Meeting: MSLC B1 Integration Learning Collaborative Meeting
Location: NH Department of Health and Human Services, Concord NH
Date: June 7, 2019
Time: 9:00 AM – 10:45 AM

Action Items:

#	Description	Owner	Status
1.	MSLC will confirm who updates the name of the PCP in the CM platform.	V. Brown	Open
2.	MAeHC will identify Medicaid clients that are included in the denominator for Assess.01 – Completion of the CCSA.	J. Baldaro	Open

I. Introduction

V. Brown opened the meeting with introductions and roll call on the phone. She reviewed the meeting goals, agenda items, and gave an overview of the Spotlight from IDN2 which is from Epsom Family Medicine.

A. M. Underwood gave an overview of this month's Spotlight. She stated that she has had positive experiences with the Collective Medical (CM) portal where they are able to drill down to identify why the patient is at the ED. They use this information to communicate with the provider and patient to have a clearer care plan. She then explained the type of information they receive and what type of release they use.
B. M. Underwood explained how she expresses the value of implementing Event Notifications to other Practice Mangers. She stated that they can look at the whole person when they present at the ED. She gave an example of a case where they were notified that a patient had 3 or more visits and then were informed that this patient had 56 visits in a year at 4 different locations.
C. M. Underwood explained that there was a process in place already for transitional care management but she now receives event notifications. She is transitioning this function to a nurse on her team.
D. M. Underwood explained that patient education is important particularly in communicating their practice hours. It is important that patients know they have t weekend hours so they do not go to the ED when they could see their PCP.
E. D. Lielasus explained that IDN2 could be affecting change with education but at this stage they are gathering information. She explained that their monthly report goes to the executive committee, supervisors, medical director, etc. and it's discussed regularly at meetings and at a higher level. They're listening and M. Underwood is not working in a vacuum.
F. M. Underwood stated they are including all of their patients and not just Medicaid. She also explained that doctors are shocked when seeing a patient that has 56 visits on paper in the past 12 months. It's bringing more attention to these trends.

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G. B. Burtis shared that CM worked with Manchester Community Health Center and developed cohorts. Workflows were developed that include case managers and Community Health Workers (CHWs) monitoring the event notifications. Each team has 2 or 3 providers, 1 CHW, 1 Case Manager, 1 BH clinician, associate nurses, and MAs. CM developed a tool that automatically runs a monthly report that is organized by providers and gives an overview of who came in, how many times, and how many visits total in the last year. In terms of patient education, they adopted a flyer/brochure from Health First in Laconia which focuses on different tiers of care, to patient education tools to potential out-of-pocket costs.

H. W. Kennerson explained that NH Healthy Families (NHHF) also follows up of ED visits. A report is generated and they have specialists and case mangers do calls to follow-up with the members. Care managers log the call in the care management record that the providers have access to so the providers do have access to the member's case management notes. They are doing outreach to educate the members. NHHF identifies where the member went, opportunities for going elsewhere if it wasn't an emergency, as well as mailing them a brochure that helps members identify when to go to the ED and when not to go to the ED. W. Kennerson stated that the audience is welcome to the brochure

I. K. Capuchino asked what the source of information is for the ED visit list.
W. Kennerson stated that they do get reports from various hospitals but they are based on claims and not real time. K. Capuchino explained that this is an opportunity for the providers to hear the continued benefit of what the MCOs are doing because the MCOs have tools and information that they want to impart upon the providers. That information can inform decision-making and workflows.

J. M. Underwood responded to a question as to whether she feels overwhelmed with the notifications. She stated that it could be very easy to become overwhelmed from the amount of data that can be received in real time. They were cautioned when picking the cohorts which is why they chose one item to concentrate on.

K. J. Sakar asked as more and more providers get on CM platform, how you think it will impact the patient side of this and make sure the patient isn't getting called 5 times by different organizations. She stated that IDN3 is trying to determine the best way to use the tool to see how a patient is being shared across organizations because the portals are all separate.

L. M. Underwood responded that she doesn't think there's enough data to determine how they share patients across organizations. It is important to keep it at the forefront and have those conversations and have an agreed upon.
Q: M Underwood asked those in the audience that use CM if the individual practices go in and update the name of the PCP.
R: Q. Tule stated that there is a way to enter providers for a patient because he has seen them populated before but he has not entered any. He doesn't know whose responsibility that is. It could be something that goes into the attribution file or it could be something they add manually in the portal.
R: K. Capuchino requested to C. Snider note this as a question to come back to. She doesn't know how the MCOs know that a patient is tied to a specific primary care.
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II. Comprehensive Core Standardized Assessment (CCSA) Panel Discussion – IDN2

A. S. Williams gave an overview of the process of identifying patients at Concord Hospital Family Health Center to receive the CCSA screening. She explained the workflow which includes patient care coordinators reviewing the next day's schedule and identifying patients that fit the criteria for CCSA completion. This criteria is based on length of appointment and the state of the patient at the time of the appointment. The medical record is marked to identify that a CCSA must be completed during the appointment. The medical assistant (MA) assists with the competition of the CCSA at the regular intake. If there are some positive responses, the MA does a warm handoff of the patient to the provider. Depending on the results of the screening, an integrated care manager or a behavioral health clinician can be called in at a moment's notice. If they are not needed during the visit, the MA is responsible for going into EMR and they're clicking the required boxes.

B. M. Underwood shared the Epsom Family Medicine's workflow. The Concord Hospital Medical Group Practice Managers spent time on the workflow to learn from each other and identify best practices and barriers. Epsom Family Medicine Practice has a total staff of 26 and they have been able to tweak the process over the last few months. Having an integrated behavioral health specialist at their practice has been life changing for everyone. The Integrated BH Specialist attends the morning huddles with each clinical team and have the screening tools ready with the patient's name, the provider, and the time of the visit. To have the ability to have that conversation in the morning and be able to pull in the IBHS is important. When the IBHC reviews the screening tool with the patient, it's more like a conversation versus being handed a form with questions that can be hard to admit.

C. M. Underwood stated that they were doing all the right things but sometimes the staff would forget to check the boxes or they would check the box but the provider didn't write the care plan for positive screening in the notes. With the reports available to them, they're able to go back into all the charts that were denied and identify what was done in the process that created the denial. She admitted it's been a little frustrating at times because they do the right thing and the patient was able to gets what they needed but it was not documented so that's what they're working on now. Additionally, they've been struggling with the significant population of non-English speaking patients. They're trying to determine how to address language barriers in a visit that can already be over 50-60 minutes long when you have an interpreter or multiple interpreters depending on the need of the patient. The screening tool has not been translated into other languages. Right now they have at least 15 different languages that the patients in this population communicate with them and that's assuming they can read in their language, which is not necessarily the case. They know they are missing a significant segment of the population for that reason alone.

Q: K. Capuchino asked what is meant by "you're missing them?"

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R: M. Underwood clarified that they are doing interventions but they're not able to give them the screening tool because it isn't in a language that they can read. It was explained that they are not capturing the hard data on those visits. They're addressing the patient's needs in the moment but they're not being completing the CCSA. Those patients are more ad hoc because it's not being completed. Epsom is missing out on the opportunity to report on these measures.
R: D. Lielasus added that this is something they've brought up to DHHS, MSLC, and to the other IDNs as an identified issue. The Family Health Center is not meeting the percentage level of CCSA that the other sites are meeting however the data reveals the number of people administering CCSA on a monthly basis is actually exceeding other sites. The FHC is a Medicaid dense, Limited English Proficiency (LEP) dense, illiteracy dense practice and that's why they are reaching out to understand how other organizations are handling this situation. It's the one reason why they are sitting on this panel today to see if we can have some conversation about that.
R: K. Capuchino stated that perhaps the way they're operatizing the comprehensive screen isn't standardized at the FHC and that they need a modified approach. They have to be able to assess all domain areas and get a holistic view through their process. However, not all domains need to be addressed in one visit and it can be different domains each time, depending on what needs to be prioritized. K. Capuchino stated that she is looking forward to that conversation with D. Lielasus on what the solution is and if other people are feeling challenged by that same thing.
Q: Would the sign interpreter be able to help with the assessment?
R: Yes and no. It will depend on if there is an interpreter present in the room. They can be present via phone or through an iPad system but it would make it very difficult. But again, it's not that we're not addressing their needs but we're prioritizing the needs that have to be addressed in that visit.
R: An interpreter would also have to be able to sit with them in the waiting room. The interpreters usually have back to back appointments so it's not like each patient gets their own interpreter in this scenario. Additionally, if the patient can't read or write and the interpreter is asking the questions out loud then the patient would have to answer sensitive questions out loud and other people in the waiting room would likely hear their responses. We're trying to respect how we collect this information so the patient feels comfortable sharing this information and comfortable with our response.
Q: It looks like from the workflow that you're the CCSA is being done after they see the provider?
R: No, it's before. The workflow needs to be updated. When it was being done after the fact and the patient had already left, they'd missed their opportunity so the workflow if constantly evolving.
R: To provide some clarification on the CCSA, providers are saying they can't get it done within 30 days. The assessment of the CCSA is when the provider looks at their answers and discusses it with the patient. So if the questions are answered before the appointment, that's not the date

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for a completion. That's just compiling data, the CCSA is when the provider discusses it with the patient.

R: K. Capuchino explained an accomplishment of a comprehensive assessment is when all domains have been reviewed, all domains have the ability to be captured, and the practice is able to refer to other providers. DHHS does not expect the providers to inconvenience a member by talking about something that's not relevant to them.

Q: D. Lielasus responded that there is a need for a crosswalk between the requirements and what we're actually doing. Everyone agrees that all of this data gathering is in the best interest of the patient but there is also the incentive of money. Checking these boxes is what pays for these positions so there is a fear of "if we don't check these boxes, we won't get that money." How do the providers receive those funds if other aspects of their health has taken priority?

Q: Does MAeHC include in their denominator only people that have been seen in the office within 12 months?

R: K. Capuchino responded that it is not all attributed members, it is only the patients who are seen by an IDN participating provider within 12 months.

Q: D. Lielasus requested that this be verified that MAeHC is doing it this way. **ACTION ITEM.**

R: K. Capuchino explained that as more providers/practitioners are brought on, open dialogue needs to continue so that people can get answers and solutions on how to navigate through this. If there's a CCSA process but not all domains can be addressed in one visit or they get punted to someone else, it's still a CCSA.

Q: J. Powell asked for clarification on how the denominator is calculated.

R: C. Trexler stated that the denominator is pulled from any of the attributed lives who are seen at one of the IDN participating providers, they then look to see if a CCSA has been completed in the past 12 months.

R: K. Capuchino clarified that the 30 day rule is not in the STC. It's a guideline to help determine whether the process needs to be changed.

Q: L. Diggins asked if we were not directing our providers to look at SDoH and do an assessment, that person would never have been referred to a case manager. So the referral to a case manager for us is enough of an intervention to move it forward. So people are inflexible on what a CCSA is.

R: C. Trexler stated that when you are looking at your denominator for MAeHC you have to realize that if a patient saw your participating provider 9 months ago when you had not initiated the CCSA yet she would still be in your denominator.

Q: Q. Tule stated that the denominator for the Assess.01 is a semi-annual measure.

R: T. Jennison noted that every 6 months they look back 12 months.

R: J. Sakar clarified that they only look at patients that have been seen in the last 6 months and of those patients, they look back to see if that patient has had a CCSA in the last 12 months.

Q: A. Goudie asked the panel if through their experience with implementing the CCSA, if there has been an increase in

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the amount of time of the visit. And if so, by how much? She would like to share this information with her practices.
R: S. Williams shared that they do not know exactly because it's not something that is being tracked. Is the concern with the amount of time that it takes the PCP or the team as a whole or the patient?
R: M. Underwood explained that the warm handoff may take time but not for the PCP. They have an IBHC that can stay with the patient as long as needed.

D. V. Brown asked the panelists what was one thing they know now that they wish they'd known when they started?
R: S. Williams explained that by listening to the audience it is clear that we are all struggling with the same thing. We have the interest of the patient at heart and we need to remember that when we struggle through this.
R: M. Underwood stated that as you roll this out to your team for the first time to have a tool and basic workflow where they are going to start. Also include resources. Staff do so well when they are provided information.

IV. Future B1 Meeting Topics

A. V. Brown stated that Pediatric integration has been added to the potential topics list.
B. K. Capuchino asked if anyone is interested in SUD Hubs and Closed Loop Referrals.
C. SUD Hubs " The Doorway" was decided for the August 2nd topic
D. K. Capuchino stated that the Semi-annual Reports are available on the website.

V. Next Steps

A. Next meeting is August 2nd, which will be in person.

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