Attachment A: Practice Transformation Support Hub Aggregated Report

Olympic Region Practice Transformation Support Hub/Qualis Health Coach Connector Activities

| **Clinics/Agencies** | **Action Steps & Quality Improvement** |
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| **Agape Unlimited SUD Services/Kitsap** | * Track MAT clients with SDoH reporting metrics for SBHO * Shared Qualis Health Integrated Billing Tool for preparing for MCO contracting |
| **Discovery Behavioral Health Services (DBH)/Jefferson** | * DBH QI Team will address the following care coordination gaps: * Treatment plan for PC and BH exists but are separate and uncoordinated with occasional sharing of information * Team states that rules and regs of 42 CFR 2 and HIPPA dictate what can/cannot be shared and this impacts level of accessibility and efficiency of BH practitioners * Client Care Teams are currently not in place * Data systems are currently shared among providers on an ad hoc basis * Funding driven by SBHO * Valent is new EHR that will be implemented in 8-9 months and should improve data systems, reports and coordination * Medication lists are kept in separate EHR * Team has no way to know if their clients have been seen in the ED * There are gaps in cross training with staff due partially to turn-over of staff. This creates QI issues around documentation. |
| **Jefferson Healthcare Primary Care Clinics/Jefferson** | * Integrated QI Team currently planning for implementation of Collaborative Care Model * Currently working with three medical social workers who primarily see Medicare patients. Team believes Collaborative Care Model will be more sustainable and serve more patients * Coach-Connector provided environmental scanning document to identify private therapists in surrounding Jefferson County who accept Medicare and preferred referral process for patients |
| **Kitsap Medical Clinics/Kitsap** | * Update pain contract and workflow map random Urine Drug Screen protocol * Coach-Connector conducted Environmental Scanning for Medicare covered mental health providers and social workers in Kitsap County * Pilot project with KMHS to utilize Collaborative Care Codes with LPN on site functioning as care coordinator and KMHS therapist providing 8 hours month of BH service. |
| **Kitsap Mental Health Services (KMHS)Admin/Kitsap** | * Reviewing SUD consent management workgroup goals and considering being pilot site for state-developed SUD consent management tool * Admin staff participating in VBP Academy and pilot project with tracking treatment to target for BH diagnoses and chronic disease * Build templates for Valent for population health for all four Behavioral Health Agencies * Utilize PreManage * Pilot Registries bases on Navos model to track treatment to target with PHQ9 |
| **Kitsap Mental Health Older Adults Team/Kitsap** | * Workflow map ROI process and limitations of 42CFR2. Admin addressing this issue. * Workflow map care continuity between established KMHS clients and co-located PCP from Harrison Health Partners and Peninsula Community Health Services * Utilize champion clinician to pilot care consultation between KMHS and PCPs |
| **Lower Elwha Tribe Health Services/Clallam** | * Formation of QI Team and teaching principles of quality improvement that includes Dental, BH, SUD and PCP services * Securing funding for new electronic health record, likely NextGen * PDSA with population health Icare screens for chronic disease and prevention tracking * Address health literacy issues related to comprehension and language services * Pilot Excel registry to track treatment to target of high ED utilizers and high risk clients |
| **North Olympic Healthcare Network/Clallam**  **BEST PRACTICE** | * PhD Psychologist managing MAT and BH Services with three BH providers as of 8/2018. * Planning for crisis response in North Olympic Healthcare Network clinic to provide warm hand-offs for providers * Coach researching billing by chemical dependency provider in FQHC |
| **NW Washington Family Medicine Residency/Kitsap** | * Medical Assistants weekly Healthcare Maintenance follow up for preventative care with empaneled patients * Administer PHQ-2 and GAD-2 for all patient visits * Collaboration with KMHS to fund three employees of KMHS to integrate in all Kitsap clinics to provide BH services and referrals to KMHS for intake and mental health services |
| **Peninsula Community Health Services-KMHS Campus/Kitsap** | * Co-located ARNP is a member of the QI team and completed the PCMH-A with team * Care gaps exist due to inability to see any shared client records * Work around developed for care continuity |
| **Peninsula Community Health Services-Community Clinics BEST PRACTICE/Kitsap** | * Champion provider who conducts huddles daily with her medical assistant will be offered as a best practice for other provider teams to pilot * Lowest Score of 9 from PCMH-A #17. Organized Evidence Based Care: Visits are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses subpopulation reports to proactively call groups of patients in for planned care visits. |
| **Port Gamble S’Klallam Tribe Wellness Clinic (BH &SUD) and Health Clinic/Kitsap** | * Behavioral Integration Team formed to lead efforts to care coordination * Preparing to share NextGen between all staff for full transparency between BH, SUD and PCP services * Workflow mapping for new integrated mental health position in primary care * Outreach strategies for substance use pre-contemplative clients * Tribe sending group to Southcentral Foundation Nuka System of Training in Anchorage, Alaska June 27-29 to develop competencies to:   + Identify recruitment, onboarding, retention strategies for integrated BH and psychiatry professionals within the primary care setting   + Examine Southcentral Foundations’ journey of integration, including challenges and success measures   + Take a deep dive into the recommended steps and best practices for fully integrating BH and psychiatry   + Compare various models and levels of integrating BH |
| **Reflections Counseling Services Group/Clallam** | * Shared Qualis Health Integrated Billing Tool for preparing for MCO contracting * Workflow map care gap with no show/cancelled clients and implement protocol for more immediate follow up to maintain engagement of client * Building referral relationships with MAT program at North Olympic Healthcare Network * Develop new family orientation event * Consider LPN or RN one day per week on-site * Purchase of new EHR Reliatraxs to improve care coordination |
| **West End Outreach Services/Clallam** | * First PDSA addressed care gap with primary care providers referrals of patients to WEOS for services and workflow mapped process to improve client engagement in services * Second PDSA to improve whole person care through Excel Registry Tool. 1) Create an Excel spreadsheet to track 30 registered WEOS high utilizers to track use of ED, jail, PCP, WEOS intake history (scheduled, attended, no show status), SUD Dx, and Treatment & Housing Status with look-back history of at least three months. Include Chronic Disease column for PCP to complete 2) QI Team will work together to check spreadsheet throughout the week to keep tracking up to date. They will utilize the data they collect during huddles to consider how to engage and support clients and close care gaps with PCP. Team believes a more pro-active approach with PCPs during visits might decrease frequency of emergencies. The tracking sheet can inform this process. Director and QI and team will decide on the 30 clients to track, build the Excel Spreadsheet and populate it for previous three months. 3) Director and Integrated Mental Health Provider in Forks Primary Care Clinics will ask PCP to complete columns on Chronic Disease diagnoses and update as needed. |
| **West Sound Treatment Services/Kitsap** | * Shared Qualis Health Integrated Billing Tool for preparing for MCO contracting * Workflow map urine analysis protocol and convene all staff meeting to address client care gaps to design new measures for more effective urine analysis services * Consider role in ED to provide on-call SUD Evaluations and bridge into SUD services |

*Acronyms in use in this attachment: 42 CFR 2 – 42 Code of Federal Regulations Part 2, ARNP – advanced registered nurse practitioner, BH – behavioral health, DBH – Discovery Behavioral Health, ED – emergency department, EHR – electronic health records, FQHC – federally qualified health center, GAD – generalized anxiety disorder, HIPPA – Health Insurance Portability and Privacy Act, KMHS – Kitsap Mental Health Services, LPN – Licensed Practical Nurse, MAT – medication assisted treatment, MCO – Managed Care Organization, PC – primary care, PCMH-A – patient-centered medical home assessment, PCP – primary care provider, PDSA – Plan Do Study Act, PHQ – patient health questionnaire, QI – quality improvement, RN – Registered Nurse, ROI – release of information, SBHO – Salish Behavioral Health Organization, SDoH – social determinants of health, SUD – Substance Use Disorder, VBP – value-based payment, WEOS – West End Outreach Services*