CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Welcome
2019 IBH Expansion Practices

2019 QUARTERLY ADULT IBH MEETING 11-14-2019

Agenda

Topic ***Presenter(s)***	**Duration**
Introductions & Review of Agenda *Rena Sheehan*	5 minutes
Practices Report Out: PDSA Plans Social Determinants of Health *Facilitated by Dr. Nelly Burdette*	50 minutes
Community Health Teams *Linda Cabral*	20 minutes with 10-minute discussion
Next Steps *Susanne Campbell*	5 minutes

Practice Report Out:
IBH Screening Results - latest

Practice Name	*Depression*	*Anxiety*	*Substance Use Disorder*
Screening Incentive Thresholds	*85%*	*60%*	*60%*
Blackstone Valley Community Health Care	96.9%	45.5%	36.4%
Brown Medicine - Warwick Primary Care	86.4%	72.5%	71.6%
PCHC Central	98.1%	97.3%	97.0%
PCHC Crossroads	96.3%	82%	80.1%
PCHC Randall Square	91.0%	93.9%	93.4%
Prospect Charter Care Physicians (baseline)	84.0%	7.5%	0.1%
Tri County - North Providence (baseline)	88.8%	88.9%	85.5%
Women's Medicine Collaborative	91.8%	93.8%	93.3%

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		

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 Plan for Social Determinants of Health

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
There will be insight as to why patient may or may not be successful with managing their health needs. Based on the responses there will be new relationships built with community resources to better help serve the practice population.	Increase in the number of referrals to the Medical Social Worker and increase in the number of referrals made to community resources.

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 Plan for Social Determinants of Health

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
Complete at least one group to Increase patient's knowledge/ education around healthy food options on a budget, and how this intersects with mood and health: with minimum of 5 patients.	By end of January, 2020

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 – 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	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 Plan for Improving Screening Rates

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
Increasing SDOH supports with absence of food boxes to decrease SDOH risk/ need of patients.	Plan to address gap of need by achieving supply (name to be determined) for patients, then track use

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 Plan for Improving Screening Rates

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
1. A greater number of patients will be evaluated for SDOH concerns.	We will evaluate the number of Dr. Lasson's patients who were screened for SDOH prior to and after PDSA implementation.
2. More patients in the practice with SDOH needs will be connected with resources.	Query providers for their utilization of the resource station.

Next Steps

Hire BH Staff if not already in place with staffing ratio of 1 FTE per 5,000 attributed lives	**Resume, date of hire, and staffing plan Due no later than June 30, 2019**	**Submit to: CTCIBH@ctc-ri.org**
Baseline Report for screening for depression, anxiety and substance use disorder	February 1, 2018-January 31, 2019 Due March 29, 2019	Submit to: CTC Portal
Report for screening patients for depression, anxiety and substance use disorders	February 1 – August 31, 2019 ♦ due September 30, 2019; and September 1 – January 31, 2020 ♦ due February 10, 2020	Submit to: CTC Portal
IBH Compact for coordination for patients with severe depression, anxiety and substance use disorder	. Due May 31, 2019	Submit to: CTCIBH@ctc-ri.org
PDSA Plan for improving screening/re-screening rates	Plan Due: August 5, 2019 PDSA results due: February 10, 2020	Submit to: CTCIBH@ctc-ri.org
PDSA Plan for addressing Social Determinants of Health	Plan Due: November 11, 2019 PDSA results due: February 10, 2020	Submit to: CTCIBH@ctc-ri.org
MoA with CHT or community agency that can help with health related SDOH	Due November 27, 2019	Submit to: CTCIBH@ctc-ri.org
Maine Assessment Tool (Post Intervention)	February 28, 2020	Submit to: CTCIBH@ctc-ri.org
Learning Networks: Orientation **Monthly Meetings with IBH Consultant** **Three Required Content Seminars**	February 28, 2019 Starts March 2019 7:30 -9:00AM Quarterly Nov 14, 2019 and Feb 13, 2020