MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

NH DSRIP
An initiative of the NH Department of Health and Human Services
Care Transitions · Building Capacity · Integration
Transforming Healthcare in the Granite State

ALL-IDN MONTHLY B1 LEARNING COLLABORATIVE

JUNE 7, 2019

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MEETING GOALS

- Identify and discuss **approaches and workflows** that IDN partners are using to **administer the CCSA** in their practices.
- Learn from your peers and in a facilitated panel discussion, **strategies to address challenges** when implementing the CCSA.
- Ensure awareness of technical assistance materials developed and available to support IDN staff.

AGENDA

- Spotlight
- Action Item Follow-up
- Comprehensive Core Standardized Assessment
- Panel Discussion
- Topic for August Meeting
- Technical Assistance Update
- Next Steps

DSRIP SPOTLIGHT

IDN2 - Epsom Family Medicine

- Conducted a case review of one patient that was identified through Collective Medical (CM) as having more than 5 Emergency Department (ED) visits in the past 3 months.
- There was an opportunity to drill down in the CM portal and present data to the provider.
- As a result, follow up will now be conducted on patients with 3+ ED visits with their individual provider and planning on reviewing one case each month with the provider team for a patient with excess number of ED visits over the past year.
- Concord Family Medicine is also beginning these meetings. Both practices will loop in with the Complex Care Coordinator

COMPREHENSIVE CORE STANDARDIZED ASSESSMENT(CCSA)

- Let's continue to connect the dots…..

CONTRIBUTORS TO HEALTH OUTCOMES

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity

PURPOSE OF THE CCSA

- **Screen** Medicaid Members.
- **Discover unmet needs-** assess for vulnerability.
- Use as the basis for an **individualized care plan** used by the **care team to guide** the treatment and management of the target population.
- **Connect members to a range of supports** for physical, behavioral, and social determinants of health.
- **Improve care** for complex members.
- Follow-up to **positive screening results.**

IDENTIFYING PATIENT NEEDS

- Vulnerability vs. Risk
- Assessment Tools
  - **CCSAs**
  - Arizona Self-Sufficiency Matrix
  - PRAPARE
  - CANS/ANSA
  - Service Utilization (claim, agency contact & self-report)

NH DSRIP STCS: COMPREHENSIVE CORE STANDARDIZED ASSESSMENT (CCSA)

- Use of the **CCSA process and care plan that will be shared among core team members.** The assessment process (conducted at a **minimum annually**) will be the basis for an individualized care plan used by the care team to guide the treatment and management of the target population.

- The assessment will include the following domains: demographic, medical, substance use (including tobacco use), housing, family & support services, education, employment and entitlement, legal, risk assessment including suicide risk, functional status (activities of daily living, instrumental activities of daily living, cognitive functioning).

- In addition, pediatric providers will ensure that all children receive standardized, validated developmental screening such as the ASQ-3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits; and use of Bright Futures or other American Academy of Pediatrics recognized developmental and behavioral screening system.

NH DSRIP 1115 (a) Medicaid Waiver, Special Terms and Conditions

PEDIATRIC ASSESSMENT

- Ages and Stages Questionnaires Third Edition (ASQ-3)
  - Ages one month- 51/2 years
  - Parent centric approach
- Ages and Stages Questionnaires Social-Emotional health (ASQ SE)
  - Parent completed, highly reliable system focused solely on social and emotional development in young children

https://agesandstages.com/products-pricing/asqse-2/

WHAT DO YOU DO WITH A POSITIVE RESULT?

- Positive results **indicate further** assessment, intervention, and connection to supports beneficial to the member.

  - Assessment requires **the capacity to respond** which requires formalization of support **referral networks** and development of a **plan** to make sure that the individual receives the required services and the referral loop is closed.

  - This includes workforce shortages, housing shortages, limited access to transportation and other barriers resulting from CCSA positive responses.

  - A plan may not link **immediately to a solution**, for instance, housing shortages result in a wait list for subsidized housing. It is still important to develop a plan that would include understanding all options and completing the myriad of applications still important for the individual.

ADDRESSING LIMITED RESOURCES

- **Identify categories** where there are limited resources such as transportation;

- **Strengthen and formalize relationships** with your IDN partners that provide these limited resources to build your network;

- **Reach out to MCOs** to identify resources and tools available to individuals through their health plan.

- **Work with your partners to look for innovative solutions** and alternative resources and develop a plan to address the shortages. An example to address transportation shortages could be to use public-private partnerships between Medicaid and Uber.

- **Advocate for policies and procedures that allocate scarce health care resources** fairly among patients and allocate resources based on medical need, urgency of need, anticipated duration of benefit, and change in quality of life. Once referral is made, close the loop.

https://www.ama-assn.org/delivering-care/ethics/allocating-limited-health-care-resources

WHAT DO YOU DO WITH A POSITIVE RESULT?

- Closed Loop Referral – bi-directional referral communication
  - Open Beds/par8o/Unite Us – Software platforms to increase access and referral management. https://www.openbeds.net/; https://learn.par8o.com/referral-management; https://www.uniteus.com/
  - 2-1-1- NH statewide, comprehensive, information and referral service. It is available in 50 states including all 6 New England State. - https://www.211nh.org/about-us/
  - NHHF Community Connector Tool/ Aunt Bertha- This tool is available to everyone to identify and refer/self-refer to needed social services. The tool allows NHHF case managers to confirm that a member presented at an agency and close the loop for referrals. - https://nhhealthyfamilies.auntbertha.com

COMMUNICATION WITH NON-ENGLISH SPEAKERS

- The United States has a growing number of people with limited English skills. About **25 million people, or nearly 9 percent of the U.S. population**, have limited proficiency in English, meaning they speak English “less than very well,” according to the U.S. Census.

  - Some have language access services such as the provision of in-person, telephone, or video interpreters and translated documents.

  - Web-based translation.

  - Some have commercially available communication boards have been developed and implemented specifically to facilitate commonly used messages with both critically ill and non-English speaking patients.

Not Recommended:

- Some use ad hoc interpreters such as family, friends, or administrative staff.

- Often communication is attempted by simply asking yes/no questions and more appropriate communication interventions are not employed.

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PANEL DISCUSSION – IDN2

INTRODUCTIONS

- Michele Underwood, Practice Manager
  Epsom Family Medicine

- Suzanne Williams, Practice Manager
  Family Health Center at Concord Hospital

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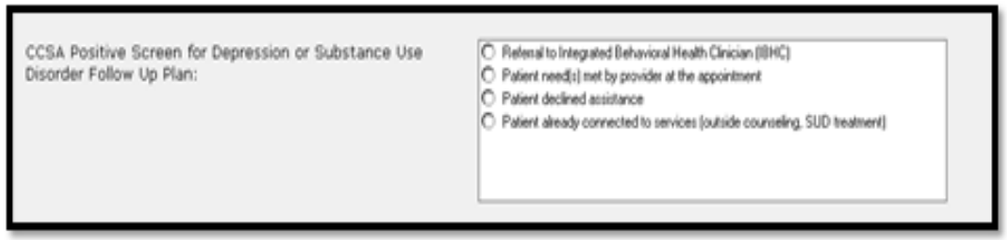
FAMILY HEALTH CENTER

CCSA Work Flow for FHCC

1. PCC identifies if patient is eligible for CCSA screener
   a. Eligibility: Age 12 or older, Medicaid as primary or secondary, has not been screened within 365 days & English-speaking, (avoiding appts for a procedure).
   b. The PCC working in Check-Out reviews the following day's clinic schedule to identify patients that meet the above qualifiers & then they place the acronym "CCSA" in the appt line.
2. When patient arrives for their scheduled appt, the Check-In PCC notes "CCSA" in appt line and will provide patient with the age-appropriate CCSA paper screening form on a clip board.
   a. The patient is asked to complete this form in the lobby while they are waiting for the clinical staff member to call them in.
3. MA/Nurse calls patient in lobby and brings them back into the exam room.
4. After taking pt vital signs and reviewing meds, allergies & tobacco use, MA/Nurse reviews CCSA form.
5. MA/Nurse enters CCSA data in EMR - **Documentation must happen in 3 places**:
   a. Adhoc form "Ambulatory (Adult or Pedi) Intake" used to document Tobacco & Depression (PHQ2)
   b. Adhoc form "SBIRT" (Adult or Pedi) used to document Substance Abuse
   c. Adhoc form "CCSA" – Document status of CCSA form completion in the first section only (Completed / Refused / In Crisis)

   1. **If positive for Tobacco use**, MA/Nurse will ask if pt is interested in discussing cessation today – then documents "Yes" in "Counseled to Quit?" field (found in the Ambulatory Intake Adhoc > Histories & Screening > Tobacco.)
   2. **If positive PHQ2** (and no active/known diagnosis of depression) - patient is given paper PHQ9 to complete & provider is informed
   3. **If positive for substance abuse, domestic violence, or any other social determinants** – MA/Nurse will inform provider
6. MA/Nurse hands Provider CCSA paper form and reports findings verbally
7. Provider and Patient discuss positive findings & determine next actions - **provider checks off one of the below options on the top of the CCSA form**:
   a. Referred to IBHC/ICM to meet with patient (they are paged to come see pt while in the office, if possible)
   b. Provider met patient's needs
   c. Patient declined assistance
   d. Patient already connected to services
   e. Negative screener – no action needed
8. Provider returns form to MA/Nurse to document in the CCSA Adhoc second field:



9. Form is sent to Medical Secretary for scanning into EMR under correct office encounter. Once scanned, original form is placed in designated folder.

10. ICM picks up CCSA forms from designated folder WEEKLY and reviews form/EMR for any missed documentation or missed follow up required.

- EPSOM FAMILY MEDICINE

Epsom Family Medicine
CCSA Work Flow

Who: Patients with Medicaid as Primary & Secondary Insurance
Age: 12 years and above
When: Once annually at any type of appointment

PCC: Prints the Resource Schedule Report from Rev Cycle for the following week
(On Thursday creates list for Mon/Tue/Wed & on Tuesday creates list for Thu/Fri)

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PCC: Reviews list and highlights patients for CCSA and documents "CCSA" in appointment subject line.

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PCC: Gives the report to the **IBHC** (Deb Wood) for review, appointment tracking and reporting at Team Huddle

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Patient arrives for appointment

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IBHC or MA: Meets with patient in Exam Room
Explains 1115 Waiver & the CCSA

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Patient is seen for appointment.
Provider – warm handoff to IBHC
MA: Call IBHC (Deb x8770) when patient is ready to be seen by IBHC. Patient remains in Exam Room.
** If IBHC not available, MA will complete the CCSA with patient.*

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YES
Patient AGREE's to complete form

↓

IBHC or MA: completes CCSA with the patient or parent

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IBHC or MA: reviews the CCSA and consults with Provider as needed for positive screening. Prompt for PHQ9 or other additional screening tools.

NO
Patient refuses to complete form
IBHC or MA writes "Refused" on top of CCSA

OR

Patient does not have time (OK to Call)
MA or Provider: will communicate to the IBHC. **IBHC** will write the appointment date & call date at the top of the CCSA. **IBHC** will call the patient to complete over telephone.

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CCSA is given to the **IBHC**. **IBHC** will document data in the CCSA Ad Hoc.

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IBHC gives the CCSA to **Medical Records** (Pat) for scanning

- Form is scanned into the EMR.
- Document Type = **Behavioral Health Outside**
- Subject Line will be updated to: CCSA and the date completed

↓

CCSA returned to **IBHC**. Forms filed in **IBHC** office.

Provider Hand Off:
I would like you to meet another member of your health care team and she will be asking you a few questions while I …. (finish up your visit summary).

HOW IT HAPPENS

- **How are your B1 partners capturing CCSA information (paper, IPads while in waiting room or office)?**

  EFM: Paper form completed by patient in the exam room before seeing the provider

  FHC: Paper form completed by patient at check-in in the waiting room

- **Who is administering the CCSA? (clinician/care manager?)**

  EFM: Medical Assistant or IBHC explains the CCSA to the patient for completion
  FHC: PCC hands out form at Check-In for patient to complete

- **Which CCSA domains do your partners find the hardest to include, particularly as they relate to referrals for positive screening results?**

  EFM & FHC: Tobacco cessation counseling & follow-up

- **What other challenges do your partners face related to completing the CCSA?**

  EFM & FHC: Knowing where in the EMR to document the information in order to get "credit"

HOW IT HAPPENS *CONTINUED*

- **What successes have your B1 partners had related to implementation of CCSA?**

  EFM & FHC: Identifying patients that require intervention or community resources that we may not have otherwise known.

- **How do you approach completing CCSA for non-English speaking individuals?**

  EFM & FHC: We currently do not screen our non-English speaking patients

- **How do your B1 partners approach the CCSA in relation to pediatrics?**

  EFM & FHC: CCSA Pediatric screening form is used for children 12-18 years of age. We encourage the parent/guardian to allow the child to answer the form on their own. Providers will typically address positive findings after they ask the parent(s)/guardian to step out of the room to determine whether intervention is required.

WHAT DO YOU KNOW NOW THAT YOU WISH YOU KNEW WHEN YOU STARTED?

- The purpose of the CCSA screener
- Where the data is being pulled from the EMR
- How other practices are handling their workflow (what is working/not working well)
- Definition of the measurements (numerator vs denominator)
- What each role (MA, RN, MD, IBHC) is responsible for

PREVIOUSLY IDENTIFIED TOPICS

- **Comprehensive Core Standardized Assessment (CCSA)**
- **Shared Care Plan**
- **Multi-disciplinary Core Team**
- Funding and Sustainability
- Site Self-Assessment
- **Risk Stratification**
- SAR Reporting
- **Closed Loop Referrals**
- Privacy
- **Social Determinants of Health**
- **Care Coordination**
- **Interagency Workflows**
- **Moving your metrics: Tools and Resources**
- **Pediatric Integration**

ACTION ITEMS FOLLOW-UP

- New Hampshire Healthy Family (NHHF) will provide information regarding what makes up the denominator when calculating risk scores for SDoH analytic tools discussed at the April 5th meeting. ***Pending***

NEXT STEPS

- Next B1 Integration Monthly LC Meeting

  - July 5th meeting cancelled due to holiday

  - Next meeting August 2nd