Manager, promote Care Manager single point of accountability for the Care Team, ensure care and transitions are closely coordinated)

5. **Promote Measurement Based Practice** (improve screening, systematic follow-up and outcome tracking)

System Level

6. **Increase Management of Population Health** (improve stratification, increase targeted outreach, and increase prioritizing of health services for persons not achieving outcomes as expected)

7. **Improve Health Care Teams' and Patient Experience of Providing Care** (increase joy at work for health care team)

8. **Decrease the Cost of Care** (reduce avoidable emergency room utilization, reduce inappropriate hospital admissions, reduce 30-day readmission rate)

Commitments/Definitions

1. Commitment statements:

    a. Prioritize the individuals, both patients and the health care team members. Keep their interests the priority (above organizational interests).
    b. During implementation, all health care organizations and associated consultants will prioritize the aim of practice transformation - improved population health status.
    c. IEHP and JCC together share a focus on the following themes:
        i. Improved Patient Experience and Health Care Team Experience
        ii. Improved Access
        iii. Improved Behavioral Health Integration, Complex Care Management and Care Coordination, and Population Health

2. Definitions:

    a. **Integrated care** "results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors, life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization." (Safety Net Medical Home Initiative, 2014)

    b. **Complex Care Management:** A practice of providing integrated, coordinated, team based clinical care which is patient centered and ensures each patient has his or her own coordinated plan of care. When care is coordinated the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and this information is used to provide safe, appropriate, and effective care to the patient. Care management includes addressing social determinants of health, comprehensive transitions of care, population health management and treat to target. Two core components of effective complex care management are care coordination and self-management.

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[i] The staffing resources that the health care organizations receive as part of the BHICCI Pilot are intended to support all patients, whether they are or are not IEHP members. This means those staff can work with patients that are not IEHP members. However, members of the *target population* (meaning individuals from whom data will be collected to assess whether the fundamental changes being tested using PDSAs are actually leading to the intended BHI-I improvements) for the Pilot must be members of IEHP because a significant amount of the quality improvement data that will be collected will be accessed from IEHP.