CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Welcome UnitedHealthcare IBH Expansion Practices

2020 QUARTERLY ADULT IBH MEETING 2-13-2020

Agenda

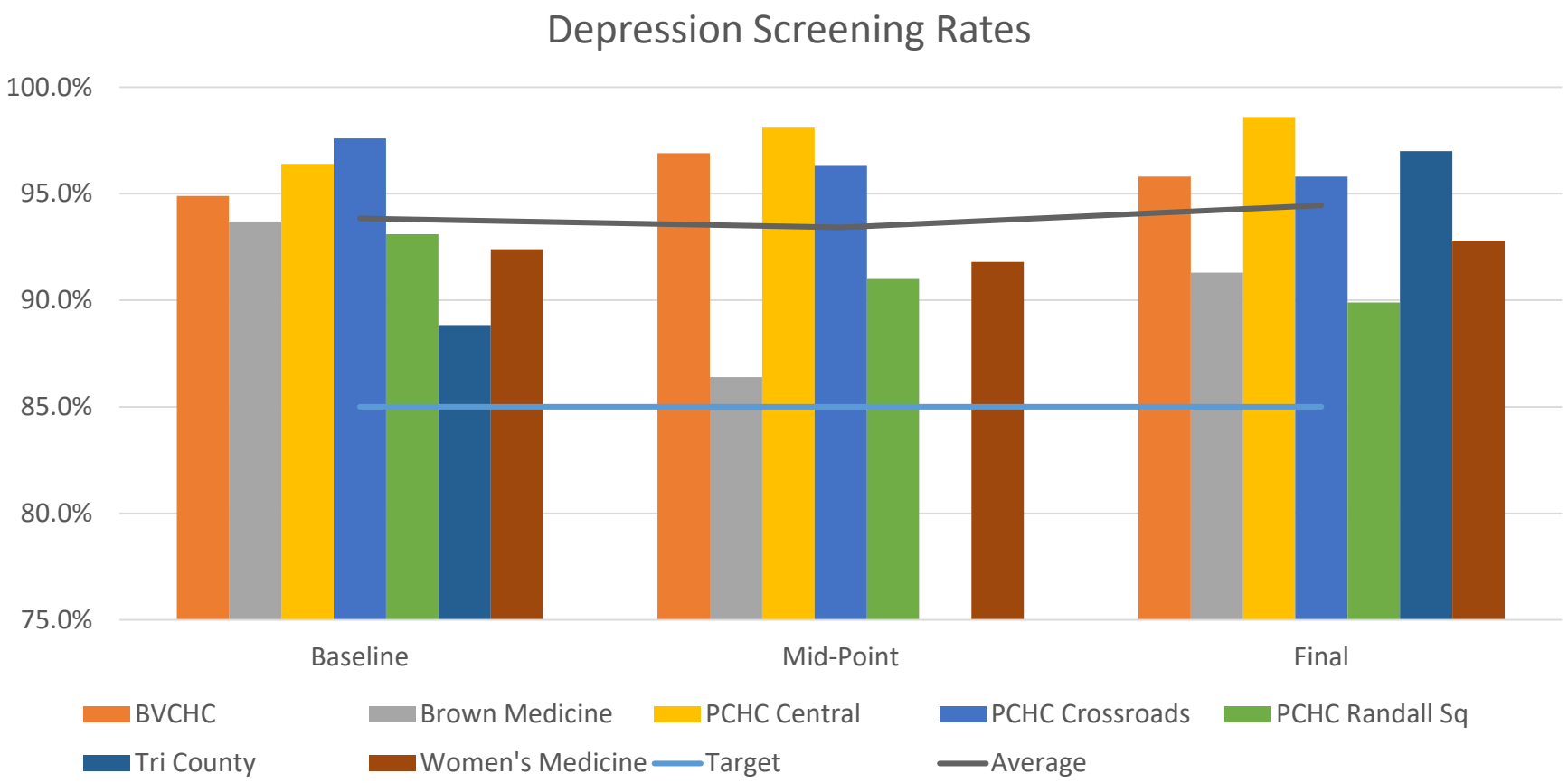
Topic *Presenter(s)*	Duration
Introductions	5 minutes
Practices Report Out: PDSA Results *Facilitated by Dr. Nelly Burdette*	60 minutes
New Online IBH Practice Facilitator Training Program *Dr. Nelly Burdette*	15 minutes
BH Telemedicine Interest *Dr. Nelly Burdette*	10 minutes

UnitedHealthcare®

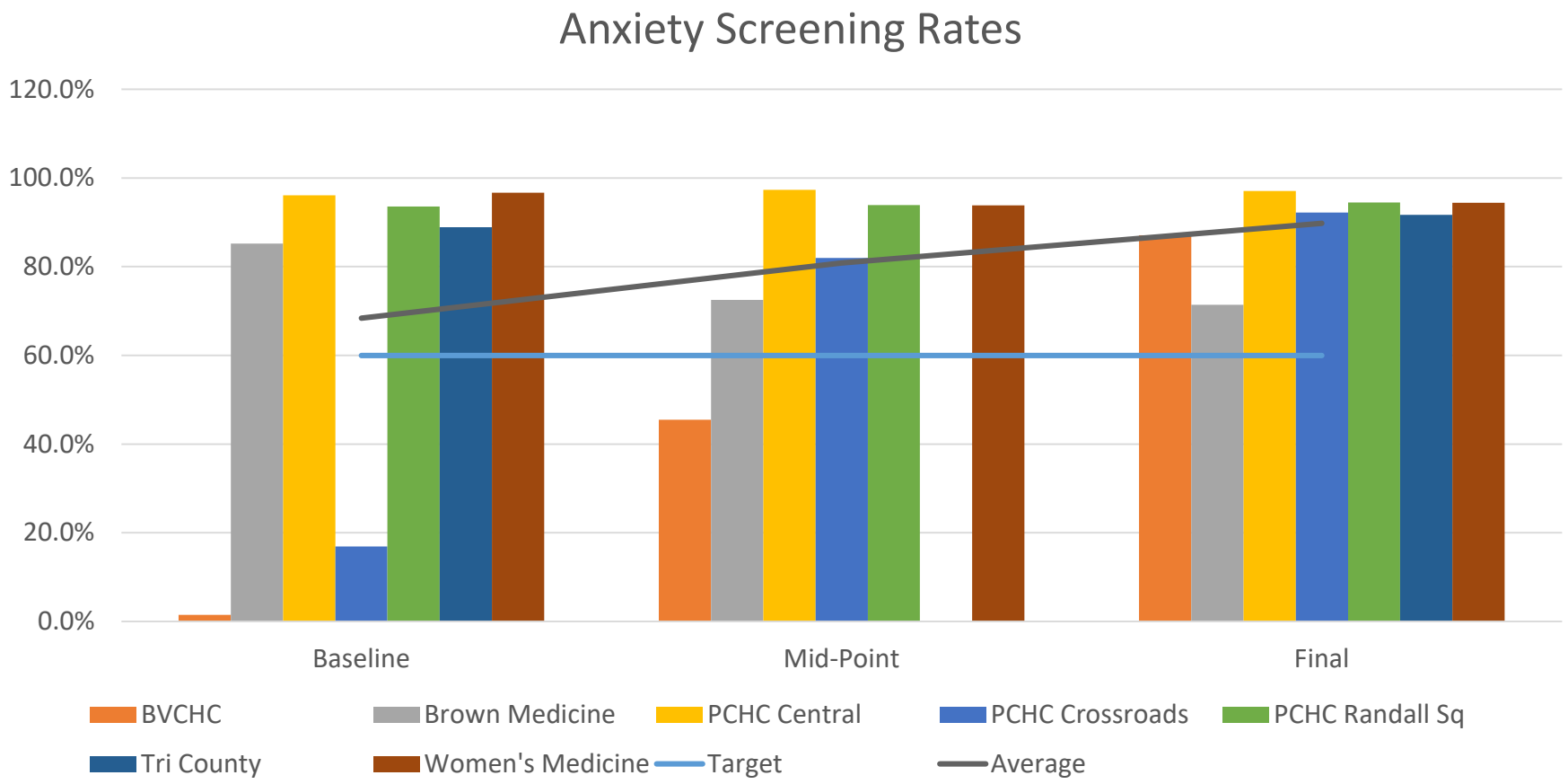
Practice Report Out:
IBH Screening Results - final

Practice Name	Depression			Anxiety			Substance Use Disorder		
	BL	Mid	Final	BL	Mid	Final	BL	Mid	Final
Screening Incentive Thresholds	85%			60%			60%		
BVCHC	94.9%	96.9%	95.8%	1.5%	45.5%	87.1%	6.6%	36.4%	69.8%
Brown Medicine	93.7%	86.4%	91.3%	85.2%	72.5%	71.4%	84.8%	71.6%	69.7%
PCHC Central	96.4%	98.1%	98.6%	96.1%	97.3%	97.1%	95.7%	97.0%	96.7%
PCHC Crossroads	97.6%	96.3%	95.8%	16.9%	82%	92.2%	3.4%	80.1%	89.2%
PCHC Randall Sq	93.1%	91.0%	89.9%	93.6%	93.9%	94.5%	92.5%	93.4%	93.8%
Tri County	88.8%		97.0%	88.9%		91.7%	85.5%		85.6%
Women's Medicine	92.4%	91.8%	92.8%	96.7%	93.8%	94.4%	96.9%	93.3%	93.1%

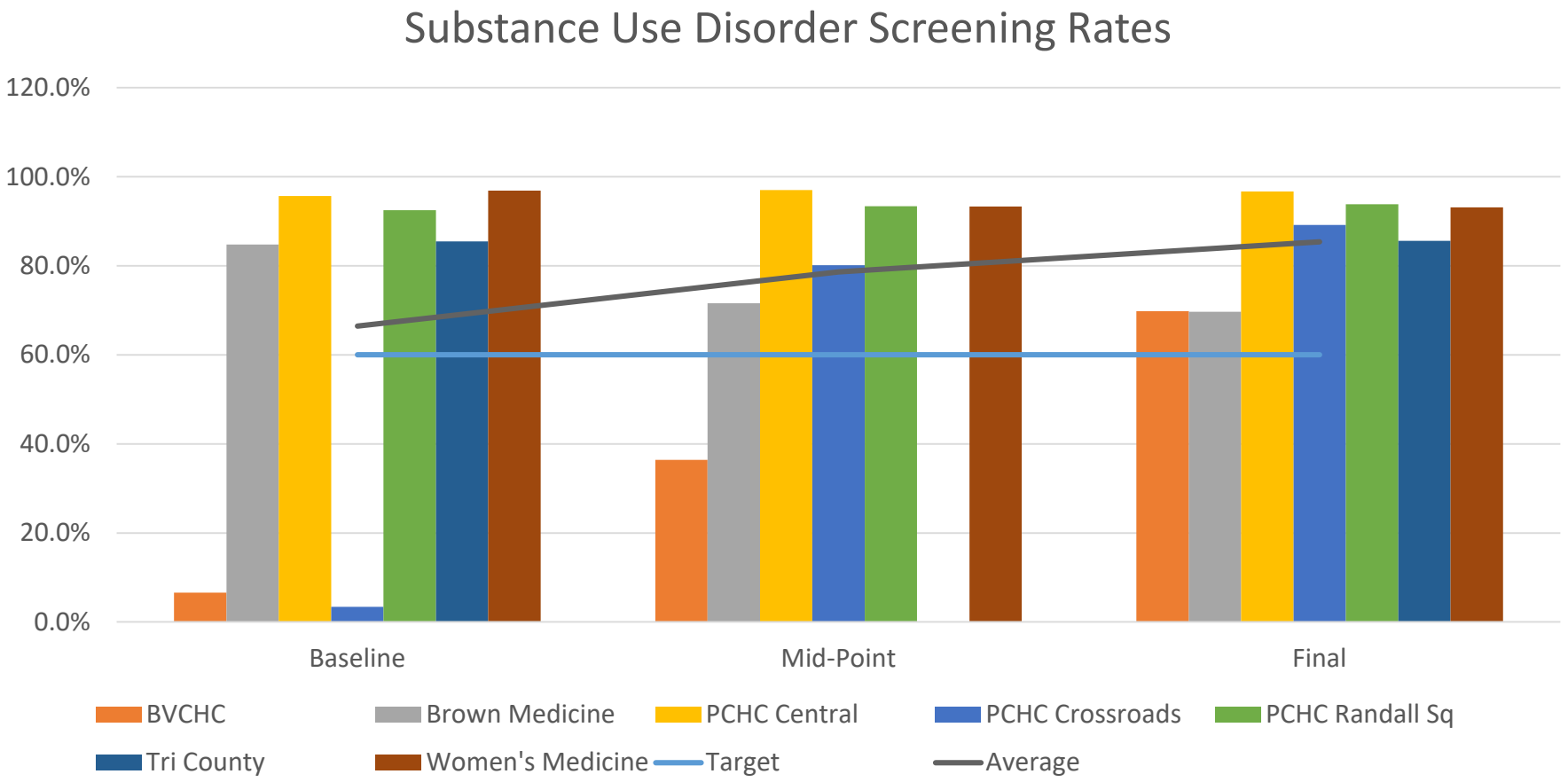
Practice Report Out:
IBH Screening Results - final



Practice Report Out:
IBH Screening Results - final



Practice Report Out:
IBH Screening Results - final



Blackstone Valley Community Health Care PDSA Plan for Social Determinants of Health

Aim:

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Addressing housing instability utilizing Health Leads SDOH Screening Tool	MA, NCM, OB RN, CHW, & BH	MA at every new patient and preventative visit. NCM at every visit. OB RN at prenatal intake visit. CHT at every visit. BH at every visit.	39 East Ave Medical pods (green, orange & red) and NCM, OB RN, and BH offices.

Blackstone Valley Community Health Care PDSA Plan for Social Determinants of Health

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Educate staff on direct impact of housing instability on primary care	BVCHC BH & CHT Department leads and Crossroad representative	Scheduled mandatory lunch training completed within 4 weeks	39 East Ave Basement Meeting Room
Facilitate a warm hand off to a CHW or BH coordinator for positive screens of housing instability.	MA, NCM, OB RN, & BH	At time of patient visit	39 East Ave Medical pods (green, orange & red) and NCM, OB RN, and BH offices.
Predict what will happen when the test is carried out	**Measures to determine if prediction succeeds**		
Increase in referrals to Crossroads	BVCHC data report on open and closed referrals to Crossroads		

Blackstone Valley Community Health Care PDSA Results for Social Determinants of Health

Results:

- Inconsistent workflows for SDOH screening.
- MAs doing a majority of screening, BH assessing without screen, and NCMS screening when patient has not already been seen this week.
- SDOH screens being completed: 4,104 screened out of 6,511 patients seen (63%).
- Most patients with positive screen already involved with BVCHC CHT.
- We need to evaluate current workflows to reduce redundancy for patients and providers.

Brown Medicine
PDSA Plan for Social Determinants of Health

Aim:

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
The Brown Medicine Primary Care – Warwick practice would like to screen all patients for SDOH at their annual visit.	The Medical Secretary will be responsible for administering questions	Annual Visit	Prior to coming for visit or in practice waiting room

Brown Medicine
PDSA Plan for Social Determinants of Health

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
The practice has identified three SDOH questions to ask the patient: Do you have enough money to buy the things that you need to live everyday such as food, clothing, or housing? How confident are you that you can control and manager your health problems? How often do you eat food that is healthy (fresh fruit, vegetables) instead of unhealthy food (fried food, sweets); do you feel that you have access to healthy food? The questions will be typed and added to Annual paperwork packet The practice will be responsible for monitoring responses to questions. Providers will address responses during the patient's visit. Based on the responses, the practice will work with internal and external resources to address the needs.	Practice Manager, Medical Assistants, Medical Social Worker	This process is expected to be rolled up in the upcoming weeks	PC-Warwick practice During Visit Post Visit

Brown Medicine
PDSA Results for Social Determinants of Health

Do **Describe what actually happened when you ran the test**

The three aforementioned questions were asked to patients coming into the office for Annual visits. The Medical Assistants (MA) were to document in the Chief Complaint section of the record if patients disclosed that they needed assistance. However, after conversations with the Lead MA at the site, she noted that patients were not scoring “positive” to the questions (as predicted).

Study **Describe the measured results and how they compared to the predictions**

As mentioned, patients were not identifying any issues with managing their health, being able to buy necessities for daily living, or having access to health foods. This contradicts our predictions as we thought more individuals would need assistance in these areas.

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

Based on the findings, we decided to reevaluate the questions being asked. A multidisciplinary team gathered (including our IBH provider) to discuss what questions would be relevant to the practice’s population. It was decided to include a question regarding stable housing. This was included in the necessities for daily living question, however, we decided to be more direct. In addition, we decided to keep the existing questions, but educate patients better as to why we are asking. Lastly, Brown Medicine has a Resource Manual that contains information on community resource support. It was decided that the provider would not be the best lead for providing patients with information, thus, an MA at the practice will be the SDoH Lead and use the manual to provide patients with information.

PCHC – Central Health Center
PDSA Plan for Social Determinants of Health

Aim: Goal to address SDOH issue: food insecurity/ access to healthy food options

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Increase patient's knowledge/ education around healthy food options on a budget, and how this intersects with mood and health: • How does food choices impact mood (Integrated Behavioral Health) • How does healthy food choices impact diabetes control (RN/CEOE)	IBH team:Stacy, LMHC provider /Jamie, BHCHA advocate Mehattie Dorsey,RN, CEOE	Within the next three months (end date 2/10/2020)	Central Health Center

PCHC – Central Health Center
PDSA Plan for Social Determinants of Health

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done

• Amanda Andrews, AHCD, Stacy Silva, LMHC, Jamie, BHCHA introduce idea in Central staff meeting
• Set up meetings with team members to discuss details of planning and implementation:
  • Utilize identified patient list obtained through informatics of A1C over 9 with mood disorder to screen for interested patients
  • Mehattie, RN/CEOE to identify patients she works with who would benefit from group
  • develop a script when calling identified patents with focus on incentives (gift cards/ food)
  • Better understand barriers to attendance when calling patients
	Stacy Silva, LMHC
	Amanda Andrews, RN/ ACHD
	IBH team:Stacy, LMHC provider /Jamie, BHCHA
	Mehattie Dorsey,RN, CEOE
		Dec., 2019
		
		Monthly Through-out 3mo period
			Central Health Center
			Via e-mail, skype or in person

• Stacy will contact RI Food Bank (Melissa) to determine level of involvement (access to food for patients who attend group) • Stacy to contact Urban Greens to determine if use of space/ scheduling	Stacy Silva, LMHC	Dec. 2019	Via phone call and or e-mail

PCHC – Central Health Center
PDSA Results for Social Determinants of Health

Do **Describe what actually happened when you ran the test**

Developed class called “real talk”, created flyers, informed clinic staff, recruited from list of identified patients and patients already involved with Integrated Behavioral Health/ Nurse Care Management. Offered one drop in class on 1/21/2020 from 4-5pm, not a single patient attended.

Study **Describe the measured results and how they compared to the predictions**

Was able to complete formulation of class, obtain clinic buy-in for need of class, but was not able to be successful in recruitment of patients to attend. Was not able to have full collaboration from food bank, did use food bank information resources and guides in curriculum, due to lack of patient interest (needed at least 10 for food bank to join). Urban Green location was not available to due booked space, but created a relationship with staff for future events/classes.

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

May want to offer class at a different time, or season to increase attendance. May need to start recruitment earlier with use of other patient lists to increase attendance to class. May open class to other health centers to increase access and improve attendance.

PCHC – Crossroads
PDSA Plan for Social Determinants of Health

Aim: Utilizing SDOH screens have elicited information about lack of social supports as a barrier to completing medical referrals. Patients without social supports have been unable to complete colonoscopy referrals. The goal of this PDSA is to assist a greater number of patients in completing a colonoscopy.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Clarify which patients with open orders for colonoscopy identify lack of social supports as barrier to completion of treatment.	Deb Jasmine	By 11/11/19	Crossroads
Outreach patient to clarify readiness/willingness to complete colonoscopy	Sarah	12/01/19	Crossroads

PCHC – Crossroads
PDSA Plan for Social Determinants of Health

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
1. Contact Specialty clinic to verify procedure for patient's without social supports 2. Evaluate possible community supports(agencies, volunteers, insurance company, etc) 3. Arrange medical transportation as needed	RNCM/IBH/CHA	02/01/20	
Predict what will happen when the test is carried out	**Measures to determine if prediction succeeds**		
Increased relationships with community agencies	Patients able to complete colonoscopy.		

PCHC – Crossroads
PDSA Results for Social Determinants of Health

Do **Describe what actually happened when you ran the test**

Multiple specialty clinics were contacted to verify procedure for patients without social supports- all but 1 clinic reported patients without social support on day of appointment would not be seen. Staff at one clinic reported history of offering to complete procedure without anesthesia for patients without social support.

Multiple community support agencies were contacted re: possible support to complete colonoscopy- including House of Hope, The Point, RI Hospital Volunteer support, Family Service of RI and homecare agencies. Through these conversations it appears that it maybe possible to arrange support for patients on a case by case basis, however this is dependent on multiple factors such as current engagement in services, age and housing status.

Study **Describe the measured results and how they compared to the predictions**

At this time we have not been able to schedule any patients with limited social supports for a colonoscopy, however we have increased communication with and learned a great deal about our local community agencies.

PCHC – Crossroads
PDSA Results for Social Determinants of Health

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

1. We will continue to engage our community partners to establish support for patients who need to complete a colonoscopy.
2. For many patients residing in shelters completing the prep required for a colonoscopy can be difficult as they are required to leave the shelter all day. We plan to meet with Crossroads leadership to establish a form letter requesting an exemption for patients completing the prep for a colonoscopy and upon their return from the procedure.
3. We plan to obtain gift cards for patients to use to engage their social supports who are able to attend a colonoscopy with patients.

PCHC – Randall Square
PDSA Plan for Social Determinants of Health

Aim: With roll out of SDOH screening Randall Square outcomes have shown that our patient population has significant food insecurity needs. With loss of food box support to address food insecurity our team home to explore providing other food/ supply options.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Address gaps in food box changes with increased clinic based basic needs support	Randall Square team	Upon completion of PDSA cycle	Clinic meetings, via phone calls During admin time and planning meetings In conjunction with AE team

PCHC – Randall Square
PDSA Plan for Improving Screening Rates

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Team meeting to present to AE plan for use of funds to address SDOH gaps • Train on use of CM/SDOH form in EHR- planning for barriers and MI to assist in addressing barriers (pre-existing in (EHR) to track • Team to identify what to put in food bags (food and/ or hygiene) • Name of support (supplemental service, care box, care bag) • Training staff on process/ documentation to track/ leverage on- going support • Ruth (IBH Sr. BHA) to visit two local Pantry sites for increased understanding of support/ gaps • Outcomes based assessment of need/ service (does it work) • Handouts/ form of informational – Chelsea NCM team (local to Randall vs. other local in city) • Is agency policy needed to address compliance related needs	Randall team On hold pending AE	X 30 days on start up of project on 12/11	Clinic meetings, via phone calls During admin time and planning meetings In conjunction with AE team

PCHC – Randall Square
PDSA Results for Improving Screening Rates

Do **Describe what actually happened when you ran the test**

- Ruth and Chelsea attended two zip code specific food pantries (Camp St. very limited, 2-3 hours window, by 12:15 ran out of food, handicap accessible- also only zip code specific, not off bus line, also possible barriers for undocumented re: demographics), (2nd site Branch Ave also zip code specific- specific system with fruits, veggies, meats, baby products, health/ beauty section, flu shots, not handicap accessible, but could have representative pick up for you, more hours, no ID or proof of address (limited box) re: undocumented details)
- PCHC Care bag (PCHC "Cares" bag)- food, health care, socks, warming, dry shampoo, fem. Hygiene, plus bag amount- must be used in partnership- with RI Food bank contract expansion, ask for 15,000- serving 500 patients at the cost of 20 per patient.
- Explore other natural supports in communities (church's , synagogue's) etc… Chelsea follow up re: community engagement side with AE

Study **Describe the measured results and how they compared to the predictions**

Once tracking system is created team to track each care bag and document use, as well as handouts/ resources for long term needs to be addressed

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

- Holding pattern at present due to budgetary areas of AE and start up
- Food box approval x one additional year
- Use of funds to provide additional bags for food and hygiene until AE funding approved

Tri-County's
PDSA Plan for Social Determinants of Health

Aim: Improve the percentage of SDOH warm hand-offs for the Community Health Worker (CHW) team.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
At Tri-County Health Center, the Community Health Team implements a 12 question SDOH screening to all new and annual physical appointment patients in order to address their needs and provide them with resources.	Community Health Team	Now – February 2020	North Providence Health Center
Our goal is to increase the amount of warm hand-offs conducted by a CHW at the time of these visits, rather than outreach at a later date and time.			

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
• Workflow change between the medical assistant and community health worker (regarding positive screenings) • CHW generating reports on a daily basis for physical exam and new patient appointments • CHW abstracting SDOH report (screening) in EHR	Amanda (HIT), medical assistants, and CHW	Now – February 2020	North Providence Health Center

Tri-County's
PDSA Results for Social Determinants of Health

Do **Describe what actually happened when you ran the test**

- CHW every morning would huddle with the provider and MA team in order to remind them about the warm hand-offs and to determine when/if a CHW should be available.
- Throughout the warm hand-offs patients seemed to be more interactive with CHW team in receiving help in person rather than over the phone.
- CHW team was able to meet the patients' needs right there or was able to print resources out on the spot instead of making sure patient was actually understanding what was being said over the phone.
- It was hard for CHW team when new providers would come over from Johnston due to workflow being different for MAs there.
- Overall, our warm hand-offs increased tremendously from the baseline data that was collected.

Tri-County's
PDSA Results for Social Determinants of Health

Study **Describe the measured results and how they compared to the predictions**

End of pilot data was collected from November 1, 2019 to January 31, 2020. Results showed that combined there were 16 positive screenings for assistance with SDOH and urgent needs. Out of that data, 10 warm hand-offs were conducted by a CHW at the time of visit. The health center team reached their aim by improving CHW warm hand-offs from 1 at the beginning of the pilot to 10 at the end.

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

Fixing the miscommunication for the workflow in North Providence would be a modification in the future. The 6 missed positive SDOH screenings were because the MA forgot that the CHW team in North Providence does a warm hand-off on the spot.
In addition, CHW team does not think this will work out in a bigger health center (Johnston location) due to providers needing a CHW at the same time. When/ if more CHWs are hired this pilot would be a success in our Johnston location as well.

Women's Medicine Collaborative
PDSA Plan for Improving Screening Rates

Aim: We aim to assess social determinants of health in primary care visits and to determine which SDOH's are most commonly endorsed in our practice

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
• To determine which SDOH indices are mostly commonly endorsed in our practice. • To develop a resource guide within primary care that providers can use to assist patients with SDOH needs.	Behavioral Health Care Manager and patient navigator	11/27/19	WMC

Women's Medicine Collaborative
PDSA Plan for Improving Screening Rates

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
1) Determine which PCPs are currently assessing for SDOH at annual visits. 2) Determine which measures of SDOH are currently in the medical record. 3) Query for 3 measures of SDOH at all annual visits of Dr. Nancy Lasson (PCP, director of primary care) 4) Evaluate which SDOH indices are most commonly endorsed. 5) Develop a resource station for PCPs when SDOH are endorsed.	Behavioral Health Care Manager, Dr. Nancy Lasson, patient navigator.	1/1/20	WMC

Women's Medicine Collaborative
PDSA Results for Improving Screening Rates

Do **Describe what actually happened when you ran the test**

Dr. Lasson queried all primary care providers in the practice to determine who was administering the SDOH measures. From chart review of the electronic medical record, we learned that the following SDOH measures are currently embedded into the social history: Financial resource strain, food insecurity, transportation needs. We then conducted a retrospective chart review of Dr. Lasson's annual visits to calculate the frequency with which SDOH questions were positively endorsed.

Study **Describe the measured results and how they compared to the predictions**

Results from this PDSA revealed that only one provider (Dr. Lasson) is consistently asking questions on SDOH at annual visits. The three SDOH measures that she is administering at annual visits are: Financial resource strain, food insecurity, transportation needs. Below we present data on the frequency with which these SDOH indicators were endorsed. Out of 138 patients seen for annual appointments between October-December 2019, 136 (99%) were screened for SDOH. 8 of 137 patients endorsed SDOH needs (5.8% of patients screened). The primary SDOH endorsed was financial insecurity, followed by food insecurity, and the least commonly endorsed SDOH was difficulty with transportation. Based on these data, we developed a primary care "resource center" for providers and staff that included information on local food banks, income assistance information, and transportation programs. This resource center is easily accessible to all providers and staff as it is centrally located behind the check-in desk for primary care patients.

Women's Medicine Collaborative
PDSA Results for Improving Screening Rates

	Finances	Transportation	Food
October	2 /46 2=somewhat hard 100% screening rate	0/46 100% screening rate	0/46 100% screening rate
November	4/53 2=somewhat hard 1=hard 1=very hard 1= did not assess 98% screening rate	1/53 1=yes 1= did not assess 98% screening rate	2/53 2= sometimes true 1= did not assess 98% screening rate
December	2/38 1=hard 1=somewhat hard 100% screening rate	0/38 100% screening rate	0/38 100% screening rate

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

We hope that, with the addition of the resource center, more PCPs will screen patients for SDOH at annual physicals. We also hope to have all patients with positive SDOH screens be connected with the patient navigator in addition to the resource center to further support our patients.

Next Steps

MoA with CHT or community agency that can help with health related SDOH	**Due February 10, 2020**	**Submit to: CTCIBH@ctc-ri.org**
Maine Assessment Tool (Post Intervention)	**February 28, 2020**	**Submit to: CTCIBH@ctc-ri.org**

New Online IBH Practice Facilitator Training Program

WHO SHOULD APPLY: Behavioral Health Clinicians (Psychologists, Therapists, Social Workers, Nurses) interested in helping organizations and primary care teams develop their skills and processes to integrate behavioral health services into their practice environment are encouraged to apply. The course is ideally designed for any clinician or nurse who has worked in a behavioral health setting and has experience integrating behavioral health within primary care that wishes to advance their career to become an integrated behavioral health practice facilitator.

WHAT YOU CAN EXPECT

- Participants will receive a reference manual with course readings
- 4 online training modules for self-study with reading and homework assignments
- Module post-tests to help participants understand level of comprehension
- Monthly calls with Dr. Burdette, CTC's Senior IBH program leader and course Instructor
- Continuing social work education credits, approval pending by NASW for 7 CEU credits
- Approximately 24-hour time commitment

Cost for Foundational Course: $750 for CTC members; $1000 for out of state

New Online IBH Practice Facilitator Training Program

- Optional, but highly recommended Advanced Onsite IBH Shadowing available
- Instructor: Nelly Burdette, Psy.D.
- Next Course Available: March, 2020
- Applications and CVs/Resumes due: February 24, 2020
- Another Training program will be offered in the Fall, 2020
- For more information contact: Carolyn Karner (CTCIBH@ctc-ri.org)
- Funding made possible by

TUFTS Health Plan

Gauging Interest in BH Telemedicine

DISCUSSION