Care Coordination Collaborative Learning
Session #3
DAY 2: Wednesday July 23rd, 2014

Day 2 Agenda

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<td>Drug Medical Waiver: Impact on Provider Roles and Care Coordination</td>
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<td>Team Report Out</td>
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<td>3:45-4:00</td>
<td>Wrap Up and Adjourn</td>
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Reflections

Questions about topics raised or discuss learning from Day 1?

Model for Improvement: Implementation and Spread

Jerry Langley,
Improvement Advisor
Associates in Process Improvement

Jerry Dennis, MD
Riverside County, Dept. of Behavioral Health

Peter Currie, PhD
Inland Empire Health Plan
IMPLEMENTING NEW RCDMH FORMS AND PROCEDURES TO IMPROVE CLIENT HEALTHCARE AND OUTCOMES OF HEALTHCARE

Jerry L. Dennis, MD
Medical Director
Riverside County Department of Mental Health
CiBHS: Care Coordination Collaborative
Learning Session #3: July 2014

ACHIEVING THE TRIPLE AIM

- LEADERSHIP
- Rising to the Challenge
- The Vision: Seeing Our Way to the Future
- The CIC Team
- The Performance Improvement Process
- Testing Change Ideas
- Analyzing Data
- Learning and Making Change Happen

- Finding Better Solutions for Integrating Care
- Developing and Implementing Policies and Procedures to Formalize Real Change
- Achieving Improved Healthcare Outcomes for Consumers
- CHANGING THE CULTURE!
Achieving the Triple Aim

– To improve the overall health and wellness of individuals with serious mental illness by providing quality healthcare services
– To improve client access to health care services through full bidirectional coordination and integration of health care services, i.e., mental health, substance abuse and primary care services
– To improve client satisfaction and create a positive experience for clients receiving healthcare services with improved outcomes of health, mental health and substance abuse services

WHY?
TO IMPROVE CLIENT HEALTHCARE

• 2010 RCDMH Morbidity and Mortality Report:
  – RCDMH M&M Committee review of adverse incidents from individual case reviews
  – Review of all adverse incidents involving death and other significant adverse outcomes to identify system issues that are related to adverse outcomes of care
  – Report of analysis of identified issues that may contribute to poor outcomes including death and serious morbidity
RCDMH M&M Report

• Analysis of 206 Adverse incidents reported from Jan 2007 – May 2010
  • 145 deaths reviewed
  • U.S. average life expectancy: 77.7 years

- M&M Report:
  • RCDMH Average Age at Death:
    – 41.8 years
    – 36 years less than general population
- Natural Causes: age at Death: 46.8 years
- Unnatural /Unexpected Causes: 38.8 years
  • Deaths in the older adults may be under-reported

Issues Identified:
Adverse Incident Analysis

• Unnatural Cause Deaths:
  – Suicide: 40%
  – Accidental: 46%
  – **High number of deaths involving Opiate Narcotics and Benzodiazepines**

• Natural Cause Deaths:
  – Cardiovascular: 50%
  – Respiratory: 9%
Issues Identified:
Adverse Incident Analysis

- 66% of accidental deaths
  - were accidental overdose deaths

- 33% of suicides
  - were intentional overdose deaths

- 50% of deaths
  - by natural causes were cardiovascular deaths

1. Failure to coordinate care with the PCP
2. Failure to identify Substance Use Disorders (SUDs)
3. Failure to make adequate referrals of clients with SUDs to appropriate treatment
4. Failure to follow-up after cancellations and “no-shows”
5. Prescribing Controlled Substances to a known substance abuser
6. Inadequate monitoring of Psychotropic Medications
RC-Care Integration Collaborative

• Established an Integrated Team
  – MH, SA, Primary Care, Health Plan

• Developed and implemented integrated clinic sites:
  – Blaine St. Adult MHC
  – Rubidoux Family Care Center (FCC)
  – Riverside/Atlanta Substance Abuse Clinic

Care Integration Model

• Full Bi-directional Integration of Care:
  – Integrated healthcare at each clinic site
  – PCP services integrated into MH Clinic
  – MH Team integrated into Family Care Clinics (FCCs)
  – Links local clinics:
    • MH Clinic, Primary Care Clinic, and Substance Use Disorder Clinic
  – Consumers achieve a One-Stop-Shop for all health care services whenever possible and based upon their needs
Riverside County Care Integration Collaborative

- RC-CIC Charter:
  - In Riverside County, coordination of care for individuals of the public with mental health (MH), substance use disorders (SUDs) and coexisting physical health conditions is poor.

  - Too many suffer the adverse consequences of having healthcare conditions that are under-recognized, under-diagnosed and untreated or under-treated, leading to premature disability and/or death.
RC-CIC CHARTER

– Individuals with serious mental illness have serious difficulties in accessing needed healthcare services or are reluctant to become engaged in needed services.

– Individuals with serious mental illness most often only access the highest cost services, i.e., hospital emergency rooms, crisis services or urgent care clinics, instead of less costly outpatient services.

– Fully coordinated, integrated healthcare services will lead to significantly improved health status, improved functioning, and help to decrease the incidence of premature disabilities and/or death, while lowering the overall costs of public healthcare for Riverside County.

Performance Improvement Process

PLAN-DO-STUDY-ACT

Going up the ramp to improvement:
PDSA Cycles/Tests

Change ideas are developed, tested, and then implemented

Hunches
Theories
Ideas

Data

Changes That Result in Improvement

Test #1

Test #2

Test #3

Test #4

1st Results of Initial Physical Healthcare Screening in Adult MH Clinic

• 149 clients completed physical health screening:
  
  – 50.3% reported having a PCP
  – 49.6% reported having no PCP
  – 24% did not know when they last had a PCP visit.
  – 53% reported having multiple medical conditions
  – 28% reported having no medical conditions

Results of Healthcare Screening

• Health Care Funding Reported:
  
  – 40% had no healthcare coverage at all!
  
  – Physical conditions reported through screening
    • 38% - Hypertension (↑ BP)
    • 26% - Hyperlipidemia (↑ Cholesterol)
    • 19% - Obesity
    • 19% - Chronic Back Pain
    • 18% - Arthritis/Joint Pain
    • 17% - Diabetes Mellitus
    • 14% - Asthma
WHAT ARE WE IMPLEMENTING?
FOUR NEW REQUIREMENTS

1. Routine Health Screening of all clients upon intake and annually thereafter using standard tools, methods and procedures
2. Referral of all clients to Primary Care Services, Substance Use Disorder Services, or Mental Health Services who based upon identified need
3. Release of (PHI) HIPAA Protected Healthcare Information to coordinate and integrate healthcare services
4. Routine Medication Reconciliation to improve safety for clients and providers in prescribing medications

Requirement # 1

- **Utilize Routine Use of Screening Tools to Identify Healthcare Issues and Needs**
  - To identify clients with Mental Health Disorders
  - To identify clients with Substance Use Disorders, and co-occurring MH/SUDs
  - To identify clients with physical health conditions that require treatment (PCP services) that are under-recognized, under-treated
  - To identify clients who are underserved, not adequately accessing or under-utilizing needed health care services
REQUIRED SCREENING TOOLS:

• Screen for Physical Health Conditions and Access to Primary Care in MH and SUD Clinics and Programs
  – ELMR Physical Health Screening Form
  – Identifies physical health condition plus access to and utilization of healthcare services

• Screen for MH and SUDS in Primary Care Clinics
  – PHQ-2 (Physical Health Questionnaire) + One Question Regarding Suicidal Ideation, or PHQ-9
  – CAGE-AID (Cut-down/Annoyed/Guilty/Eye-opener) (Adapted to Include Drugs)

Requirement # 2

• Utilize Standardized Referral Format and Process to Make Healthcare Referrals and to Respond to Referrals
  – To be used among all providers
  – To be used among all health plans
  – To establish universal, standardized format and process for making healthcare referrals and for providers to respond to referrals
  – To document referrals and responses to referrals, and close the loop of the referral/response process
Electronic Universal Referral & Response Format and Process

– One page: Referral and Response to Referral
– Essential Information that must be exchanged:
  • Name / Client ID / Demographic Info
  • Providers / Clinics / Contact Info
  • Diagnoses
  • Reasons for Referral
  • Relevant Hx of Tx, Labs/Diagnostics
  • Medications and Tx
  • Recommendations and Plans

Requirement #3

• Utilize a Universal Consent/ Release of Information Format and Process to Obtain and Share HIPAA Protected Healthcare Information (PHI) Among Providers
  – To be used among all providers
  – To be used among all health plans
  – To establish universal, standardized format and process for releasing PHI
  – To document HIPAA protected release of information including specially protected PHI involving:
    • MH, SUD, and HIV-related information that is necessary to coordinate and integrate healthcare services
Electronic, Universal Consent/ROI

- Utilize an Electronic, Universal Consent/ROI Form and Process to authorize release of Protected Health Information (PHI)
  - Broad release of all HIPAA Specially Protected Health Information – All in one form
  - Releases all PHI including health history, treatment, tests, hospitalizations, and outpatient treatment
  - ** Releases specially protected MH, SUD, and STDs (HIV/AIDS) health information **

Screen, Referral, Release PHI

- Use Screening Tools to identify clients who may need referrals for other health care services
- Use Referral Form and Process provides universal format for referrals and responses to referrals that is fully documented and closes the referral loop, all in one form
- Use Universal Consent/ROI format for full bidirectional release of health information for the referral and response to the referral, all in one form
Requirement #4

• Utilize Routine Medication Reconciliation to Identify All Medications That the Client Is Taking and What the Client Should Be Taking
  – Process begins and ends with the client
  – Requires closed-loop feedback to the client to inform client about what medications should be continued, changed or discontinued
  – All medications that are prescribed by any provider should be identified and reconciled for each client
  – Reconciliation also includes OTC, herbals, vitamins and supplements
  – The client leaves each appointment with a list of what medications they should continue to take

Complete Medication Reconciliation

• Requires that process starts with consumer and ends with consumer
• Requires care providers to reconcile all prescription medications, and OTC, supplements, vitamins or herbal remedies against what the consumer reports and the consumers health records
• Reconciliation can be shared across systems: electronic documentation of reconciled medications
SPREADING CHANGES TO NEW SITES
Implementing full Bi-Directional Integration Model

• At Lake Elsinore, Ca.
  – Integration Involves All Ages:
    • Child, Adult, Older Adult
• At Indio, Ca., and up to 10 County-Operated FQHC-LAs
• Integrated RCDPH HIV Clinic Services in 3 Sites across Riverside Co.
• Integrated Services for AB-109 clients and other special populations (ID/Autism)

Continuing Challenges for Care Integration

• Funding of Primary Care Services in MH/SA settings:
  – FQHC Look-Alike funding may be utilized to support provision of primary care services in MH and SA settings
  – Can obtain a Change of Scope of the FQHC L-A or establish a primary care “satellite clinic”
  – Further State and Federal action is needed to address and resolve funding issues under the ACA
Continuing Challenges for Care Integration

• Maintaining the Effort:
  – Continuing Leadership support is essential!
  – Maintaining the focus of the VISION
    • And continuing to move towards positive change is challenging in the face of other emerging priorities but remain a top priority with health care reform proceeding forward.
  – Spreading positive changes that have been achieved
    • To other health care entities will be challenging, labor intensive and time consuming!

Success = Never Giving Up!

• Keep Striving to Achieve the Vision!
  – Endless Problems: Barriers to be Overcome:
    • Lack of information and resistance to sharing of information
    • Human Resistance to Change can’t be underestimated
      – Tendency to return back to old habits and ways of doing business, maintaining the status quo
    • Fears of what will happen if information IS shared:
      – Liabilities and risks of exposure
Keep Striving to Achieve the Vision!

– Endless Problems: Barriers to be Overcome

• **New or Improved Infra-Structures Needed**
  – IT Systems, Business Practices, New Methods of Service Delivery

• **Health Plans have new roles under ACA**
  – Mild to Moderately Ill versus SMI/Specialty MH Services

• **How to get IT, EHR Systems to talk to each other to achieve full e-sharing of HIPAA PHI??**

• **Local Systems and Key Staff Changes**
  – Are ongoing and can slow or halt process of making positive changes

Keep Striving to Achieve the Vision!

– **New Laws Rules and Regulations:**
  • ACA: Healthcare Reform still unfolding
  • Parity is not yet a reality
  • Diagnosis Changes: DSM-V and ICD-10

– **Fear of Failure:**
  • It will cost too much! Who will pay?
  • It takes too much time of my time. Other demand on time and other priorities
  • It will take too long to do anything! Shortcuts?
  • It’s too complicated! Make it simple!
Other New Policy Development as a Result of Care Integration Collaborative

- **Proposed New RCDMH Policy:**
  - **Controlled Substances Prescription:**
    - Requirements:
      - Frequent and Random Urine Drug Screens (UDSs)
      - Check CURES for Controlled Substance Prescriptions
      - Prescriber/Client Agreement, including one prescriber and one pharmacy
      - Require Universal Consent/ROI to coordinate care with all other providers
  - **Goal:** Adverse Incidents Involving Controlled Substances

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I HAVE A DREAM!

FULLY INTEGRATED HEALTH SERVICE CENTERS:

To serve the healthcare needs of the public

Across Riverside County:
  - Local
  - Regional

Across California?

Across the USA?
Vision of the Future

• Achieve Fully Integrated Healthcare Service Centers for the public

• Focus on Health:
  – Healing and Recovery
  – Improved Health and Wellness
  – Prevention, Early Intervention

• People living happier, healthier, longer, and more meaningful, productive lives!

• And at less cost to everyone

Questions?
BREAK

Story Board Presentation:
Modoc CCC
Team
Modoc County CCC

Celebrating Successes

Valuing Failures

Learning Session # 3

Executive Leads
Karen Stockton, BH
Greta Elliott, Canby Clinic

Site Team Leads
Tristin Harer, BH
Christiana Hesser, CC

BH Clinical Staff
Alisha Romesha, Clinician
CeCe Toaetolu, Nurse

Clinical Supervisor:
Michael Traverso, BH

Data Lead/Peer
Billy Diaz, BH

Care Coordinator
Julie Williams, BH

Back-at-Home Team Members
Canby Clinic – Matthew Edmonds, MD; James Babcock; Christine Marchessault
Behavioral Health – Thomas Andrews, MD; Amber Hand
The Modoc County CCC will:

- change the systems of collaboration, communication and integration between the Canby Family Practice Clinic and Modoc County Behavioral Health...
- to improve coordination of care, develop a more holistic treatment approach, and achieve better outcomes for our shared clients/patients.
- These changes will result in a seamless experience of care that is person-centered, cost effective, and results in improved health and wellness.

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### Modoc CCC Objective # 1

- Improve access to coordinated care for target pop.
  - Identify Target Population
  - Secure valid ROI for a minimum of 85% of TP
  - Develop/implement shared forms/processes for bi-directional referrals
  - Develop tools/protocols for screening 85% of TP
    - MH/SU at Canby Clinic
    - Physical health needs at Behavioral Health
Modoc CCC
Objective # 2

Improve medication reconciliation across CFPC and MCBH systems

- Determine types of medications for data gathering (e.g., prescribed, med marijuana, OTC, herbal)
- Develop protocols/tools for gathering client data on medications
- Implement electronic processes for medication reconciliation for a minimum of 85% of TP

Modoc CCC
Objectives # 3 & 4

3. Improve health outcomes for a minimum of 25% of T.P. using CCC data elements available in the Tracker.

4. A minimum of 90% of T.P. will report satisfaction with services (“4” or “5” on the scale used for measuring satisfaction in the Tracker).
Modoc CCC Objective # 5

A minimum of 85% of target population will report self-efficacy/confidence in their ability to manage their own health conditions ("4" or "5" on the scale used for measuring confidence in the Tracker).

Modoc CCC Target Population

If we adopted the “narrower” Target Pop definition, the Modoc CCC T.P. would consist of fewer individuals than depicted in the photo above.

So, our T.P. consists of all shared clients/patients of Modoc County Behavioral Health and the Canby Family Practice Clinic.

... That’s our story, and we’re sticking to it.
Highlighting Modoc CCC Successes . . .

- Before testing any changes, MCBH discovered 62% of TP had valid ROIs – success from previous LC.
- While addressing med reconciliation, MCBH discovered serious problem with timeliness of labs for patients receiving meds through BH, resulting in PDSAs to successfully address the problem, thereby improving patient care.
- We successfully recruited Julie to take on the Care Coordinator position.

Useful, Instructive Learning

- We have learned that it is extremely difficult for 2 very small, short-staffed organizations to find the time to collaborate effectively.
- We learned that meds reconciliation is not complete even if both agencies' lists match … many unanswered questions.
- We continue to have reinforced that it is easy to get bogged down in minutiae, when the goal is direct work with our clients.
- We learned that when testing clinical tools (e.g., BAP), we need to take into consideration the therapeutic styles of particular practitioners, as well as the tx objectives already in place with a particular client and whether the tool being tested “fits” at that point in the process.
We were reminded when gathering data from clients to double-check to ensure we are understanding the client’s perspective. For instance, clients responded “no,” when asked if they had heart disease, but later volunteered they were diagnosed with CHF or COPD.

We learned that, even with small scale testing, staff and clients need to understand what we’re trying to do and have some level of “buy-in” prior to being asked to participate in a PDSA cycle. Without buy-in, staff are more likely to fail to follow through and clients are more likely to refuse to participate.

Without adequate information that might lead to buy-in, we are at risk of both staff and clients becoming a little “testy” when their usual session routine is changed/disrupted in order to accommodate a small-scale test.

**A Change Successfully Implemented for Modoc County Behavioral Health**

**Securing Up-to-Date Information on Primary Care Provider & Verifying/Inputting Info in EHR**

**Four Testing Cycles prior to implementation:**

- **1.0** – Tested Calling a Small Sample of TP to ask for PCP information (not effective)
- **1.1** – For a 3 week period, assigned a staff member to meet briefly with each client coming in for an appointment to gather PCP information (somewhat effective)
- **1.2** – Verified the data gathered from 1.1 was in our EHR, and corrected the info if it was not current. (effective, but limited)
- **1.3** – Changed the “sign-in” process when clients come in for an appointment, requesting that they review the information we have for them on PCP and contact information (address, phone) and update if not accurate. Updated info put in EHR.

We implemented the change tested in cycle 1.3 for all Modoc County BH clients, which allowed for on-going monitoring of data related to Primary Care Provider and contact information.
Modoc CCC
The Next 6 Months

• Addressing changes to the collaborative inter-agency processes to test how BH can provide additional support to Canby Clinic
• Identify TP with most extensive need for care coordination and test ways to engage them in CC services.
• Work with Sunrays of Hope Wellness Center to test potential roles for peers in care coordination processes.

Thank you!
Change Idea Presentation/Exercise: Use Multidisciplinary Care Coordination Clinical Team Meetings

Marc Avery, MD
University of Washington, AIMS Center
&
Gale Bataille, MSW
California Institute for Behavioral Health Solutions

Learning Objectives

Conducting Systematic Caseload Review team meetings to systematically review care coordination caseload using population management principles to assess and adjust care for patients with complex conditions.

- Identify at least three approaches to holding care coordination meetings for clients with complex conditions.
- CCC teams will develop structure, identify participants and initial schedule for their CCC population-based care coordination meeting(s).
- Teams will share “Systematic Caseload Review” team meeting strategies with other CCC teams.
Overview of Session Process

- **(15 min)** Goals and elements of CC Systematic Caseload Review (CC-SCR) meetings
- **(30 min)** Teams design CC-SCR meeting structure and process for their partnership
- **(20 min)** Report out on teams’ CC-SCR plans—how will you test and modify, if needed?
- **(10 min)** Teams identify/make adjustments in CC-SCR plan based on ideas from prior discussion

Types of CC Meetings

Effective communication requires various kinds of meetings. Today we are focused on CC-Systematic Caseload Reviews. Here are some examples of other CC meeting types:

<table>
<thead>
<tr>
<th>Table 1: Example Clinical Meeting schedule for non-co-located Integrated care teams.</th>
<th>Patient / Consumer</th>
<th>Coordinator</th>
<th>PCP</th>
<th>Nurse</th>
<th>SU</th>
<th>Counselor</th>
<th>Medical Consultant</th>
<th>Psychiatric Consultant</th>
<th>Others</th>
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<tbody>
<tr>
<td>Daily Medical Huddle</td>
<td>Daily</td>
<td>(x)</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Care Coordination Meeting</td>
<td>Weekly</td>
<td>x</td>
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<tr>
<td>CD Caseload Review</td>
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<td>x</td>
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<tr>
<td>Multidisciplinary Meeting</td>
<td>Quarterly</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>MH Case Manager</td>
<td>Family / Advocate</td>
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<td></td>
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<td></td>
<td>Psychiatrist</td>
<td>Peer Counselor</td>
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Elements of/Conducting CC-SCR Meetings

Key Principles of CC-SCR Meetings

- **Population-based**: Assure all patients in a given population or caseload receive systematic care oversight and necessary care coordination
- **Treat to target**: Use structured data (such as PHQ nine scores or be the most recent blood pressure) to guide us in selecting patients for discussion
- **Evidence-based**: Use evidence to guide decisions re: how the care plan should be adjusted. ‘Evidence’ could be know effective treatments, or information obtained from the team/CC, consumer or family

Doing Population-Based Care in a CC-SCR Meeting—How is it Different?

- Identify population using registry or spreadsheet
- Establish process for who gets discussed...how many clients?
- Structure for CC-SCR case review—what gets discussed?
- Technology and space for meeting
- Who needs to be present routinely?
  - medical expertise (Psychiatrist and Primary Care MD)
  - Care Coordinator
  - Other Providers?
  - Note: Patients/significant others would participate in individual Care Conferences
- Results—Recommendations (based on Treat to Target/Evidence) and how are CC-SCR results shared?
Teams design CC-SCR meeting structure and process for their partnership (30 min)

Use the CC-SCR Planning Worksheet (in packet)
1. Who will routinely attend the CC-SCR meeting?
2. How often? Where? How long?
3. Who runs the meeting?
4. Logistics: What do you need for space, telephone, computers, etc?
5. What patient information will you bring to the meeting? A registry/spreadsheet? Patient files?
6. Who takes notes?
7. How will recommendations be communicated to care providers and incorporated in CC Plan?
8. How can you test CC-SCR plan prior to full implementation?

Report Out and Discussion of Teams’ CC-SCR Plans

• Briefly describe your planned CC-Systematic Caseload Review process
  – Structure, use of registry or spread sheet, frequency, participants, communicating results, etc...
• What challenges do you anticipate?
• How might you test and then implement using PDSA Cycles?
Teams identify/make adjustments in CC-SCR plan based on full group discussion

In the next 10 minutes, discuss and add to your worksheet any changes that you may want to make to your CC Systematic Caseload Review plan.

Drug Medi-Cal Waiver: Impact on Provider Roles and Care Coordination

Darren Urada, PhD
UCLA Integrated Substance Abuse Programs
Drug Medi-Cal, SBIRT, and Screening for Substance Use Disorders
Darren Urada, Ph.D.
UCLA Integrated Substance Abuse Programs
Care Coordination Collaborative Learning Session
Sacramento, CA
July 23, 2014

Today’s Discussion
• Drug Medi-Cal Waiver – how will it affect you?
• Screening tools and new the SBIRT benefit.
• Implementing Substance Use Disorder screening and referrals with your team
Drug Medi-Cal Waiver

DMC Waiver: Coordination with Managed Care Plans

The following elements should be implemented at the point of care:
• Comprehensive substance use, physical, and mental health screening;
• Beneficiary engagement and participation in an integrated care program as needed;
• Shared development of care plans by the beneficiary, caregivers and all providers;
• Care coordination and effective communication among providers;
• Navigation support for patients and caregivers; and
• Facilitation and tracking of referrals between systems.
• The participating county shall enter into a memorandum of understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by (Drug Medi-Cal).

Drug Medi-Cal Waiver

• Currently in draft form.

• Additional assessment needed for placement (ASAM Criteria).

• Better rates, more county control.

• Implementation ~2015

• Full draft:  

Screening Tools and the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Benefit
Screening Requirement

“REQUIREMENTS:
Beginning January 1, 2014, MCPs* are responsible to cover and pay for an expanded alcohol screening . . . Also, MCPs shall cover and pay for brief intervention(s) . . . Any member identified with possible alcohol use disorders should be referred to the alcohol and drug program in the county where the member resides for evaluation and treatment.”

*MCPs - Medi-Cal managed care health plans. MCPs must ensure that PCPs carry out the above.

Source: DHCS ALL PLAN LETTER 14-004:

Screening Requirement

“When a member answers “yes” to the SHA alcohol pre-screen question, the MCP must ensure that the PCP offers the member an expanded, validated alcohol screening questionnaire. While any validated screening tool is acceptable, DHCS recommends the use of the Alcohol Use Disorder Identification Test (AUDIT) or Alcohol Use Disorder Identification Test—Consumption (AUDIT-C).”

Source: DHCS ALL PLAN LETTER 14-004:
Wait, what’s the SHA?

Alcohol Question

In the past year, have you had:

☐ (men) 5 or more alcohol drinks in one day?
☐ (women) 4 or more alcohol drinks in one day?

(exact same question used for CCC)
AUDIT Alcohol Use Disorders Identification Test

AUDIT-C Alcohol Use Disorders Identification Test - Consumption

1. How often do you have a drink containing alcohol? (Score)
   - Never (0)
   - Monthly or less (1)
   - Two to four times a month (2)
   - Two to three times a week (3)
   - Four or more times a week (4)

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   - 1 or 2 (0)
   - 3 or 4 (1)
   - 5 to 9 (2)
   - 10 or more (4)

3. How often do you have six or more drinks on one occasion?
   - Never (0)
   - Less than monthly (1)
   - Monthly (2)
   - Weekly (3)
   - Daily or almost daily (4)

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   - Never (0)
   - Less than monthly (1)
   - Monthly (2)
   - Weekly (3)
   - Daily or almost daily (4)

5. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   - Never (0)
   - Less than monthly (1)
   - Monthly (2)
   - Weekly (3)
   - Daily or almost daily (4)

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   - Never (0)
   - Less than monthly (1)
   - Monthly (2)
   - Weekly (3)
   - Daily or almost daily (4)

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   - Never (0)
   - Less than monthly (1)
   - Monthly (2)
   - Weekly (3)
   - Daily or almost daily (4)

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   - Never (0)
   - Yes, but not in the last year (2)
   - Yes, during the last year (4)

9. Have you or someone else been injured as a result of your drinking?
   - No (0)
   - Yes, but not in the last year (2)
   - Yes, during the last year (4)

10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking, or suggested you cut down?
    - No (0)
    - Yes, but not in the last year (2)
    - Yes, during the last year (4)

Q9: How many drinks did you have on a typical day when you were drinking in the past year?
   - 1 or 2 (0 points)
   - 3 or 4 (1 point)
   - 5 to 9 (2 points)
   - 10 or more (4 points)

Q9h: How often did you have six or more drinks on one occasion in the past year?
   - Never (0 points)
   - Less than monthly (1 point)
   - Monthly (2 points)
   - Weekly (3 points)
   - Daily or almost daily (4 points)
Discussion

If your team is already screening for SUD:
• How is your team addressing the needs of people who screen positive?
• Are there any lessons learned can you share with the collaborative?
• What challenge/questions are you still working on?

If your team has not started systematically screening for SUD:
• What are your next steps to identify and treat people with SUD?
• What SUD resources can you access? What are your challenges/possible strategies to test and implement SUD screening?
CONTACT

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LUNCH!
Story Board Presentations:

Solano County, Lake County, and Tuolumne County

Solano County Integrated Care Collaborative Taskforce
Celebrating Successes
Valuing Failures

CCC Learning Session #3
July 22-23, 2014
Project Team

**Executive Leaders:**
- Dr. Michael Stacey, Public Health Deputy Director & Chief Medical Officer
- Halsey Simmons, Mental Health Deputy Director
- Jayleen Richards, Public Health Administrator

**Team Leader:**
- Dr. Karyn Tribble, Health Services Manager

**Data Team Leader:**
- Shabnam Chabi, Health Services Manager

**Team Members:**
- Shawan Casborn, Project Manager
- Chris DeLima, Mental Health Clinical Supervisor
- Hollis Ellis, Peer Provider
- Rachel Ford, Consumer Liaison
- Rob George, Quality Assurance Supervisor
- Amber Siddle-Manas, Public Health Office Assistant
- Marie-Fe Tiongson, Public Health Nurse Manager

Charter Aim

**Projected Timeline: 18 months**

**Aim:**
Solano County residents with severe mental illness will receive whole-person, empowering, coordinated physical and behavioral health care in a stable medical home. Staff and technical resources will be used to assure continuous feedback between client, psychiatrist, primary care physician, and/or other behavioral health providers or specialty medical providers as necessary, with the end in mind of reducing morbidity and mortality. In order to ensure system-wide integration and efficacy, this Collaborative will focus its initial pilot project efforts on the Fairfield Adult Integrated Care Clinic prior to systematically expanding services to the remaining Solano County Family Health Services clinics.
Target Population

Through diligent efforts Solano County has identified 21 clients who are shared patients between our panel providers:

- Kelly Doyle-Matta, Physician Assistant
- Dr. Nadavathusery Jacob, Psychiatrist

Charter Objectives

1. To improve coordinated use of the common medical-psychiatric Electronic Health Record (EHR) system.

2. Ensure appropriate releases or legal coverage for all communication, whether verbal or written.

3. Create an individualized, multi-disciplinary, person-centered Care Coordination Plan (CCP).

4. Ensure all Integrated Care Clinic (ICC) psychiatric clients in the cohort group have a medical home in the FQHC, or if necessary another medical home.

5. Ensure that individuals are receiving non-medical and mental health services, as appropriate and available.
Charter Objectives

6. Establish a collaborative culture which reinforces the notion that all team members are joint care coordinators.

7. Guarantee that all individuals in the cohort are assisted with obtaining a full physical from the Family Health Clinic.

8. Monitor, evaluate and incorporate into treatment, routine and episodic tests to improve chronic disease management.

9. Ensure that screening tests, recurrent chronic disease tests, and other appropriate preventive care is coordinated, tracked and available in a timely manner.

10. Provide chronic disease management support individually or in through group modalities.

Instructive Learning

- **The Goal**: to pull our target population from NextGen by cross-referencing provider case loads and selecting the clients who had an A1c test result greater than 9.

- **The Result**: NextGen could not create a report based on a specific lab result, nor one based on a diagnosis of diabetes.

- **The Lesson Learned**: NextGen, with its current limitations and capabilities, cannot support the data-portion of this project the way we had planned.

- **The Solution**: Instead of relying on an electronic system, we tapped into the knowledge-base of a few Medical Assistants and administrative support staff to help us piece together our Target Population.
Highlighting Successes

- Established weekly case conference meetings between both providers
- Building relationships with clinic staff
- Identified Target Population (with assistance from clinical staff)
- Identified clients for potential outreach, through Higher Utilizers report from Partnership HealthPlan

Change Implementation

~ Current Change Being Tested

**Engage and strengthen relationships between provider organizations convened**

- Each provider has medical assistants designated to them
- All ICC staff meet biweekly to discuss program needs and outreach efforts
- Providers created a hard copy filing system for tracking labs and results, clinic visits, and shared care plans (all data is also uploaded into the clinic’s EHR system)
- All cases are discuss during provider’s case conference meetings
- Newly assigned Project Manager now acts as liaison between CCC team and ICC.
Planning Ahead: The Next 6 Mos.

Changes Planned for the Next 6 Months:

- Outreach
- Develop roles of peer provider
- Screen clients’ whole health
- Engaging clients in Care Coordination services and self management
- Develop and use standard referral processes and protocol between providers
- Design a single page Care Coordination service plan

Thank you!
Story Board Presentation:

Lake County
CCC Team

Celebrating Successes
Valuing Failures

Tuolumne County Behavioral Health
Integrated Care Coordination

CCC Learning
Session #3
July 22-23, 2014
Project Team

- **Senior Leader(s):**
  - BHD: Rita Austin, LCSW – Director
  - Mathiesen Clinic: Andy Anderson – Clinic Director

- **Team Leader:**
  - BHD: Mark Gee, MFT – Clinical Care Manager
  - Mathiesen: Toni Roe – Clinic Manager
  - Calif H&W: Reina Hudson, LCSW
  - Anthem: Jo Miller, LCSW

- **Team Members:**
  - BHD: Donna Jergentz, PT – Care Coor.
    - Angie Gisi – Peer Leadership
  - Mathiesen: Dora Meza – Medical Asst.

  Faculty Support: Jennifer Clancy and Darren Urada

Charter

**Aim:**
To build a comprehensive and consumer oriented health care model between Behavioral Health and a primary care clinic that can be fully or partially replicated throughout the County with other clinics or providers in order to improve the coordination of care and outcomes of persons served.

**Objectives (Summarized):**
- Establish method to identify shared clients.
- Develop a method of coordination and referral tailored to respond to unique care needs.
- Incorporate a strong Peer Support orientation.
- Assure measureable outcomes to improve system efficacy.

**Target Population:** Adult persons who meet the criteria for admission to the MHP (Tuolumne Behavioral Health) and are active to the Mathiesen Memorial Health Clinic as their Health Home for their primary care. Persons shall have been identified as having at least one qualifying condition to each organization and be willing participants in their care coordination.
The Journey:
From Cold Send-off to
Warm Hand-off

- Persons needing Behavioral Health Services who were at Primary Care settings didn't want to come to the County BHD, due to stigma, inconvenience and fear.
- People were “instructed” by PCP to request services from BHD and sometimes the PCP would FAX a referral.
- Some persons followed through and went through the standard processes of intake and assessment.
- Many persons had difficulty articulating why they had come and were hesitant to disclose the PCP concerns or reason for their service needs.
- . . . They fell through the cracks early in the referral process . . . PCPs received no feedback . . . . Everyone was left out in the cold.

A warm hand-off was initiated . . . And trialed through the PDSA process.
In the final cycle, a process to engage persons referred to BHD from the PCP was implemented to be individualized based on the ability and comfort of the person referred.
Warm hand offs include a contact by the care coordinator upon receipt of the referral to determine if there are any barriers to coming in for an appointment and provide a solution focused strategy to facilitate access.
The outreach to meet the person where they are at, both psychologically and sometimes at field locations, has resulted in 100% transition to start the access to BHD.
Useful, Instructive Learning

Well . . . . . It worked well for the clients and care coordinator -

- Whoops . . . .
- The warm hand-off resulted in a deviation from the standard access process.
- Great efforts in facilitation the warm hand-off interrupted the existing protocols and practices of the BHD entry which bypassed Access Log, Triage protocols, some paperwork processes and signatures.
- Discovery of the need to evaluate entries through alternative “doors” of the system occurred only after Compliance “discovered” there were parallel alternative practices being implemented to accommodate the “new” referral process.

How Did this Learning Inform Next Steps and Pursuit of Changes that Work? . . . . Well . . . . We are making system change!

How We are Responding

- A Change being considered for implementation:
  - Cross train the care coordinator to complete the triage process and create alternative/more entry processes for PCP referrals.
  - Complete all ROI with care coordinator prior to full intake and attach to initial paperwork.
  - Open calendar for care coordinator to set intake appointments, set up peer support if needed for completion of initial paperwork and track to assure obstacles to accessing services are removed.
PDSA’s and Data Use

- Team members continue to use PDSA’s for evaluating progress of various changes. The PDSA exercise structure has been helpful to better memorialize the processes and apply or generalize to similar situations related to systems issues. Sometimes, the greatest challenge for the team members is the writing/documentation of the PDSA.

- Data tracking is challenging as the partnership and flow of information (even with releases) is often hampered by limited staff availability and supporting business practice change with the primary clinic partner.

Planning Ahead: The Next 6 Mos.

- Implement the “new door for warm hand-off” process and incorporate into the agency protocol and process.
- Develop a relationship with the MCPs to better utilize.
- Assure full integration of SUD treatment referral and hand-off.
- Perform evaluation of model for sustainability, cost benefit and staffing needs if necessary.
- Develop a consistent and/or predictable mechanism for sharing health outcomes and/or changes.
- Implement in-home peer support for healthy habit management to supplement and support total coordinated care.
- Initiate peer support for WRAP plan reflecting coordinated health care.
Thank you!

Data for Improvement: Using CCC Measures

Jerry Langley,
Improvement Advisor
Associates in Process Improvement
Organizational Team Meeting #2

Team Report Out
Wrap Up and Adjourn

Reflection On The Learning Session And Review Key Dates

Have a Safe Trip Home!

Next Learning Session: November 12-13
Los Angeles, CA