MaineCare Health Home Webinar:
Tips & Tools to Integrate Behavioral Health, Community Resources, and Patient Feedback Into Your Practice

Thursday, November 14, 2013
**Important Webinar Notes**

- To minimize background noise, all lines have been muted
  - To **UNMUTE** line and talk, press *7
  - To **MUTE** line, press *6

- To ask questions or share comments:
  - Via Chat: Type your question or comment into the “Chat” box on the lower left-hand side of the screen
  - To speak via Webinar: Use “Raise your Hand” function, we’ll call on you to speak
  - Via Phone: UNMUTE (*7)

- **Please state your name and practice team when speaking**

- This call is being recorded

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Webinar Objectives

MaineCare Health Home Core Expectations

1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Enhanced access to care
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community
9. Commitment to waste reduction
10. Patient-centered HIT

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Webinar Objectives

- Behavioral Health Integration (BHI)
  - Define Behavioral Health Integration (BHI) in primary care setting
  - Discuss the BHI Site Self-Assessment
- Connection to Community Resources
  - Identify ways to link patients to support services in community
- Inclusion of Patients & Families in Practice
  - Highlight examples of how to engage patients/families in your practice to improve quality of care

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Your Path to Improving the Linkage between Physical and Behavioral Healthcare

Mary Jean Mork, LCSW
Quality Counts
November 14, 2013
Objectives

1. Identify key aspects of behavioral health integration in relation to Health Homes
2. Develop your vision for behavioral health integration for your practice considering READINESS and the LEVEL you’re aiming for
3. Begin to evaluate your change readiness using the SSA, and plan the direction ahead
Behavioral health services in primary care, when appropriate, have positive impacts:

- **Increased adherence** - to regimens and treatment of mental health disorders

- **Improved patient outcomes** - clinical and functional

- **Improved patient satisfaction** with care

- **Increased cost efficiency** - including primary and specialty costs for physical health care
The Triple Aim

Triple AIM Framework
Institute for Healthcare Improvement
to derive better health care value from the resources we invest.

Population Health
Improve the health of a population

Per Capita Cost
Reduce the per capita cost of care

Experience of Care
Enhance the patient care experience (including quality and access)

One cannot achieve improvement in one dimension without attending to improvement in others.
Patient Centered Medical Home (PCMH) – the Concept

From deGruy 2010
Maine PCMH Core Expectations

- Demonstrated physician leadership
- Team-based approach
- Population risk-stratification & management
- Practice integrated care management
- Same-day access
- Cost effective care
- **Behavioral-physical health integration**
- Patient/Family Involvement
- Community Connection
- Commitment to waste reduction
- Patient-centered HIT
Behavioral-Physical Integration

1. Using the SSA, participate in baseline assessment of current behavioral-physical health integration capacity

2. Take steps to make improvements
   - Implement a system to routinely conduct standard screening and assessment
     - Depression - PHQ-2, PHQ-9
     - Anxiety disorders – GAD-2, GAD-7
     - Substance Use – SBIRT, CRAFTT, CAGE, AUDIT
     - Pediatric Symptom Checklist
   - Incorporate a behavioral health clinician into the practice
Are you ready?

What will it take to move forward?
Behavioral Health Integration Improvement Process

- Readiness
- Level of Integration you’re seeking
- Site Self Assessment Practice results
- Opportunities for improvement
- SSA Change ideas
- BHI Action plan
- Your plan for next steps

Readiness questionnaire
Basic Readiness Questions

Could you do more to emphasize the importance of mental health?

Do you:

- Screen for common mental health problems?
- Know where to refer?
- Routinely link patients with behavioral health providers?

Do your leaders support integration?

Do the providers "buy-in" to the idea of sharing with behavioral health clinicians?
Coming into your practice

- Do you have space?
- Do you have an EMR that will support the behavioral health work?
- Is your billing department prepared?
- Is your office staff prepared?
Joining the team

- Have you identified ways to make improvements in teamwork?
- Do you have regular and effective methods of communication, e.g., huddles, staff meetings?
- Do your team members learn from each other?
- Do team members understand and appreciate the different roles in the practice?
- Are you ready to share some of your more challenging patients with other members of the team?
Team functions that support integration

- Warm hand-off
- Morning huddles
- Provider meetings and Lunch and Learn’s
- Informal check-in
- EMR: One record
- Coordinated care
# Levels of Integration

<table>
<thead>
<tr>
<th>Levels of Integration</th>
<th>Level</th>
<th>Attributes</th>
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<tbody>
<tr>
<td>Coordinated Minimal Collaboration</td>
<td>Ⅰ</td>
<td>Separate site &amp; systems Minimal communication</td>
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<tr>
<td>Basic Collaboration at a distance</td>
<td>Ⅱ</td>
<td>Active referral linkages Some regular communication</td>
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<tr>
<td>Co-Located Basic Collaboration on site</td>
<td>Ⅲ</td>
<td>Shared site; separate systems Regular communication</td>
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<tr>
<td>Close Collaboration Onsite</td>
<td>Ⅳ</td>
<td>Shared site, some shared systems Routine communication and coordination</td>
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<td>Integrated Close Collaborative Approaching Integrated Practice</td>
<td>Ⅴ</td>
<td>Shared site; shared systems Coordinated treatment plans Regular communication</td>
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<tr>
<td>Full Collaboration in a Transformed Integrated Practice</td>
<td>Ⅵ</td>
<td>Shared site, vision, systems Shared treatment plans Regular team meetings Population based behavioral health</td>
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Elements contributing to levels

- Location of Behavioral health clinician
- Operations and systems
- Treatment plan sharing
- Patient experience
- Organizational and leadership support
- Business model
What is your current level of integration?
What is your goal?
What could you do to get to the next level?
Site Self-Assessment (SSA)

Part I; 9 Q: Integrated Services & Pt/Family-Centeredness

Part II; 9 Q: Practice/Organization

Practice team to complete

This is not a report card!

Next steps:

1. Review results
2. Identify one component to work on; develop an aim
3. Plan a first small test of change to work towards that aim
2. Emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)  

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<tr>
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<th>not assessed (in this site)</th>
<th>occasionally assessed; protocols are not standardized or are nonexistent</th>
<th>assessment is integrated into care on a pilot basis; assessment results are documented prior to treatment</th>
<th>assessment tools integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized protocols are used and documented.</th>
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Screening and Assessment

- Addresses under-recognition of common mental health conditions

Change ideas:
- Choose
  - a high risk population
  - one or more conditions for screening (depression, anxiety, substance use)
- Implement a process
  - to routinely screen
  - to use screening results
Tips for any Level

- Start with patient centered perspective
- Plan strategically
- Value flexibility
- Engage all your staff in planning
- Plan for the bumps and growing pains
Next Steps

- Where is your practice and where do you want to be?
Resources

- [www.integratedprimarycare.com](http://www.integratedprimarycare.com)
- [www.mehaf.org](http://www.mehaf.org) – Maine Health Access Foundation
- [www.ahrq.gov](http://www.ahrq.gov) - Agency for Healthcare Research and Quality
- [www.thenationalcouncil.org](http://www.thenationalcouncil.org) – the National Council for Community Behavioral Healthcare
- [www.ibhp.org](http://www.ibhp.org) – Integrated Behavioral Health Project
- [www.mainehealth.org/mentalhealthintegration](http://www.mainehealth.org/mentalhealthintegration)
We can help

- **Neil Korsen**, MD MS,  korsen@mainehealth.org, 662-6881

- **Missy Cormier**, LCSW, Maine Mental Health Partners,  cormim@springharbor.org, 662-7165

- **Mary Jean Mork**, LCSW, Maine Mental Health Partners and MaineHealth,  morkm@mmc.org, 662-2490

- **Cynthia Cartwright**, MT RN MSEd, MaineHealth  cartwc@mainehealth.org, 662-3529
Start where you are
Use what you’ve got
Do what you can

Arthur Ashe
Community Care Teams (CCT)

• SMAA began taking referrals from CCTs in April 2013
  • SMAA Resource Specialist maintains ongoing communication with the referring CCT
• CCT referring to SMAA include:
  • Maine Medical Partners (6 practices)
  • Martin’s Point Healthcare (1 practice)
    – “other” indicates that referral was sent from a CCT practice outside of SMAA’s service area.
3 patients refused SMAA assistance after the referral was made by the CCT.
Community Links

• Community Links is a partnership between medical care providers and the Aging & Disability Resource Center (ADRC) at SMAA, which has been developed to help support a model of comprehensive care. The partnership is based on the idea that social service providers are well positioned to play an important and complimentary role in optimizing care delivery.

• The ADRC is staffed by Resource Specialists who are all licensed social workers. With the patient’s permission, staff at the ADRC follows up with the patient to provide guidance and support.
  – The ADRC may work with the patient directly or with their caregiver(s), depending on the nature of the referral and what the patient prefers.

• To expedite the referral process a confidential, electronic referral is sent through: www.mainecommunitylinks.org

• Follow-up information is provided to the referral source to ensure thorough communication
Community Links Referrals: July 2012 - July 2013

Referring Practice by County:

<table>
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<tr>
<th>Referring Practice by County:</th>
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<tbody>
<tr>
<td>Number of Referrals</td>
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<tr>
<td>Cumberland county</td>
</tr>
<tr>
<td>York county</td>
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<tr>
<td>Other &amp; Unknown</td>
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</table>

Community Links Referrals by Age

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<td>60+ yrs.</td>
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<tr>
<td>Under 60 yrs.</td>
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<tr>
<td>Age unknown</td>
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Community Links Referrals per Month
SMAA/ADRC Top 10 "Needs": 2012

- Health/Medical: 1154
- Nutrition: 1118
- Advocacy/Outreach: 1181
- Homecare: 1814
- Information (General): 2271
- Financial Aid: 1589, 6%
- Housing: 2392
- Caregiver Assistance: 3078
- Legal: 830

GRAND TOTAL of contacts: 40406

Other Need Inquiries: 3612

Top 10 total: 36794
Inclusion of Patients & Families

• Must Pass:
  o Patients/families regular part of leadership meetings or advisory process
  o Tangible supports to enable patients/families to be involved
  o Practice systematically draws upon patient/family input at least annually
    ▪ **Examples**: mail survey, phone survey, focus groups

• Resources on the Quality Counts website:

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Inclusion of Patients & Families

How do busy practices work towards this Core Expectation?

Examples of Challenges:

- Geographic distance between patients and practices
- Lack of resources
- Perceived lack of interest from patients/families
- Time constraints

Examples of Solutions:

- Thinking outside the “Patient Advisory Council” box
- “Meet patients where they are at”
- What are other practices doing?
Upcoming Webinars

• Next MaineCare Health Home Webinar:
  o Thursday, December 12
  o 7:30 – 8:30 a.m. or 4:30 – 5:30 p.m.
  o Topic: Care Transitions and The Primary Care Roadmap to Change

• Important Change for 2014 Health Home Webinars:
  o Will be combined with Patient Centered Medical Home (PCMH) webinars
  o New Webinar DATES for 2014 – 4\textsuperscript{th} Wednesday of each Month
  o January 22, 2014 @ 7:30 a.m. or 4:30 p.m.

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Maine Patient Centered Medical Home

Recognizing the essential role of primary care in our healthcare system, the Dirigo Health Agency’s Maine Quality Forum (MQF), Maine Quality Counts, and the Maine Health Management Coalition work together to lead the Maine Patient Centered Medical Home (PCMH) Pilot. The participating practices include a diverse mix of adult and pediatric practices from around the state that were selected for their demonstrated leadership for and commitment to the principles of the PCMH model.

As part of their participation in the Pilot, practices are expected to implement a set of ten “Core Expectations” addressing key practice changes, and will be supported in their continued efforts to transform to a more patient centered model of care through participation in a PCMH Learning Collaborative. The ultimate goal of this effort is to sustain and revitalize primary care both to improve health outcomes for all Maine people and to reduce overall healthcare costs.

What is a Patient Centered Medical Home (PCMH)?

A patient centered “medical home” is an approach to providing primary care to people of all ages. It is not a building or place, but a team of health professionals who work together to provide a central point for coordinating care to help people become as healthy as possible.
Contact Info/Questions

- Maine Quality Counts
  - www.mainequalitycounts.org
  - Maine PCMH Pilot
  - (See “Programs” → PCMH)

- Your QI Specialist

- PCMH Pilot: Lisa Tuttle
  - ltuttle@mainequalitycounts.org

- Community Care Teams (CCT): Helena Peterson
  - Hpeterson@mainequalitycounts.org or 207.266.7211

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