Phase II: Develop Integrated Complex Care Systems (Whole Health Homes)

DOMAIN 6: DEFINE AND IDENTIFY POPULATION TO RECEIVE INTEGRATED COMPLEX CARE MANAGEMENT

Change Areas

Identify a target population (TP) of individuals who are expected to benefit from care management/care coordination (CM/CC).

Activities

July - Oct 2016

- Define the TP at the clinic/site level to include individuals with co-occurring behavioral health and medical conditions who have high risk/high needs and complexity consistent with HHP criteria and are expected to benefit from CM/CC.
  - For BH organizations, stratify for individuals with medical and care management needs
- Introduce use of Johns Hopkins' ACG as a predictive modeling tool to stratify patients by condition, risk factors and cost
- Using existing data sources (clinic level data, EMR and clinical staff knowledge of patients) to identify 100-300 patients as TP for BHICCI
  - Consider selecting initial TP from 1-2 interested/ engaged providers

Oct 2016 - Feb 2017

- Use predictive modeling capacity, such a ACG tool, as a ongoing predictiv modeling tool to stratify patients by condition, risk factors and cost
- Continue TP identification processes as needed to reach/maintain caseload of 100-300 patients

Feb - July 2017

- Test steppingdown patient/ clients to lower level of care when clinically indicated
  - Includes stepdown for BH clients from complex medical to integrated medical care
- Refresh TP with new patient/ clients who meet criteria
- Spread and test use of stratification methodologies (IEHP based HCO client data) to identify HCO TP for Health Home Program

Jul 2017 - Feb 2018*

- Monitor PCP panel size and access to inform decisions about BH clinic's capacity to provide ongoing integrated medical care to BH clients who no longer meet complex care management criteria
- Use stratification methodologies to continue identification of patients in need of integrated complex care

BHICCI Phases of Coaching

DOMAIN 6: DEFINE AND IDENTIFY POPULATION TO RECEIVE INTEGRATED COMPLEX CARE MANAGEMENT

References

TeamSTEPPS-a teamwork system, AHRQ and the Department of Defense, http://www.ahrq.gov/teamstepps/instructor/index.html

Cambridge Health Alliance Model Toolkit: nuts and bolts of team processes, huddles http://www.integration.samhsa.gov/workforce/team-members/Cambridge_health_alliance_team-based_care_toolkit.pdf

AIMS Center web site includes multiple resources: aims.uw.edu

- https://aims.uw.edu/collaborative-care/team-structure
- http://aims.uw.edu/sites/default/files/ClinicalWorkflowPlan.pdf

Structured Communication to build the highly effective team: SBAR http://www.ihi.org/resources/pages/tools/sbartoolkit.aspx

UCSF Center for Excellence in Primary Care, http://cepc.ucsf.edu/tools-transformation
Core Principles and Values of Effective, Team-Based Health Care, National Academy of Sciences (2012) https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-Values.pdf