Behavioral Health Change Plan

Key:	Required Outcomes are in **BOLD**
	Recommended Tactics are indicated with an * and in BLUE
	For the purposes of MTP, the term "Behavioral Health" as defined by Washington State Health Care Authority (HCA) encompasses both Mental Health and Substance Use Disorder (SUD) services.

Domain	Focus Area	Outcome	Check O 'X'	Start Date	Target Date	Tactics	Check T 'X'	Notes
1. Care Coordination	1. Population Health Management	**A. Population-based platform is systematically utilized to follow subpopulations for more efficient and effective care**				* 1. Standardize identification of and track sub-populations needing more efficient management and effective care based on conditions and/or risk levels		
						a) Substance Use Disorder		
						b) Opioid Use Disorder		
						c) Co-occurring Mental health and Substance Use Disorder		
						d) Behavioral health and chronic disease		
						e) Depression		
						f) Pediatric oral health		
						g) Adult oral health		
						h) Asthma		
						i) Diabetes		
						j) Hypertension		
						k) Cardiovascular disease		
						l) Historical trauma and Adverse Childhood Experiences (ACEs)		
						m) Women of childbearing age (15-44)		
						n) Children overdue for well-child visits		
						o) Children under 2 who are not up-to-date with immunizations		
						p) High utilizers of the ED		
						q) High utilizers of the criminal justice system		
						r) Experiencing homelessness and/or food insecurity		
						s) Other		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
						* 2. Track those with targeted conditions and/or at high-risk to ensure continued engagement and that conditions are treated to target		
						3. Empanel patients/clients to a care team		
						4. Disaggregate patient/client data by subpopulations to identify and track inequities (race, gender, age, other)		
		B. Social determinants of health (SDOH) are assessed and integrated into standard practice				1. Train staff about the impacts of SDOH on health and using SDOH screening tool		
						2. Integrate SDOH screening tool in intake process and routine care		
						* 3. Patients/clients are screened for specific SDOH needs		
						a) Housing status/needs		
						b) Employment status/needs		
						c) Transportation status/needs		
						d) Food status/needs		
						e) Other		
		C. Care coordination protocols that include screening, appropriate referal, and closing the loop on referrals are developed to connect specific subpopulations to clinical or community services				1. Organization focuses on linking specific subpopulations to appropriate clinical or community services		
						a) Children who are overdue for well-child visits to primary care		
						b) Patients receiving treatment for substance use disorder or mental illness who have chronic disease to primary care		
						* c) Patients post psychiatric stay, residential treatment, or ED visit related to overdose, substance use disorder, or mental illness to primary care and/or behavioral health care		
						d) Patients with housing, transportation, employment support, and food needs to community-based organizations		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
						e) Families, women, and children to community-based organizations		
						f) Pregnant women to dental providers for dental care		
						g) Adults with diabetes to dental providers for dental care		
						h) All patients/clients needing dental care to community dental providers, and/or mobile dental services		
						i) Coordinate with host agency to embed mobile dental services on site		
						j) Women in first trimester of pregnancy to prenatal care		
						k) Women with risky health behaviors (alcohol use, tobacco use, illicit drug use, disordered eating, etc.) to evidence-based community support programs and specialty care		
						l) Women with prior adverse pregnancy outcomes and women with other identified risks (including social determinants) to community-based programs that provide intensive services during the prenatal and interconception periods (NFP, Healthy Start)		
						m) Other		
						2. Offer referrals (verbal or written) to patients/clients informing where they can receive needed services		
						* 3. Sign Business Associate Agreements or equivalent with partners invovled with the patient's care to support referrals OR sub-contract with community partners to ensure shared patients/clients receive appropriate services		List Partner(s): _____
						* 4. Create and implement protocol to follow-up with referral partner after referral is made		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
	2. Shared Care Management	**A. Streamlined process is in place for information to be shared in a timely manner for shared patients/clients**				1. Implement protocol to obtain shared patient/client records		
						* 2. Sign inter-organizational agreements for access to records of referred and/or shared patients/clients		List Partner(s): _____
						3. Participate in a technology platform that allows necessary patient/client information to be exchanged between the referee and referral organization		
						4. Maintain collaborative care plan in both physical and behavioral health records or in the same shared record		
						5. Establish and document a protocol for convening cross-sector care meetings		
	3. ED Diversion	A. At ED visit, patients are linked to a patient-centered medical home (PCMH) and appropriate services to treat mental health, substance use disorders and/or co-occurring disorders				1. Implement process to link patients to their patient-centered medical home or primary care provider. If they do not have one, establish a new patient referral to a primary care provider		
						2. Implement process to link patients needing behavioral health services to a behavioral health provider		
						3. *Kitsap NCC:* Embed community health workers in the ED to link patients to a patient-centered medical home or primary care provider		
						4. Implement process to review the PRC (patient review and coordination) list and EDIE feeds, assess patient needs, and link patients to community providers		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
		B. Organization develops or enhances services to help keep patients/clients out of ED				1. *Jefferson and Clallam NCC:* Community paramedics or EMTs perform home visits through a sub contractual relationship with your organization		
						2. *Jefferson and Clallam NCC:* Community paramedics or EMTs perform alternative transports through a sub contractual relationship with your organization		
						3. Create new open access/same-day/walk-in capacity		
		C. Patients/clients are assisted to understand appropriate settings for receiving health care services including ED utilization				1. Provide information or education to patients/clients about appropriate care settings		
						2. Ensure patients and their caregivers have access to instructions on how to get advice after hours		
						3. Assign care managers to assist those with recurrent ED overuse to identify barriers to accessing primary care, identify solutions, and resolve issues		
						4. Provide on-call staff with resources including crisis intervention lines		
						5. Follow-up with patients following ED visit and guide toward more appropriate setting in future as needed		
		D. Providers are notified of patient/client ED visits				* 1. Establish notification system between hospital and patient's medical/behavioral health home within NCC when a patient/client visits the ED		
						2. Implement workflows to review Emergency Department Information Exchange (EDIE) feeds		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
						3. Implement Pre-Manage		
	4. Jail Diversion	A. Individuals utilizing the criminal justice system are linked to a patient-centered medical home and appropriate services to treat mental health, substance use disorders and/or co-occurring disorders				1. *Kitsap NCC:* Embed community health workers in the criminal justice setting to link individuals to primary care, behavioral health, and/or other community services		
		B. Services are provided to individuals to keep them out of jail				1. Implement protocol with community partners to coordinate care for patients/clients/individuals/tribal members who have been recently incarcerated in order to reduce recidivism to the jail and reduce 9-1-1 calls		
2. Care Integration	1. Behavioral Health Integrating Primary Care	A. Organization chooses and implements an evidence-based program for care integration				1. Train providers in Chronic Disease Management in a behavioral health setting		
						2. Assess clinicians and care teams understanding of Chronic Disease Management in a behavioral health setting and provide training where needed		
						3. Establish protocol for tracking Chronic Disease Management in the electronic health record		
		B. Patients are screened for physical health conditions and patient tracking is initiated				* 1. Screen all clients for engagement with a primary care provider		
						2. Screen high-risk clients for ongoing engagement in medical care		
						3. Screen for history of chronic disease (physical)		
						4. Create a process to link clients to a primary care provider as needed		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
						* 5. Track referrals between behavioral and physical health including closing the loop with confirmation that clients/patients attended or did not attend an appointment		
		C. Staff work together regularly across behavioral and physical health to coordinate care				1. Design integrated care teams to function as a collaborative practice to support patients/clients to achieve treatment goals		List Partners:_____
						2. Develop shared care plans for patients/clients for integrated treatment		
						3. Incorporate recommendations of primary care providers into the overall plan of care		
						4. Track patient/client status over time with standardized workflows to ensure they are treated to target for both physical and behavioral health treatment goals		
						5. Co-manage patients with positive physical health screens until they achieve their treatment outcomes or are connected with appropriate services		List Partner(s): _____
						6. Survey shared patients/clients regularly regarding access, outcomes and experience		
		D. Access to physical health services is convenient and timely				* 1. Create an agreement with at least one physical health care provider to provide care for patients in need of physical health services		List Partner(s): _____
						2. Make "same day" physical health services available through face-to-face and/or virtual interactions		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
						3. Co-locate a physical health provider on site		
						4. Make physical health pre-consultation available to assist with urgent needs		
	2. Integrating Oral Health	A. Oral health education and screening are integrated into care				1. Screen clients for oral health needs and engagement with oral health provider		
						2. Refer clients in need to oral health provider and close the loop on referral		
						3. Provide oral health counseling and education to patients		
3. Care Transformation	1. Opioid Misuse and Abuse Prevention	E. Public is offered education and awareness around opioid epidemic				1. Link to public awareness programs such as It Starts with One		
						2. Use local data to raise awareness of regional impact of opioid epidemic		
	2. Opioid Overdose Prevention	A. Nalaxone is accessible				3. Train staff to recognize and appropriately respond to an overdose		
	3. Opioid Use Disorder Treatment	**A. Full spectrum of evidence-based care for OUD is available**				1. Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options		
						2. Incorporate SBIRT into workflow		
						3. Increase the number of providers waivered to provide MAT		
						4. Offer patients MAT		
						5. Offer patients psychosocial support services		
						6. Train outpatient SUD providers in best practices for treatment of OUD		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
						7. Build linkages/communication/referral pathways between those providers providing medication and those providing psychosocial therapies		
						8. Support staff to attend quarterly convenings between prescribers and providers		
						9. Develop regional standards of practice (adopt Bree OUD report and treatment recommendations)		
						10. Build structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers and staff to implement and sustain medication assisted treatment, such as methadone and buprenorphine; examples of evidence-based models include the hub and spoke and nurse care manager models		
						11. Give pharmacists tools on where to refer patients who may be misusing prescription pain medication		
						12. Enhance referrals to syringe exchange program		
						13. Develop/support linkages between syringe exchange programs and physical health providers to treat any medical needs that require referral		
						14. Develop/support linkages between syringe exchange programs and behavioral health providers to treat any behavioral health needs that require referral		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
						15. Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery		
		C. Treatment is expanded to those with OUD in the criminal justice system *Note: Strongly encourage at least one physical health provider per NCC to take this on*				1. Train and provide technical assistance to criminal justice professionals to endorse and implement best practices for the treatment of OUD for people under criminal sanctions		
						2. Optimize access to OUD treatment services for offenders who have been released from correctional facilities into the community and for offenders living in the community under correctional supervision, through effective care coordination and engagement in transitional services		
						3. Ensure continuity of treatment for persons with an identified OUD need upon exiting correctional facilities by providing direct linkage to community providers for ongoing care		
						4. Provide access to treatment and recovery support services/MAT services at jail		
		D. Hospitals and primary care clinics partner with mental health and substance use disorder providers to deliver acute care and recovery services to patients with OUD				1. Formalize referral relationship through inter-organizational agreement with providers who offer these services		List Partner(s): _____
						2. Employ or contract with providers who offer these services		List partner(s):_____
						3. Create informal referral relationships with providers who offer these services		List partner(s):_____

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
	4. Chronic Disease Prevention and Control	**A. Culture shift across organization to prioritize chronic disease prevention and management is created**				1. All levels of staff participate in Chronic Care Model training		
						* 2. Support chronic care improvement at all levels of the organization, beginning with the senior leader		
						3. Encourage transparent and systematic handling of errors and quality problems to improve chronic care		
		B. Health information technology is used efficiently to facilitate effective care				* 1. Identify relevant sub-populations by creating disease-specific registry/module/report in EHR/or appropriate electronic tracking tool		
							a) Asthma	
							b) Diabetes	
							c) Hypertension	
							d) Cardiovascular	
							e) Other	
						2. Close the loop for referrals		
						3. Systematically integrate information from referrals into care plan		
						4. Provide timely reminders to patients and staff of case management activities (follow-up calls and appointments, bi-directional coordination with community providers)		
						5. Monitor performance of practice team and care system within agency's quality improvement (QI) processes; course correct as needed		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
		C. Community-clinical linkages are enhanced to ensure patients are supported and active participants in their disease management				* 1. Form bi-directional referral system within the Natural Community of Care between clinical and community partner for effective chronic care services such as Diabetes Prevention Program (DPP), Chronic Disease Self-Management (CDSM), Whole Health Action Management (WHAM), exercise programs, and/or other; refer to appropriate programs depending on patient profile		List partner(s):_____
						2. Maintain internal community resource list to provide ongoing self-management support to patients		
						3. Engage local health coalitions, to advocate for policies to improve patient care and to develop programs to address social determinants within community		
		D. Patients are empowered and prepared to manage their own health care				1. Facilitate patient care planning, including coordinated care plan with community partners that provide evidence-based programs in disease self-management and identification of patient role/responsibility in self-management		
						2. Use and refer to effective, culturally-relevant self-management support strategies that include assessment, goal setting, action planning, problem-solving and follow-up		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
						3. Provide team-based (including specialists) clinical case management services for complex patients, including regular follow-up by the care team and planned interactions to support evidence-based care		
						4. Embed evidence-based guidelines into daily clinical practices, including provider education methods and evidence-based guidelines for patients		
4. Care Infrastructure	1. Capacity Infrastructure	A. Access to care is increased				1. Ensure all patients eligible for health insurance are enrolled		
						2. Increase marketing and uptake of a patient portal; patient scheduling through patient portal		
						3. Expand dental care through capital campaign projects		
						4. Purchase operatories, supplies, and/or equipment to expand access to care		
						5. Host a mobile dental clinic		
						6. Operate a mobile dental clinic		
						7. Purchase, store, distribute, and dispose of expired naloxone appropriately		
						8. Offer telehealth or telepsychiatry to patients where appropriate		
		B. Health information is exchanged securely, appropriately, timely, and efficiently				1. Explore a common or interoperable EHR (electronic health record) or EBHR (electronic behavioral health record) within Natural Community of Care		
						2. Explore a shared population health management system within Natural Community of Care		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
						3. Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent to Share		
						4. Integrate dental records into the medical EHR		
		C. All staff understand the impact of trauma and health inequities on health				1. Offer training in health equity		
						2. Offer training in LGBTQ-inclusive care		
						3. Offer training in NEAR sciences, historical trauma, and trauma-informed care		
		D. Patients receive the care they need from a trained workforce				1. Share workforce with another organization		
						2. Partner with an institute to establish a residency training program		
						a) MD		
						b) DO		
						c) ND		
						d) ARNP		
						e) Other		
						3. Partner with community college programs to recruit allied health professionals as they graduate		
						4. Hire Community Health Worker or similar workforce		
						a) Community Health Worker		
						b) Peer Advocate		
						c) Navigators		
						d) Other		
						5. Incorporate telehealth into your practice		

Domain	Focus Area	Outcome	Check O	Start Date	Target Date	Tactics	Check T	Notes
		E. Quality improvement methods are used to improve care and care delivery				* 1. Form and maintain a diverse quality improvement (QI) team of clinical and administrative staff with protected time to examine and improve upon clinical outcomes, quality of care, and patient satisfaction		
	2. Sustainability	**A. Transformation is sustained beyond the Medicaid Transformation Project**				* 1. Implement value-based payment arrangements with MCOs		
						* 2. Offer organization financial or in-kind match of DSRIP funding		
						* 3. Report on value-based metrics that will be in MCO contracts (not actionable until 2019, when providers will know which metrics will be in the contracts)		
						4. Support all-payer collaboration to foster system-wide transformation		
	3. Administrative	**A. Organization can exercise effective leadership, management, transparency and accountability of MTP activities throughout the duration of its Change Plan**				* 1. Establish and maintain an effective governance structure, and public access/reporting protocols regarding all MTP-related planning and decision-making		
						* 2. Implement reporting policies and practices to ensure complete and timely reporting of change plan activities to OCH		