Instructions for Completing the BHICCI Case Rate Readiness Assessment (CRRA) and Workplan

IEHP intends to sustain integrated complex care through case rate funding to health care organizations/clinics that demonstrate competency in providing complex care while reducing costs, or at a minimum maintaining cost neutrality. The Case Rate Readiness Assessment process described below is designed to identify where teams are excelling, and areas where special attention is needed to ensure that teams are in the best possible position to receive case rate funding beginning in August of 2018.

Both the CRRA and the related Workplan are due to IEHP, Practice Transformations Department by November 22, 2017. During February/March 2018, the IEHP Practice Transformation Department will follow up with teams to assess progress.

The initial Case Rate Readiness Assessment process has two parts:

- **Part I: Case Rate Readiness Assessment (CRRA)** provides for an assessment of a team's level of proficiency in key practice areas and activities that are foundational to integrated care for patients with complex conditions. The CRRA identifies practice areas that will become be a focus of the Workplan.

- **Part II: Case Rate Readiness Assessment Workplan** – describes the steps teams and their health care organizations will take to increase and demonstrate competency and readiness for transitioning to case rate funding.

Completing the CRRA and CRRA Workplan

In partnership with your Practice Coach, the CRRA is used to assess each HCO's team's competency, based on a set of defined criteria organized into three levels, "functioning", "performing", or "sustaining" across 8 key practice change areas from the BHICCI roadmap. Based on the CRRA, the Workplan requires the team/HCO to develop a specific plan for how the team will achieve "performing" for key practice change areas that are currently rated as "functioning". Teams are also encouraged, but not required to develop plans for achieving "Sustaining", where feasible. The goal is that teams are "performing" in as many key areas as possible or are reasonably expected to meet criteria for" performing" when IEHP conducts site visits in Spring 2018.

Before meeting with your Practice Coach, we encourage teams to review the tool to begin to identify areas of strength and where improvement is needed. **It is very desirable to obtain input from your entire team including leadership**.

Part I: Case Rate Readiness Assessment: The team, HCO leader(s) and Practice Coach complete the CRRA by rating the team's performance in each domain.

- Domains: For the items contained with columns "functioning, "performing" and "sustaining", place a check mark if the site fully meets the requirement of the item described.

- Assessment: Indicate performance level for each domain. The team and the Practice Coach discuss/agree on the team's level of achievement in each practice change area. If there is a disagreement about whether a site has fully demonstrated the level of "performing" vs. "functioning", the

Practice Coach will further describe steps the team can take to meet "performing". The Practice Coach and the HCO must both sign off on the CRRA including determination of which change areas should be a focus area of the Workplan.

Part II: Case Rate Readiness Assessment Workplan: The team, HCO leader(s) and Practice Coach complete the CRRA Workplan by identifying domains for improvement and developing specific improvement strategies. Following submission, teams will use the Workplan to record and track their progress toward "performing" or "sustaining".

- Information/Sign-off: For a Workplan to be considered completed, the HCO must identify and include the BHICCI contact person, HCO leader, and the Practice Coach to formally sign-off on the completed plan. Signatures are not required for plan revisions. The HCO is ultimately responsible for submitting to Dr. Pomerance by the due date of November 22, 2017 by the end of the business day.

- Domain: The Workplan must address those Domains where the site is at a "functioning" level. Including areas that the site will target to move from “performing” to “sustaining” is encouraged; however, this is not required for the CRRA Workplan.

- Assessment: Summarize the findings from the CRRA that identify domain and activity priorities for the Workplan.

- How will you get to performing/sustaining?: Describe the improvement plan, including specific planned activities, target dates, and the person responsible for monitoring improvement.

- How will we know the change is implemented?: Describe the documents/data/or reporting that will demonstrate the change has been implemented.

- Date Completed: The date that the action plan is fully completed.

Please submit a completed BHICCI CRRA and Workplans signed off by an Executive Leader, BHICCI contact person, and your Practice Coach by **November 22nd, 2017**. If you have questions, please contact **your Practice Coach or Dr. Elise Pomerance**, elise.pomerance@iehp.org. Thank you!

BHICCI Case Rate Readiness Assessment (CRRA)

BHICCI HCO: Clinic Site:
Practice Coach: Date:
Team Members Present for Assessment:

DOMAIN 1: Engage Leaders			
	FUNCTIONING	PERFORMING	SUSTAINING
Leaders actively support BHICCI through timely recruitment and hiring of team members, access to adequate physical space and operational resources, and integration of team into clinic culture.	☐ Core team members are hired and on-boarded. ☐ Sufficient work space is allocated.	☐ Leadership supports BHICCI team to address barriers and celebrate successes. ☐ Leadership responds with urgency to staffing changes. ☐ Leadership communicates integral role of BHICCI team across HCO.	☐ Leadership engages in sustainability planning for BHICCI team.
Assessment:			

DOMAIN 2 & 3: Engage Teams & Partner with Patients on Experience (EXP)			
	FUNCTIONING	PERFORMING	SUSTAINING
Team and patient EXP surveys are consistently completed, and survey data is incorporated into goal setting sessions where SMART goals are set to positively impact team and patient EXP.	☐ A team and patient EXP lead is identified on the team. ☐ The EXP lead facilitates the implementation of team and patient EXP surveys.	☐ Team and patient EXP survey results are regularly used to inform goal setting sessions. ☐ The team regularly engages in team and patient EXP goal setting sessions, sets SMART goals, and follows through on associated tasks.	☐ Based on learning from the BHICCI EXP work, the HCO adopts a framework for improving team and patient experience across the organization.
Assessment:			

DOMAIN 5: Adopt a Quality Improvement (QI) Method			
	FUNCTIONING	PERFORMING	SUSTAINING
The team consistently uses QI methods, including PDSAs, to test, implement, and spread integrated complex care management practice changes.	☐ A QI method is adopted but not routinely used for testing practice changes. ☐ The BHICCI team has participated in QI (MFI or LEAN) training or has received education in PDSAs. ☐ At least 1 PDSA was documented over the last 3 months.	☐ PDSAs are used to test new workflows and practice changes, and at least 3 PDSAs were documented over the last 3 months.	☐ PDSAs are routinely used and documented as an improvement method. Evidence exists that teams can manage more than one PDSA cycle at a time. ☐ The HCO adopts an improvement method (LEAN or MFI), and provides ongoing training and support for staff at all levels to ensure application to existing practices and new initiatives.
Assessment:			

DOMAIN 6: Identify, Engage, and Maintain the Target Population (TP)			
	FUNCTIONING	PERFORMING	SUSTAINING
The TP is appropriately defined to include individuals with BH and medical conditions who would benefit from complex care, outreach and engagement activities are conducted, and the team monitors the population to ensure appropriate step down and transitions.	☐ Team members understand criteria for the BHICCI TP. ☐ The team uses data sources to identify patients for the TP (i.e. ACG and EMR data, including BH and medical measures). ☐ Team members understand their roles in outreach and engagement activities. ☐ The team identifies and begins testing outreach activities to engage identified TP; as contact is made, patient-centered engagement strategies are utilized.	☐ The team uses a registry to assess and monitor the TP over time for changes in health outcomes. ☐ The team actively tests step down guidelines and protocols. ☐ The team adopts guidelines for step down that include clinical criteria and an assessment of utilization patterns. ☐ The team develops written protocols for timely outreach (including community based outreach) to patients who are disengaged.	☐ The team continues to use stratification processes and data sources to maintain and refresh the TP. ☐ Protocols exist for stratifying and identifying new patients for the TP. ☐ Step down protocols are formally adopted and shared with clinic providers to ensure smooth transitions of care. ☐ Written protocols are in place for outreach activities, including field-based work.
Assessment:			

DOMAIN 7: Build Multidisciplinary Complex Care Team			
	FUNCTIONING	PERFORMING	SUSTAINING
The multidisciplinary care team effectively works together to provide patient-centered, team-based care.	☐ Role descriptions for each team member are developed and include key responsibilities that align with the BHICCI core competencies. ☐ Team members understand their roles in supporting key workflows. ☐ Team members are trained in effective communication strategies such as SBAR and Motivational Interviewing (MI).	☐ The team develops and tests a method for assigning a primary care manager to each patient. ☐ Team members participate in core competency trainings. ☐ The team develops and tests a workflow that ensures the target population has time-sensitive access to the BH clinician.	☐ There is written documentation that delineates the roles and tasks of key team members for at least three care processes. ☐ There are written on-boarding, orientation, and training materials for new team members.
Assessment:			

DOMAIN 8: Integrate Behavioral Health Services with Complex Care			
	FUNCTIONING	PERFORMING	SUSTAINING
The BH clinician(s) within the team provide evidence-based treatment for mental health and substance use disorders.	☐ The BH clinician is trained in MI. ☐ The BH clinician(s) is trained in the use of the registry as a real-time clinical support tool and uses it to track outcomes at the individual patient and population level to guide treatment.	☐ The MI skills of the BH clinician(s) are evaluated using the core competency/MI skills evaluation card. ☐ The BH clinician(s) routinely and systematically uses the registry to identify which patients are not improving and proactively provides consultation to the team in care meetings, SCR, and curb-side consultations.	☐ The clinic has a training plan to increase team and clinic staff capacity to provide evidence-based SUD treatment, including Medically Assisted Treatment. ☐ SUD screening and outcome tracking is fully integrated into health screening and outcome tracking workflows at the clinic.

DOMAIN 8: Integrate Behavioral Health Services with Complex Care (Continued from previous page)			
	FUNCTIONING	PERFORMING	SUSTAINING
The BH clinician(s) within the team provide evidence-based treatment for mental health and substance use disorders.	☐ All team members are trained in the use of evidence-based SUD screens or the BHICCI SUA screening and outcome tracking tool.	☐ The team tests routine screening and tracking procedures for evidence-based SUD screens or the BHICCI SUA screening and outcome tracking tool.	☐ The clinic has a plan to offer integrated behavioral health services to their entire clinic population. ☐ The BH clinician(s) is trained in and routinely provides MI and behavioral health training to all clinical and support staff.
Assessment:			

DOMAIN 9: Offer Integrated Complex Care Management			
	FUNCTIONING	PERFORMING	SUSTAINING
All team members support patient development of self-management skills.	☐ Self-management is promoted by referrals to wellness/self-management groups, classes, or educators. ☐ Team members are trained in motivational interviewing and teach back as methods to build patient confidence and activation in selecting and acting on self-management goals.	☐ Self-management goals are included in patients' shared care plans. ☐ Team members follow up between face-to-face appointments with patients on self-management goals and activities. ☐ With patient permission, a family member or significant other is included in planned approaches to supporting wellness/self-management goals.	☐ All members of the team routinely check-in to reinforce and support wellness/self-management goals during patient contacts. ☐ The clinic has built, or is expanding, connections to local community-based organizations that support wellness and healthy behaviors, such as reduced cost access to gyms, farmers' markets/food programs, community healthy cooking classes, and walking groups.
Assessment:			

DOMAIN 9: Offer Integrated Complex Care Management			
	FUNCTIONING	PERFORMING	SUSTAINING
Team members coordinate care, facilitate timely and effective communication with providers, and ensure tracking and completion of referrals.	☐ The team identifies barriers to effective care coordination, including challenges related to sharing care plans, accessing lab results, reconciling medication changes, and transitions of care. ☐ Team members understand their roles in coordinating care for their patients, and providers know who to contact on the team for assistance with care coordination. ☐ The team defines roles and responsibilities for managing referrals and supporting referral completion.	☐ The team has in place, or is testing, protocols for sharing care plans and medication reconciliation results with providers. ☐ The team has adopted, or is testing, a referral process that includes preparing patients for referrals and tracking referral completion.	☐ The clinic and/or the HCO is testing and plans to adopt care coordination and referral management protocols for patients with complex needs. ☐ The team implements a referral process protocol and routinely prepares patients for appointments with other providers.
Assessment:			

DOMAIN 9: Offer Integrated Complex Care Management			
	FUNCTIONING	PERFORMING	SUSTAINING
Shared decision-making guides care, and it is reflected in shared care plans.	☐ The team tests and implements shared-care planning. ☐ The HCO adopts a Shared Care Plan.	☐ The team tests processes (using secure fax, EHR messaging, etc.) to communicate shared care plans within the team and with other providers (PC, MH, SUD, and specialty providers).	☐ A shared care plan is integrated into the EHR. ☐ Protocols are in place that address communicating shared care plans with providers. ☐ QI processes are identified for reviewing shared care plans.
Assessment:			

DOMAIN 9: Offer Integrated Complex Care Management			
	FUNCTIONING	PERFORMING	SUSTAINING
Team members use a registry to facilitate Measurement-based Care (MBC) by monitoring clinical outcomes obtained through the regular use of standardized measures, and they integrate clinical outcomes in patient care and population management.	☐ A functional registry is in place. ☐ Enrollees are entered in the registry. ☐ BH and PH measures are selected, collected, and documented in the registry. ☐ The registry is used to facilitate SCR.	☐ BH and PH measures are consistently updated on a clinically appropriate basis and incorporated into care-plan goals. ☐ All BHICCI team members routinely access the registry, review outcome trends, and actively share relevant outcomes with patients. ☐ Systems are in place to identify patients who are not improving, and clinical guidelines are used to facilitate changes in treatment.	☐ Patient-level outcomes data is incorporated into direct patient care.
Assessment:			

DOMAIN 9: Offer Integrated Complex Care Management			
	FUNCTIONING	PERFORMING	SUSTAINING
Team regularly conducts Systematic Caseload Reviews (SCRs) to provide frequent updates and changes in management for a defined population.	☐ SCR occurs 2x per month for a minimum of 1-hour per meeting. ☐ The full multidisciplinary team, including physician, attends, and key SCR roles are assigned (i.e. time keeper, scribe). ☐ Team members come prepared with cases to discuss.	☐ The team begins to use data to identify cases for discussion, including new patients, and patients who aren't improving as expected. ☐ Action items are documented in the registry and EMR.	☐ The team systematically uses data to ensure all patients are discussed at regular intervals. ☐ Strategies are defined for communicating action items to clinic providers. ☐ Systems are defined, and key protocols/processes documented, for closing the loop on action items across team members and providers.
Assessment:			