Session # J8

Community-Based Implementation: Rolling out Three Integrated Approaches within one City Initiative

- Monica Williams Harrison, MSW, LCSW, Consultant, Center of Excellence for Integrated Care
- Amelia Muse, PhD, LMFT, Director, Center of Excellence for Integrated Care
- Sara Herrity, MS, LMFTA, Integration Specialist, Center of Excellence for Integrated Care
- Mary Moran, PhD, LMFT, LPC, Trauma Research Coordinator, Summa Health
- Antonia Monk Richburg, PhD, Vice President and Senior Program Officer, Cone Health Foundation

CFHA 20th Annual Conference
October 18-20, 2018 • Rochester, New York

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosure

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

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.

Learning Objectives

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

- Identify best practices for managing partnerships during community-based implementation.
- Discuss how three integrated care approaches can be utilized within one project and system to maximize access to care.
- Describe best practices for data collection and collaboration within and between diverse community health and service entities.

Bibliography / Reference

1. Aveling, E. L., Martin, G., Herbert, G., & Armstrong, N. (2017). Optimising the community-based approach to healthcare improvement: Comparative case studies of the clinical community model in practice. *Social Science & Medicine*, 173, 96-103.
2. Hall, J., Cohen, D. J., Davis, M., Gunn, R., Blount, A., Pollack, D. A., ... & Miller, B. F. (2015). Preparing the workforce for behavioral health and primary care integration, *The Journal of the American Board of Family Medicine, 28*(Supplement 1), S41-S51.
3. Payán, D. D., Sloane, D. C., Illum, J., Vargas, R. B., Lee, D., Galloway-Gilliam, L., & Lewis, L. B. (2017). Catalyzing Implementation of Evidence-Based Interventions in Safety Net Settings: A Clinical–Community Partnership in South Los Angeles. *Health Promotion Practice, 18*(4), 586-597.
4. Pettinati, H. M., O'Brien, C. P., & Dundon, W. D. (2015). Current status of co-occurring mood and substance use disorders: a new therapeutic target. *Focus, 13*(3), 356-362.
5. Reiss-Brennan, B., Brunisholz, K. D., Dredge, C., Briot, P., Grazier, K., Wilcox, A., ... & James, B. (2016). Association of integrated team-based care with health care quality, utilization, and cost. *JAMA, 316*(8), 826-834.

Learning Assessment

A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.

Acknowledgements

Cathy Hudgins, PhD, LMFT

Cone Health Foundation Board of Directors

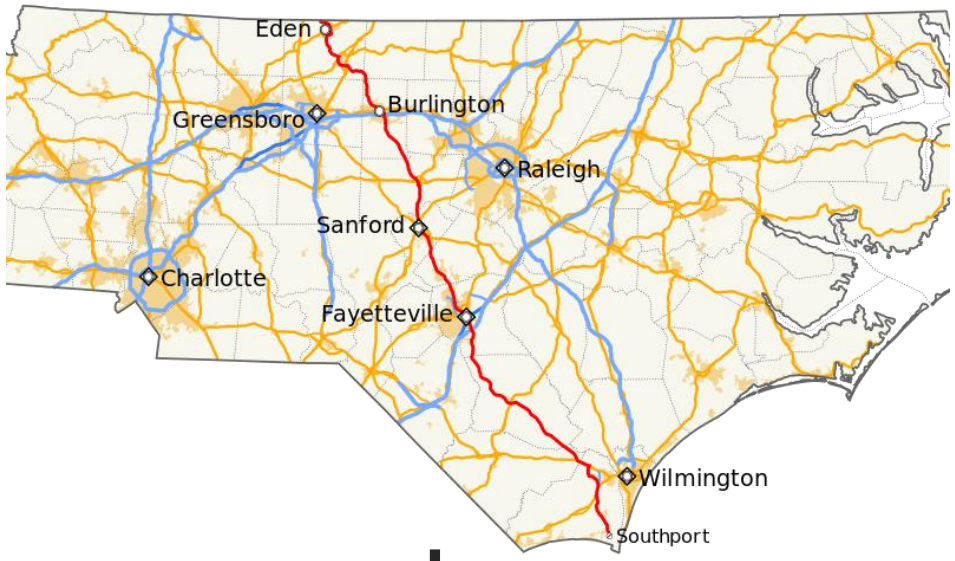
Cone Health Foundation Staff

Sites and Partners

Ken Gruber, PhD

Overview

- Community & Population Health
- Integrated Care Approaches
- Assessment Tools
- Data Results
- Lessons Learned



Getting Started

CONE HEALTH FOUNDATION

Investing in Health. Creating Change.

MISSION

To ***invest*** in the development and support of activities, programs and organizations that ***measurably*** improve the health of people in the greater Greensboro area.

VISION

Cone Health Foundation is a primary catalyst providing leadership for overcoming selected health barriers through investment and partnership.

CONE HEALTH FOUNDATION

Investing in Health. Creating Change.

This local foundation was established in 1997. It provides funding to support:

- Access to Care
- Adolescent Pregnancy Prevention
- HIV/AIDS
- Substance Use and Mental Health Disorders

The Foundation is improving population health in several ways:

- Pooling data
- Improving accessibility of care, quality and satisfaction
- Reducing duplication of efforts and costs

Goal of the initiative: Provide integrated services to 5,000 new, uninsured patients in 5 years

CONE HEALTH FOUNDATION

Investing in Health. Creating Change.

Proactive Grantmaking:

- Invitation Only RFP

Funded 23 total Sites:

7 Integrated Care Clinics with TA Only

1 Co-Occurring Disorders Clinic with TA Only

15 TA and Funding (Inclusive of Connectors)

- 1 Infectious Disease Clinic
- 9 Integrated Care Clinics
- 5 COD Clinics

CONE HEALTH FOUNDATION

Investing in Health. Creating Change.

Agencies Involved:

- Center for New North Carolinians
- Cone Health Foundation Access to Care Sites
- Cone Health Foundation Connector Sites
- Cone Health Foundation Co-Occurring Sites
- Guilford Community Care Network
- Guilford County Department of Public Health
- Center Of Excellence (COE)-FHLI
- UNC Greensboro Department of Social Work

Implementation Activities

Learning Collaboratives
- Whole Person Care

Networking for collaboration among competitors

Baseline Assessment
- Annual follow-up assessments

Promotion of Peer-to-Peer Learning

(Aveling et al., 2017; Payán et al., 2017)

Implementation Activities

Process, policy, procedure development & support

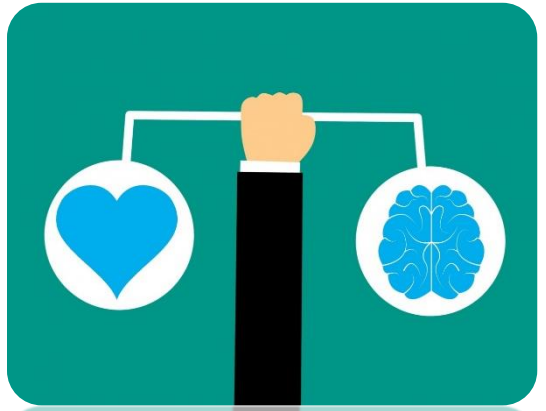
Utilization of communication platform

On-site visits

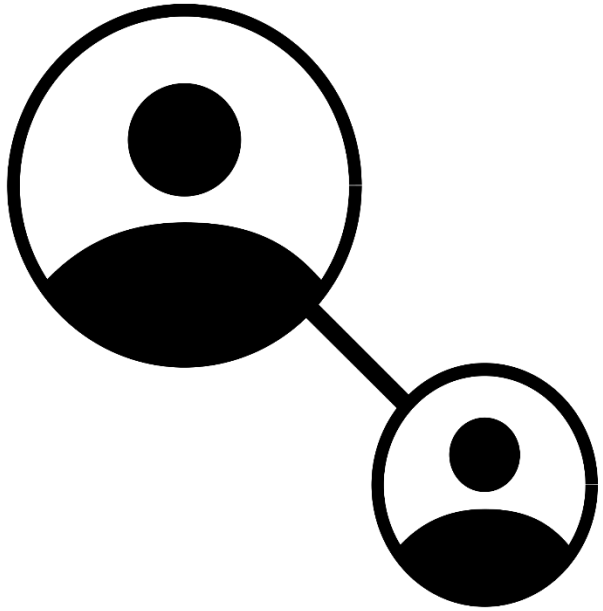
- Shadowing and coaching
- Presentations and training

The Approaches

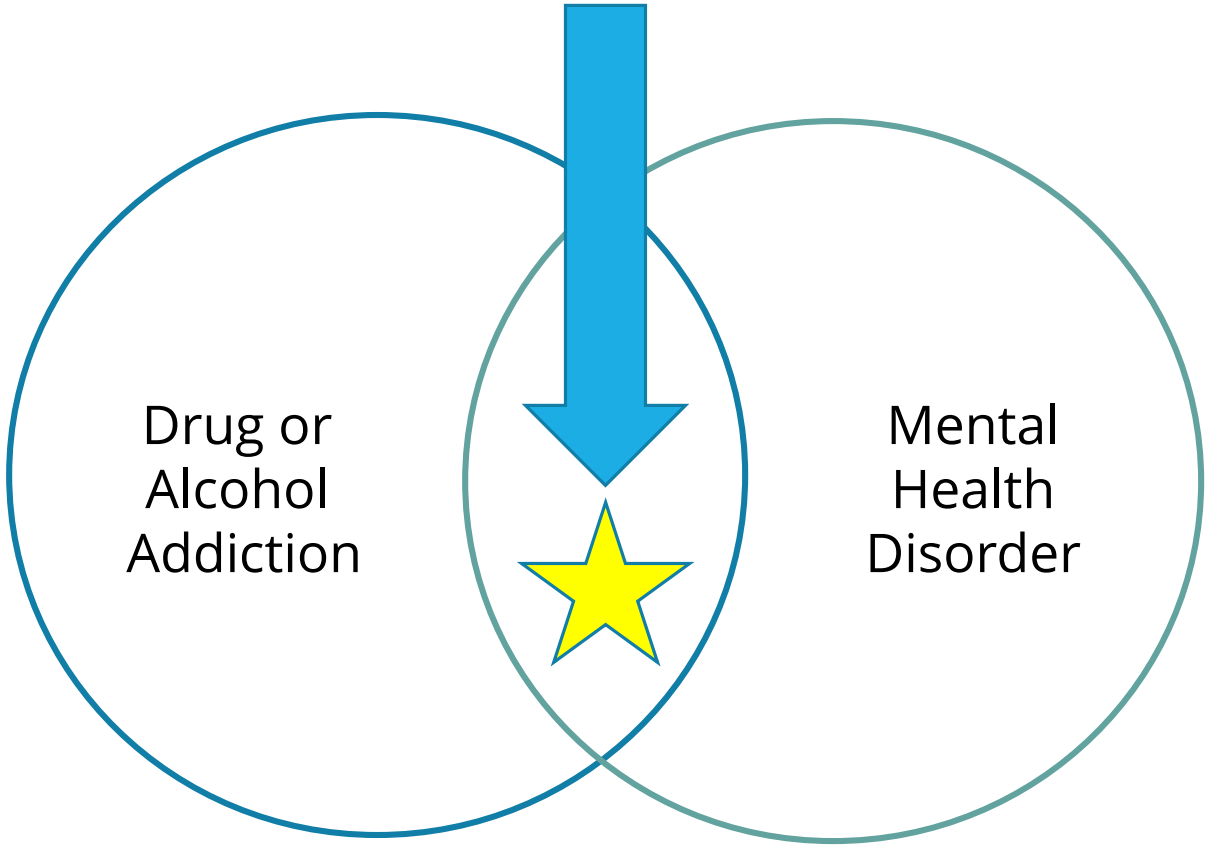
Primary Care Behavioral Health (PCBH)



Co-Located



Co-Occurring Disorders



Assessment Tools

Site-level assessment

- Measure current status along several dimensions of integrated care
- To stimulate conversations and gain consensus and buy-in among the site's integrated care team members.
- To assist in identifying priority areas for improvement for goal setting and planning for practice transformation.
- To identify specific implementation steps to meet the identified goals.

MeHAF Plus

Scheirer, M.A., Leonard, B.A., Ronan, L., Boober, B.H. 2008, revised 2010. Site Self Assessment Tool for the Maine Health Access Foundation Integrated Care Initiative. Augusta, Maine: Maine Health Access Foundation.

DDCAT/DDCMHT

Substance Abuse and Mental Health Services Administration, Dual Diagnosis Capability in Mental Health Treatment Toolkit Version 4.0. HHS Publication No. SMA-XX-XXXX, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

MeHAF Plus (Scheirer et al., 2008)

- Two sections
  - Clinical services – 12 items
    - COE added 3 to the original assessment
  - Practice/organizational infrastructure – 9 items

- Scale 1 - 10 based on the level of integration or patient-centered care achieved

MeHAF Clinical Domains

Domain Name	Content Evaluated
Integration	Overall level of integration
Screening	Systematic screening of emotional/behavioral health needs
Treatment Plan	Degree of shared treatment plan between medical and behavioral health providers
Evidence	Patient care is based on best practice evidence for BH/MH and primary care
Family	Degree the patient/family are involved in care plan
Communication	Degree of communication with patients about IC
Follow – Up	Coordination of follow-ups for assessments, tests, treatment, referrals, etc.
Social	Development of social support plans to help with treatment recommendations
Linkages	Degree of assisting patients to community resources

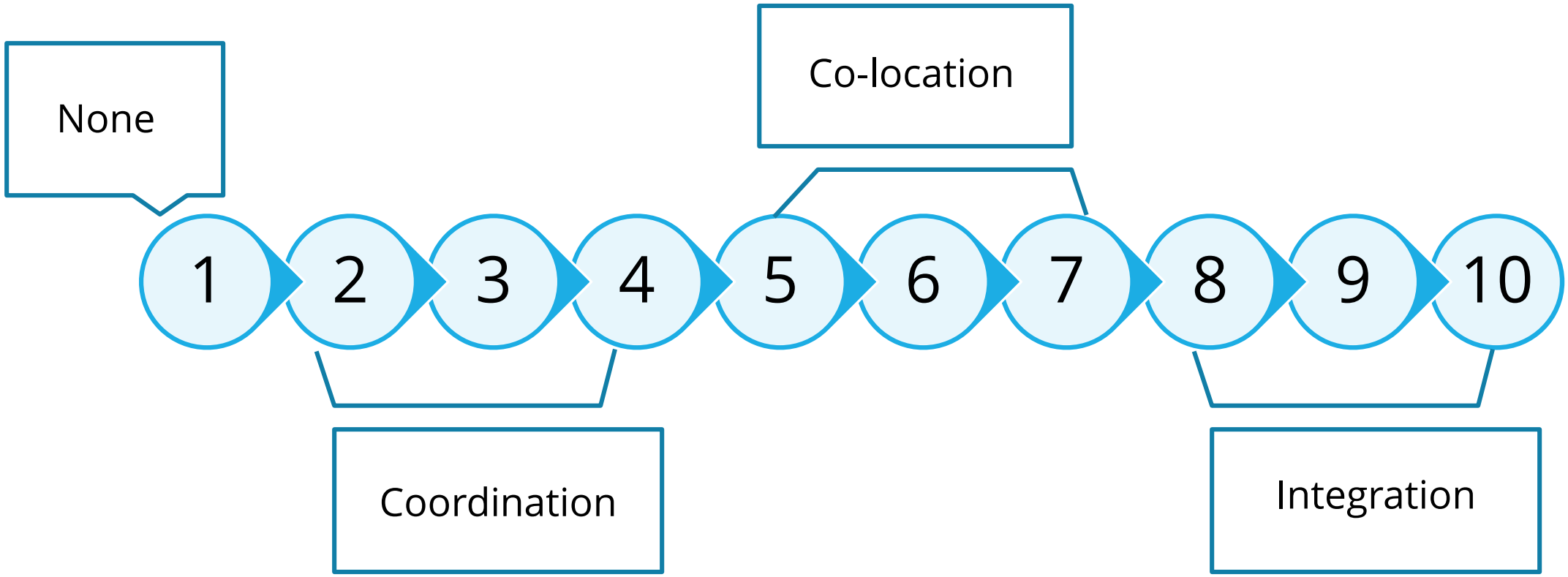
MeHAF Plus

Domain Name	Content Evaluated
Prescribing	Patient care informed by best practice evidence for psychotropic medications
Registries	Tracking of vulnerable patient groups
Efficiency	Accessibility & efficiency of BHCs

MeHAF Operational Domains

Domain Name	Content Evaluated
Leadership	Support provided by organizational leadership for IC efforts
Care Team	Patient care team to implement the IC model
Buy-In	Provider engagement with the IC effort
Continuity	Systematic continuity of care in place between the primary care and behavioral health
Coordination	Tracking and coordination of both medical and behavioral health referrals
EHR	Integration and accessibility of records and data
Advocacy	Patients and families voice regarding integration efforts
CE	Provider and staff training and education regarding integrated care
Funding	Integration of funding sources with staffing, infrastructure, and resource sharing

MeHAF: Overall integration



DDCAT/DDCMHT (SAMHSA, 2011)

Dual diagnosis capability/capacity

Mental health and co-occurring substance use disorders

Policy, clinical practice, workforce capacity

Includes chart review and clinical observation

DDCAT/DDCMHT Domains

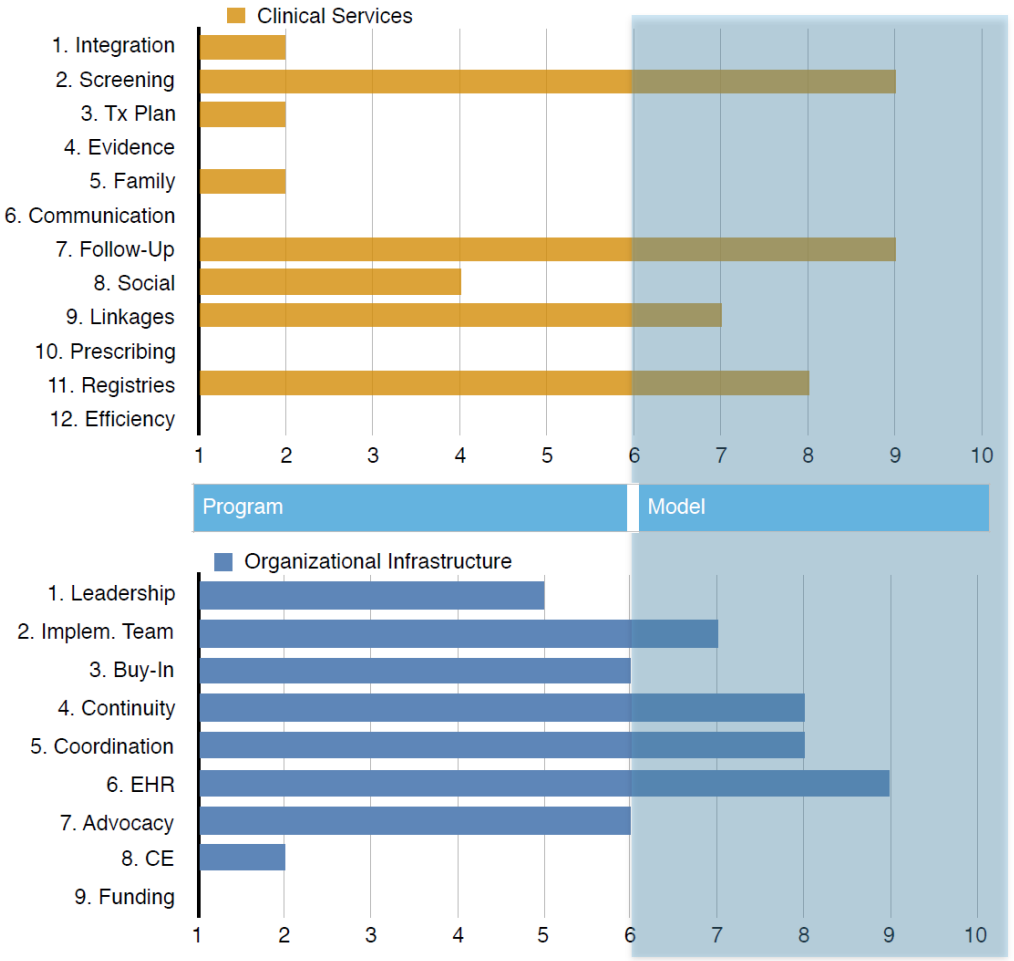
Domains
Program Structure
Program Milieu
Clinical Process: Assessment
Clinical Process: Treatment
Continuity of Care
Staffing
Training

Dual Diagnosis Capability (1-5)	
1 - 1.99	MHOS – Mental Health Only Services
2 - 2.99	MHOS/DDC
3 - 3.49	DDC- Dual Diagnosis Capable
3.5 – 4.49	DDC/DDE
4.5 – 5.0	DDE- Dual Diagnosis Enhanced

Center of Excellence for Integrated Care

MeHAF Dashboard

Site: [redacted]
Date of Debriefing: 12/19/17
Date of Evaluation: 11/15/17



Key & Definitions:
MeHAF Level: refers to the degree of integration of physical and mental/behavioral health at a particular site *compared to usual care.*
Program: refers to a site- specific effort to increase the *level* of integration (that is *not* defined by a model) compared to usual care. This effort is not generalizable to other sites and is not evidence-based.
Model: refers to a discrete, well defined, empirically validated, replicable set of characteristics and pathways which systematically apply studied strategies using a defined workforce to achieve integrated care.
Reach: refers to the extent to which a model impacts or touches the population of a site and is represented by the Four Quadrant metric.
MeHAF Form Link: https://ncfahp.sharepoint.com/programs/coe/_layouts/15/guestaccess.aspx?guestaccesstoken=AHdO8yIZLf0cw5FChyLo8%2f2VC

	Observations
Description of Assessment	Site visit by COE Technical Assistance Consultant to establish baseline MeHAF score. The MeHAF site self assessment tool was scored collaboratively with site representatives. The site will use the outcome of the tool to consider their strengths, identify their needs, and plan their next steps.
Readiness	This site serves patients from a variety of payors, with a higher proportion of medicaid patients. The site is going through PCMH attestation for the first time. Patients with behavioral health needs are being referred to a psychiatric practice with a team of social workers, when PCPs want information back from the BH referral, the MediHealth team obtains the information with prompting.
Overall Recommendation	This site has many clinical and organizational strengths, as highlighted by the bar charts on the left. To further improve the integration of behavioral and medical services, this site could work on improving partnership with a community mental health agency to embed a BHC in the practice.

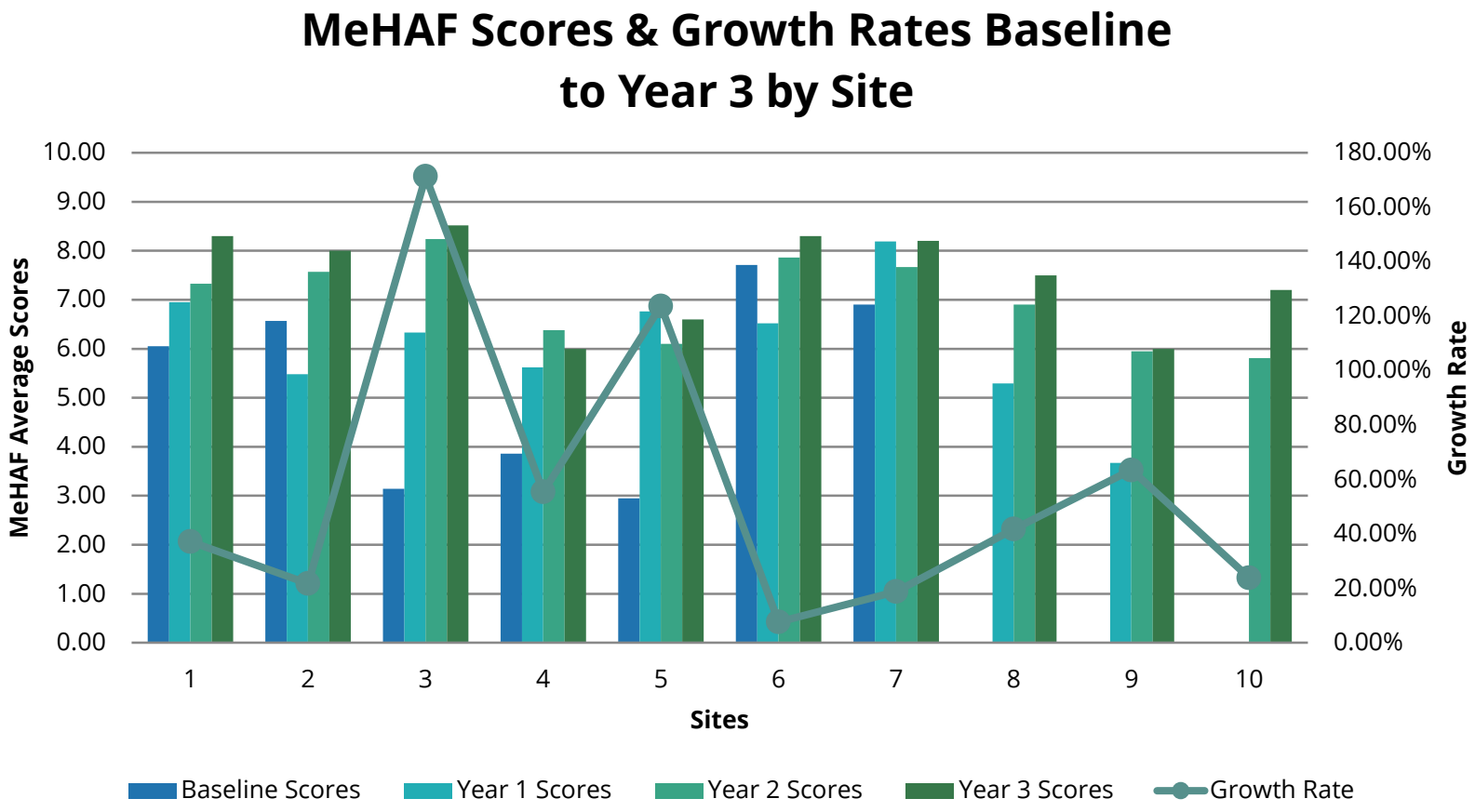
Dates	Average Score	Composite Score	Clinical Services	Organizational Infrastructure	Six Levels Correlation	Four Quadrant
Reference Range	(1-10)	(21-210)	(1-10)	(1-10)	(1-6)	(I-IV)
November 2017	4.71	99	3.92	5.78	2	I

Target Competencies	Recommendations
Treatment Planning/ Communication	Consider how to streamline information flow between the physical health and MH/SU providers in order to provide biopsychosocial treatment and a more unified treatment plan. Discuss with staff how incoming information from outside BH providers can be utilized by PCPs and documented in care plans.
Evidence/ Prescribing	Consider how to increase the training, use, and documentation of evidence-based interventions for both medical and behavioral health treatment. Consider how to increase the availability and systematic application of evidence based guidelines for behavioral health conditions in primary care for providers.
Efficiency	Pursue hiring/contracting with a behavioral health provider to increase access to behavioral health services. CHS will support process for embedding a behavioral health clinician at the site.
CE	Consider increasing availability of and engagement with training about integrated care for all staff members. Consider how to increase MediHealth care team's understanding and comfort with physical and mental health conditions. Consider conducting an all staff training to discuss the dissemination of integrated care to patients.

Acknowledgement: Neftali Serrano, PsyD

The Data

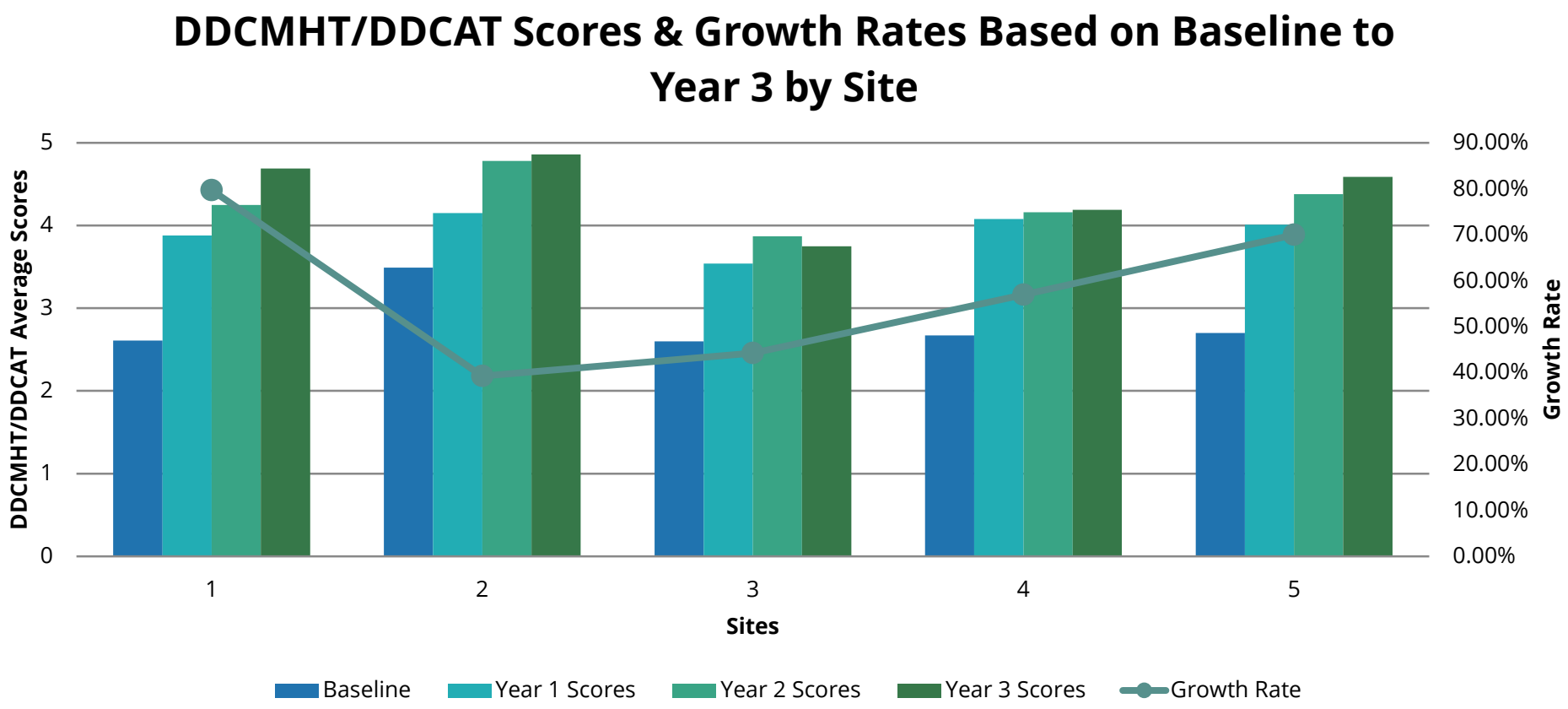
MeHAF Data


MeHAF Scores & Growth Rates Baseline to Year 3 by Site
MeHAF Average Scores
10.00
9.00
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
0.00
180.00%
160.00%
140.00%
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Growth Rate
1
2
3
4
5
6
7
8
9
10
Sites
Baseline Scores
Year 1 Scores
Year 2 Scores
Year 3 Scores
Growth Rate

MeHAF Data

	2-Tail unpaired with unequal variance	1-tail paired with equal variance
Baseline to year 1	.04	.07
Year 1 to year 2	.10	.01
Year 2 to year 3	.26	.00
Baseline to year 3	.03	.00

DDCAT/DDCMHT Data



DDCAT/DDCMHT Data

	2-Tail unpaired with unequal variance	1-tail paired with equal variance
Baseline to year 1	.00	.00
Year 1 to year 2	.15	.058
Year 2 to year 3	.39	.067
Baseline to year 3	8.50e-05	.00

Collaborative-level data collection

- October 1, 2015 – June 30, 2018

Community Connector Services	Patient Contacts
Provided Consultation/Education/Support Regarding Visits to a Primary Care Provider	5031
Provided Services to Clients with Primary or Behavioral Health Care Needs	4487
Provided Assistance with Making an Appointment with a Primary Care Provider	3642
Orange Card Enrollment Enabling Access to Integrated Care Services	2984
Conducted Primary Care/Behavioral Health Screenings or Assessments	1006

- Different data systems across collaborative members

(Numbers represent client contacts; Reiss-Brennan et al., 2016)

Collaborative-level data collection

- October 1, 2015 – June 30, 2018

Integrated Primary Care Behavioral Health Services	Patient Contacts
Number of New Uninsured Adult Patients	8,612
Number of New Uninsured Adult Patients Screened for Behavioral Health Care/Substance Use Issues	7,331
Number of New Uninsured Adult Patients Identified with a Mental Health or Substance Use Issue	4,762
Number of Returning Patients Identified with a Behavioral Health Care/Substance Use Issue	3,421

- 5 Year Target (2015-2020): Provide services to 5,000 uninsured patients
  - June 30, 2018 = **95.2%** of goal met
- Different electronic health record systems across collaborative members

(Numbers represent client contacts; Reiss-Brennan et al., 2016)

Collaborative-level data collection

- October 1, 2015 – June 30, 2018

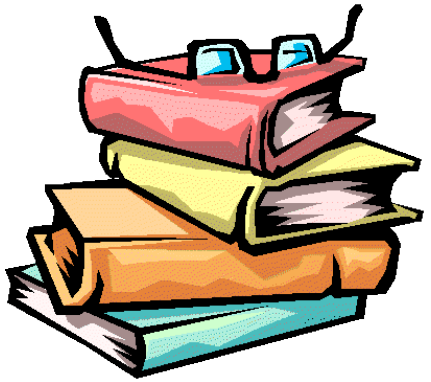
Co-Occurring Disorders	Patient Contacts
Number of New Patients Screened for Co-Occurring Disorders	9,230
Number of New Patients Accepted for Treatment with Co-Occurring Disorder Diagnoses	2,469
Number of New Uninsured Adult Patients Identified with a Mental Health or Substance Use Issue	4,762
Number of Returning Patients Identified with a Behavioral Health Care/Substance Use Issue	3,421

- 5 Year Target (2015-2020): Provide services to 5,000 uninsured patients
  - June 30, 2018 = 49.4% progress to goal
- Different electronic health record systems across collaborative members

(Numbers represent client contacts; Reiss-Brennan et al., 2016)

Lessons Learned

- Set metrics during project concept discussions
- Assess data collection capacity
- Determine most accessible numerators and denominators
- Provide technical support for data collection
- BHC/Staff Turnover
- Training of traditionally-trained workforce
- “Dedication of participant providers and what they have been able to accomplish and continue to accomplish on limited resources.”



(Hall et al., 2015)

Next Steps

Continuing to serve uninsured patients in our community collaborative.

The collaborative is being extended for three years with:

- 5 Co-Occurring sites
- 6 Connector Sites
- 9 Access to Care sites
- Opioid crisis focus

What resonated with you?

Conclusion

Managing community partnerships

Measuring collaboration

The spirit of the work

Session Evaluation- J8

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION