Health Care Workforce Transformation Fund
Advisory Board
June 24, 2015
9:30 a.m. to 11:00 a.m.

Commonwealth Corporation
2 Oliver Street, Fifth Floor
Boston, MA 02109

1. Welcome/Introductions: Secretary Ronald L. Walker, II

2. Update on the Health Care Workforce Transformation Fund Training Grants: Karen Shack

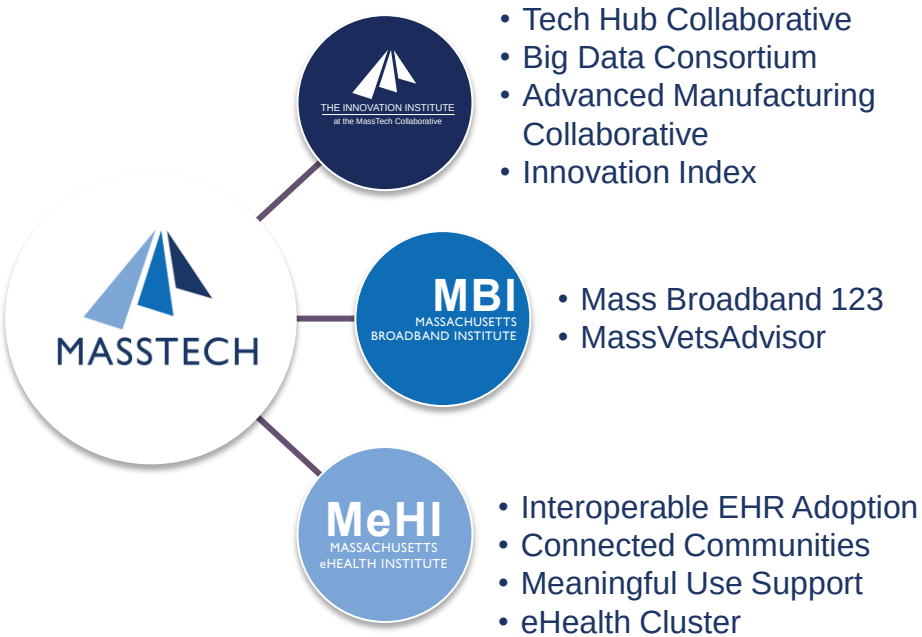
3. Mass Tech presents on the Springfield Technical Community College Grant: Laurance Stuntz

4. Community Hospital Acceleration, Revitalization, and Transformation (CHART)- Round 1 Update: Margaret Senese

5. Care Dimensions Grantee Presentation: Susan Lysaght Hurley

6. Announcements and Closing Comments: Secretary Ronald L. Walker, II

MeHI Overview



- Tech Hub Collaborative
- Big Data Consortium
- Advanced Manufacturing Collaborative
- Innovation Index

- Mass Broadband 123
- MassVetsAdvisor

- Interoperable EHR Adoption
- Connected Communities
- Meaningful Use Support
- eHealth Cluster

MeHI is a division of the Massachusetts Technology Collaborative, a public economic development agency

MeHI is the designated state agency for:

- Coordinating health care innovation, technology and competitiveness
- Accelerating the adoption of health information technologies
- Promoting health IT to improve the safety, quality and efficiency of health care in Massachusetts
- Advancing the dissemination of electronic health records systems in all health care provider settings

MeHI MASSACHUSETTS eHEALTH INSTITUTE at the MassTech Collaborative

MeHI Vision, Mission, and Goals

VISION

Massachusetts is the global eHealth leader. Our connected communities enjoy better health at lower cost and serve as models of innovation and economic development.

MISSION

To engage the healthcare community and catalyze the development, adoption and effective use of health IT

GOALS

Adoption

Interoperable EHRs

Support Health Reform

- ✓ Better Health
- ✓ Better Care
- ✓ Lower Costs

Consumer eHealth Engagement

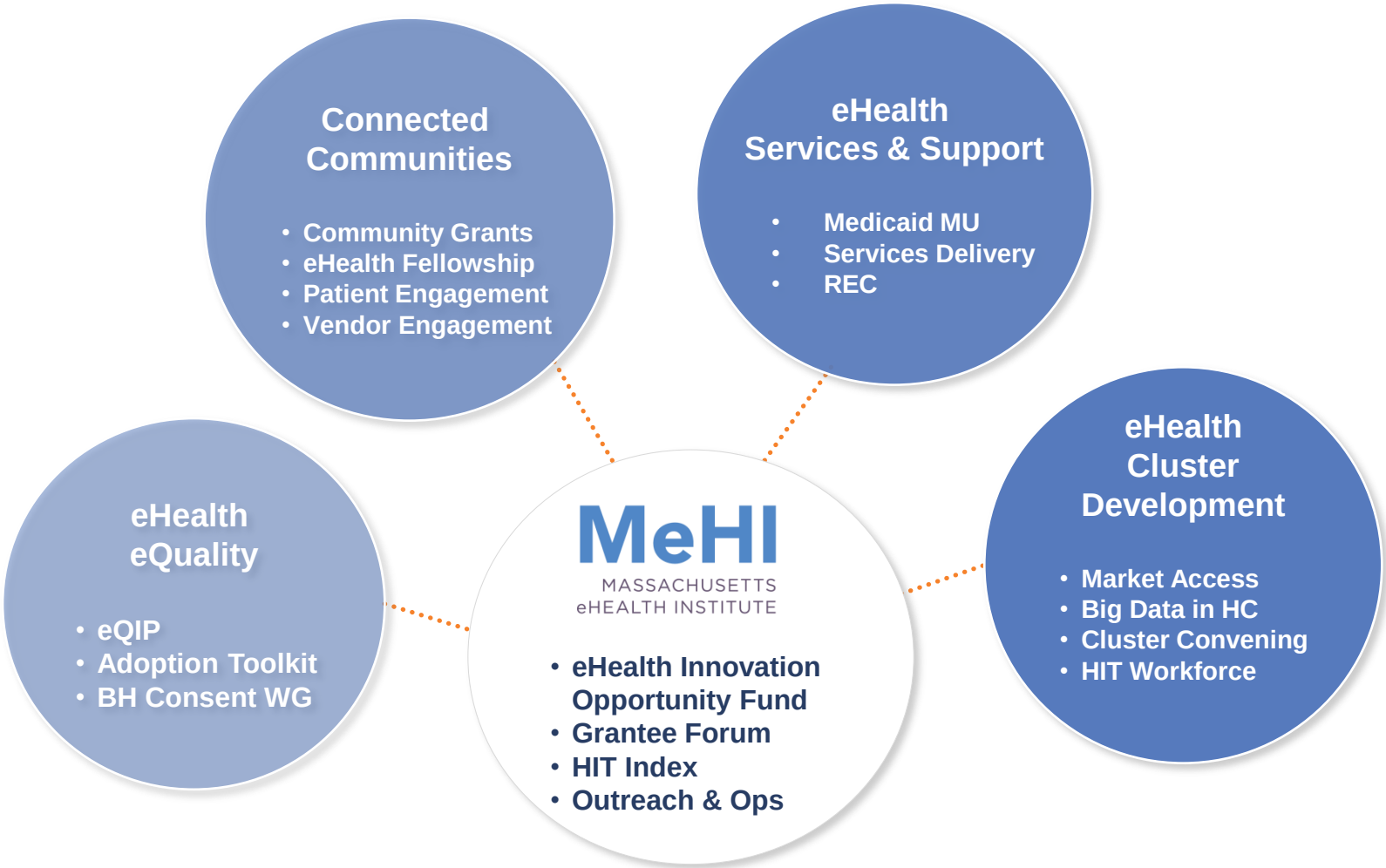
Grow & Promote Innovation & eHealth Cluster

2020

400+ **companies** / **$15 billion**
15,000+ **employees**

MeHI MASSACHUSETTS eHEALTH INSTITUTE at the MassTech Collaborative

MeHI Initiatives 2015 - 2016



CORE VALUES

Innovation • Insight • Collaboration • Accountability

MeHI MASSACHUSETTS eHEALTH INSTITUTE at the MassTech Collaborative

Workforce Training Program Goals

- Meet Ch. 224 mandate to establish a pilot partnership with a community college or vocational technical school
- Address gap in health IT training in CNA and LPN programs
- Consider health IT training needs specific to LTPAC and home health care agencies:
  - High rates of employee turnover
  - Disparate locations
- Funded by Commonwealth Corporation through the Healthcare Workforce Transformation Fund

Workforce Training Program Structure

- Development of Health IT Curriculum Module
  - Aimed at specific needs in LTPAC and home health care sectors
  - Focused on 1-2 Health IT topics, including privacy/security
- Train-The-Trainer Module
  - Develop module to train staff in delivery of the curriculum module
  - Conduct pilot program with staff from LTPAC and home health care agencies, trade associations, and MeHI
- Direct Delivery
  - Trained trainers teach the curriculum directly to their staff

Partners

Curriculum Development & Training:

Springfield Technical Community College

Cape Cod Community College

MIDDLESEX Community College

Long Term Care Partners:

LIFE CARE CENTER OF MERRIMACK VALLEY

WINGATE HEALTHCARE

Home Care Partners:

HopeHealth℠ Touching Lives

Timeline

- Kick-Off Meeting (May 26th)
- Focus Groups (June – July)
  - 6 focus groups hosted by community college partners
  - Representatives from local home health care and LTPAC organizations and related trade associations
  - Soliciting feedback on proposed delivery model and curriculum topics
- Curriculum Development & Testing (July – August)
- Recruit & Train Trainers (September – February)
- Direct Curriculum Delivery (February – April)
- Post-Pilot Roundtables & Final Report (April – June 2016)

COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

CHART Phase 1: Foundational Investments for Transformation

June 24, 2015

Agenda

- CHART Investment Program
- CHART Phase 1 and Summative Report Findings
- Implications for CHART Phase 2

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Ongoing HPC Responsibilities

The HPC's activities are broadly grouped in four key areas:

1. Promote the adoption of new delivery system models through a certification program for patient-centered medical homes and accountable care organizations
2. Make investments in the Commonwealth's community hospitals to establish the foundation necessary for sustainable system transformation
3. Monitor system transformation in the Commonwealth and cost drivers therein
4. Examine significant changes in the health care marketplace and their potential impact on cost, quality, access, and market competitiveness

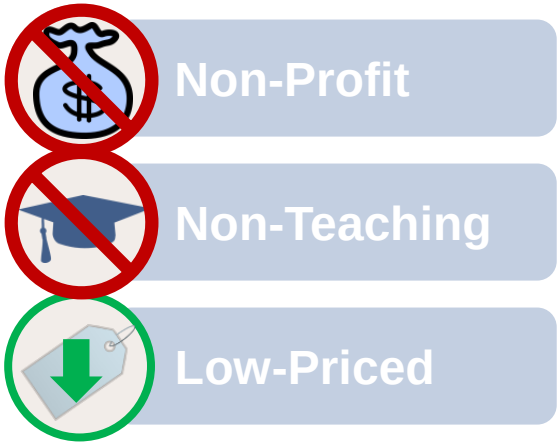
Foundational Investments in System Transformation

2

Make investments in the Commonwealth's community hospitals to establish the foundation necessary for sustainable system transformation

- Funded by the one-time assessment on payers and select providers
- Total amount of $119.08M ($128.25M, less $9.17M provided in mitigation to qualifying acute hospitals)
- Unexpended funds may be rolled over to the following year; do not revert to the General Fund
- Competitive proposal to receive funds

Strict eligibility criteria:

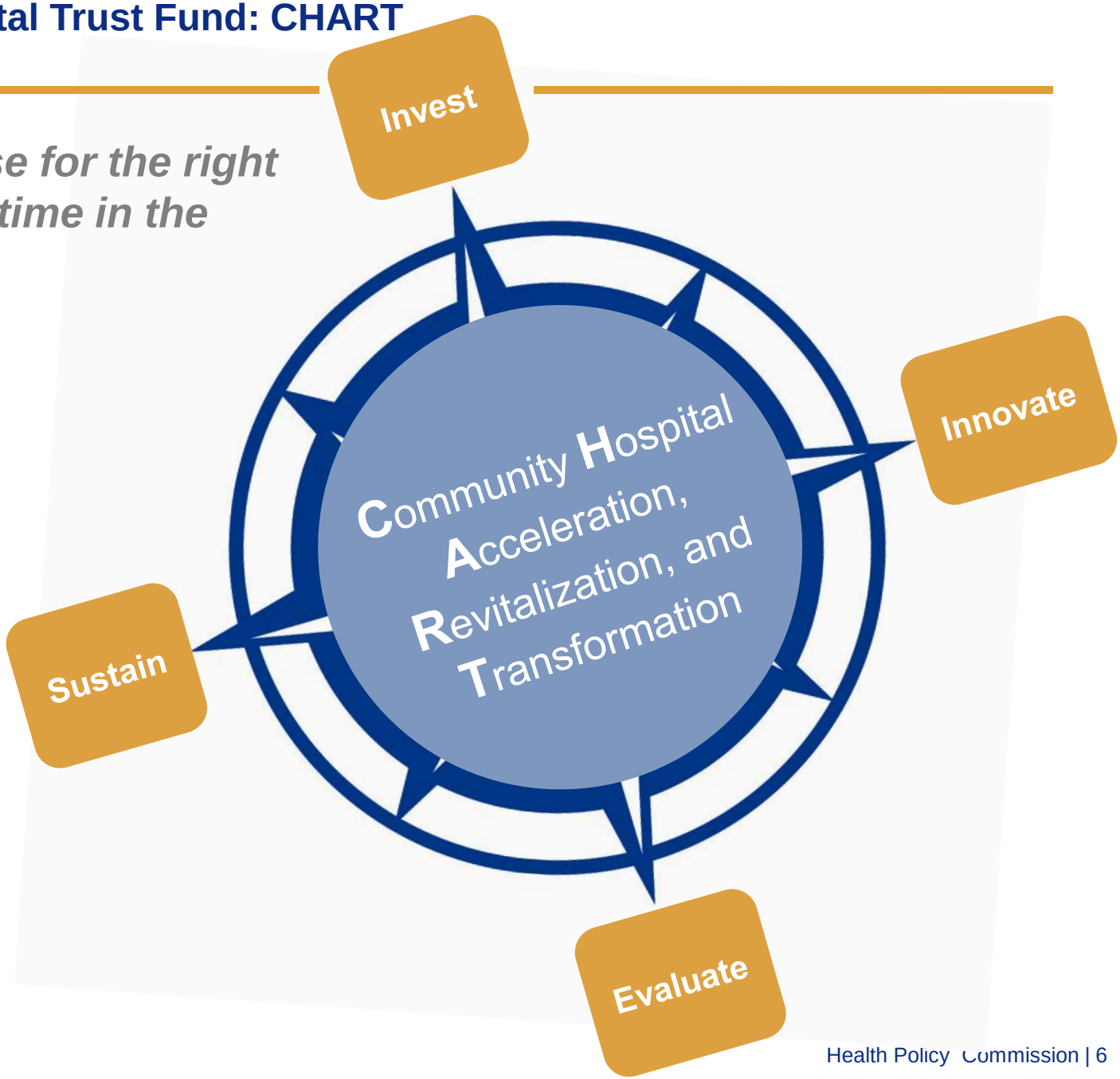


Achieve sustainable, scalable interventions that benefit communities

Source: M.G.L. Chapter 29, Section 2GGGG; 958 CMR 5.00

Distressed Hospital Trust Fund: CHART

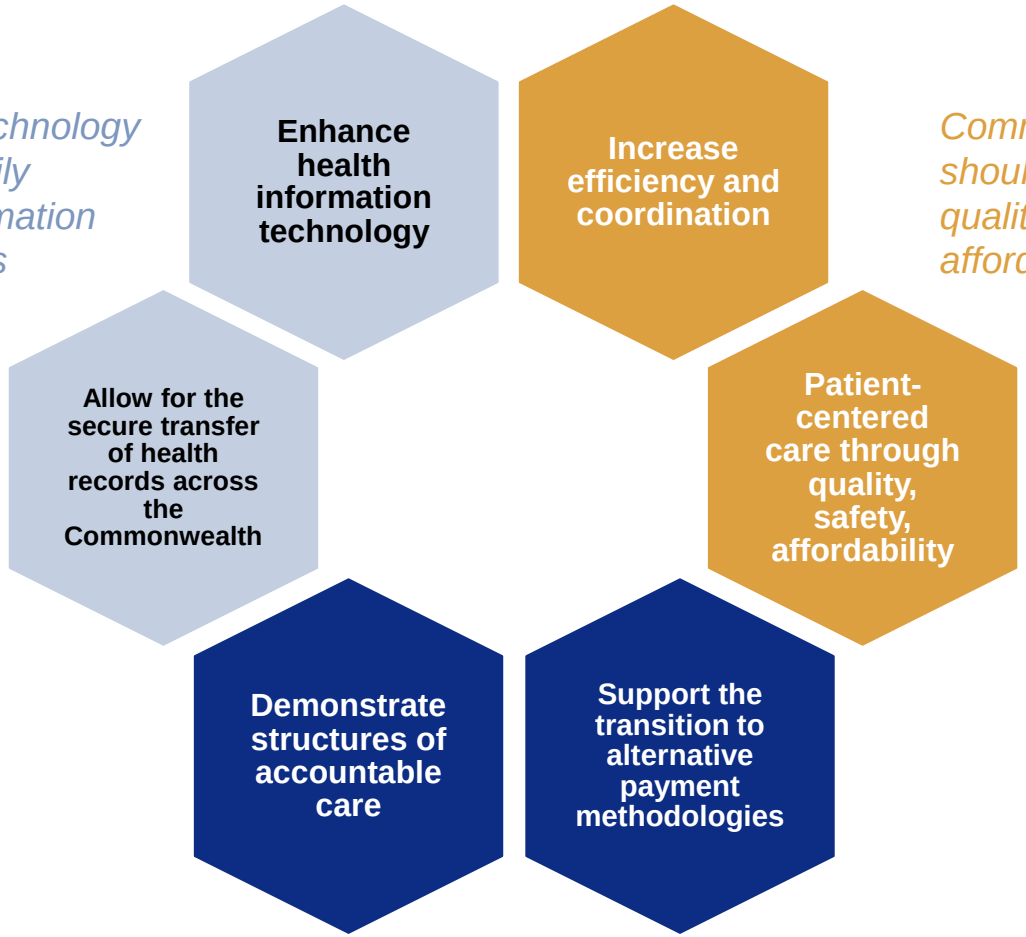
Charting a course for the right care at the right time in the right place



Statutory Goals

Investments shall support at least one of six statutory goals:

Encouraging technology adoption to easily exchange information across hospitals



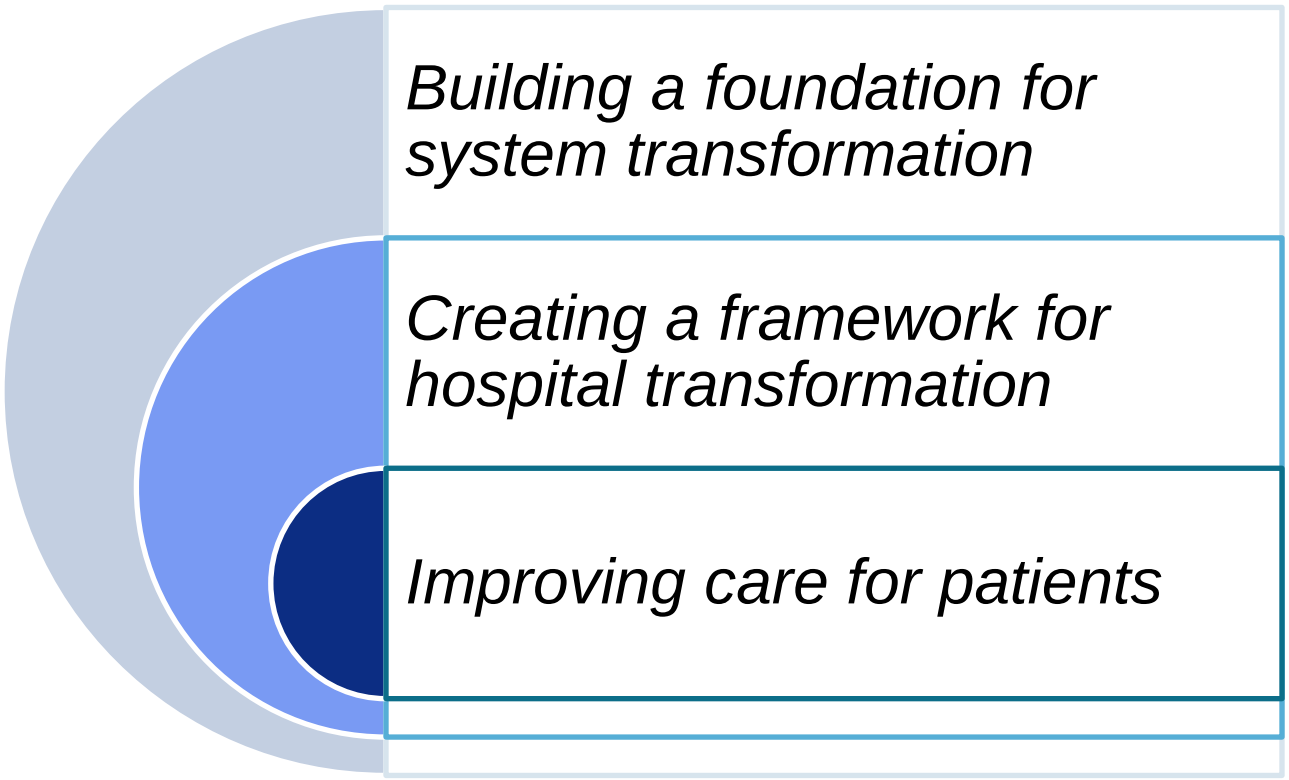
Community-based care should be efficient, high-quality, safe, and affordable

Building a structure for creating accountable care

Source: M.G.L. Chapter 29, Section 2GGGG; 958 CMR 5.00

CHART Investment Priorities

CHART investment priorities are structured to support transformation at the system, hospital, and patient care levels



Agenda

- CHART Investment Program
- CHART Phase 1 and Summative Report Findings
- Implications for CHART Phase 2

CHART Phase 1 Summative Report

CHART Phase 1 Report

Key Report Sections

1. **Overview**
   Understanding the CHART Hospital Context
   CHART – Supporting Efforts to Meet the Health Care Cost Growth Benchmark
   CHART Program Goals and Theory of Change
   Seeking System Transformation
   The HPC Investment Approach: Building a Foundation for Transformation

2. **Hospital Initiatives**
   Reducing Readmissions and Improving Transfers to Post-Acute Care
   Reducing Unnecessary Emergency Department Use and Enhancing Behavioral Health Care
   Building Technology Foundations
   The CHART Engagement Model

3. **Lessons Learned**

4. **Moving into Phase 2**
   Conclusion

Overview of Phase 1 investments, impacts, lessons & implications

CHART Phase 1 Application Process

On October 23, 2013, the HPC issued a Request for Proposals (RFP) for Foundational Activities to Prime System Transformation.

$10 million
total funding cap

$500,000
total award cap

28 applications
for investments in one or more pathway:

- Rapid-cycle pilots
- Capability and capacity building
- Planning for improvement

HPC staff, Commissioners, key content experts, and representatives of the Massachusetts Executive Office Health and Human Services and the Office of Medicaid **participated in review and selection of awardees**

All applicants received rewards, ranging from $65,000 to $500,000, with an average award of
$355,559

CHART Phase 1: $9.2M

2,334
Hospital employees trained

400+
Hours of direct technical assistance to awardees

27 HOSPITALS | **260** UNITS
Primed for transformation

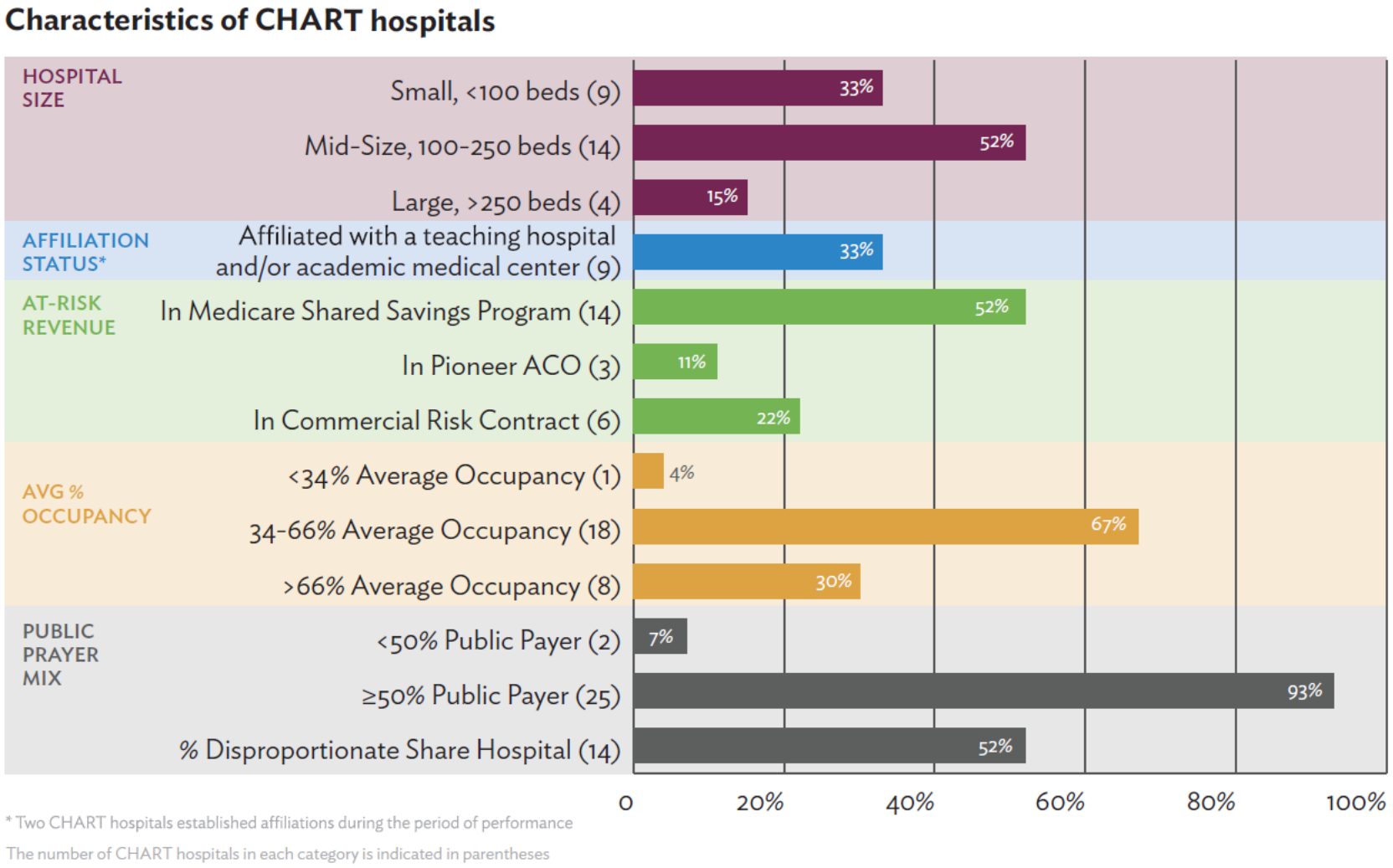
90%
of respondents believed that CHART Phase 1 moved their organization along the path to system transformation

316
Community partnerships formed or enhanced by awardees

167,000+
Patients impacted by Phase 1 initiatives

PHASE ONE

CHART awardees - while exhibiting marked differences - are a generally heterogeneous group of hospitals, reflected in specific indicators

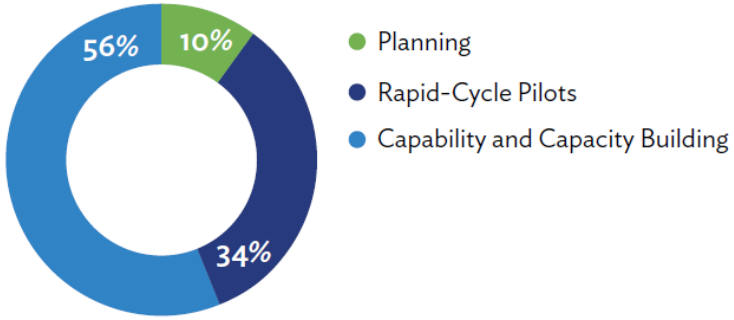


Investment Approach

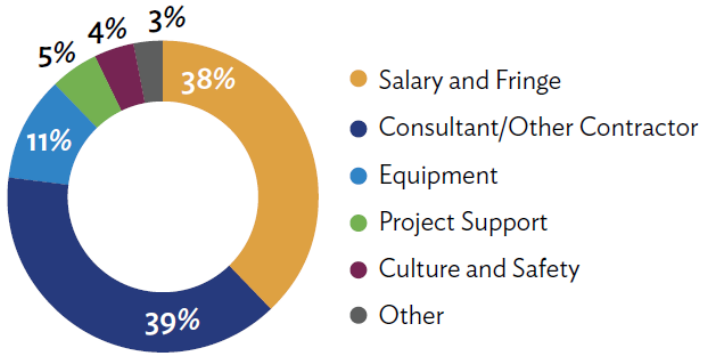
Investments were categorized in to one or more of three specified pathways

1. **Rapid-Cycle Pilots:** Investments in rapid tests of change around hospitals' adaptive capacity, leading to meaningful learning about the organizations' capacity for transformation, as well as early test results to inform delivery redesign activities.
2. **Capability and Capacity Building:** Investments in one or more high-need priorities directly tied to hospitals' plans for transformation. These included process improvement and skill-based trainings for staff as well as the acquisition and implementation of enabling technology.
3. **Planning for Improvement:** Investments in strategic and operational planning activities

The amount of the awards spent in each pathway



The amount of the awards spent in each category



Other refers to money dispersed to NARH

The CHART Hospital Engagement Model

Supporting Hospitals and their Communities in Transformation

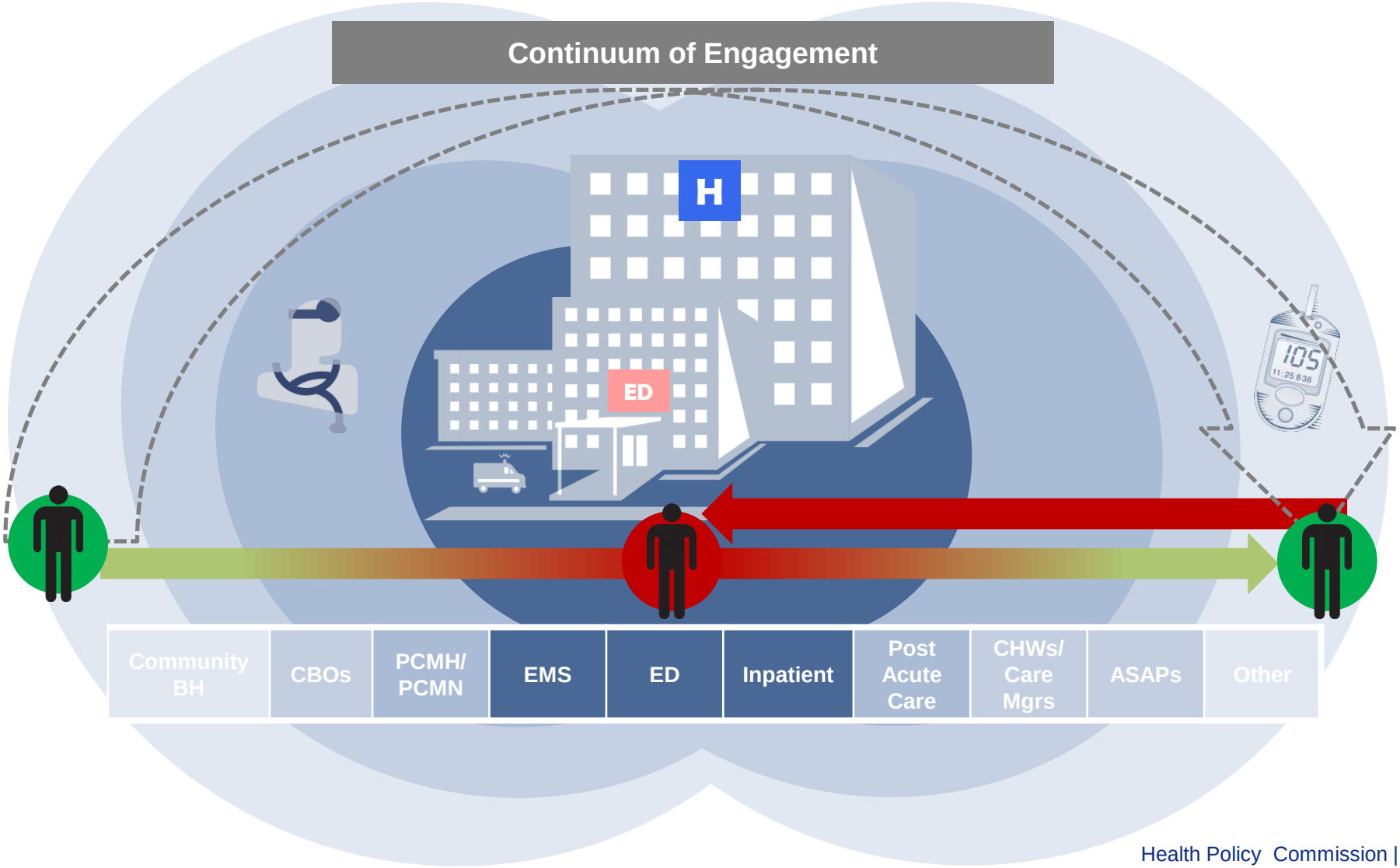


CHART Investment Priorities: Reducing Readmissions

Addison Gilbert Hospital
A member of Lahey Health

Reducing readmissions

Addison Gilbert Hospital sought to reduce 30-day all-cause readmissions by piloting a high-risk intervention team (HRIT) and monitoring its performance.

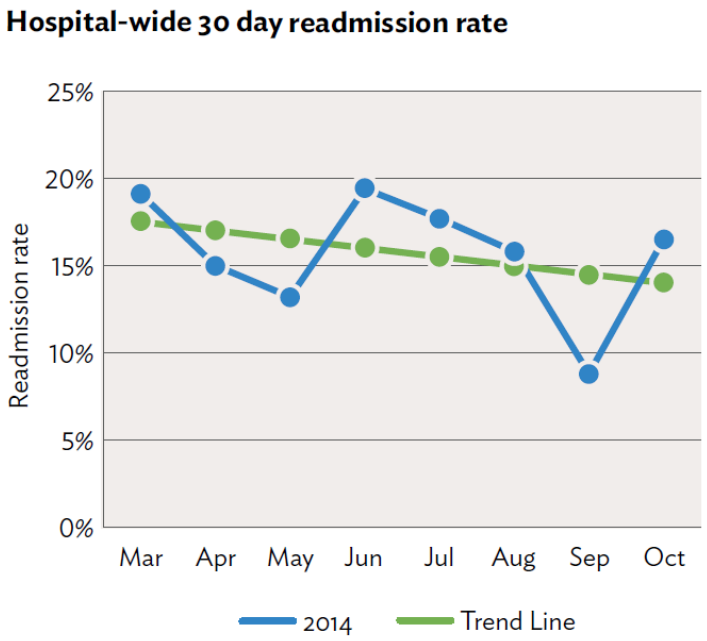


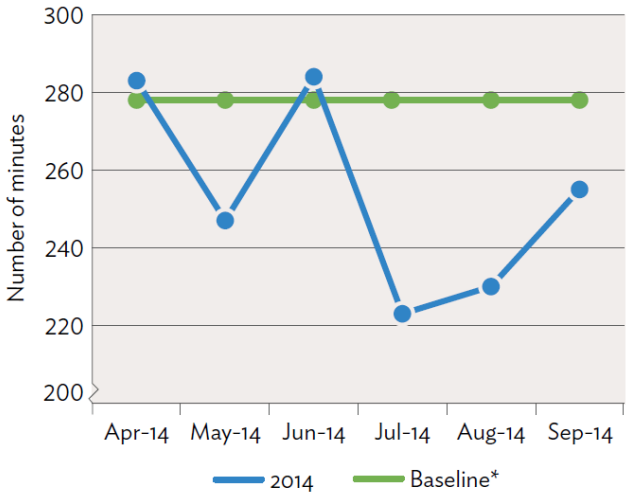
CHART Investment Priorities: Optimizing ED Utilization

Optimizing ED Utilization

UMassMemorial HealthAlliance Hospital

HealthAlliance Hospital partnered with local community providers to develop an ED Navigator Care Coordination Model for patients with serious mental illnesses (SMI). The intervention aimed to connect all patients with a behavioral health condition to a primary care provider and to increase communication across all service areas.

Length of stay for emergency department visits for behavioral health reasons



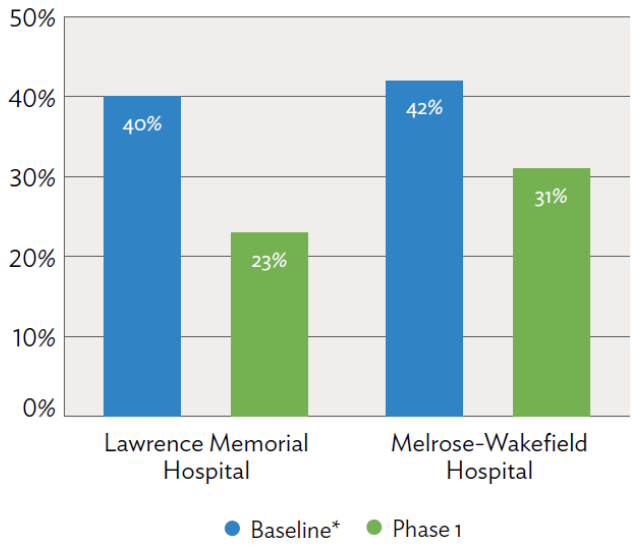
*Baseline is average length of stay April-Sept 2013

CHART Investment Priorities: Enhancing Behavioral Health Care

Enhancing Behavioral Health Care

Hallmark Health System developed standardized clinical practice guidelines for patients with lower back pain in EDs at its hospitals. Hallmark documented substantial reduction in use of opioids for lower back pain management.

Opioid prescribing rates in the Melrose-Wakefield and Lawrence Memorial Hospital EDs



* Baseline is April–June 2013

CHART Investment Priorities: Building Technology Foundations

Building Technology Foundations

Baystate Mary Lane Hospital developed telemedicine programs in 6 clinical departments to increase patient access to specialty providers. The hospital reduced overall patient waiting time for appointments to less than 20 days, versus over 80 days on average for in-person appointment

Wait time (number of days) to third appointment: Baystate Mary Lane Hospital

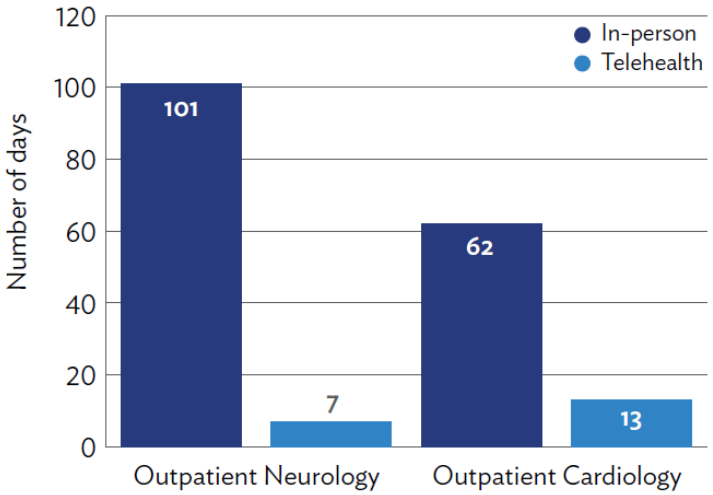
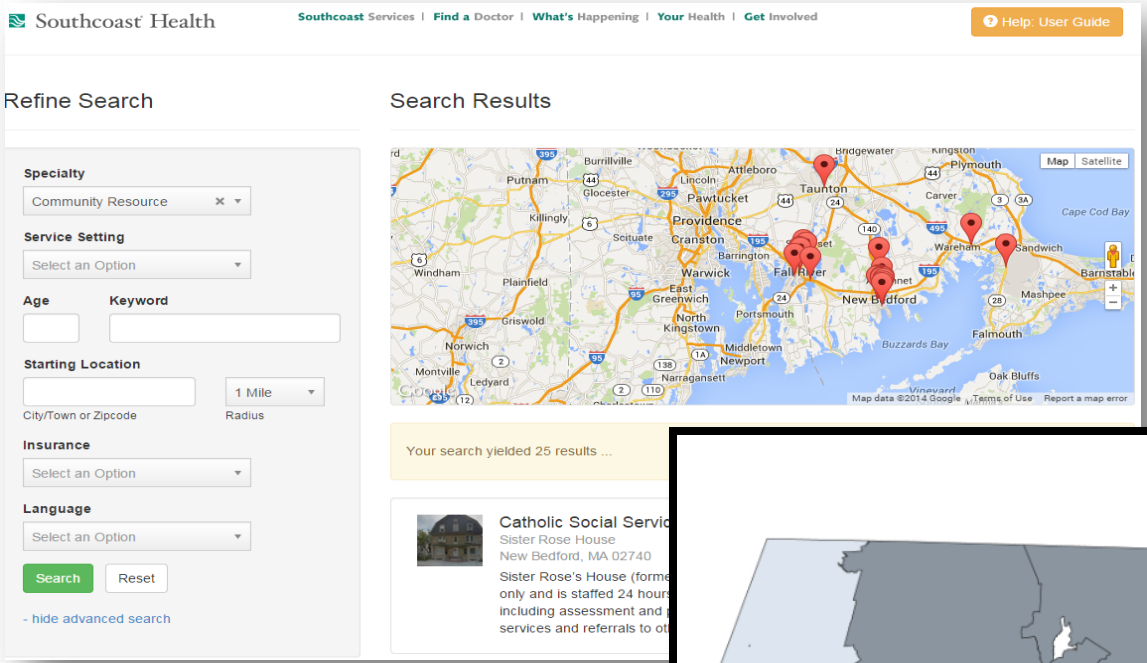


CHART hospitals formed or enhanced more than 315 partnerships with medical practices, behavioral health providers, and community resources



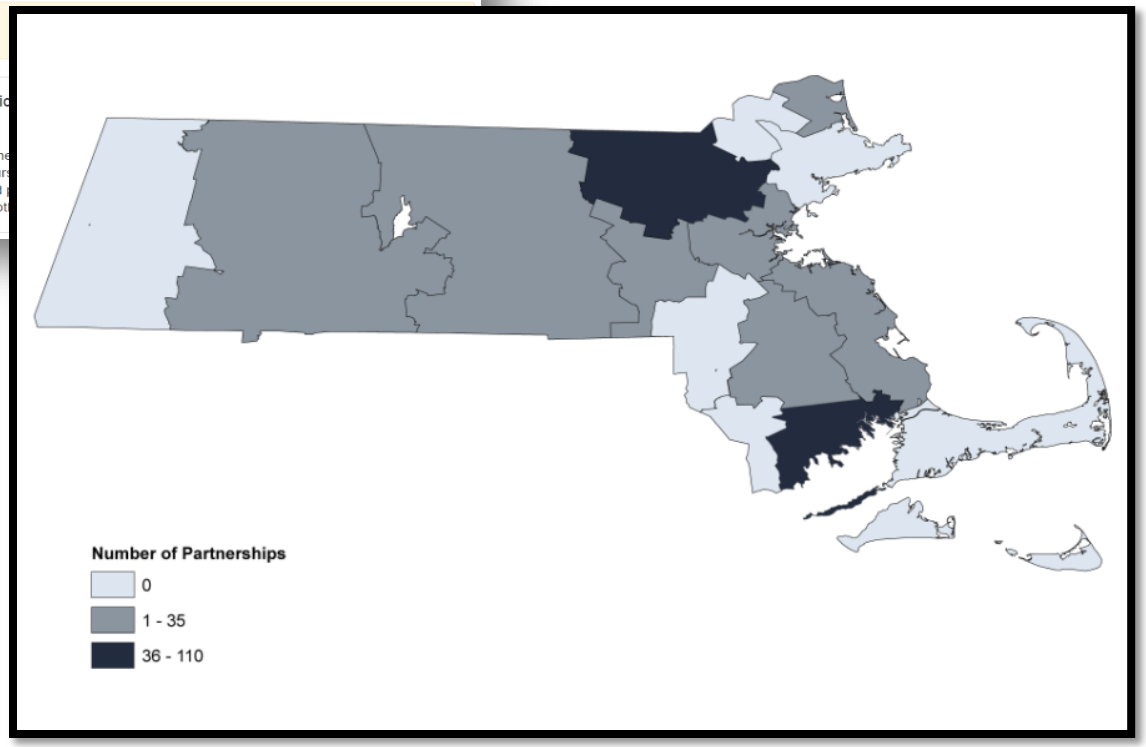
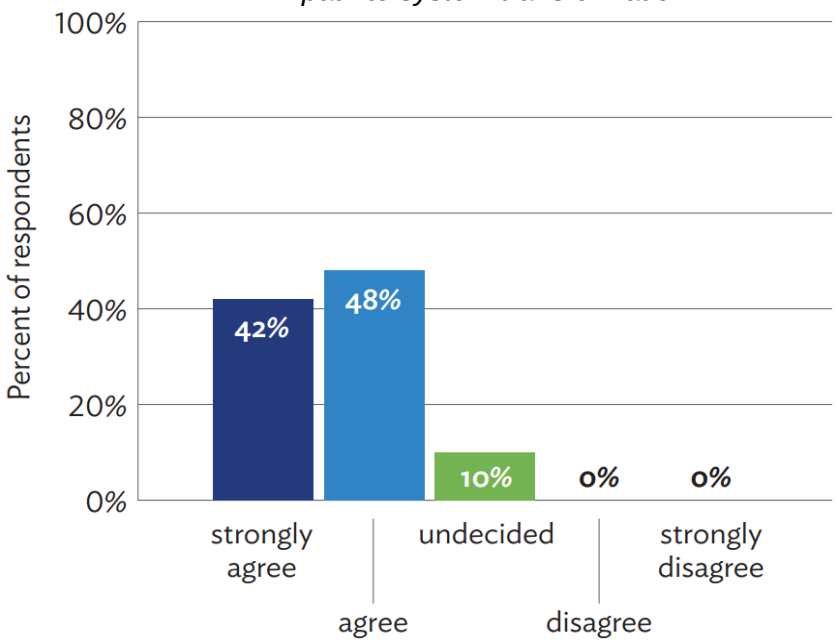


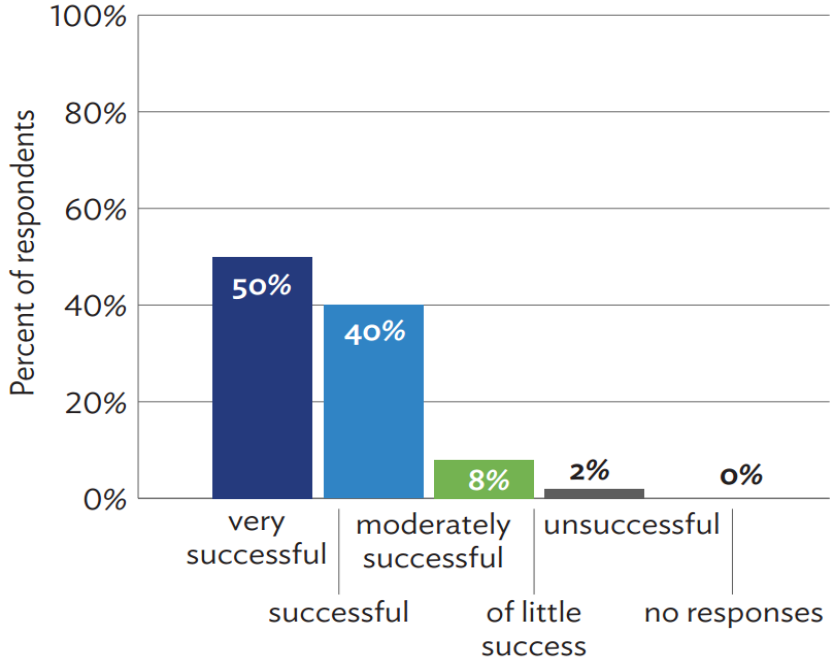
CHART hospitals self-evaluated as being generally successful

Anonymous end of phase survey provided key insights into CHART's benefits and their own perspective of performance

Hospital respondents self-reported their belief that CHART Phase 1 moved their organization along the path to system transformation



Hospital respondents self-rated their performance on Phase 1 initiatives

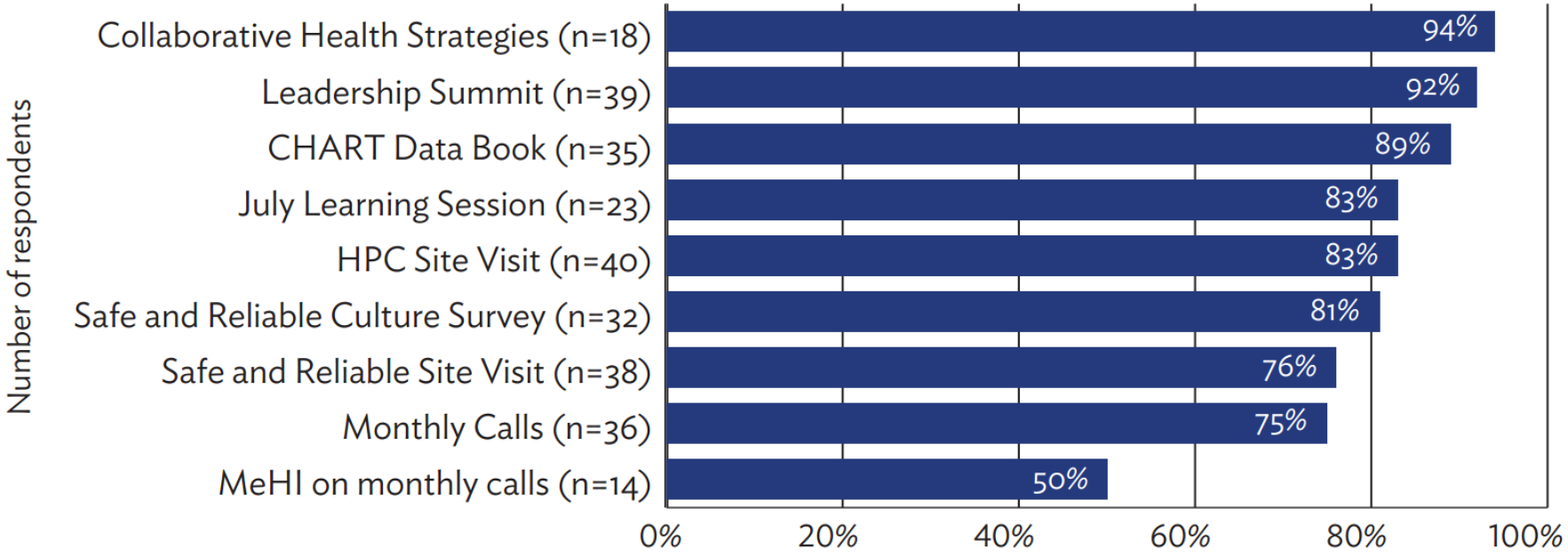


Directly informed Phase 2

CHART Phase 1 provided value to awardees

Hospitals generally found TA to be valuable, with variation between provider engagement activities

Percent of hospital respondents who found TA types valuable:



Directly informed Phase 2

Key Lessons Learned from Hospital Performance in Phase 1

1. **The composition of transformation teams is important.** Multi-disciplinary skill sets were key to success.

2. **Process improvement leads to increased efficiency.** CHART initiatives that focused on process improvement improved efficiency and led to measureable outcomes.

3. **Leadership and project management must be engaged throughout the improvement process.** Leadership involvement and dedicated project managers were correlated to the success of an initiative.

4. **Data analysis is essential to measure performance and drive improvement.** The presence of meaningful data drives and enables improvement by defining target populations, monitoring progress, and assessing outcomes.

5. **Community partnerships are critical to success.** While challenging to build, community partnerships extend the reach of hospital staff through collaboration with external resources.

6. **Low-cost options for acute care are critical to maintaining a value-based system.** CHART awardees were encouraged to focus on building internal capacity and capability to increase sustainability.

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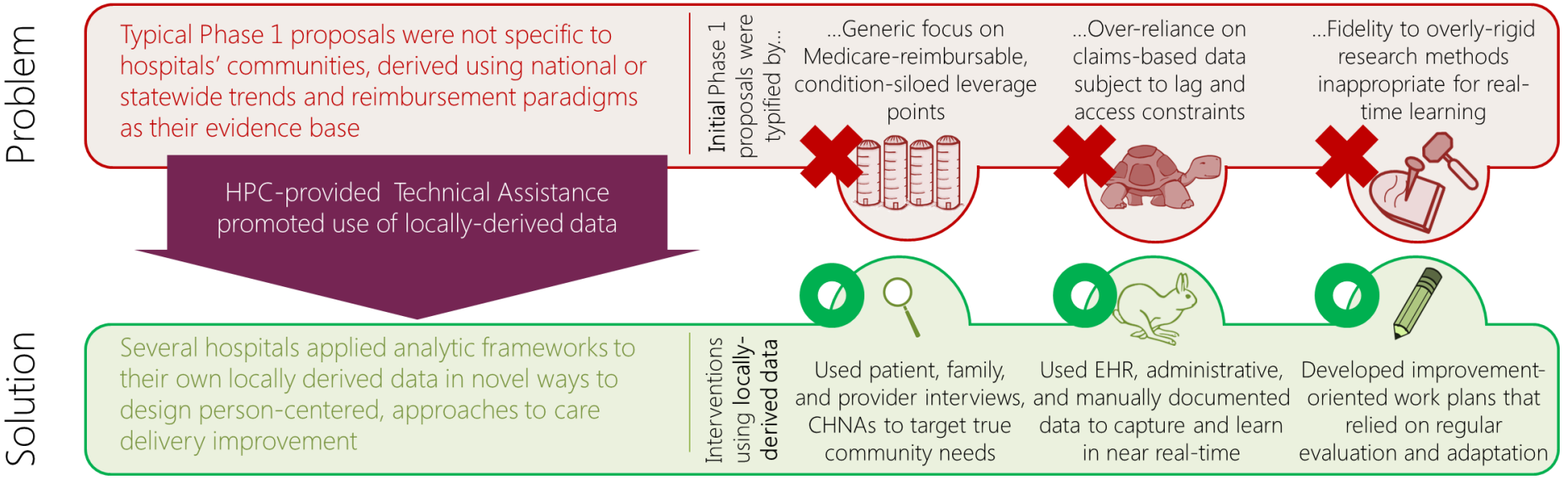
An adaptive Phase 1 approach resulted in tailored, data-driven solutions

The CHART Phase 1 proposal process was iterative in nature, and through hospital-HPC collaboration, many projects ultimately addressed hospital-specific needs



A Uniform Approach to Implementation Planning

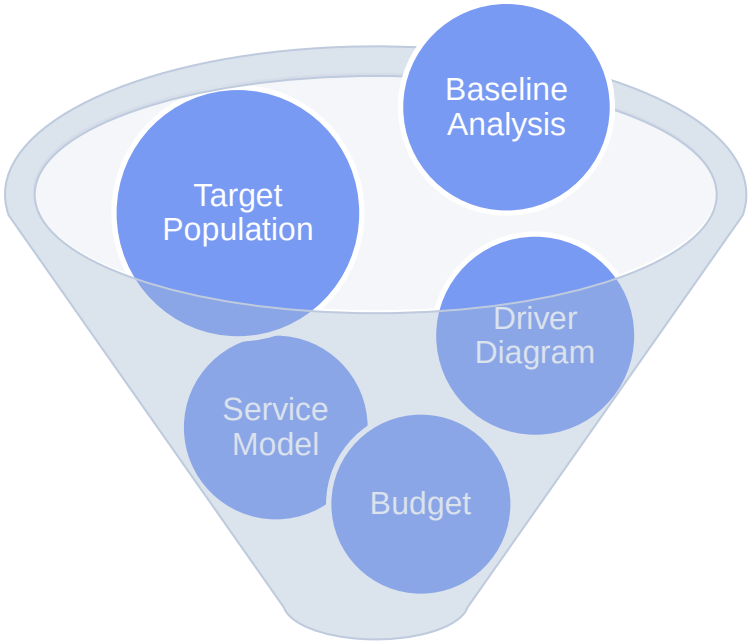
Implementation Planning Period (IPP): November 2014 – June 2015

Objectives of IPP

- Ensure all projects are positioned to successfully achieve their aim
- Establish rigorous program oversight framework and management approach
- Standardize vetting of program elements across all projects

Principles of IPP

- Meet the needs of communities served by CHART hospitals
- Patients are the foremost priority
- There are no easy answers
- Adaptation is key
- Collaboration is essential



Detailed implementation plan for success over the next two years

+

Baseline metrics to build milestones and payment terms


Reducing Inpatient Readmissions
Reducing Emergency Department Visits
Quantification Scale (inpatient discharges and ED visits)
Up to 2,000 events
Up to 4,000 events
Up to 8,000 events
Over 8,000 events
Berkshire Medical Center
Baystate Franklin Medical Center
Heywood Hospital
Athol Memorial Hospital
HealthAlliance Hospital
Holyoke Medical Center
Noble Hospital
Mercy Medical Center
Baystate Mary Lane Hospital
Baystate Wing Hospital
Harrington Memorial Hospital
Lowell General Hospital
Anna Jaques Hospital
Lawrence General Hospital
Addison Gilbert Hospital
Beverly Hospital
Winchester Hospital
Melrose-Wakefield Hospital
Lawrence Memorial Hospital
Emerson Hospital
Marlborough Hospital
BID-Milton
Milford Regional Medical Center
Signature Healthcare Brockton Hospital
BID-Plymouth
Southcoast-Tobey Hospital
Southcoast-Charlton Memorial Hospital
Southcoast-St. Luke's Hospital
550+
Hours of direct technical assistance for Awardees during IPP, alone
81%
Of CHART Hospital respondents found HPC Staff support helpful
PHASE TWO
28 Hospitals, 24 Months, $60M

Contact Information

For more information about the Health Policy Commission:

Visit us: http://www.mass.gov/hpc

Follow us: @Mass_HPC

E-mail us: HPC-Info@state.ma.us

CareDimensions™

Compassionate expertise for advanced illness

Founded in 1978 as
Hospice of the North Shore

Measuring Business Impact

June 24, 2015

Susan Lysaght Hurley, PhD, GNP-BC, ACHPN
Director of Research/Hospice and Palliative Care Nurse Practitioner

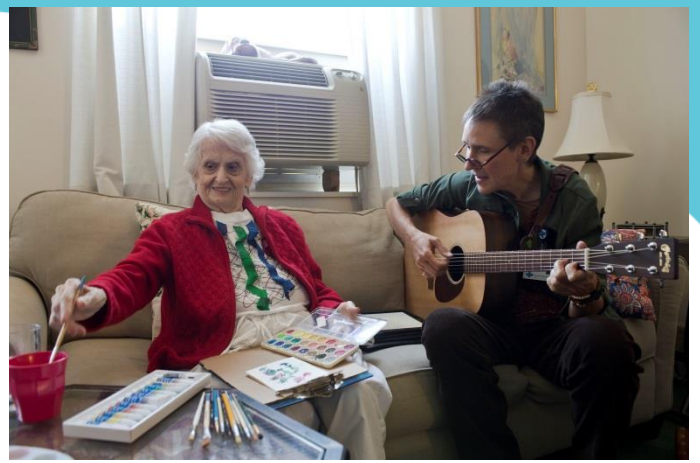
Care Dimensions – An Introduction

- Not-for-profit provider of hospice, palliative care and grief support services
- Largest hospice provider in Massachusetts, serving 90 communities
- Cared for 4500 patients and families in 2014
- Founded in 1978 as Hospice of the North Shore; acquired Partners Hospice in 2011
- 401 employees
- 440 volunteers

CareDimensions

Our Mission & Team

- Care Dimensions enriches quality of life for those affected by life-limiting illness, death and loss by providing exceptional care, support, education and consultation.
- Interdisciplinary hospice team – physician, nurse, chaplain, social worker, hospice aide, complementary therapies, trained volunteers



CareDimensions

Employee Demographics

- Full Time: 64% Part Time: 36%
- Female: 93% Male: 7%
- Average Age: 47
- Length of Service
  - < 5 years: 73%
  - > 5 to 10 years: 17%
  - > 10: 10%

Leader in Advanced Illness Care

- First free-standing licensed inpatient hospice facility in state; opened in Danvers in 2005
- Specialty programs -- cardiac, respiratory, dementia, pediatric
- Unique programs for Veterans, Jewish patients, developmentally disabled adults
- Expansive grief support programs
- Certified by Medicare, MA Dept of Public Health; Community Health Accreditation Program

Patient Volume

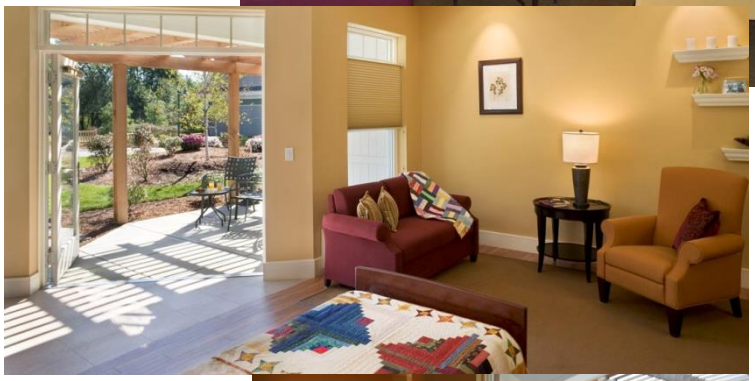
Average Daily Census – approx. 600 hospice patients/day

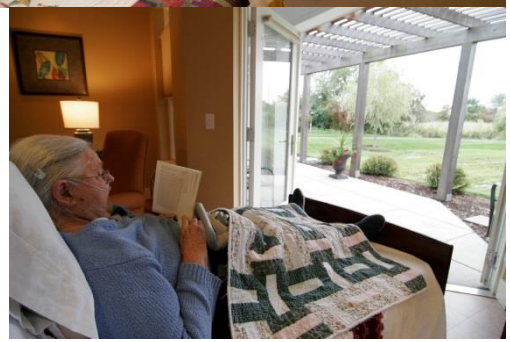
- Homes: 52%
- LTC: 31%
- Assisted Living Facilities: 13%
- Kaplan Family Hospice House: 4%

- 1500 palliative care visits in 2014

Inpatient Hospice House – An Alternative to Hospitalization

- Inpatient-level care provided in a home-like atmosphere
- For acute symptom management and end of life
- 20 private rooms
- Comfortable amenities for families – living rooms, playrooms, kitchen, gardens, chapel, library





CareDimensions

Workforce Training Grant

- In partnership with Regis College
- $249,974.37
- Award start February 1, 2015

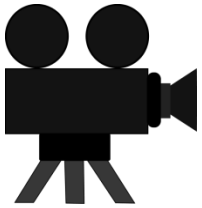
Workforce Challenges

Task in CH224	Our Challenge	Underlying Causes
Improve significantly the quality and efficiency of care provided to patients	Nurse Retention/Recruitment	Increased patient acuity Frequent nurse turnover Stress of professional isolation
Add/strengthen capacity to provide palliative care and end of life options	Cost	Up to a year to orient and prepare a newly hired nurse
Enable employees to work to the maximum capacity of their license/training to achieve increased efficiencies or improved quality of care	Specialty Care Training	Gap in professional education and clinical skills needed

Main Goals

- Draw a wider pool of interest with recruitment
- Retain experienced nurses
- Contain agency costs
- Increased use of whole interdisciplinary team

Grant Components



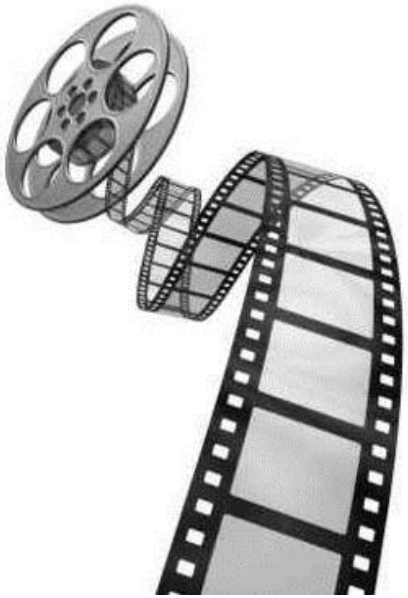
Video Modules

Hospice Nurse Residency

Preceptor Training

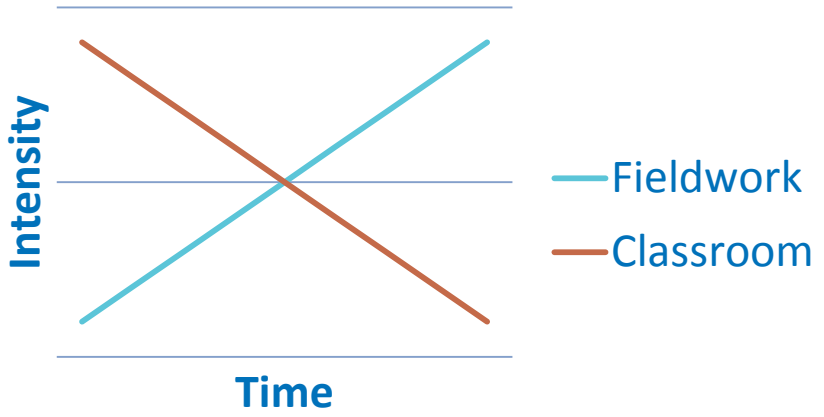
Video Modules

- Point of care education
- Available on iPhone anytime
- 20 topics



Hospice Nurse Residency

- Two groups of 6 nurses (12 total)
- New graduates and experienced RNs who are new to hospice and palliative care
- New graduates complete 6 month training; experienced RNs complete 3 month training
- Classroom/Fieldwork
- Emphasize interdisciplinary team work



CareDimensions

Preceptor Training

- RN Preceptor/Mentors
- Full day training at Regis
  - » Topics: New Graduate vs. Experienced RN
  - » Conflict Resolution
  - » Case Studies/Role Play
- Follow up training

Timeline

2015

- Begin grant infrastructure
- Preceptor Training
- Begin 1st cohort of nurse residents
- Develop and film video modules
- Upload videos to iPhones
- Hire 2nd cohort of nurse residents

2016

- Compile program evaluation from 1st cohort
- Start 2nd cohort of Hospice Nurse Residency
- Track video viewing
- Follow up Preceptor Training
- Complete 2nd cohort of Hospice Nurse Residency
- Begin overall program evaluation

2017

- Analysis and outcome measurement of the training grant
- Final report submission

<u>Beyond the grant:</u>

- Nurse Resident Graduates sit for Hospice and Palliative Care Certification
- Agency evaluation of Residency continuation

Outcome Measurement

- Measuring reaction and learning
  - » Completion of training
  - » Program evaluation
  - » Reflection
  - » Objective measurements of confidence, skills
- Measuring behavior
  - » Use of online video modules

Finding Appropriate Business Impact Measures

- The “so what”…
- How would you present to the Board of Directors that this is a successful model?
- Where does it impact the business bottom-line?

Original Business Impact Measures

- Rates of retention of all nurses annually
- Rates of retention of nurses who have completed the residency program
- Number of nurses who utilize these tools to prepare for national certification and pass.
- Impact on staff job satisfaction through regular survey work
- Scores on the five key patient family satisfaction measures with the goal to meet or exceed the respective national benchmarks and our current baseline measures.

Business Impact

1. Shorter time to full caseload for new nurses

   ***Initiated tracking**

   Baseline: 21.5 weeks

2. Increased visits by interdisciplinary team members for patients followed by nurse residency graduates

   Baseline: 2.61 social work and chaplain visits per patient per month

Thank you

Health Care Workforce Transformation Fund
Advisory Board
November 18, 2015
9:30 a.m. to 11:00 a.m.

Commonwealth Corporation
2 Oliver Street, Fifth Floor
Boston, MA 02109

1. **Welcome/Introductions**
   Undersecretary Ronald Marlow

2. **Overview of Behavioral Health Integration**
   Katherine Record, Deputy Director, Behavioral Health Integration & Accountable Care, Health Policy Commission

3. **Health Care Workforce Transformation Fund Grantee Presentation**
   Jane Simonds and Katherine Moss, Behavioral Health Network (Carson Center for Human Services)

4. **Update on the Health Care Workforce Transformation Fund Training Grants**
   Rebekah Lashman, Commonwealth Corporation

5. **Announcements**

COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

The Role of Behavioral Health Providers within Accountable Care Organizations

November 18, 2015

Agenda

- HPC's accountable care strategy
- HPC's certification programs
  - PCMH
  - ACO
  - CCBHC
- Implications of accountable care strategy for workforce
- Appendix

Agenda

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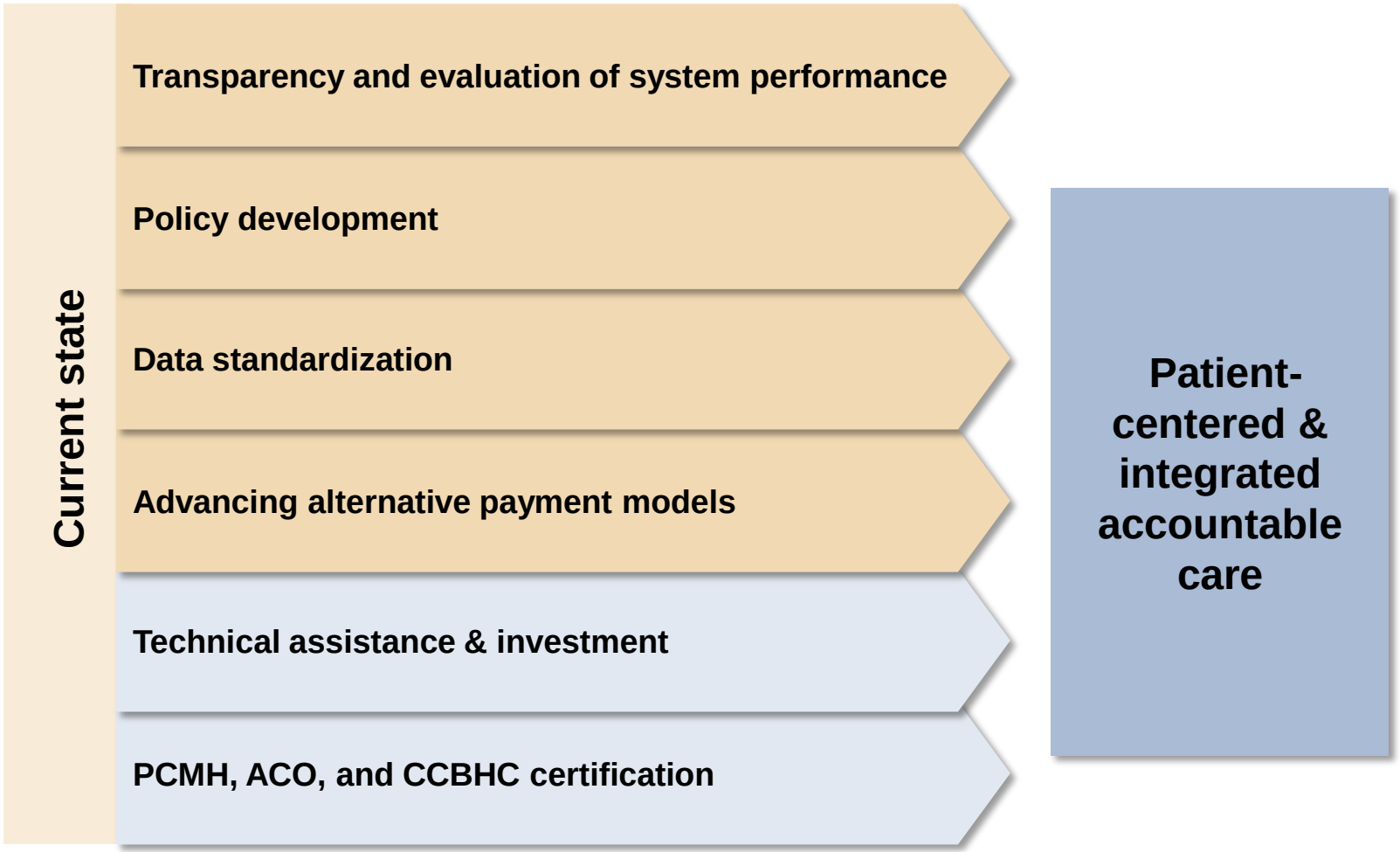
HPC's accountable care strategy



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HPC's PCMH certification program

HPC is promoting integration of BH into primary care. HPC certification requires NCQA PCMH accreditation, plus satisfying at least 7 of 13 BHI criteria

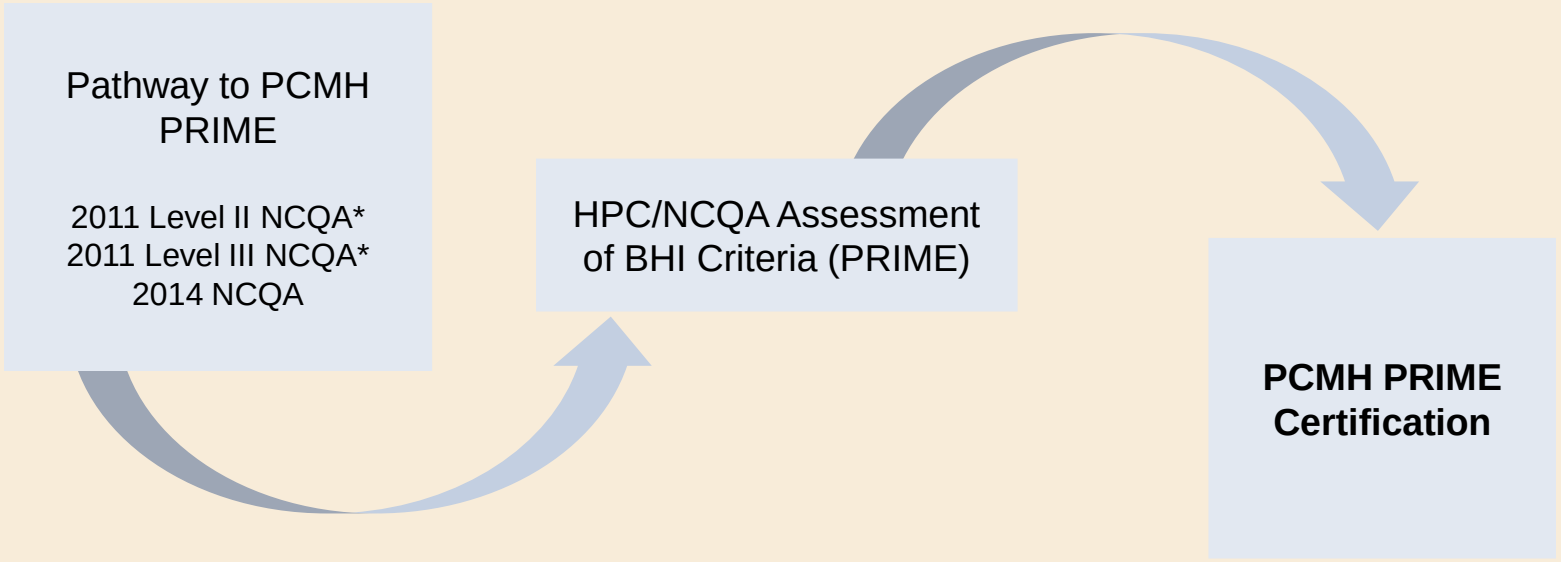
Practice has **MOUs** with – **or co-located** – behavioral health providers
Practice integrates behavioral healthcare providers within the practice site
Practice collects and regularly updates a comprehensive health assessment that includes **behaviors affecting health and mental health/substance use history of patient and family**
Practice collects and regularly updates a comprehensive health assessment that includes **developmental screening** using a standardized tool
Practice collects and regularly updates a comprehensive health assessment that includes **depression screening** using a standardized tool
Practice collects and regularly updates a comprehensive health assessment that includes **anxiety screening** using a standardized tool
Practice collects and regularly updates a comprehensive health assessment that includes **SUD screening** using a standardized tool (N/A for practices with no adolescent or adult patients)
For patients who have recently given birth, the practice screens for **post-partum depression** using a standardized tool (e.g., at 6 weeks and 4 months
Practice implements **clinical decision support following evidence based guidelines** for a mental health and substance use disorder
Practice establishes a systematic process and criteria for identifying patients who may benefit from **care management**. The process includes consideration of behavioral health conditions.
If practice includes a **care manager**, s/he must be qualified to identify/coordinate behavioral health needs
Practice has one or more PCPs on staff licensed to prescribe **buprenorphine**
Practice **tracks referrals** until the consultant or specialist's report is available, flagging and following up on overdue reports

HPC-created factor

“PCMH PRIME” recognition

Ongoing HPC Technical Assistance (content under development)

Practices achieve HPC PRIME recognition by demonstrating capacity in BHI (meeting HPC’s criteria) on a rolling basis (i.e., must meet 7 or more BHI criteria w/in given number of months after entering into technical assistance period)



May be modified and used for certification as health home

HPC certified ACOs must report on percent of participating practices that are PCMH PRIME, and describe and deploy plans to increase that rate

*Practices must convert to NCQA 2014 standards at end of their current 2011 recognition period

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ACO certification program goals

HPC is charged with developing **a voluntary certification program** to recognize accountable care organizations (ACOs), that will "encourage the adoption of integrated delivery systems in the Commonwealth for the purpose of **cost containment, quality improvement, and patient protection**".

1. Collaborate with providers, payers, and consumers to obtain feedback on ACO development and enabling policy development
2. Create a roadmap towards care delivery transformation – balancing the establishment of minimum standards with room (and technical support) for innovation
3. Establish an evaluation framework for data collection, information gathering, and dissemination of best practices to promote transparency
4. Enhance patient protection and engagement, including increasing patient access to services, especially for vulnerable populations
5. **Promote behavioral health integration by including BH-specific criteria, quality metrics, and technical assistance**
6. Align with payers' principles for accountable care (e.g., MassHealth and GIC)
7. Where possible, align with other state and federal programmatic requirements to minimize administrative burden for providers

HPC requirements related to ACO certification

Section 15 of Chapter 224 tasks the HPC with creating a **voluntary ACO certification program** meant to "**encourage the adoption of integrated delivery systems** in the commonwealth for the purpose of **cost containment, quality improvement, and patient protection**."

Additionally, the ACO certification program should be one that:

- Reduces growth of health status adjusted total expenses
- Improves quality of health services using standardized measures
- **Ensures access across care continuum**
- **Promotes APMs & incentives to drive quality & care coordination**
- Improves primary care services
- **Improves access for vulnerable populations**
- **Promotes integration of behavioral health (BH) services into primary care**
- Promotes patient-centeredness
- **Promotes health information technology (HIT) adoption**
- **Promotes demonstration of care coordination & disease mgmt**.
- Promotes protocols for provider integration
- **Promotes community based wellness programs**
- Promotes health and well-being of children
- **Promotes worker training programs**
- Adopts governance structure standards, including those related to financial conflict of interest & transparency

Proposed ACO certification approach

1 Mandatory Criteria:

- ✓ Legal and governance structures
- ✓ Risk stratification and population specific interventions
- ✓ Cross continuum network: access to BH & LTSS providers
- ✓ Participation in MassHealth APMs
- ✓ PCMH adoption rate
- ✓ Analytic capacity
- ✓ Patient and family experience
- ✓ Community health

2 Reporting Only Criteria:

- ✓ Palliative care
- ✓ Care coordination
- ✓ Peer support
- ✓ Adherence to evidence-based guidelines
- ✓ APM adoption for primary care
- ✓ Flow of payment to providers
- ✓ ACO population demographics and preferences
- ✓ EHR interoperability commitment

3 Market and Patient Protection

- ✓ Risk-bearing provider organizations (RBPO)
- ✓ Filing Material Change Notices (MCNs)
- ✓ Anti-trust commitment
- ✓ Patient protection

Mandatory criteria

ACOs must demonstrate that they meet these criteria in order to be HPC certified.

Criteria:

- ✓ Legal and governance structures
- ✓ Risk stratification and population specific interventions
- ✓ Cross continuum network: access to BH and LTSS providers
- ✓ Participation in MassHealth APMs
- ✓ PCMH adoption rate
- ✓ Analytic capacity
- ✓ Patient and family experience
- ✓ Community health
- ✓ Market and patient protection

Mandatory criteria relating to behavioral health integration

DRAFT - FOR DISCUSSION

Legal and governance structures

ACO governance structure provides for **meaningful participation of primary care, addiction, mental health (including outpatient), and specialist providers**.

Mandatory criteria relating to behavioral health integration

DRAFT - FOR DISCUSSION

Risk stratification and population specific interventions

The ACO has **approaches for risk stratification** of its patient population based on criteria including, at minimum:

- Behavioral health conditions
- High cost/high utilization
- Number and type of chronic conditions
- Social determinants of health

The approach *may* also include:

- Functional status, activities of daily living (ADLs), instrumental activities of daily living (IADLs)
- Health literacy

Using data from health assessments and risk stratification or other patient information**, the ACO designs programs** targeted at **improving health outcomes for its patient population. At least one of these programs addresses mental health, addiction, and/or social issues**.

Mandatory criteria relating to behavioral health integration

DRAFT - FOR DISCUSSION

Cross continuum network: access to BH and LTSS providers

ACO **demonstrates and assesses effectiveness of ongoing collaborations** with and referrals to:

- Hospitals
- Specialists
- Post-acute care providers (i.e. SNFs, LTACs)
- **Behavioral health providers (both mental health and substance use disorders)**
- Long-term services and supports (LTSS) providers (i.e. home health, adult day health, PCA, etc.)
- Community/social services organizations (i.e. food pantry, transportation, shelters, schools, etc.)

ACO has agreements with mental health providers, addiction specialists, and LTSS providers to address the needs of patient population. Agreements should reflect a categorized approach for services by severity of patient needs. These agreements should also include provisions for access and data sharing as permitted within current laws and regulations.

Mandatory criteria relating to behavioral health integration

DRAFT - FOR DISCUSSION

PCMH adoption rate

The ACO reports on **NCQA and HPC PCMH recognition rates** and levels (e.g., II, III) of its participating primary care providers.

The ACO describes a plan to **increase these rates, particularly for assisting practices to fulfill HPC's PCMH PRIME criteria.**

Reporting only criteria

The certification application will ask ACOs to describe whether they currently meet these criteria; if so, how; and if not whether they are or will consider working toward these criteria in the near term. This information will not be used by HPC to evaluate ACOs for certification in the first year, but will be collected for learning purposes and monitoring by the HPC, and may inform future updates to the certification program.

Criteria:

- ✓ Palliative care
- ✓ Care coordination
- ✓ Peer support
- ✓ Adherence to evidence-based guidelines
- ✓ APM adoption for primary care
- ✓ Flow of payment to providers
- ✓ ACO population demographics and preferences
- ✓ EHR interoperability commitment

Reporting only criteria relating to behavioral health integration

DRAFT - FOR DISCUSSION

Care coordination

The ACO has a process to **track tests and referrals across specialty and facility-based care both within and outside of the ACO**.

The ACO demonstrates a process for identifying **preferred providers**, with specific emphasis to increase use of providers in the patient's community, as appropriate, specifically for:

- oncology
- orthopedics
- pediatrics
- obstetrics

The ACO has a process for **regular review of patient medication** lists for **reconciliation** and **optimization** in partnership with patients' PCPs.

Reporting only criteria relating to behavioral health integration

DRAFT - FOR DISCUSSION

Care coordination

The ACO assesses current capacity to, and develops and implements a **plan of improvement** for:

- sending and receiving **real-time event notifications** (admissions, discharges, transfers)
- utilizing **decision support rules** to help direct notifications to the right person in the ACO at the right time (i.e., prioritized based on urgency)
- setting up **protocols** to determine how event notifications should lead to changes in clinical interventions

Reporting only criteria relating to behavioral health integration

DRAFT - FOR DISCUSSION

Peer support & adherence to evidence-based guidelines

The ACO provides patients and family members access to **peer support programs**, particularly to assist patients with chronic conditions, complex care needs, and behavioral health needs. The ACO also provides training to peers as needed to support them in performing their role effectively.

The ACO monitors **adherence to evidence-based guidelines** and identifies areas where improved adherence is recommended or required. The ACO develops initiatives to support improvements in rates of adherence.

Reporting only criteria relating to behavioral health integration

DRAFT - FOR DISCUSSION

APM adoption for primary care & flow of payment to providers

The ACO reports the **percentage of its primary care revenue *or* patients that are covered under outcomes-based contracts**.*

The ACO **distributes funds** among participating providers using a methodology and process that are **transparent** to all participating providers. Documentation must include both a description of the methodology and a demonstration of communication to all participating providers.

**Outcomes-based contracts are those that require a provider to accept a population-based contract centered on either a spending target (shared savings only) or a global budget (including down-side risk).*

Reporting only criteria relating to behavioral health integration

DRAFT - FOR DISCUSSION

ACO population demographics & preferences

The ACO assesses the **needs and preferences** of its patient population with regard to **race, ethnicity, gender identity, sexual preference, language, culture, literacy, social needs (food, transportation, housing, etc.), and other characteristics** and develops plan(s) to meet those needs. This includes provision of interpretation/translation services and materials printed in languages representing the patient population (5% rule).

Reporting only criteria relating to behavioral health integration

DRAFT - FOR DISCUSSION

EHR interoperability commitment

ACO **identifies network certified electronic health record (EHR) adoption** and integration rates within the ACO by provider type/geographic region; **and develops and implements a plan to increase adoption and integration** rates of certified EHRs.

ACO identifies current **connection rates to the Mass HIway** and has a plan to improve rates over next year.

Agenda

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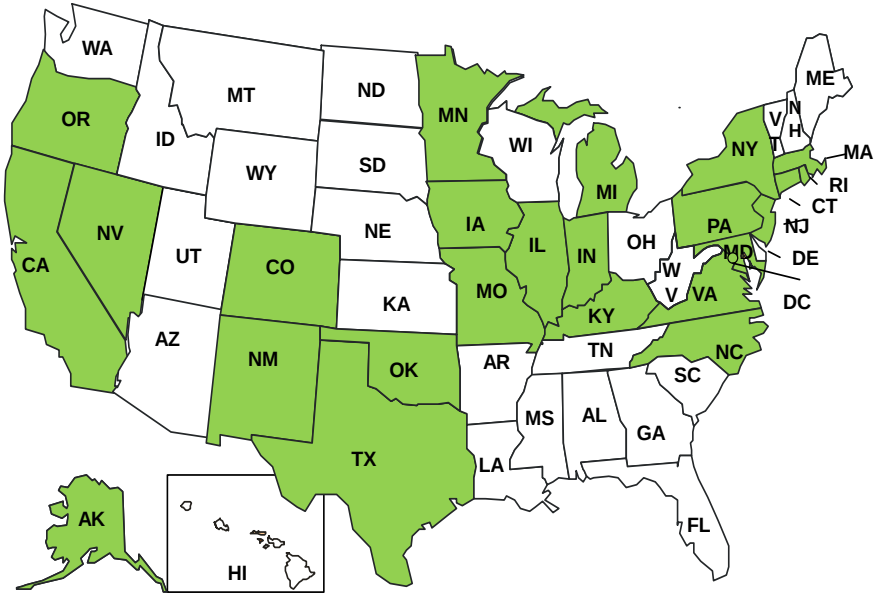
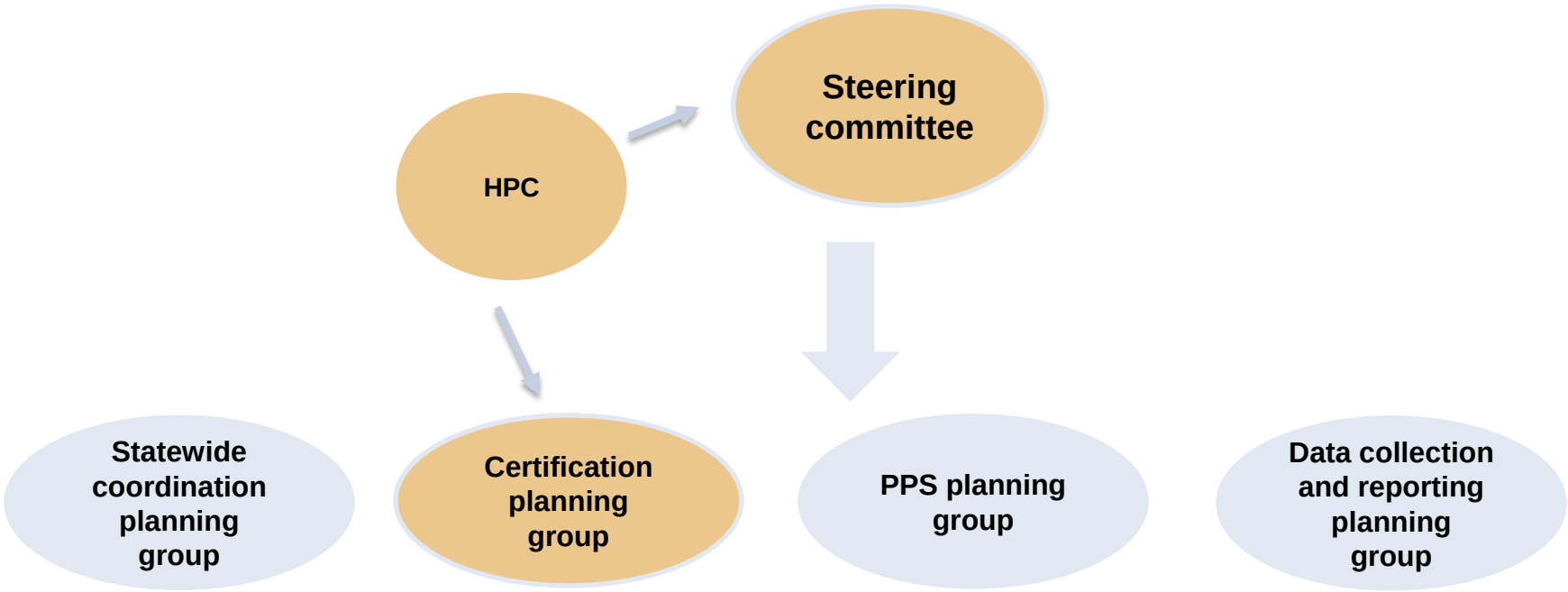
Certified Community Behavioral Health Clinics (CCBHCs)

- MA received $982,373 **planning grant** to design **certification and prospective payment system** for behavioral health clinics
- **HPC, DPH, MassHealth, and DMH** charged with designing demonstration program (increased FMAP) to launch in 2017

24 States Awarded Planning Grants for CCBHCs



MA CCBHC planning team



- Coordination of grant activities at the state level
- State Steering Committee process and composition
- Establish CCBHC governance requirements
- Establish required evidence-based practices
- **Establish staffing requirements**
- Select CCBHC sites

- Certify clinics
- Develop certification tools
- Approve needs assessments
- Crisis response waivers
- **Provide training**
- **Set staffing requirements**

- Operationalize PPS - determine fee for service rates and managed care payment
- CMS CCBHC cost report orientation
- TA on treatment of select items of cost
- TA on determining population-specific rates
- TA on outlier and quality bonus payments
- FMAP TA on direct service vs. administrative costs

- Data collection requirements (quality measures and claims/ encounter data)
- Obtain input from states on the design of the national evaluation including comparison group design

CCBHC certification goals

- Create application processes and review procedures for clinics seeking certification
- Develop certification tools
- Certify at least 2 CCBHCs (1 rural, 1 urban)
  - Assist clinics to meet standards
  - Verify CCBHCs receive input from patients & family members of patients
- Plan for recruitment, training, & development of CCBHC workforce (ensuring cultural diversity and competence)

For each beneficiary enrolled in a CCBHC, state receives increased FMAP for all billable services (versus solely care coordination services – health home model)

- 65% federal match instead of 50% for adults
- 88% federal match for children

How Massachusetts CCBHC planning will be assessed

Performance measures
# of organizations implementing BH training programs as result of planning grant
# of people newly credentialed to provide BH services
# of financing policy changes made as result of grant
# of communities that establish IT system links across multiple agencies
and % of advisory group members who are patients or family members
of policy changes completed as a result of the grant
# of organizations collaborating / coordinating resources as result of grant

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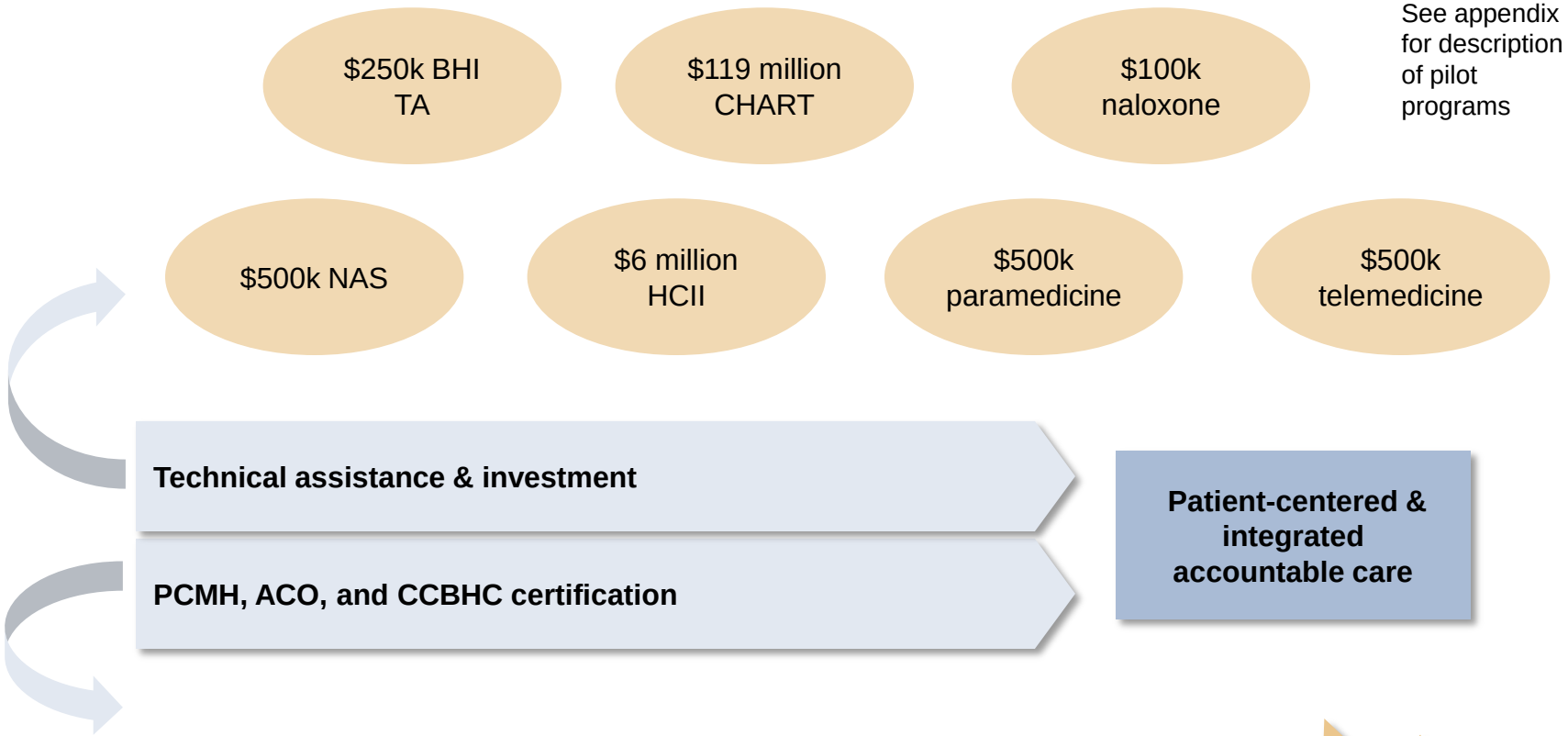
HPC's accountable care strategy – implications for workforce



- Number of MassHealth patients served by HPC certified PCMHs and ACOs will increase by 80% by 2019*
- Adoption of alternative payment models (APMs) (required by certification programs) will change workforce reimbursement structures

BH workforce development is essential for an accountable care system

*Massachusetts State Innovation Model Operational Plan, Model Test Year 2, Nov. 2, 2015

Federal efforts to build health care workforce

SAMHSA-HRSA Center for Integrated Health Solutions is addressing workforce gaps as systems work to integrate behavioral health

1. Expand the role of consumers and their families to participate in, direct, or accept responsibility for their own care
2. Expand the role and capacity of communities to identify local needs and promote health and wellness
3. Implement systematic federal, state, and local recruitment and retention strategies
4. Increase the relevance, effectiveness, and accessibility of training and education
5. Actively foster leadership development among all segments of the workforce
6. Enhance available infrastructure to support & coordinate workforce development efforts
7. Implement a national research and evaluation agenda on workforce development

BHI loan forgiveness programs

Up to **$50,000** awarded towards student debt

Eligible disciplines:

- Allopathic and Osteopathic Physicians - Psychiatry (MD or DO)
- Health Service Psychologists (HSP)
- Licensed Clinical Social Workers (LCSW)
- Licensed Professional Counselors (LPC)
- Marriage and Family Therapists (MFT)
- Psychiatric Nurse Specialists (PNS)
- Nurse Practitioners - Mental Health (NP)
- Physician Assistants - Mental Health (PA)

*National Health Service Corps & MA state loan repayment program

https://nhsc.hrsa.gov/loanrepayment/

Clinical training on BHI for students entering social work field

Council on Social Work Education Social Work and Integrated Behavioral Healthcare Project*

Curriculum modules include:

- Introduction to Integrated Healthcare and the Culture of Health
- The Role of Social Work in Integrated Healthcare
- Comprehensive Assessment
- Structured Assessments and Screenings
- Common Behavioral Health Conditions in Primary Care
- Cross-Cultural Issues in Integrated Healthcare
- Medication and Integrated Healthcare
- Care Planning and Documentation
- Interventions in Integrated Healthcare
- Motivational Interviewing

Clinical field placement experience at integrated care settings (students receive $10k stipend for completing integrated practicum)

*Funding from SAMHSA-HRSA Center for Integrated Health Solutions

http://www.cswe.org/CentersInitiatives/DataStatistics/58020.aspx

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Naloxone Pilot Program

Develop training and TA to improve capacity and ability for PCPs to prescribe naloxone (Narcan)

FY 2016 Budget Initiatives

$100,000 → **PCPs across the Commonwealth**

Summary of Statute

- HPC is to develop training and TA program to **improve and expand capacity and ability of PCPs to co-prescribe naloxone** & to **identify and educate at-risk patients and family members** about administration protocol
- PCPs participating in training may receive supply of naloxone
- HPC to report to joint committee on mental health and substance abuse and the house and senate committees on ways and means 12 months following completion of pilot program

Objectives

1. Stand up pilot program for **training and TA for PCPs to prescribe naloxone**
2. **Prevent deaths by opioid overdose** in every county of the Commonwealth by **expanding PCP capacity to engage with peers/family of at risk individuals about naloxone**

Key Dates

Q3-Q4'15	Q1-Q2'16	Q3-Q4'16	Q1-Q2' 17
Stakeholder engagement Define eligibility	Issue RFP Select participants Identify trainers	Implement trainings Distribute naloxone if applicable	Evaluate & report on outcomes

Sustainability

Neonatal Abstinence Syndrome Pilot Program

Implement a fully integrated model of post-natal supports for families with newborns exhibiting NAS

FY 2016 Budget Initiatives

$500,000 → **Eligible birthing hospitals**

Summary of Statute

HPC is to implement a fully **integrated model** of post-natal supports for families with newborns exhibiting NAS (neonatal abstinence syndrome)

- obstetrics and gynecology
- pediatrics
- behavioral health
- social work
- early intervention providers
- social service providers to provide full family care

- Model to be informed by **evidence-based practices** and consultation with **DPH & DCF**

Objectives

1. **Identify emerging best practices** around inpatient treatment of and post-discharge follow-up on NAS
2. **Reduce LOS** associated with NAS by increasing adoption of best practices (e.g., breastfeeding, rooming-in protocols); **reduce costs** while ensuring readmission rates also decline (or do not increase)

Key Dates

Q3-Q4'15	Q1-Q2'16	Q3-Q4'16	Q1-Q2' 17
Align with DPH's federal grant on NAS Define scope of intervention Issue RFP	Notify grantees Implement inpatient QI bundles		Evaluate & report on outcomes Disseminate learnings to all birth hospitals in Commonwealth

Sustainability

Behavioral Health Integration TA

Support BHI efforts in patient centered medical homes

FY 2016 Budget Initiatives

$250,000 → **HPC PCMH Certified Sites**

Summary of Statute

- HPC to establish a program to **accelerate and support BHI** within practices **on path to HPC PCMH certification**
- Will support efforts to **build the partnerships & infrastructure** needed to **initiate or expand the provision of BH services within primary care settings** and may take form of training, education, TA, or direct grants

Objectives

1. **Accelerate and support BHI** within PCMH's on path to HPC certification
2. Increase capacity to **meet HPC BHI criteria** that supplements NCQA PCMH criteria (e.g., diagnostic screenings, care coordination, buprenorphine waivers)

Key Dates

Q3-Q4'15	Q1-Q2'16	Q3-Q4'16	Q1-Q2' 17
Define TA opportunities Seek provider feedback on TA prioritization	Identify providers eligible for TA Initiate TA trainings Convene providers across the state regardless of PCMH status to disseminate learnings		Evaluate and report on efficacy of TA in accelerating BHI in primary care settings

Sustainability

Quincy Community Paramedicine Pilot

Innovative health care pilot in Quincy to treat patients with mental health or substance use disorders

FY 2016 Budget Initiatives

$500,000 → **EMS, BH Providers, CHCs, and Hospitals in Greater Quincy**

Summary of Statute

- HPC is to implement model of **field triage of behavioral health patients** under medical control by specially-trained **emergency medical services** providers
  - Care for appropriate patients at **home** by such providers in coordination with behavioral health care providers,
  - **Transport** of appropriate, non-medically complex patients to a behavioral health site of care
- Pilot in the greater **Quincy** area affected by the recent hospital
- Pilot to be evaluated on its effectiveness, efficiency, and sustainability by HPC

Objectives

1. Test currently **non-reimbursed payment** for innovative model of field triage, direct care by EMS, and ED bypass for complex BH patients
2. Reduce **ED boarding** and hospital crowding to increase access and decrease cost

Key Dates

Q3-Q4'15	Q1-Q2'16	Q3-Q4'16	Q1-Q2' 17
Pilot Planning & Community Engagement	Pilot Implementation and Rapid-Cycle Testing		Evaluation

Sustainability

Telemedicine Pilot

A 1-year regional pilot program to further the development and utilization of telemedicine in the commonwealth

FY 2016 Budget Initiatives

$500,000 → **Community-based providers and telehealth suppliers**

Summary of Statute

- The HPC is to develop and implement a one-year **regional telemedicine pilot** program to advance use of telemedicine in Massachusetts.
  - The pilot shall **incentivize** the use of **community-based providers** and the delivery of patient care in a **community setting**
- To foster partnership, the pilot should facilitate **collaboration** between participating **community providers and teaching hospitals**
- Pilot is to be evaluated on cost savings, patient satisfaction, patient flow and quality of care by HPC

Objectives

1. Demonstrate **cost savings potential** of telemedicine
2. Implement telemedicine model that preserves or improves **quality and patient satisfaction**
3. Develop **multi-provider (regional) partnerships** related to telemedicine

Key Dates

Q3-Q4'15	Q1-Q2'16	Q3-Q4'16	Q1-Q2' 17
Pilot Planning & Community Engagement	Pilot Implementation and Rapid-Cycle Testing		Evaluation

Sustainability

Health Care Innovation Investment Program

A multi-phase grant program for eligible payers/providers to execute new and innovative health care delivery models

Chapter 224 Initiatives

$6M

Foster innovation in health care payment and delivery

Summary of Statute

- The HPC is to **develop** and **implement** a **new grant program** centered on health care innovation
  - The grant program will be **one-of-a-kind at the HPC** in that it will seek to innovate health care in **previously unused methods**
  - The program will also be **leveraged and aligned** with other funding streams (i.e. CHART, DSTI, etc.)
- To **foster widespread innovation**, the program will encourage payers and providers to work together on grants
- The program is to be evaluated on **cost savings, patient satisfaction, and dissemination of best practices**

Objectives

1. **Support** and further efforts to meet the **health care cost growth benchmark**
2. **Improve overall quality** of and **access** to the health care delivery system
3. Increase the **diverse use** of incentives, investments, TA, and other unique partnerships

Key Dates

Q3-Q4'15	Q1-Q2'16	Q3-Q4'16	Q1-Q2' 17
Pilot Planning & Community Engagement	Application Review & Launch		Evaluation and Dissemination

Sustainability

Contact information

For more information about the Health Policy Commission:

Visit us: http://www.mass.gov/hpc

Follow us: @Mass_HPC

E-mail us: HPC-Info@state.ma.us

Three-Pronged Approach to Medical Integration

Carson Center, a Program of BHN, Inc.
Jane Simonds, LICSW
Katherine Moss, Ph.D.
November 18, 2015

Agency Overview

- Carson Center:
  - Westfield Area MH Center in 1963
  - Re-named Carson Center in 1990s
- Full-service BH provider
  - Mental health, wellness, and education services
  - All ages
  - Greater Westfield and Ware (Quaboag Hills) regions
  - OP & SUD services, CBHI, CBFS, DV, TBI, DDS services, EI, and Early Childhood Education & Care, etc.

Agency Overview (cont'd)

- Merged with BHN, Inc., July 2015
  - Increased catchment area: Pittsfield to western Worcester County
  - Expanded range and depth of services
  - 1800 employees. $85 million budget
  - Affiliated with 15 PCP sites & Health Centers in Westfield, Springfield, Holyoke, and Ware.
  - Reverse integration SAMHSA pilot in Springfield

Medical Integration

- What is it?
- Why do it?
- How to do it?

A Legacy of Separate and Parallel Systems

Medical Care

Mental Health Care

A forced choice between:

- 2 kinds of problems
- 2 kinds of clinicians
- 2 kinds of clinics
- 2 kinds of treatments
- 2 kinds of insurance

Led to fractured care, duplicative care, contraindicated care, poor care or no care.

Original Source: CJ Peek 1996

So…

What is Medical Integration?

Medical Integration– One Person, One Team, One Plan

- Integrating behavioral health into primary care health home
- Integrating primary care into behavioral health home
- Coordinating care between providers
- Connecting health goals with community supports

So…

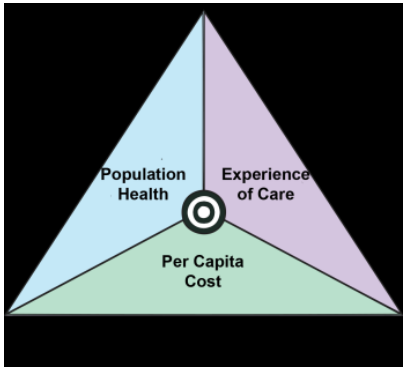
Why Medical Integration?

Specifically,

Why integrate behavioral health with primary care?

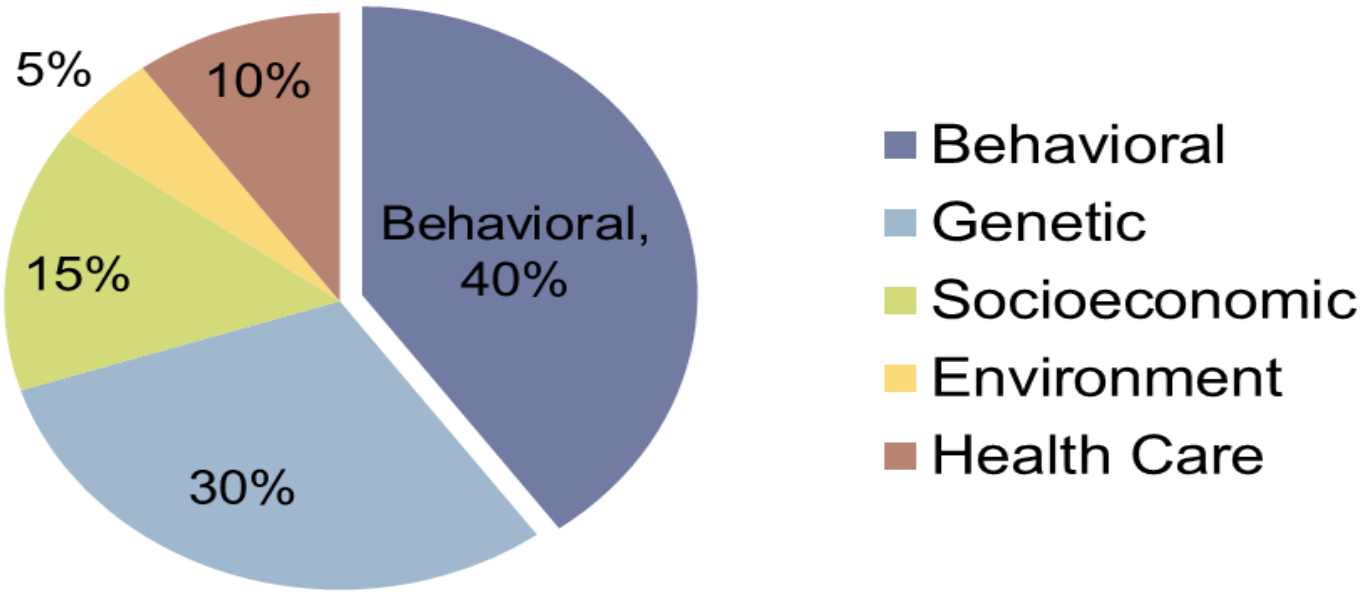
1. **High prevalence** of behavioral health problems in primary care (needing long-term follow-up)
2. **High burden** of behavioral health in primary care
3. **High cost** of unmet behavioral health needs
4. **Lower cost** when behavioral health needs are met
5. **Better health** outcomes
6. **Improved satisfaction**

Behavioral health integration achieves the triple aim.



Prevalence

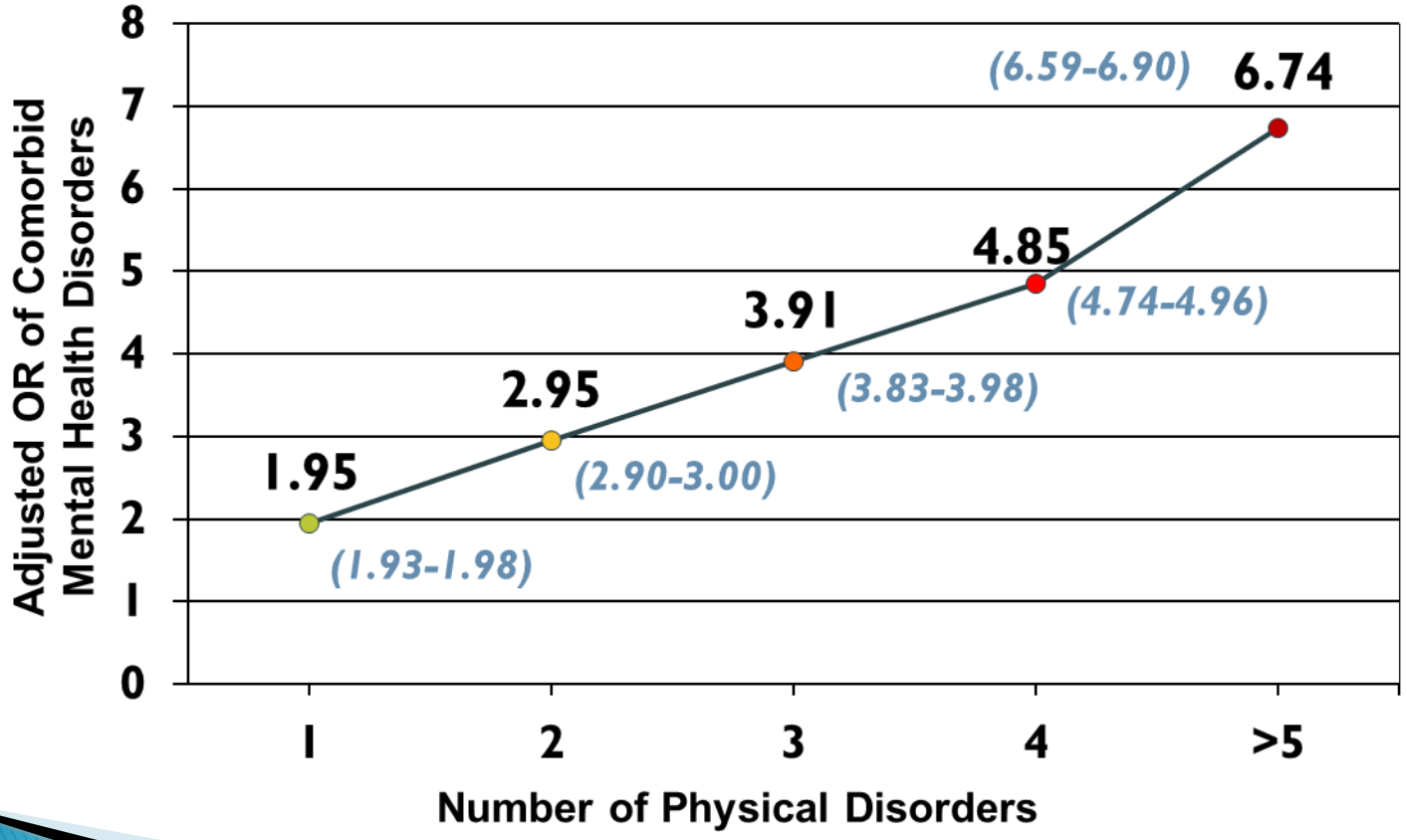
Leading Determinants of Overall Health are Behavioral[1,2]



Sources: [1]McGinnis JM et al. JAMA 1993; 270:2207-12. [2]Mokdad AH, et al. JAMA 2004; 291:1230-1245.

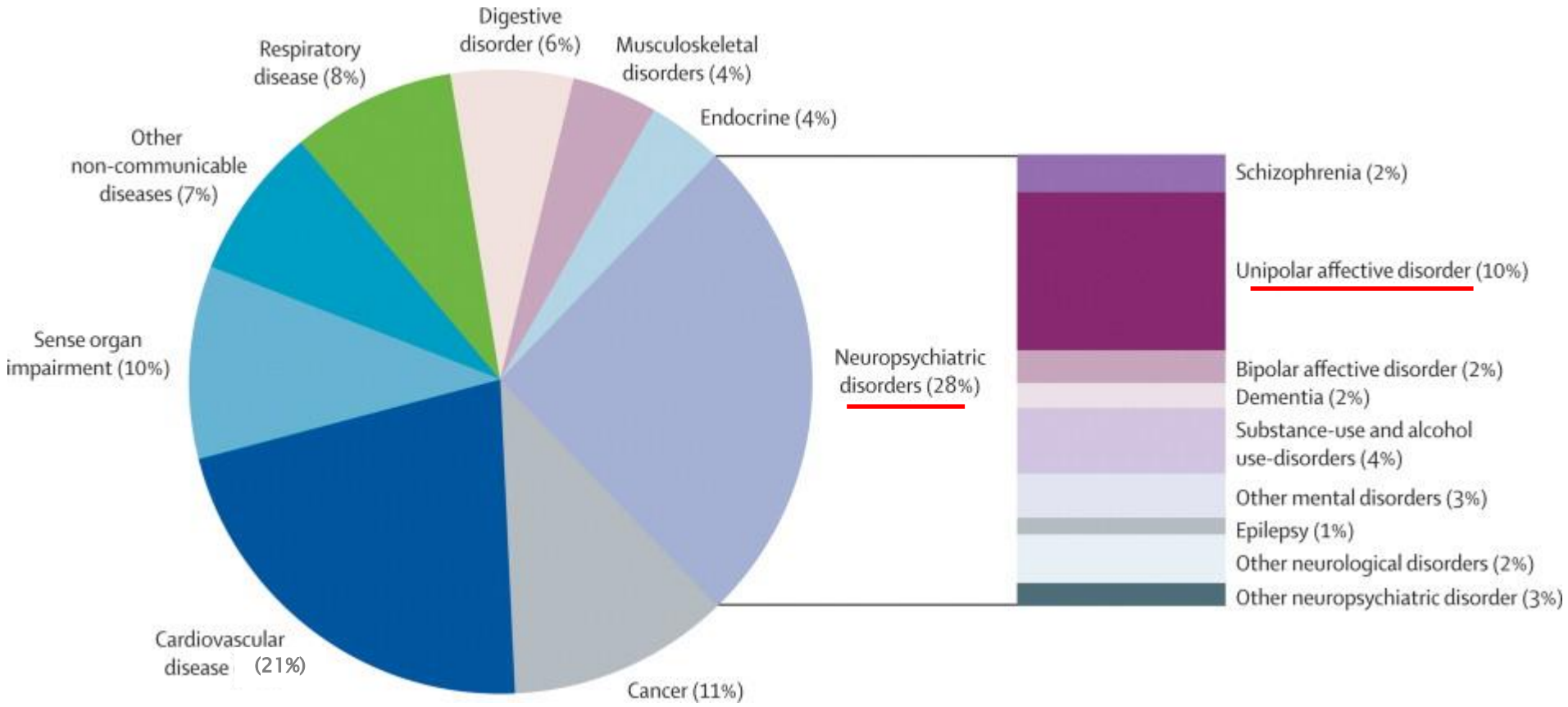
Prevalence

As physical health worsens, the odds of having mental illness increase.



Source: Barnett et al, Lancet 2012

Unmet Behavioral Health Needs



Behavioral health conditions account for the largest proportion of years of productive life lost (YPLL).

Source: Martin et al., Lancet. 2007; 370:859-877

Lower Cost when Behavioral Health Treated

- **Medical use decreased 15.7%** for those receiving behavioral health treatment while medical use increased 12.3%[1] for controls who did not receive behavioral health treatment
- Depression treatment in primary care for those with diabetes resulted in **$896 lower** total health care cost over 24 months[2]
- Depression treatment in primary care resulted in $3,300 lower total health care cost over 48 months[3]
  - This resulted in a **return of $6.50 for every $1 spent**
- Multi-condition collaborative care for **depression** and **diabetes** saved **$594 per patient** over 24 months.[4]

Sources: [1]Chiles et al., Clinical Psychology. 1999;6:204-220. [2]Katon et al., Diabetes Care. 2006;29:265-270. [3]Unützer et al., American Journal of Managed Care 2008;14:95-100. [4]Katon et al. Arch Gen Psych. 2012;69:506-514

So…

How Implement Medical Integration?

Successful Implementation Requires Additional/ Alternative Funding

- **Highly trained, *re-trained* workforce**: Significant additional training expense and higher salary than standard grade

- **Low show rates; services not FFS billable**: Lower FFS productivity = lower revenue

$$$ Needed

- **Close partnerships**: More administrative time to build and maintain partnerships
- **New models**: More administrative time to build, modify and gather data.
- **Financial implications**: decreased revenue, increased expense. Not sustainable without contract/ grants or funding restructuring.

Plus Education & Training

Successful Implementation Requires Re-Trained Workforce

- **Align specialty BH skills and practice routines with PCP, creating new level of BH care**
  - Brief BH screening, assessment, consultation
  - Team-based service delivery
  - Use of BH skills to promote positive health behaviors in patients co-morbid diseases
  - Brief BH treatment: "How can I add value today for this patient with anxiety who I may not see again?

Re-Trained Workforce

- Transform BH outreach workforce into a whole health outreach workforce, akin to community health workers

Carson Center/ BHN Strategic Approach to Medical Integration

- Seek grant funding to support substantial expense of retraining workforce
- Partner with insurance agencies to explore alternative payment options
- Invest capital in developing models and implementation, with the expectation of future return on investment

Guiding Principles for Carson Center's Medical Integration (MI) Initiative

- Optimal health care occurs at the intersection of behavioral and physical health
- No wrong door for services
- BH broadly defined
  - Diagnosable mental health conditions
  - Health behaviors that impact physical and mental health
- Concurrent screening and clinical expertise in the treatment of SUDs
- Must beTrauma-Informed—implications of ACE study for whole health care

Commonwealth Corporation Workforce Transformation Grant – Scope and Goals

- **Goal**: Launch local adult and child health care practices that can skillfully integrate behavioral health and medical services at multiple access points
- **Access Point 1**: ***Primary Care Behavioral Health***: Improve early detection and intervention by training BH clinicians and PCPs in PCBH, and piloting PCBH integration. Includes real-time access to BH/SUD screening and brief interventions during PCP visits

Scope & Goals for Grant Project (cont'd)

- **Access Point 2**: *Integrate Outreach Workforce*: Train existing BH outreach workforce in whole health care monitoring, coaching, & coordination. Thereby expand reach of PCP via weekly community contact with youth and adults with SEDs and SPMI as well as chronic medical conditions;
- **Access Point 3**: *Increase Medical Assistant Capacity* Train up 1-2 admin support staff to become medical assistants in a BHN medication clinic. Help psychiatrists monitor patient physical as well as behavioral health.

Anticipated Outcomes

- **Access Point 1**: Increase patient initiation and engagement rates in BH and/or SUD services by 20 % from baseline of 15%, reducing healthcare costs for those patients by 5%
- **Access Point 2**: Increase competency and practice of integrated care coordination and outreach activities with shared PCP patients by 30%, resulting in improved care and healthcare savings of 3% for the patients
- **Access Point 3**: Save up to $30,000 in potential unemployment claims and then $30,000 or more annually in healthcare delivery costs by training up 1-2 support staff at risk of lay-off into MA positions.

What Led to Application for Grant

- 80% of the US population in need of BH/SU treatment are more likely to go to PCPs for help than to specialty BH/SU clinics
- PCPs prescribe 80% of anti-depressants prescribed in US and 67% of all psychotropic medications
- BH needs to do a better job of reaching people in health care settings they frequent

High BH/SU Traffic in PCPs

- **The local PCP survey numbers**:
  - 26% of patients in our partner PCP practices have at least one observable BH/SU problem (range 20-35%), 1000-3000 patients depending on practice size
  - PCPs spend an average of 14 minutes longer than the15 min allotted on 44% of patient visits (range 25-75%)
  - BH/SU account for 50% of the longer visits
  - PCPs refer 13% of patients with observable BH/SU to specialty care; 85% receive no follow-up care

What the Survey Numbers Mean

At PAHC with 2 sites, 10,000 patients and 37,850 annual patient encounters:

- 8,327 patient encounters longer because of BH/SU
- PCPs spend 115,318 extra minutes annually, equivalent to 7,688 additional 15 min PCP visits
- PCP is the treatment of choice for adults and families with BH/SU
- PCPs spend a great deal of time treating BH/SU they are neither paid nor trained to treat—and all in the midst of a PCP shortage

High Cost of Health Care Silos

- Numbers don't tell the many stories of ineffective and costly health care delivered in silos
- Inefficacy of depression treatment in PCP practices
- Inefficacy of physical health treatment in BH – Story of "Jim" and "Mary"

Carson Grant Activities, to date (pre-merger)

- Candidate for certified medical assisting selected & now in MA training
- 3 OP clinicians and 6 PCP physician leaders and practice managers trained in PCBH; 4 more clinicians currently in training
- 17 BH care coordinators and outreach workers trained in Integrated Care Management
- Health Literacy trainings launched in August 2015—5 additional monthly trainings scheduled, November through March

Project Barriers & Adaptations

- Staff recruitment challenges for PCBH and ICM trainings; Spring 2015 training undersubscribed.

  ADAPTATION: increase outreach to teams/ staff education about the role of BH in transforming healthcare; scale back project size

- UMass CIPC training in ICM provided great information about how to promote health and coordinate care within PCP sites, trainees wanted more information about this work *in the community*.

  ADAPTATION: re-direct grant funds to develop internal community-focused ICM model. Makes training more relevant and sustainable.

Project Barriers & Adaptations (cont'd)

- Staff recruitment challenges for PCBH pilots: compensation, the challenge of fit for PCBH level of care.

  ADAPTATIONS: creative monetary incentives; applying lessons learned about fit

- Sustainability of skill set post-training: 2 of 4 PCBH trainees from Spring 2015 have left agency.

  ADAPTATIONS: focus on workforce retention efforts AND re-directing grant funds to build internal, replicable training curriculum.

Project Barriers & Adaptations (cont'd)

- Loss of Baystate PCP partners mid year

  ADAPTATION: Found new partners and continued negotiations with Baystate about PCP pilot

- Delay in delivering Health Literacy 101 trainings. Underestimated the time and labor required to develop the trainings, leaving less time for multiple trainings.

  ADAPTATION: Film the trainings to extend their reach and the number of trainings offered across BHN

Project Barriers & Adaptations (cont'd)

- Unanticipated merger slowed training progress. Carson staff focused on adapting to new electronic health record and new policies/ procedures.

  ADAPTATION: Used the time to convene PCBH and ICM design teams to work on developing internal practice models and identifying staff training needs

- Only 1 of 2 support staff is training for medical assisting roles. Seven initially applied, but only 2 were able to take on the commitment.

  ADAPTATION: recruit and hire 2nd MA from outside the agency.

Accomplishments & Milestones

- Flexibility—adapt the scope and scale of proposed projects to meet realities on the ground (thanks also to Commonwealth Corporation!)
- Sowing the seeds of behavioral healthcare transformation & cultivating a BH workforce increasingly savvy to health care integration
- Merger with BHN—and deepening coordination with the seasoned BHN Medical Integration Team
- Baystate Health's recent agreement to partner on a PCBH pilot in their Westfield medical practices
- Hospitals, PCP sites, and health centers increasingly eager to partner with community-based BH services

BHN Medical Integration
(pre-merger)

Site- type	Site- #	FTE of PCBH	Warm hand-off per month	Scheduled visits per month
FQHC	1	2.5	99	106
Hospital community health center	4	2.5	118	190
Large group practice	2	1.5	10	16
Small group practice	3	1	10	16

Grant Activities Moving Forward

Build Sustainable Internal Training Plan:

- PCBH:
  - PCBH Design Team established
  - Team developing internal PCBH training curriculum.
    - Initial 5 hour basic training
    - Support model: shadow, mentor and supervision
    - 7 Booster trainings, 4 hours each, on advanced topics.
  - Team and coordinator embedding training in broader agency on-boarding protocol.

Moving Forward, cont.

Sustainable Internal Training Plan:

- **ICM:**
  - ICM Design Team established
  - Team and Coordinator creating internal ICM curriculum designed for outreach BH workforce

Moving Forward, cont.

Integration Partnerships/ Implemention

- **PCBH:**
  - Implement at PAHC
  - Cultivate relationship and build workflows with adult practice.
- **ICM:**
  - Cultivate relationship and build workflows for ICM at two adult practices.

Moving Forward, cont.

- **Reinforce Training and Install Skills**
  - On-going training support
  - Booster/ expert trainings for PCBH and ICM
  - Will include legacy BHN and Carson workforce

- **Measure Outcomes and Impact**