Session # F8

Maximizing Partnerships for Integration Success: A Quality Improvement Approach for Engaging Practices

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- William B. Gunn, PhD, Director of Clinical Integration

CFHA Annual Conference
October 17-19, 2019 • Denver, Colorado

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

2

Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

3

Learning Objectives

At the conclusion of this session, the participant will be able to:

- Discuss the importance of harnessing inter-professional vertical and horizontal relationships that
  - Advance integration
  - Increase workforce capacity
- Engage practices in a quality improvement process to maintain momentum in integration efforts
- Use a quality improvement activity with inter-professional teams

4

Bibliography / Reference

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2. Scheirer, M., Leonard, B., Ronan, L., & Boober, B. (2015). Site Self-Assessment Tool for the Maine Health Access Foundation Integration Initiative (p. 11). Augusta, Maine: Maine Health Access Foundation. Retrieved from http://integrationacademy.ahrq.gov/measures/C8%20Site%20Self%20assessment%20Evaluation%20Tool
3. Ryer, J., Highland, J., Hodder, L., Miller, P., Doyle, M., & Garin, H. (2016). Integrating behavioral health and primary care in New Hampshire: A path forward to sustainable practice and payment. A preliminary report (White Paper). Concord, NH: University of New Hampshire, New Hampshire Citizens Health Initiative.
4. Flieger, S. P. (2017). Impact of a Patient-Centered Medical Home Pilot on Utilization, Quality, and Costs and Variation in Medical Homeness. The Journal of Ambulatory Care Management, 40(3), 228–237. https://doi.org/10.1097/JAC.0000000000000162
5. Flieger SP. (2017). Implementing the patient-centered medical home in complex adaptive systems: Becoming a relationship-centered patient-centered medical home. Health Care Management Review, 42(2),

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Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

6

INTRODUCTIONS

7

RELATIONSHIPS
Building community within the region

ASSESSMENT
Content-based practice facilitation

DATA
Data reporting, program development, and data-driven decision making

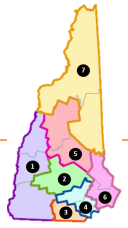
COACHING
Content-based practice facilitation

8

Integrated Delivery Networks

NH CHI is currently engaged in projects with 6 IDNs.

- Three regions are receiving intensive practice facilitation and coaching.
- Six are engaged with completion of Self Site Assessment (SSA) assistance
- Two are receiving intensive facilitation of their SSAs in partner practices
- One is receiving additional confidentiality and consent support



Building Partnerships

This project is providing support to partners who are transforming the way they operate to consider the whole person when providing care by:

- Screening for social determinates of health and BH issues
- Decreasing stigma by normalizing conversations about Behavioral Health topics
- Creating workflow pathways to adequately address identified needs
- Developing joint workflows and closed loop referrals to ensure continuity of care

The ultimate goal is to transform our system of care for a healthier NH population.

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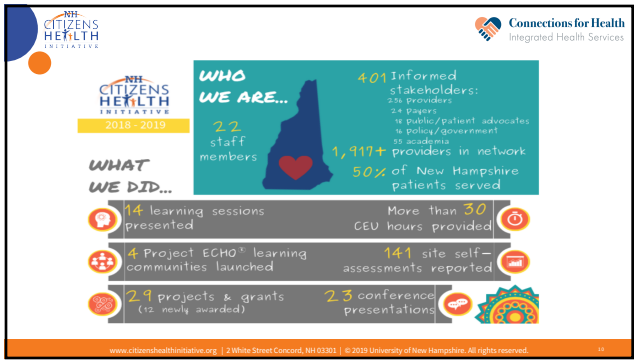
NH CITIZENS HEALTH INITIATIVE
Connections for Health
Integrated Health Services
2018 - 2019
WHO WE ARE...
22 staff members
401 informed stakeholders:
2.5% providers
2.4 payers
1% public/patient advocates
1% policy/government
.5 academia
1,917+ providers in network
50% of New Hampshire patients served
WHAT WE DID...
14 learning sessions presented
More than 30 CEU hours provided
4 Project ECHO® learning communities launched
141 site self-assessments reported
29 projects & grants (12 newly awarded)
23 conference presentations
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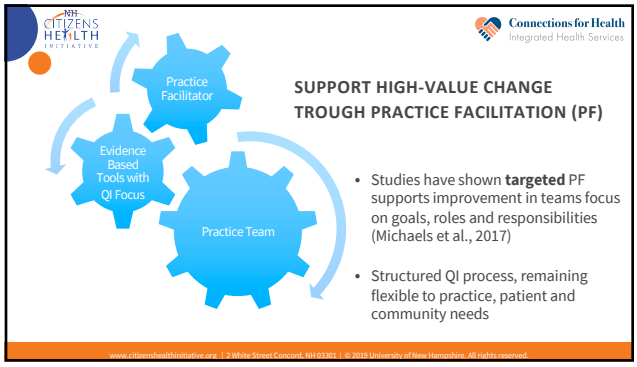
NH CITIZENS HEALTH INITIATIVE
Connections for Health
Integrated Health Services
Practice Facilitator
Evidence Based Tools with QI Focus
Practice Team
SUPPORT HIGH-VALUE CHANGE TROUGH PRACTICE FACILITATION (PF)
• Studies have shown **targeted** PF supports improvement in teams focus on goals, roles and responsibilities (Michaels et al., 2017)
• Structured QI process, remaining flexible to practice, patient and community needs
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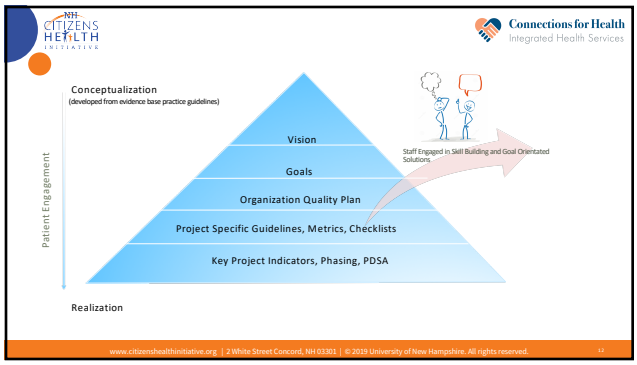
NH CITIZENS HEALTH INITIATIVE
Connections for Health
Integrated Health Services
Conceptualization
(developed from evidence base practice guidelines)
Vision
Goals
Organization Quality Plan
Project Specific Guidelines, Metrics, Checklists
Key Project Indicators, Phasing, PDSA
Staff Engaged in Skill Building and Goal Orientated Solutions
Patient Engagement
Realization
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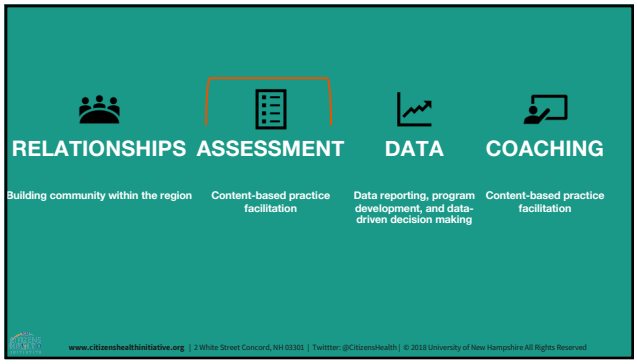
RELATIONSHIPS
Building community within the region
ASSESSMENT
Content-based practice facilitation
DATA
Data reporting, program development, and data-driven decision making
COACHING
Content-based practice facilitation
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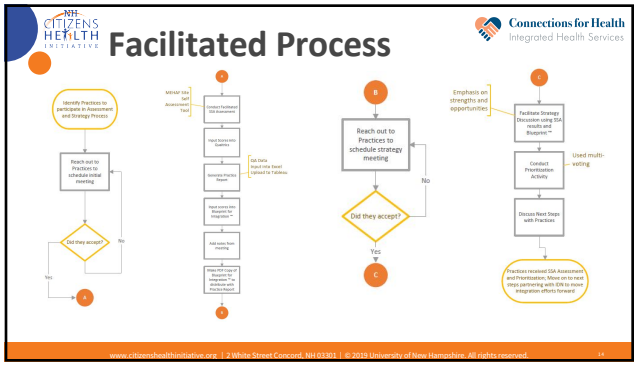
NH CITIZENS HEALTH INITIATIVE
Facilitated Process
Connections for Health
Integrated Health Services
Identify Practices to participate in Assessment and Strategy Process
Reach out to Practices to schedule initial meeting
Did they accept?
No
Yes
A
MEHAF SSA Self Assessment Tool
Conduct Facilitated SSA Assessment
Input Scores into Qualtrics
Generate Practice Report
Input scores into Practice Integrator™
Add notes from meeting
Make PDF Copy of Report for Practice to distribute with Practice Report
SSA Data Input into Excel Upload to Tableau
B
Reach out to Practices to schedule strategy meeting
Did they accept?
No
Yes
C
Emphasis on strengths and opportunities
Facilitate Strategy Discussion using SSA results and Blueprint™
Conduct Prioritization Activity
Used multi-voting
Discuss Next Steps with Practices
Practices received SSA Assessment and Prioritization, Move on to next steps partnering with IDN to move integration efforts forward
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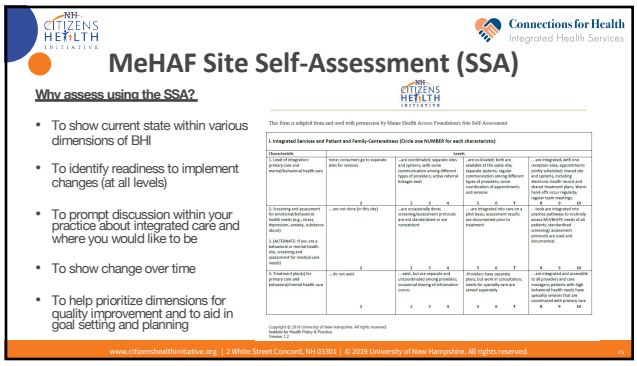
NH CITIZENS HEALTH INITIATIVE
Connections for Health
Integrated Health Services
MeHAF Site Self-Assessment (SSA)
Why assess using the SSA?
To show current state within various dimensions of BHI
To identify readiness to implement changes (at all levels)
To prompt discussion within your practice about integrated care and where you would like to be
To show change over time
To help prioritize dimensions for quality improvement and to aid in goal setting and planning
NH CITIZENS HEALTH INITIATIVE
This form is adapted from and used with permission by Maine Health Access Foundation's Site Self-Assessment
I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)
Characteristic
Levels
1. Level of integration: primary care and mental/behavioral health care
none; consumers go to separate sites for services
...are coordinated; separate sites and systems, with some communication among different types of providers unless referral linkages exist
...are co-located; both are available at the same site, separate systems, regular communication among different types of providers; some coordination of appointments and services
...are integrated, with one reception area, appointments jointly scheduled; shared site and systems, such as an electronic health record and shared treatment plans. Warm hand-offs occur regularly, regular team meetings.
1 2 3 4 5 6 7 8 9 10
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)
2. [ALTERNATE: If you are a specialty mental health clinic, screening and assessment for medical care needs]
...are not done (in this site)
...are occasionally done; screening/assessment protocols are not standardized or are nonexistent
...are integrated into care on a pilot basis; assessment results are documented poke to treatment
...tools are integrated into practice pathways to routinely assess ALL/MOST needs of all patients; results of screening/ assessment are documented.
1 2 3 4 5 6 7 8 9 10
3. Treatment plan(s) for primary care and behavioral/mental health care
...do not exist
...exist, but are separate and uncoordinated among providers; occasional sharing of information occurs
Providers have separate plans, but work in consultation; needs for specialty care are served separately
...are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care
1 2 3 4 5 6 7 8 9 10
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SAMHSA/SSA Crosswalk - Guideline

SAMHSA Six Levels of Integration					
COORDINATED CARE		CO-LOCATED CARE		INTEGRATED CARE	
I Minimal Coordinated Care, Silos	II Basic Collaboration at a Distance	III Basic Onsite Collaboration	IV Close Collaboration On Site with Some Systems Collaboration	V Close Collaboration Approaching a Fully Integrated Practice	VI Fully Collaboration Merge Transformed Integrated Practice
Separate systems Separate culture Limited communication	Separate systems Separate culture Communication mostly written	Separate systems Separate culture Same facilities Occasional face-to-face meetings General role appreciation Communication occasionally face-to-face	Some shared systems Face-to-face consultation Coordinated treatment plans Basic appreciation of each other's role and cultures Collaborative routines difficult, time and operation barriers Influence sharing	Shared systems and facilities Consumers and providers have same expectations In-depth appreciation of roles and culture Collaborative routines Conscious influence	Single transformed practice, treats the whole patient

MeHAF Site Self-Assessment Score Levels										
1	2	3	4	5	6	7	8	9	10	
INTEGRATED SERVICES AND PATIENT AND FAMILY-CENTEREDNESS and PRACTICE/ORGANIZATION DOMAIN TOTAL										
0-18	*19-46*		*47-82*		*83-126*		*127-162*		*163-180*	

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Blueprint for Achieving Behavioral Health Integration

New Hampshire Citizens Health Initiative's
Blueprint for Achieving Behavioral Health Integration

The *Blueprint for Achieving Behavioral Health Integration* links a practice's current score from the Maine Health Access Foundation (MeHAF) Site Self-Assessment (SSA) tool, with recommendations for increasing its level of integration based on the SAMHSA Six Levels of Integration framework. The Blueprint is intended as a guideline to identify the key areas of focus for a practice to achieve optimal person-centered behavioral health integration.

Based on decades of evidence and models … Whole Person Care

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Blueprint for Achieving BHI

Domain 1: Integrated Services and Patient and Family Centeredness
Date: 9/30/2019

Enter Author's Initials Below

Your Score	Level of Integration	Domain	Description	Key Concept	What You've Accomplished	Recommended Action to Increase Your Score by One	Notes
3	Basic Collaborative	1.9	Linking to Community Resources	Community linkages and resources are integral to providing comprehensive resources for person centered care.	Using data, identify disparities that may be addressed with community linkages. Note: If your practice is part of SIM P-H, integration effort, your target population will include Medicaid beneficiaries who will have an annual Comprehensive Care Standardized Assessment (CCSA - see handout).	Based on the use and sharing of assessment data, develop person centered interventions, programs and referrals.	Questions are embedded in the EMR. There has been discussion to screen for food insecurity but providers are concerned about what action can be taken for positive screens.
4	Basic Collaborative	1.1	Co-location of treatment for primary care and mental/behavioral health care	Understand the levels of integration and apply them to your practice vision.	Coordinate services based on patient need addressing the whole person. In order to understand patient need, the practice must identify the incidence and prevalence of important conditions and health concerns of the patient population. This will advance the practice's work in many other areas of integration.	Engage staff at all levels to evaluate the current or future service(s) provided at the practice. Do the services address the current needs of the patients and community? Are the sustainable? Have you address the social determinants of health in your plan?	The practice has established referral partners as its internal capacity has not set been developed. Current Clinical Care Coordinator occasionally helps with behavioral health-related needs, and is pursuing licensure.
5	Co-Located/ Collaborative	1.3	Treatment plan(s) for primary care and behavioral/mental health care	Shared care plans address the whole person.	The practice will develop ways to systematically identify patients who may benefit from enhanced services. Resources do not exist, nor is it needed, to have every patient receiving intensive and costly services. The practice should consider patients that are poorly controlled or with complex conditions.	The practice shall develop a protocol to identify patients and monitors the process and impact quantitatively.	PC and BH plans are separate and live separately because the practice is referring externally for behavioral health services. As a patient-centered medical home, the practice expects that PC treatment plans are being written, and the practice is particularly strong in its development of care plans for medically complex patients. BH treatment plans are less

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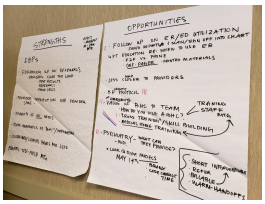
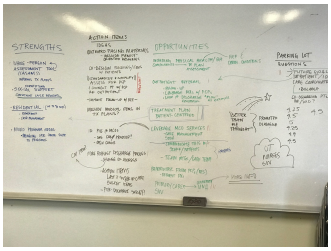
Facilitated Strategy Meeting

Connections for Health
Integrated Health Services





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RELATIONSHIPS	ASSESSMENT	DATA	COACHING
Building community within the region	Content-based practice facilitation	Data reporting, program development, and data-driven decision making	Content-based practice facilitation

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Connections for Health
Integrated Health Services

SSA Collection Process Overview

Facilitated Practice BHI Team SSA

+

Facilitate Practice BHI Team Strategy Session

=

- 16 practice meetings
- Identified practice & regional opportunities
- Reinforced Integration concepts
- Continued relationship building

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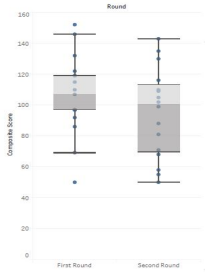
Aggregated Results

Themes/Sub-Themes	Examples
Referrals/Connections Supports	Connecting with PCPs; Routing Patients to MH services; SUD Services; Connecting with University supports; Coordination with community resources;
Screening and Workflow Supports	SDOH; SUD tools; Triaging patients with MH issues; intake process/criteria; scheduling
Needs and Supports	
Training	BHI; Interdisciplinary; Value of BHC
Team-Based Care	Huddles; Role Definitions; Multi-disciplinary Team Meetings; Care coordination meetings; Connecting across disciplines
Workforce Support	Dedicated Care Managers; Filling in open positions; Flow of care between BHC and PCP
Quality Improvement Support	Communication within practice; Data collection and reporting; data; access redesign; Community outreach
Reimbursement/Payment	Leveraging MCO services; budget



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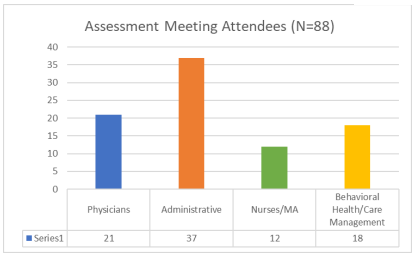
Assessment Meeting Attendees (N=88)



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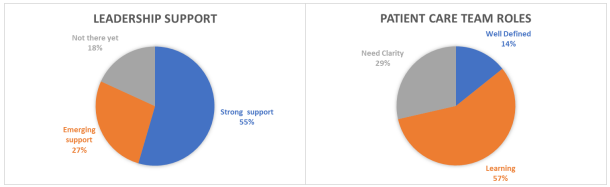
Qualitative Analysis



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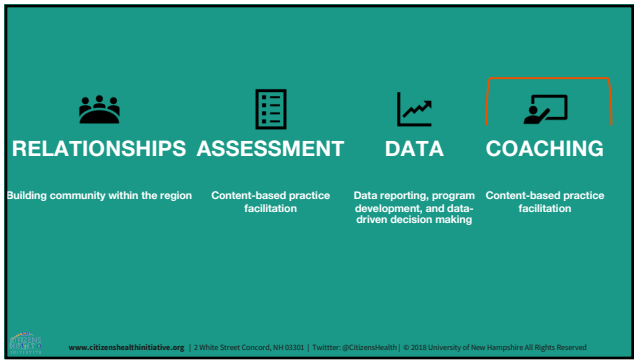
RELATIONSHIPS
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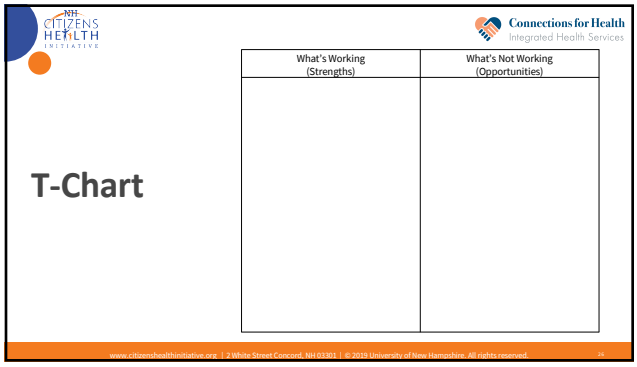
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Connections for Health
Integrated Health Services
T-Chart
What's Working (Strengths)
What's Not Working (Opportunities)
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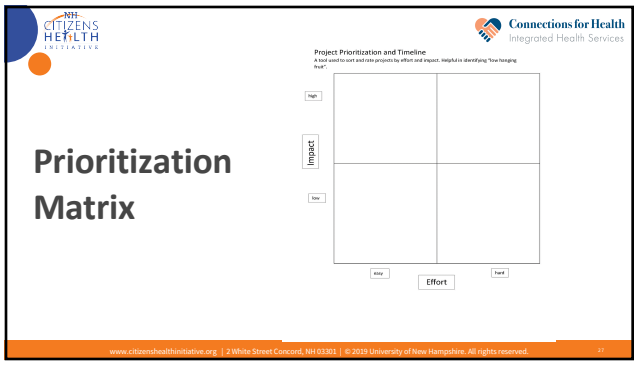
NH CITIZENS HEALTH INITIATIVE
Connections for Health
Integrated Health Services
Prioritization Matrix
Project Prioritization and Timeline
Impact
high
low
Effort
easy
hard
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Summary

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Photo Credit: Justine Bryant

Coping with Permanent White Water (*Peter B. Vaill*)

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Session Survey

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