The Critical Link:
Defining the Role of Primary Care, Community Care Teams, and Behavioral Health Homes in Improving Care Transitions

PCMH/Health Homes, BHH, and CCT Learning Session
Augusta Civic Center • Friday, October 2, 2015 • 7:30 am – 3:30 pm

DRAFT Agenda

LIGHT BREAKFAST AND REGISTRATION/CHECK-IN
7:30 – 8:15 am

WELCOME AND OPENING REMARKS
8:15 am – 8:30 am
Speaker: Lisa Letourneau, MD, MPH, Executive Director, Maine Quality Counts

MORNING KEYNOTE PLENARY: REDUCING READMISSIONS THROUGH CROSS-CONTINUUM COLLABORATION
8:30 am – 9:30 am
Speaker: Amy Boutwell, MD, MPP, Collaborative Healthcare Strategies

Learning Objectives:
- Understand specific issues contributing to re-admissions for varying patient populations, including Medicaid and Medicare
- Highlight key learnings and best practices to leverage the assets of the primary care team and community-based teams (such as Community Care Teams and Behavioral Health Homes) in improving care transitions
- Identify aligned opportunities for primary care practices, hospitals, Community Care Teams, and Behavioral Health Homes to reduce readmissions and improve care transitions

TRANSITION TO MORNING BREAKOUT SESSIONS

PART A - MORNING BREAKOUT SESSIONS
9:45AM – 10:45AM

A1) MAXIMIZING USE OF THE HEALTHINFONET (HIN) NOTIFICATIONS FUNCTION TO REDUCE ADMISSIONS AND READMISSIONS
Facilitators/Presenters: Sharon Bearor, RN, BSN, HealthInfoNet; Angela Richards, RN, BSN, Androscoggin Home Care & Hospice
Targeted Attendees: Primary Care Practice Teams

Learning Objectives:
- Identify value added with HealthInfoNet (HIN) notification function to practice setting to improve communication and care transitions
- Learn best practices and successful strategies to identify patients at high risk of potentially avoidable admission or readmission by using the HealthInfoNet notification function
- Identify strategies and tips for implementing the HIN notification function into practice workflow
A2) Care Management in Health Care
Facilitators/Presenters: Louise Morang, RN
Targeted Attendees: Behavioral Health Home Teams and Primary Care Teams, Community Care Teams
Learning Objectives:
- Identify the function of care management in Primary Care, CCTs and BHHs and clarify how staff roles impact care transitions and admissions/readmissions
- Acknowledge differences and similarities between CCT, Primary Care and BHH in managing care
- Discuss strategies for alignment and collaboration between Primary Care, CCTs and BHHs to strengthen care management to improve care transitions for shared patients/clients

A3) PRIVACY AND SECURITY OF HEALTH INFORMATION FOR HEALTH HOMES AND BEHAVIORAL HEALTH HOMES
Facilitators/Presenters: Stacey Mondschein Katz, Esq., Maine Dept. of Health and Human Services
Targeted Attendees: Primary Care Practice Teams, Behavioral Health Home Teams, and Community Care Teams
Learning Objectives:
- Review the regulations on sharing patient/client information between primary care and behavioral health
- Identify promising strategies and approaches for appropriately sharing patient/client information between primary care and behavioral health providers
- Learn tools and tips for providers to share information between partner organization and others

A4) MANAGING CARE THROUGH THE MAINECARE VALUE BASED PURCHASING MANAGEMENT SYSTEM (VMS PORTAL)
Facilitators/Presenters: Charyl Malik, MaineCare Services and Catherine Gunn, Muskie School of Public Service
Targeted Attendees: Behavioral Health Home Teams, Community Care Teams and Health Home Teams
Learning Objectives:
- Review VMS Portal Dashboard data for Health Homes, Behavioral Health Homes, and Community Care Teams
- Identify strategies to use the VMS Portal to manage care for patients/consumers

A5) FINDING YOUR VOICE IN NAVIGATING THE HEALTH CARE SYSTEM: BUILDING CONFIDENCE IN ADVOCATING FOR YOURSELF AND OTHERS
Facilitators/Presenters: Christine Canty Brooks, NAMI Maine; Simonne Maline, Consumer Council System of Maine; Vickie McCarty, Consumer Council System of Maine
Targeted Attendees: Patient Partners/Consumers, Primary Care Practice Teams, Behavioral Health Home Teams
Learning Objectives:
- Review common challenges in managing your care
- Identify successful strategies and tools in managing your healthcare

A6) ENGAGING PATIENTS IN THE CONVERSATION ABOUT SUBSTANCE USE AND ABUSE SCREENING AND TREATMENT AND MATCHING APPROPRIATE HEALTH CARE SERVICES TO NEEDS
Facilitators/Presenters: Eric Haram, LADC, Mid Coast Hospital and Catherine Chichester, MSN, APRN, BC, Co-Occurring Collaborative Serving Maine
Targeted Attendees: Primary Care Practice Teams, Patient Partners/Consumers
Learning Objectives:
- Learn effective talking points to address substance abuse screening and treatment with individuals in primary care settings
- Identify strategies to engage individuals in care discussions about substance abuse prevention, screening, treatment
- Learn tips and strategies to empower individuals at risk of substance abuse to have an active role in self-management and care planning
A7) Enhancing Access to Care and Transitions of Care for Individuals with Intellectual and/or Developmental Disabilities

Speaker: Doris Babbage, RN, BSN, CDDN, LNHA, Maine Developmental Disabilities Nursing Association

Targeted Attendees: Primary Care Practice Teams, Behavioral Health Home Teams, Patient Partners/Consumers

Learning Objectives:
- Learn common clinical reasons for behavior changes in individuals with intellectual and developmental disabilities
- Understand why an increase in inappropriate behaviors may have a direct correlation to pain in individuals with intellectual and developmental disabilities
- Learn strategies to decrease pain and or emotional distress as a part of the initial plan of care and decrease the use of antipsychotic medication until pain has been ruled out

A8) Show Me the Money! Successful and Practical Use of Medicare Transitional Care Management Codes to Support Your Practice

Facilitators/Presenters: Debra McGill, RN, Maine Medical Partners; Gisele Biron, CPC, Maine Medical Partners; Denise Breer, RN, BSN, Winthrop Family Medicine

Targeted Attendees: Primary Care Practice Teams

Learning Objectives:
- Understand definition of Transitional Care Management (TCM) services
- Highlight opportunities for increased income to practice by utilizing TCM codes
- Identify concrete and successful workflows for utilizing TCM codes in the primary care setting

PART B – MORNING BREAKOUT SESSIONS

11:00AM – 12:00PM

B1) Maximizing Use of the HealthInfoNet (HIN) Notifications Function to Reduce Admissions and Readmissions

Facilitators/Presenters: Sharon Bearor, RN, BSN, HealthInfoNet

Targeted Attendees: Primary Care Practice Teams

Learning Objectives:
- Identify value added with HealthInfoNet (HIN) notification function to practice setting to improve communication and care transitions
- Learn best practices and successful strategies to identify patients at high risk of potentially avoidable admission or readmission by using the HealthInfoNet notification function
- Identify strategies and tips for implementing the HIN notification function into practice workflow

B2) Privacy and Security of Health Information for Health Homes and Behavioral Health Homes

Facilitators/Presenters: Stacey Mondschein Katz, Esq., Maine Dept. of Health and Human Services

Targeted Attendees: Primary Care Practice Teams, Behavioral Health Home Teams, and Community Care Teams

Learning Objectives:
- Review the regulations of sharing patient/client information between primary care and behavioral health
- Identify promising strategies and approaches for appropriately sharing patient/client information between primary care and behavioral health providers
- Learn tools and tips for providers to share information between partner organization and others

B3) Operationalizing Best Practices for Medication Reconciliation

Facilitators/Presenters: Rebekah Gardner, MD, HealthCentricAdvisors; Felicity Homsted, PharmD, BCPS, Penobscot Community Health Center; Maureen Leary, HealthCentricAdvisors
**Targeted Attendees:** Primary Care Practice Teams, Behavioral Health Home Teams

**Learning Objectives:**
- Define medication reconciliation in primary care
- Differentiate between medication list and medication reconciliation
- Identify criteria to target patients who will best benefit from medication reconciliation
- Summarize key aspects of established “landmark” care transitions programs

**B4) CARE TRANSITIONS, ADMISSIONS, READMISSIONS, AND CHRONIC CONDITIONS: STORIES FROM THE FIELD**

*Facilitators/Presenters:* Kim Humphrey, MPH; Holly Gartmayer DeYoung, BSN, MBA, Eastport Health Care; Lori Lyons, John F. Murphy Homes; Brenda Voisine, Eastport Health Care

*Targeted Attendees:* Primary Care Practice Teams, Behavioral Health Home Teams, Patient Partners/Consumers

**Learning Objectives:**
- Understand key challenges for patients/caregivers when dealing with chronic condition(s) that impact access to care and care transitions
- Identify ideas for change as well as strategies to improve communication and coordination of care between care teams, patients, and caregivers

**B5) COORDINATING CARE FROM YOUTH TO ADULTHOOD**

*Facilitators/Presenters:* Christopher Pezzullo, DO, Maine Centers for Disease Control and Prevention

*Targeted Attendees:* Primary Care Practice Teams, Behavioral Health Home Teams

**Learning Objectives:**
- Identify gaps in care coordination for youth transitioning to adult services
- Explore strategies to connect youth to appropriate adult services
- Share strategies and tools to successfully transition youth care to adult care

**B6) ENHANCING ACCESS TO CARE AND TRANSITIONS OF CARE FOR INDIVIDUALS WITH INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITIES**

*Speaker:* Doris Babbage, RN, BSN, CDDN, LNHA, Maine Developmental Disabilities Nursing Association

*Targeted Attendees:* Primary Care Practice Teams, Behavioral Health Home Teams, Patient Partners/Consumers

**Learning Objectives:**
- Learn common clinical reasons for behavior changes in individuals with intellectual and developmental disabilities
- Understand why an increase in inappropriate behaviors may have a direct correlation to pain in individuals with intellectual and developmental disabilities
- Learn strategies to decrease pain and or emotional distress as a part of the initial plan of care and decrease the use of antipsychotic medication until pain has been ruled out

**B7) DIFFUSING EVIDENCE-BASED PRACTICES FOR SUBSTANCE USE SCREENING AND INTERVENTION IN PRIMARY CARE: STRATEGIES FOR SPREAD ACROSS YOUR SYSTEM AND LESSONS LEARNED USING THE SBIRT MODEL**

*Facilitators/Presenters:* Eric Haram, LADC, Mid Coast Hospital and Catherine Chichester, MSN, APRN, BC, Co-Occurring Collaborative Serving Maine

*Targeted Attendees:* Primary Care Practice Teams already implementing or beginning to implement the SBIRT model

**Learning Objectives:**
- For practice teams already implementing or starting to implement the SBIRT (Screening, Brief Intervention, and Referral to Treatment) model:
- Learn strategies for how to keep your gains in successful SBIRT implementation across your health care
• Learn how to analyze the spread of evidence-based practice for substance use and abuse screening in your practice setting
• Identify ways to sustain evidence-based practices for substance use and abuse screening through measurements

**B8) WORKSHOP FOR BHH QUALITY IMPROVEMENT PROJECTS**

*Facilitators/Presenters:* Mary Beyer, MS, Maine Quality Counts and Liz Miller, MPH, Maine Quality Counts  
*Targeted Attendees:* Behavioral Health Home Teams  
*Learning Objectives:*  
  • Identify improvements for BHH QI Improvement AIM Statements, measures, and timelines  
  • Refine BHH QI Project alignment to reducing readmissions, emergency department visits, and avoidable costs

**B9) THE ROAD HOME – UTILIZING COMMUNITY CARE TEAMS TO LIGHT THE WAY**

*Facilitators/Presenters:* Helena Peterson, RN, MPh, CPHQ, Maine Quality Counts; Michelle Couillard RN, Androscoggin CCT; Jaime Boyington, LCSW, Beacon Health; Margaret Towle, Community Health Partners; Cindy Tack, LCSW, MaineHealth  
*Targeted Attendees:* Community Care Teams  
*Learning Objectives:*  
  • Identify best practices for “hospital to home” care coordination for complex patients from literature and national models.  
  • Describe lessons learned from Maine “hospital to home” initiatives, including key elements for success.  
  • List three new ways my CCT can improve “hospital to home” transitions for complex patients.  
  • Forge new and stronger connections between hospital discharge staff and CCTs.

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**LUNCH AND NETWORKING/TEAM TIME  12:00 PM – 12:30PM**

**AFTERNOON PLENARY: A PATIENT’S TALE OF CARE TRANSITIONS AND COORDINATION**

12:30 – 1:00  
*Speakers:* Grace Cleaves, BA, CPC, Beyond Clinical Competence, LLC and Kym Dakin-Neal  
*Learning Objectives:*  
  • Acknowledge the challenges faced by an individual living with serious mental illness and chronic physical conditions, especially during transitions of care  
  • Achieve a deeper level of understanding from a patient/client perspective when experiencing transitions of care with multiple health care settings/teams  
  • Identify opportunities to improve care coordination and reduce unnecessary admissions/readmissions by empowering people and improving their health care experience

**TRANSITION TO AFTERNOON REGIONAL WORKSHOPS**

**AFTERNOON REGIONAL WORKSHOP 1 – FINDING YOUR ROADMAP AND YOUR REGIONAL PARTNERS**

1:15 – 2:20  
*Attendees will go to room they are assigned to (indicated on name tag).*  
*Faculty/Facilitators:* Quality Improvement Specialists will facilitate.  
*Targeted Attendees:* All Learning Session Attendees  
*Learning Objectives:*  
  • Share progress and barriers for improving care transitions and reducing readmissions in your region
• Share opportunities for identifying patients/consumers who are at moderate/high risk for admission/readmission
• Identify useful tips and workflows for transitions of care (e.g. warm hand-offs, timely follow-up, multi-way communication...etc.)
• Share opportunities for developing partnerships with organizations across the continuum of care

**AFTERNOON REGIONAL WORKSHOP 2 – BEST PRACTICES AND ACTION PLANNING TO REDUCE READMISSIONS**

2:30–3:30pm

*After brief break, attendees will return to their assigned room (indicated on name tag – same room as they were in for Workshop 1).*

**Faculty/Facilitators:** Quality Improvement Specialists will facilitate.

**Targeted Attendees:** All Learning Session Attendees

**Learning Objectives:**

• Leverage partnerships and opportunities for improvement across the care continuum
• Identify steps for “getting started” and increasing collaboration among patients, community-based partners, acute care/hospital settings, and primary care.
• Develop an action plan with partners in your region to improve care transitions and reduce readmissions

**CLOSING REMARKS - REFLECT, RESPOND, RECOMMEND 3:30 PM**

Learning Session Attendees will take a moment to reflect on the learning session, respond to the positive aspects of the day, and recommend any improvements that can be made to make their experience better in upcoming Learning Sessions.