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SUPPORT for ME Results from the Care Integration Assessment

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SUPPORT for ME

Results from the Care Integration Assessment

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CUTLER INSTITUTE
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SUPPORT for ME

Overview

SUPPORT for ME
Care Integration Assessment Overview

Support for ME Project Overview

- In 2019, Maine's Department of Health & Human Services received a $2.1 million grant from the Centers for Medicare and Medicaid Services (CMS) SUPPORT Act, establishing the SUPPORT for ME initiative within the Office of MaineCare Services.

- The primary goal of this planning grant is to increase MaineCare providers' capacity to deliver Substance Use Disorder (SUD) treatment and recovery services for Medicaid beneficiaries. Priority populations include:
  - AI/AN Communities
  - Transitional Populations
  - Rural Populations
  - Underserved Communities
  - Adolescents and Youth (12-21)
  - Dual-eligible beneficiaries

- One key component of this project is an assessment to collect information from Maine organizations to help MaineCare better understand levels of care integrations within organizations and across several dimensions of care ("Care Integration Assessment")

Care Integration Assessment Context

- For the purposes of this assessment, care integration refers to the care coordination between patients/clients and their physical health, mental health, and substance use disorder (SUD) treatment providers.

- Care integration is a vital component to ensuring that individuals with Substance Use Disorder (SUD):
    1) have individualized treatment plans focused on person-centered goals;
    2) have their physical, behavioral, and social needs coordinated across providers and care settings; and
    3) are able to access appropriate treatment and recovery services across the continuum of care as their needs evolve.

Care Integration Assessment: Context

- CMS requires all SUPPORT Act grantees to conduct an assessment of the level of physical and behavioral integration among agencies serving individuals with substance use disorder (SUD) in order to assess the current state of care integration and inform strategic planning efforts.

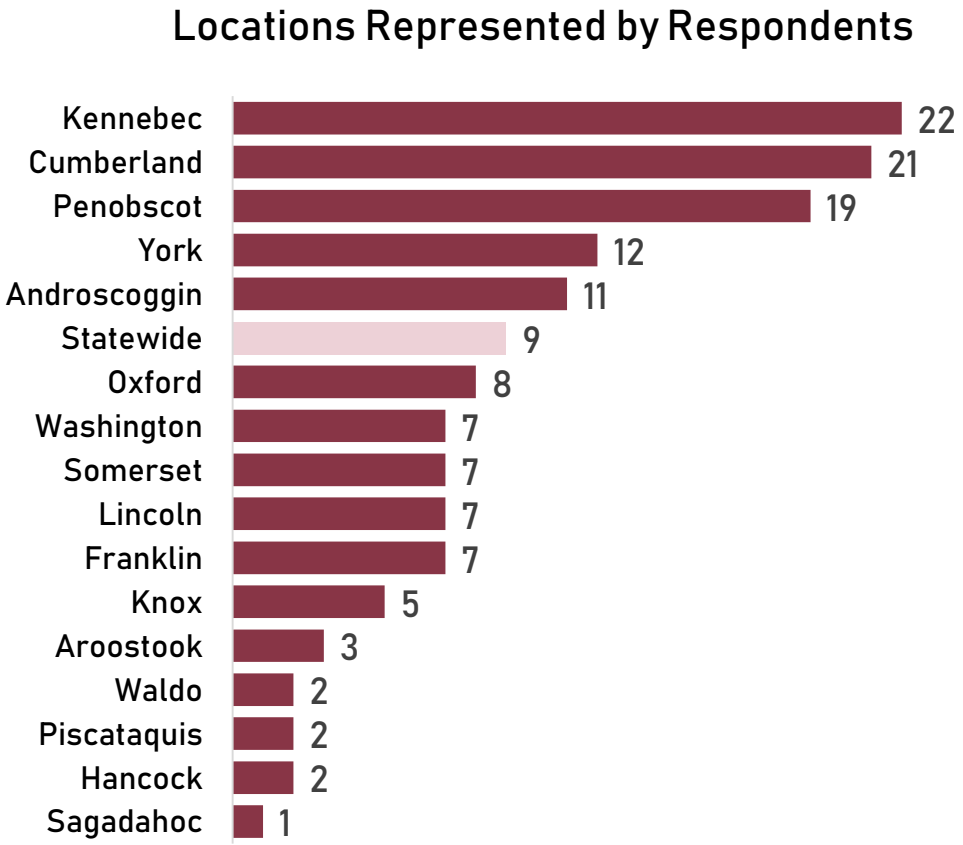
- The Care Integration Assessment tool used for the SUPPORT for ME assessment was selected by the project Advisory Committee in May of 2020.
  - The advisory committee reviewed and ranked eight tools before making their selection
  - The Maine Health Access Foundation Site Self-Assessment (SSA) was used to evaluate progress towards bi-directional behavioral and physical health integration.

- Organizations represented addiction specialty treatment programs, community mental heath centers, opioid treatment programs, behavioral health providers, residential treatment, recovery housing, FQHCs, hospital settings and private practice as well as health homes (HH/BH/OH); all respondents indicated their organization provides care to MaineCare Members

- Percentages in this presentation may not add to 100% due to rounding

Demographics

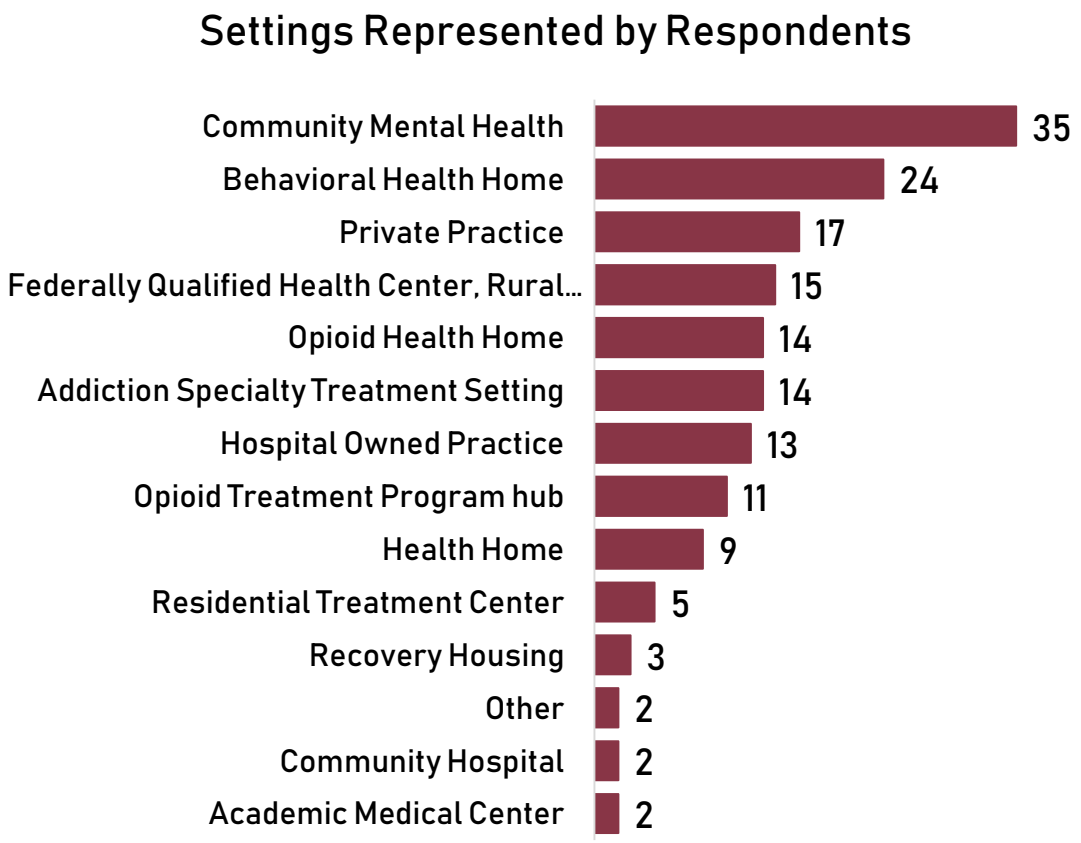
Demographics: Geography



There were responses from all 16 counties for this assessment, with 9 respondents indicating their organization serves clients/patients statewide

Note: sum of numbers shown on graphs are not equal to the total number of respondents (n=104), as respondents could indicate more than one location/setting

Demographics: Settings



For respondents who only chose "Other" for their setting (in a choose all that apply question), responses were recoded into existing categories

- Only two responses could not be re-categorized and were left as a response of "Other" (a shelter and a specialized care management agency)

Note: sum of numbers shown on graphs are not equal to the total number of respondents (n=104), as respondents could indicate more than one location/setting

Demographics: Homes

For the analysis of this assessment, results are shown for all respondents as well as for Opioid Health Homes (OHH), Behavioral Health Homes (BHH) and Health Homes (HH).

Results were also grouped together for respondents who represented organizations with designations of two or three types of homes

Home Type	Frequency	Percent
OHH	8	13%
BHH	14	23%
HH	19	32%
2 or more types of homes (n=19):		
BHH/OHH	10	17%
HH/BHH	2	3%
HH/OHH	5	8%
HH/BHH/OHH	2	3%

Note: Respondents were able to select whether they were part of a OHH, BBH, and/or HH in the assessment. For this analysis, the Cutler Evaluation Team cross-referenced respondent organizations with lists of OHHs, BHHs, and HHs. When there was a discrepancy, responses were reclassified to reflect the lists from Maine DHHS.

Key Takeaways

Key Takeaways: Areas of Strength

Areas of Strength:	Top 3 Areas of Strength by Respondent Category (Top 3 Mean Scores)				
	All (n=104)	OHH (n=8)	BHH (n=14)	HH (n=19)	2 or More Types of Homes (n=19)
Patient and family involvement in care plans: integral part of systems of care; collaboration occurs among patient/family and team members and takes into account family, work, or community barriers and resources (Q11)	X		X		
Social support: standard practices on assessing needs and linking patients with services and follow-up on social support plans using household, community, or other resources (Q14)	X	X			X
Organizational leadership: strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models (Q17)	X	X	X		X

Key Takeaways: Areas Needing Improvement

Areas in Need of Improvement:	Top 3 Areas in Need of Improvement by Respondent Category (Bottom 3 Mean Scores)				
	All (n=104)	Opioid Health Home (n=8)	Behavioral Health Home (n=14)	Health Home (n=19)	2 or More Types of Homes (n=19)
Co-locations of treatment for primary care and behavioral health care: the ability for appointments to be jointly scheduled, so that one visit can address multiple needs (Q7)	X	X	X		X
Integrated and accessible treatment plans for primary care and behavioral health care: specialty services for patients with high behavioral health needs can be coordinated (Q9)	X	X	X		
Increase funding and sharing of resources: funding is fully integrated, resources can be shared across providers; billing is maximized for all types of treatment; flexibility in the use of resources and staffing (Q25)	X	X	X	X	X

Overall Assessment Scores (0-3 scale)

Areas Highlighted in Green indicate areas of strength (highest 3 mean scores)

Areas Highlighted in Gray indicate areas in most need of improvement (lowest 3 mean scores)

	All Responses n=104	OHH	BHH	HH	2 or More Homes
Co-location of Treatment (Q7)	1.6	1.9	1.4	2.5	2.0
Assessment of Needs (Q8)	2.5	2.8	2.6	3	2.7
Coordination of Treatment (Q9)	2	2	1.9	2.5	2.3
Best Practices for Patient Care (Q10)	2.4	2.6	2.3	2.7	2.5
Patient/Family Involvement (Q11)	2.5	2.3	2.7	2.7	2.6
Communication (Q12)	2.2	2.8	2.1	2.4	2.4
Follow-Up (Q13)	2.3	2.8	2.4	2.8	2.4
Social Support Linkages (Q14)	2.5	3	2.5	2.4	2.7
Community Resource Linkages (Q15)	2.3	2.9	2.4	2.2	2.3
Organizational Leadership (Q17)	2.5	2.9	2.6	2.6	2.8
Patient Care Teams (Q18)	2.2	2.8	2.4	2.3	2.3
Providers' Engagement (Q19)	2.3	2.9	2.1	2.7	2.4
Continuity of Care (Q20)	2.4	2.8	2.3	2.8	2.5
Coordination of Referrals, Specialists (Q21)	2.2	2.5	2	2.6	2.3
Data Systems and Patient Records (Q22)	2.1	2.9	2.1	2.6	2.2
Patient/Family Input (Q23)	2	2.3	2.1	2.4	2.2
Education and Training (Q24)	2	2.8	2.2	2.4	2.1
Sharing of Funding and Resources (Q25)	1.5	1.6	1.4	2.2	1.6

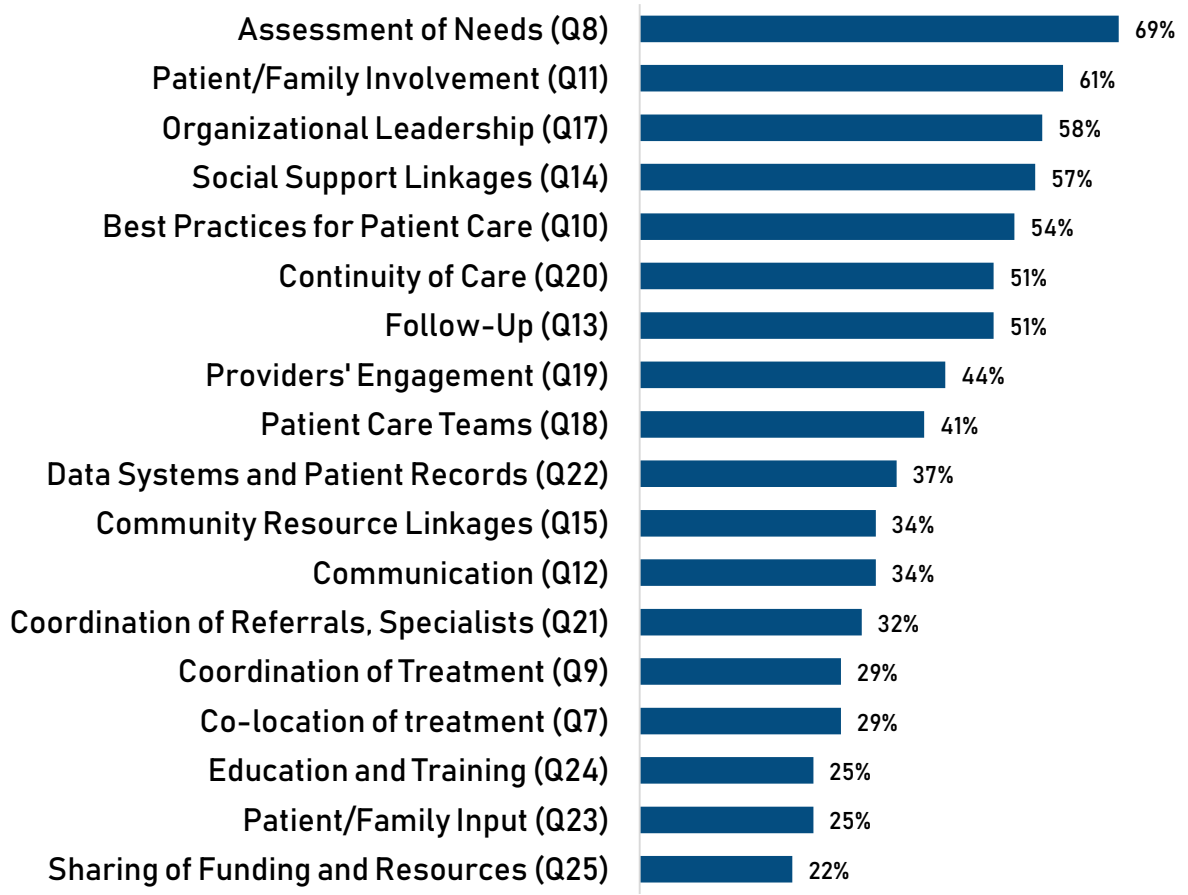
Note: Mean scores shown are rounded

Overall Progress: All Respondents

Components at the top of the graph indicate areas of care integration where the most progress has been made

Components with the fewest respondents choosing "regular part of care" were:

- Sharing of Funding and Resources
- Patient/Family Input to Integration Management
- Education and Training

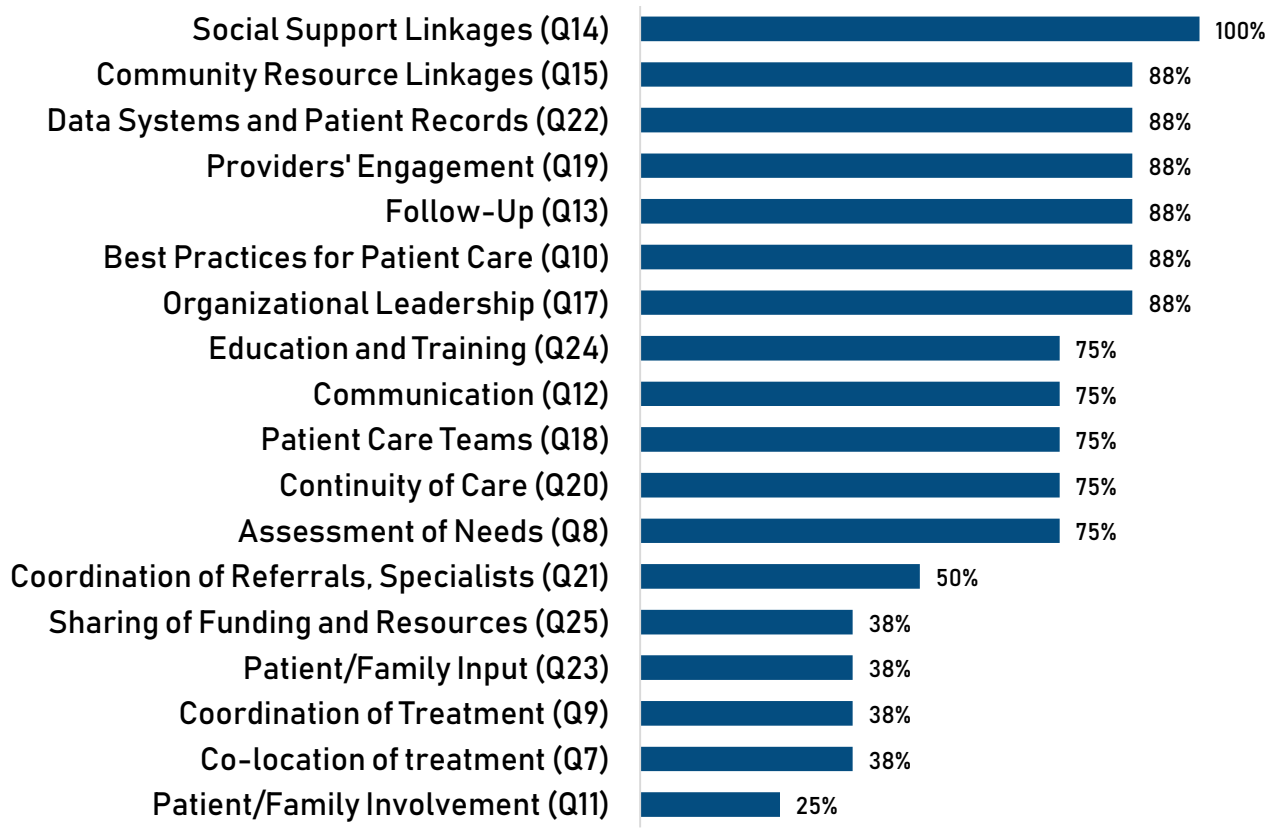


Overall Progress: Opioid Health Homes

Components at the top of the graph indicate areas of care integration where the most progress has been made

Components with the fewest respondents choosing "regular part of care" were:

- Patient/Family Involvement in Care Plan
- Co-location of Treatment
- Coordination of Treatment

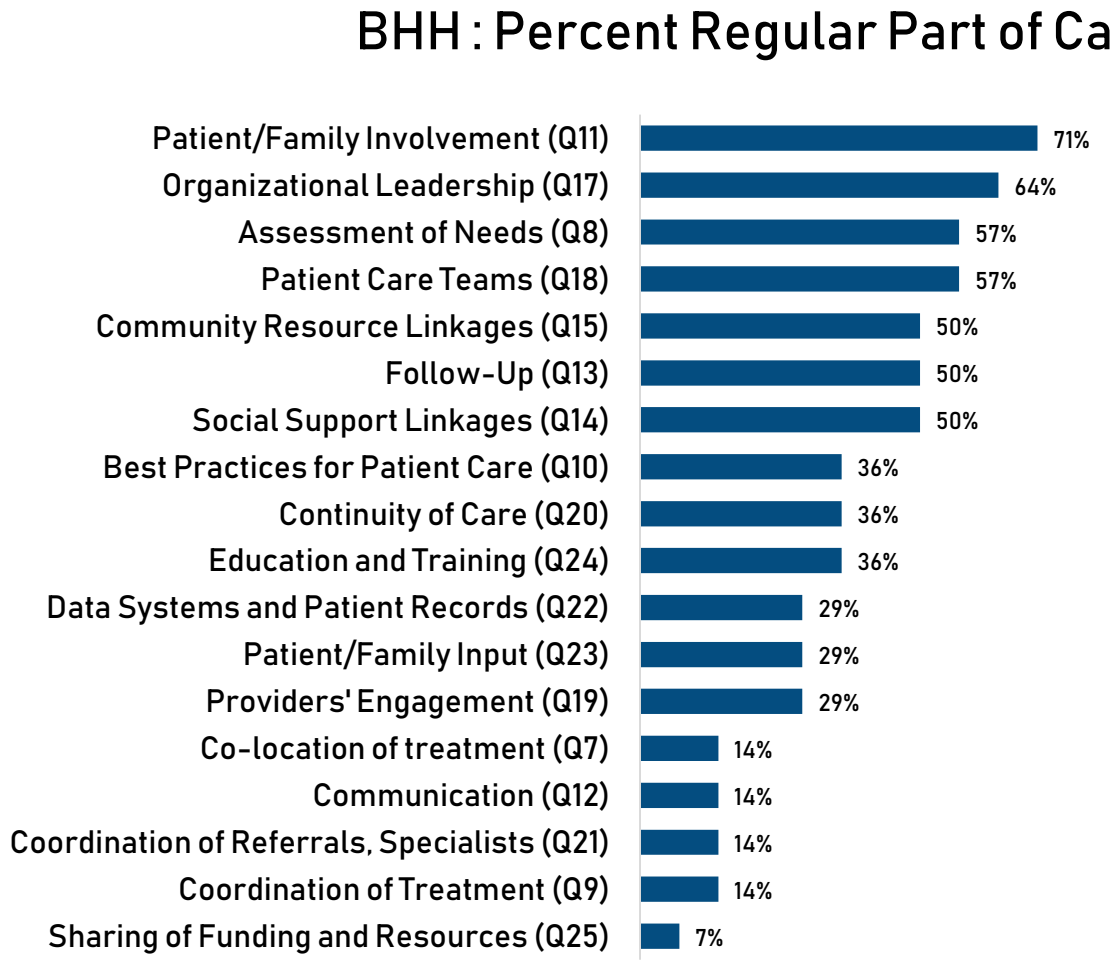


Overall Progress: Behavioral Health Homes

Components at the top of the graph indicate areas of care integration where the most progress has been made

Components with the fewest respondents choosing "regular part of care" were:

- Sharing of Funding and Resources
- Coordination of Treatment
- Coordination of Referrals and Specialists

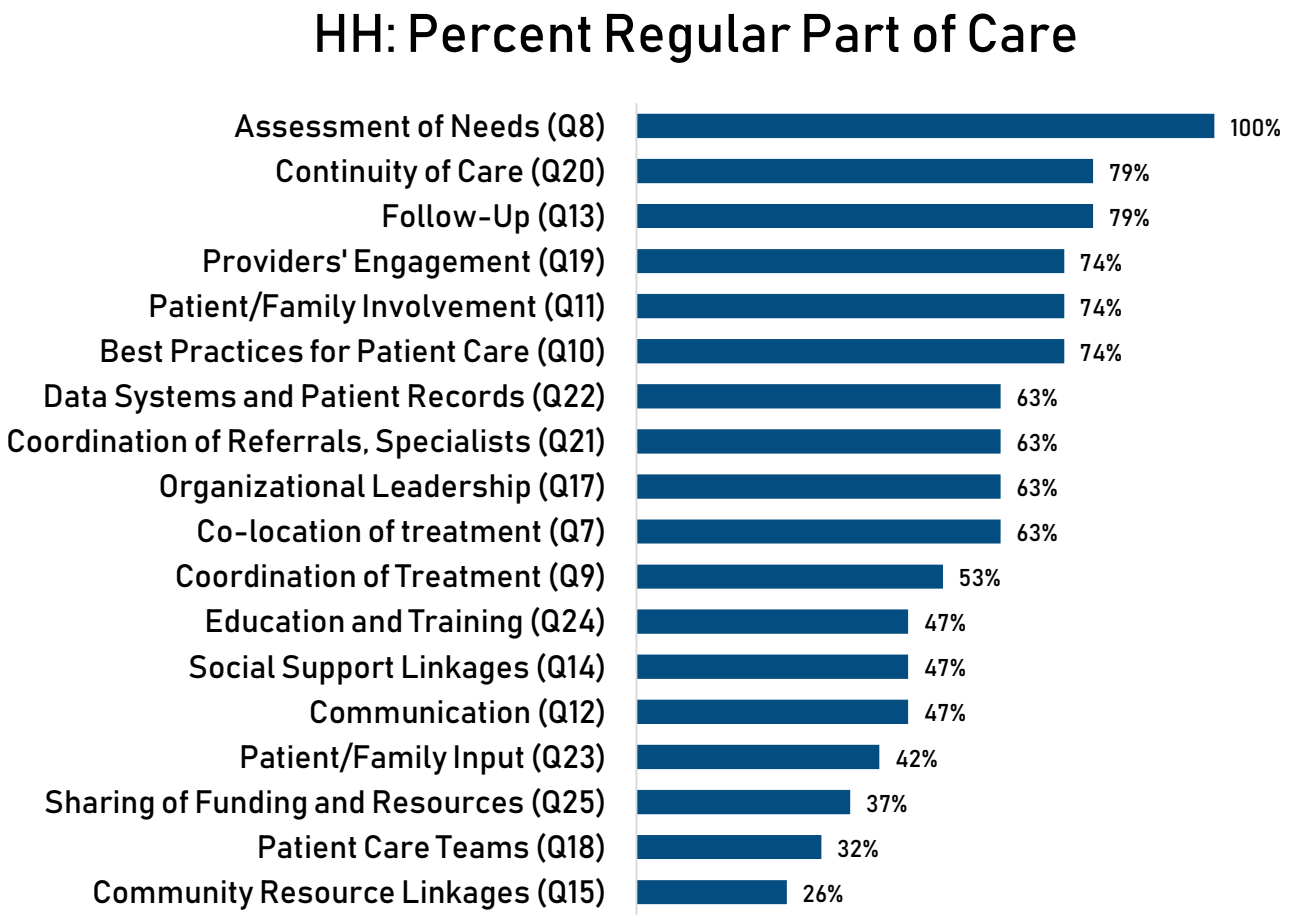


Overall Progress: Health Homes

Components at the top of the graph indicate areas of care integration where the most progress has been made

Components with the fewest respondents choosing "regular part of care" were:

- Community Resource Linkages
- Patient Care Teams
- Sharing of Funding and Resources

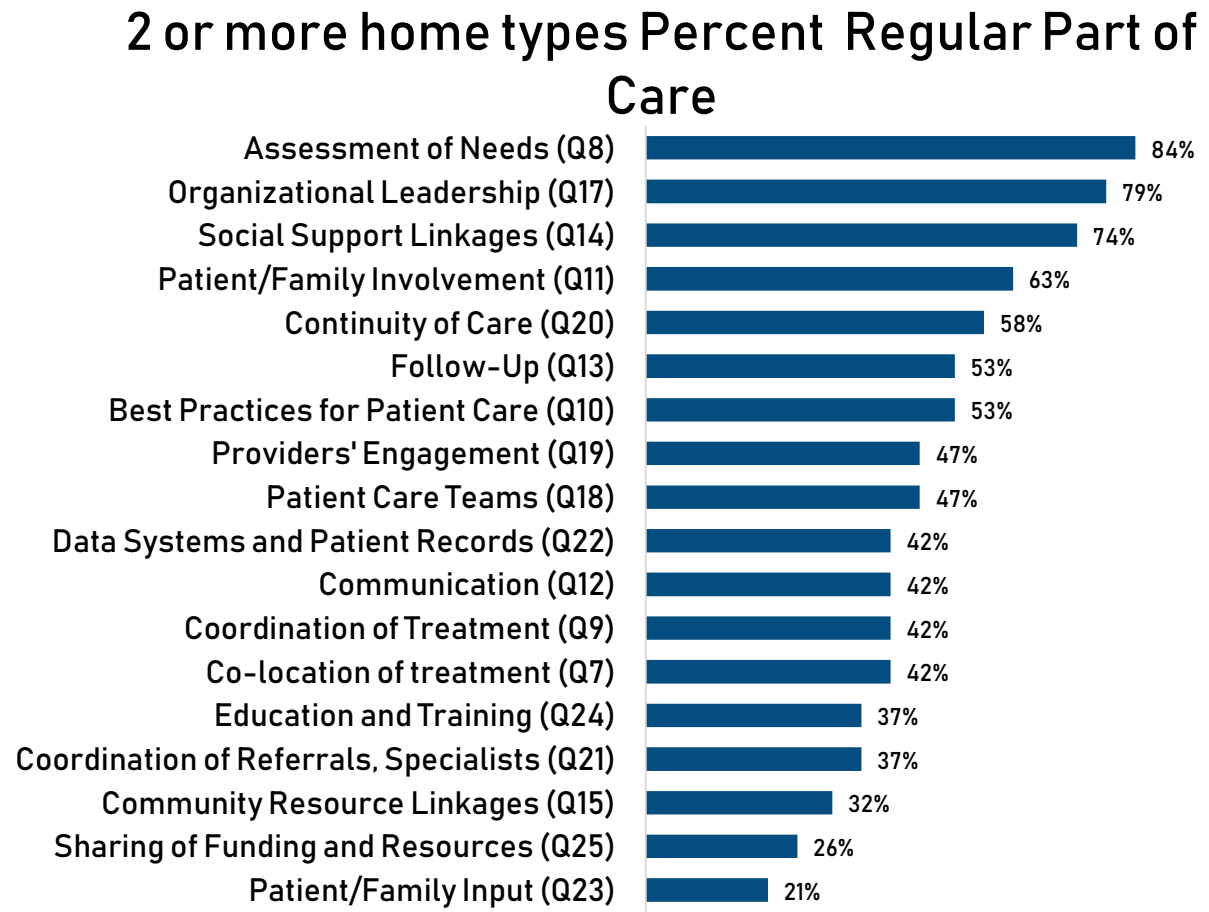


Overall Progress: 2 more types of Homes

Components at the top of the graph indicate areas of care integration where the most progress has been made

Components with the fewest respondents choosing "regular part of care" were:

- Patient/Family Input to Integration Management
- Sharing of Funding and Resources
- Community Resource Linkages



Assessment Results:

Integrated Services
and
Patient and Family-Centeredness

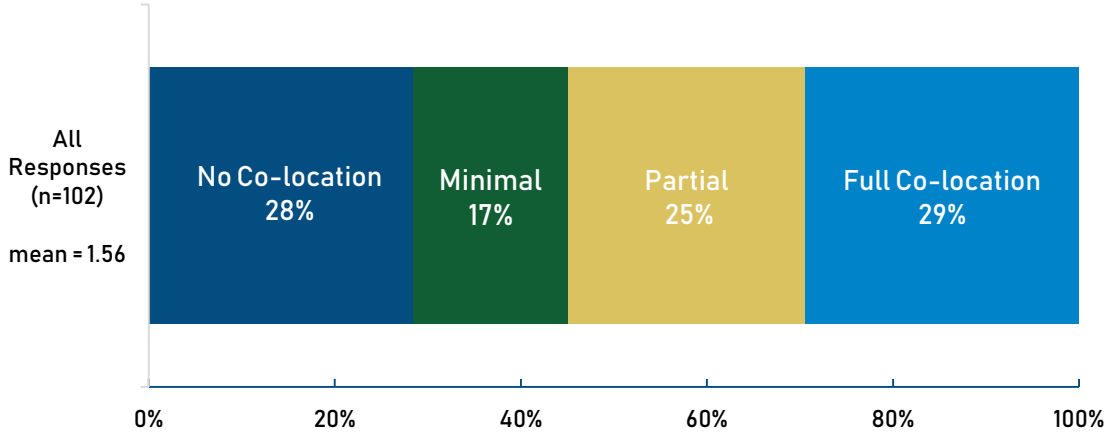
Co-Location of Services (All Respondents)

29% of respondents indicated that the co-location of primary care and behavioral health care is a regular part of care at their organization

40% of respondents indicating early (16%) or moderate (25%) levels of integration

Note: while results indicate 28% of respondents said co-location of services does not exist, this type of model may not have been applicable to their organization

Co-Location Status of Treatment for Primary Care and Behavioral Health Care



- does not exist; consumers go to separate sites for services (no progress)
- is minimal; but some conversations occur among types of providers; established referral partners exist (early progress)
- is partially provided; multiple services are available at same site; some coordination of appointments and services (moderate progress)
- exists, with one reception area; appointments jointly schedules; one visit addresses multiple needs (regular part of care)

Q7

Co-Location of Services (All Respondents)

Health Homes were the most likely to have existing co-location of treatment for primary care and behavioral health care (63%)

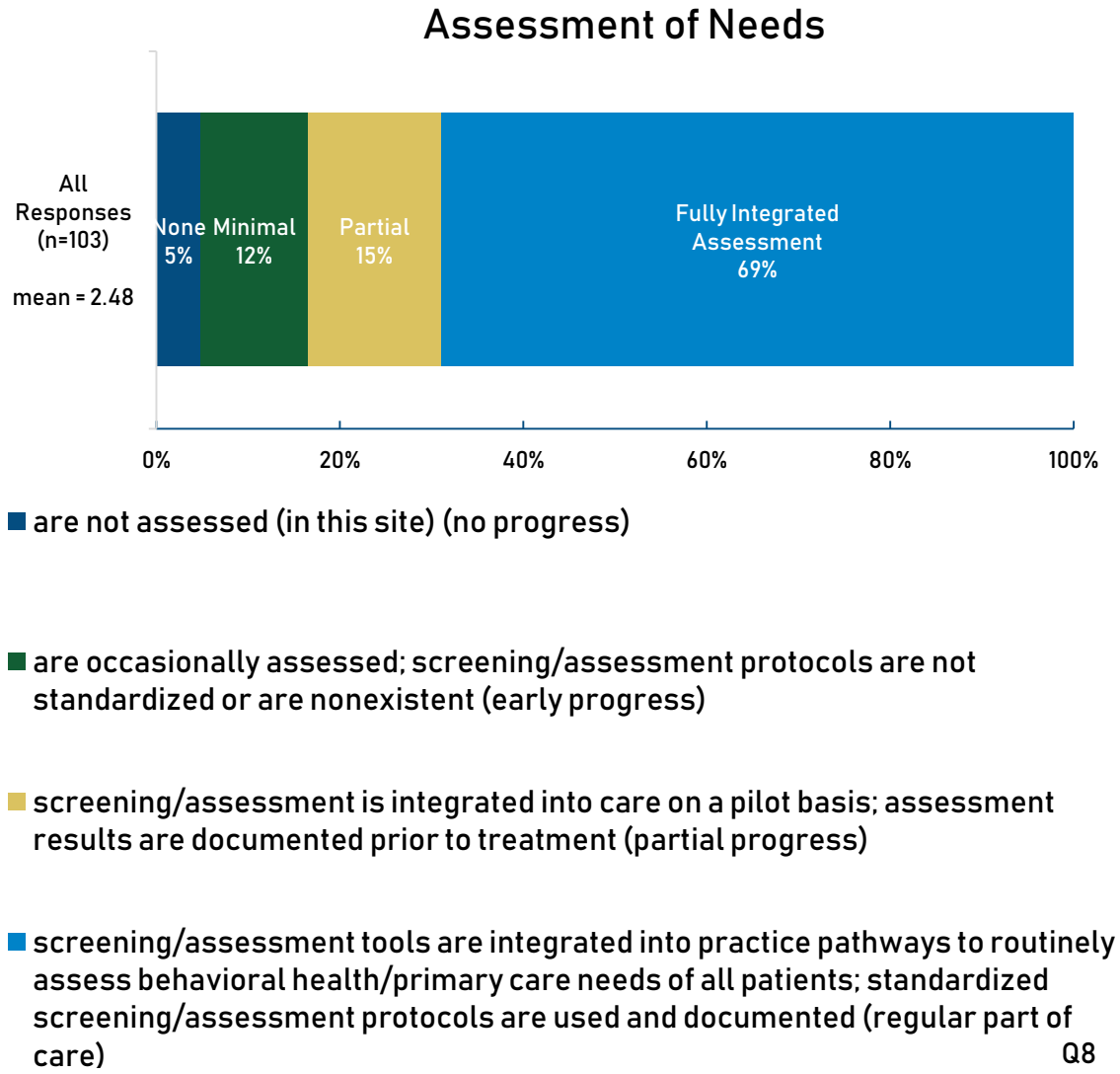
	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	1.88	25%	0%	38%	38%
BHH n=14	1.43	21%	29%	36%	14%
HH n=19	2.47	5%	5%	26%	63%
2 or more home types n=19	2.05	5%	26%	26%	42%

Assessment of Needs (All Respondents)

Assessment of Needs:

Emotional/behavioral health needs are assessed at medical appointments OR medical care needs are assessed at behavioral health appointments

Most respondents (69%) reported the integration of screening and assessment tools for emotional and behavioral health needs as a regular part of care



Assessment of Needs (By Home Types)

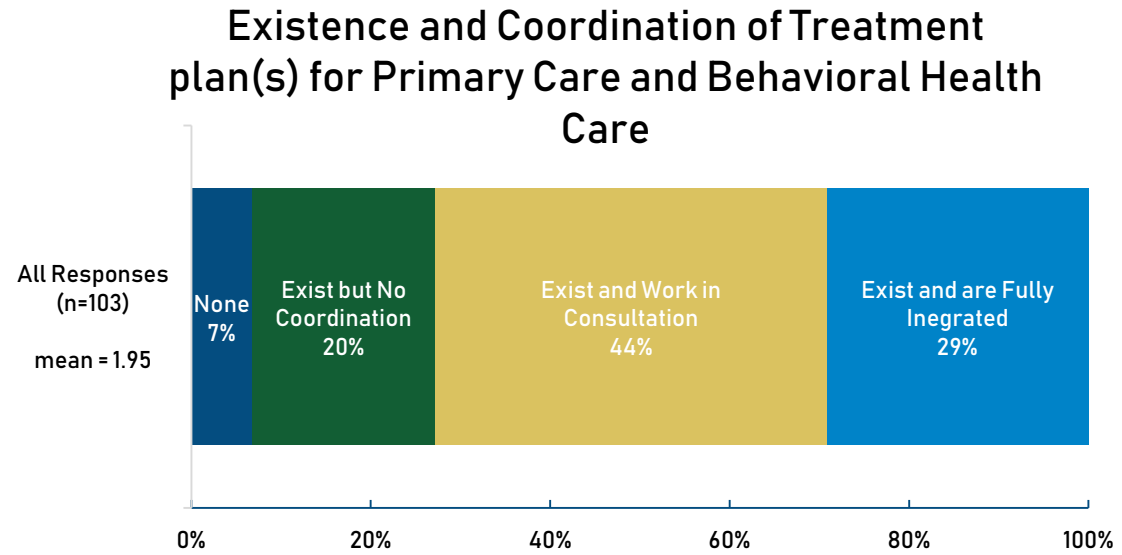
Behavioral Health Homes were the least likely to have assessments of medical and behavioral health needs integrated as a regular part of care (57%)

All Health Home respondents indicated assessments as a regular part of care

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.75			25%	75%
BHH n=14	2.57			43%	57%
HH n=19	3.00				100%
2 or more home types n=19	2.74		11%	5%	84%

Existence and Coordination of Treatment Plans (All Respondents)

Most respondents (43%) reported moderate progress for treatment plans, with providers having separate plans but working in consultation



- do not exist (no progress)
- exist, but are separate and uncoordinated among providers; occasional sharing of information occurs (early progress)
- Providers have separate plans, but work in consultation; needs for specialty care are served seperately (moderate progress)
- are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care (regular part of care)

Q9

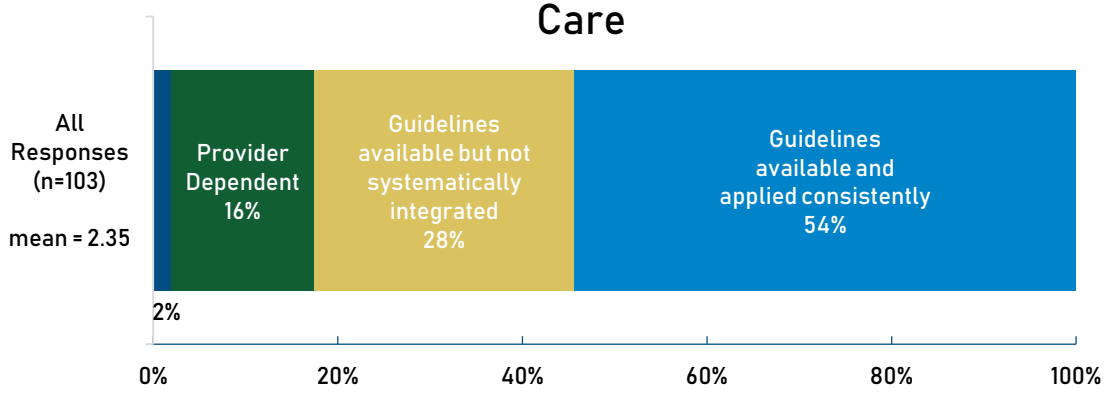
Existence and Coordination (By Home Types)

Health Homes were the most likely and Behavioral Health Homes were the least likely to have assessments of medical and behavioral health needs integrated and accessible to all providers and care managers

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.00	13%	13%	38%	38%
BHH n=14	1.93		21%	64%	14%
HH n=19	2.53			47%	53%
2 or more home types n=19	2.32		11%	47%	42%

Use of Best Practices for Patient Care(All Respondents)

Most respondents (54%) reported that following evidence-based guidelines for treatment and practices are a regular part of care

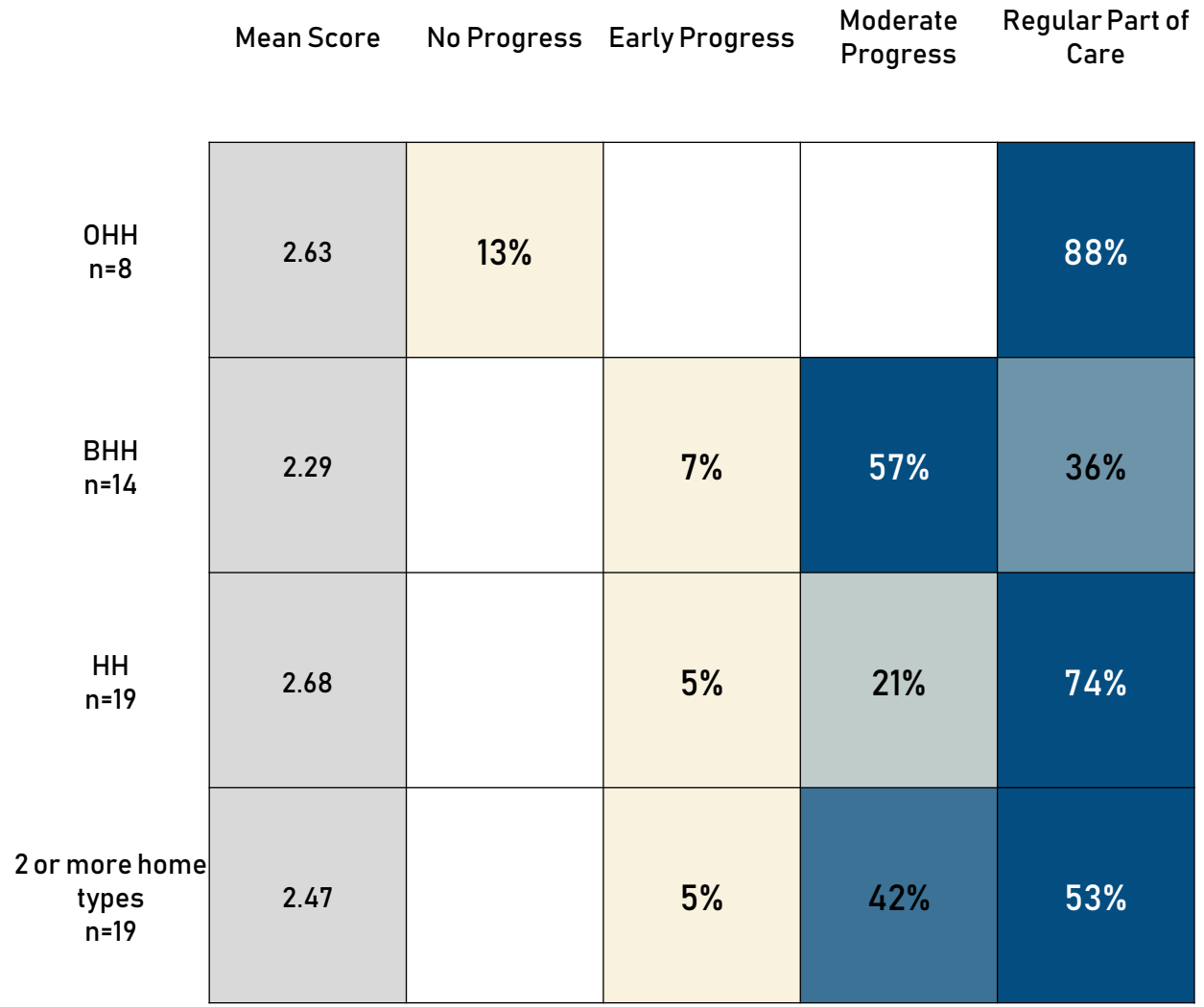


- does not exist in a systematic way (no progress)
- depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases (early progress)
- evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers (moderate progress)
- follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently (regular part of care)

Q10

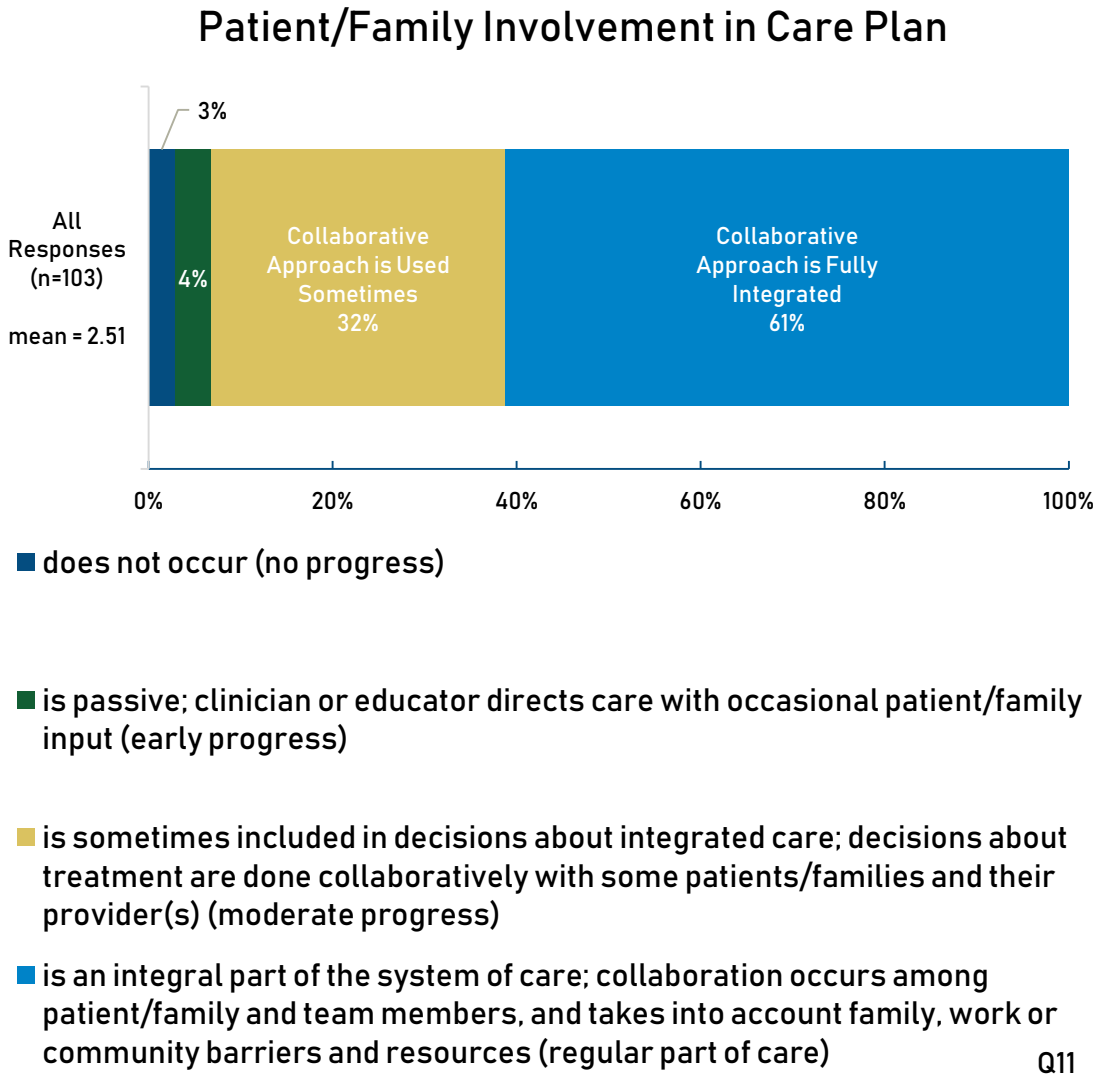
Use of Best Practices for Patient Care (By Home Types)

Opioid Health Homes were the most likely to have patient care that is appropriately and consistently based on evidence-based guidelines for treatment and practices



Patient/Family Involvement in Care Plan (All Respondents)

Most respondents (61%) indicated that patient/family involvement in the care plan is an integral part of the system of care; collaboration occurs among patient/family team members and takes into account family, work, or community barriers/resources



Q11

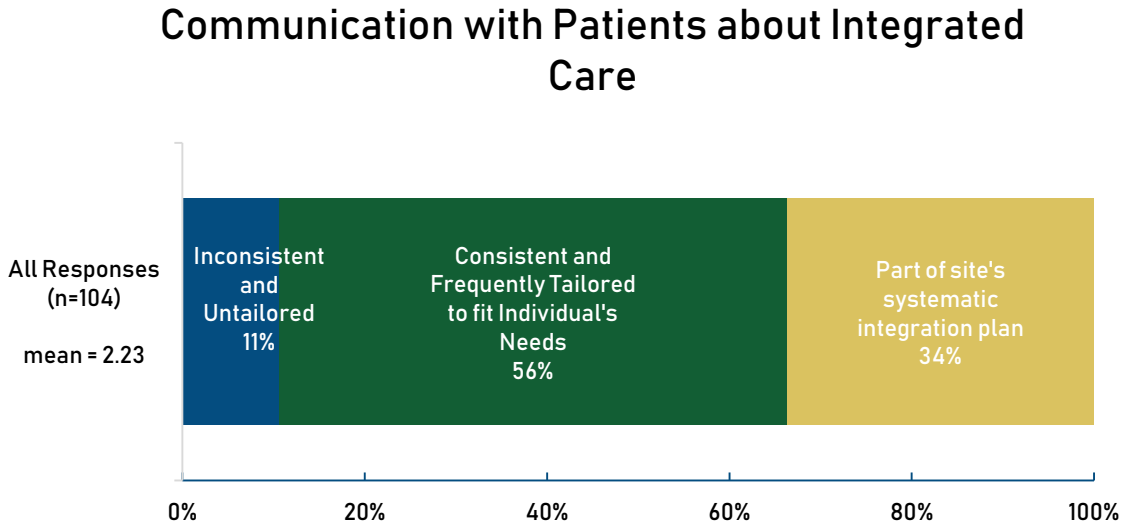
Patient/Family Involvement in Care Plan (By Home Types)

Opioid Health Homes were the least likely to regularly have patient/family involvement in care plans (25%), however 75% of OHH respondents said it happens sometimes

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.25			75%	25%
BHH n=14	2.71			29%	71%
HH n=19	2.74			26%	74%
2 or more home types n=19	2.58		5%	32%	63%

Communication about Integrated Care (All Respondents)

Most respondents reported moderate progress (56%) with communication regarding integrated care occurring as part of patient visits



- occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style (early progress)
- a part of patient visits; team members communicate w/patients about integrated care; encourage patients to become active participants in care + decision making; tailoring to patient/family cultures, learning styles is frequent (moderate progress)
- is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in how to communicate with patients about integrated care (regular part of care)

Q12

Communication about Integrated Care (By Home Types)

Nearly all respondents indicated communication with patients about integrated care occurs at a patient visit or is systematically a part of care

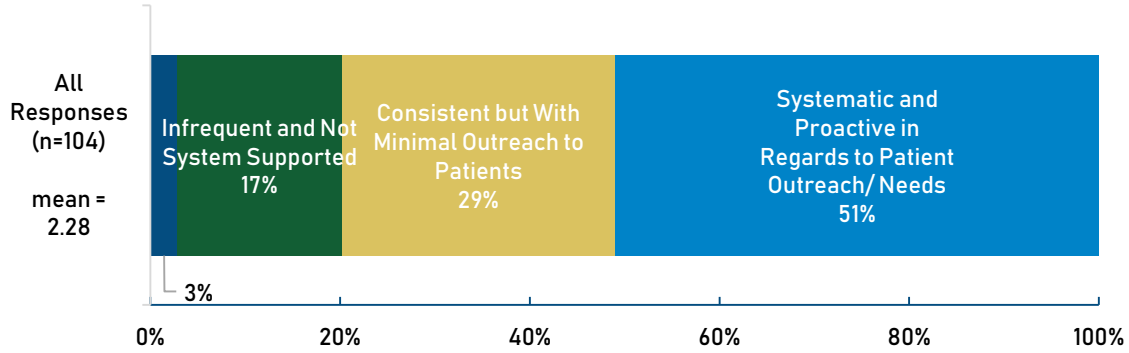
Opioid Health Homes were the most likely to regularly communicate with patients about integrated care and have this communication as a systematic part of a site's integration plan

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.75			25%	75%
BHH n=14	2.14			86%	14%
HH n=19	2.42		5%	47%	47%
2 or more home types n=19	2.37		5%	53%	42%

Following-Up With Patients (All Respondents)

Most respondents reported the follow-up of assessments, tests, treatment, referrals, and other services as a regular part of care (51%)

Provider Responsibility for Follow-up of Assessments, Tests, Treatment, Referrals and Other Services



- is done at the initiative of the patient/family members (no progress)
- is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up (early progress)
- is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments (moderate progress)
- is done by a systematic process including monitoring utilization; includes interpretation of assessments/lab tests; is customized to patients' needs, using varied methods; proactive in outreach to patients who miss appointments (regular part of care) Q13

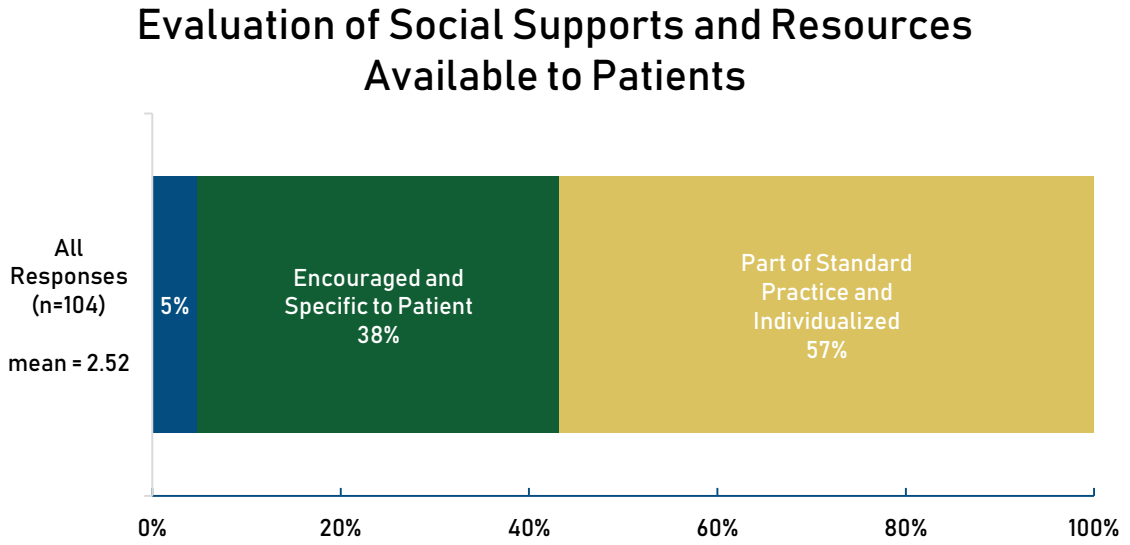
Following-Up With Patients (By Home Types)

The majority of respondents indicated following-up with patients for assessments, tests, treatment, referrals, and other services as a regular part of care, however Health Homes indicate they have made the most progress overall (mean score 2.79)

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.75		13%		88%
BHH n=14	2.36		14%	36%	50%
HH n=19	2.79			21%	79%
2 or more home types n=19	2.42		11%	37%	53%

Social Support Linkages (All Respondents)

Most respondents reported linking patients with social supports for treatment implementation as a regular part of care (57%)



- is discussed in general terms, not based on an assessment of patient's individual needs or resources (early progress)
- is encouraged through collaborative exploration of resources available (e.g. significant others, education groups, support groups) to meet individual needs (moderate progress)
- is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources (regular part of care)

Q14

Social Support Linkages (By Home Types)

All Opioid Health Home respondents indicated linking to community resources is based on in-place systems for coordinated referrals; there is referral follow-up and communication among sites, resource organizations, and patients

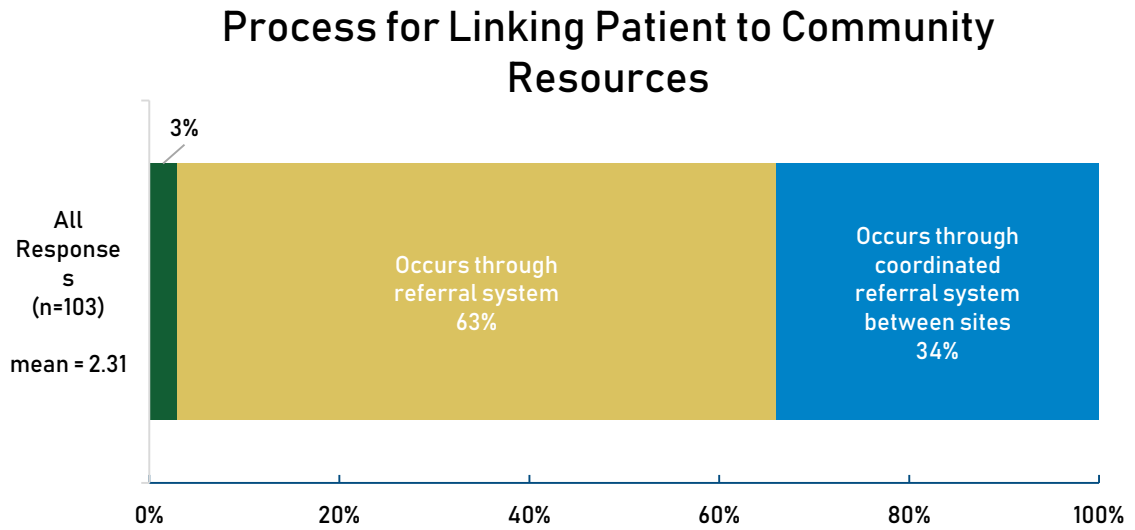
Health Home responses indicate there is room for improvement in regards to linking patients to social supports

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	3.00				100%
BHH n=14	2.50			50%	50%
HH n=19	2.37		11%	42%	47%
2 or more home types n=19	2.74			26%	74%

Community Resource Linkages (All Respondents)

Most respondents reported moderate progress towards linking patients with community resources (63%)

Responses indicate there are opportunities to progress towards integrating systems for coordinated referrals, follow-ups, and communications among community resources/organizations



- is limited to a list or pamphlet of contact information for relevant resources (early progress)
- occurs through a referral system; staff member discusses patient needs, barriers and appropriate resources before making referral (partial progress)
- is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and patients (regular part of care)

Q15

Community Resource Linkages (By Home Types)

Opioid Health Homes were the most likely to indicate they actively link patients to community resources via a system for coordinated referrals, follow-ups, and communications among community resources/organizations

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.88			13%	88%
BHH n=14	2.64			36%	64%
HH n=19	2.58		5%	32%	63%
2 or more home types n=19	2.79			21%	79%

Assessment Results:

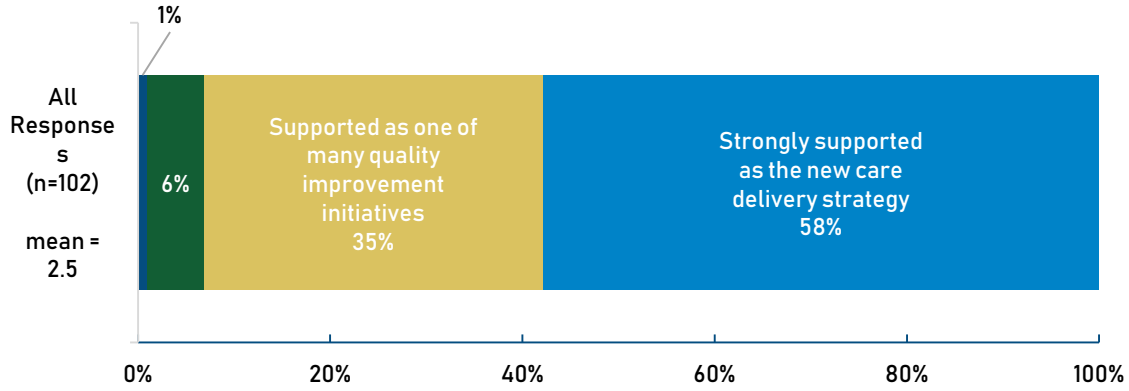
Practice and Organizational Level Integration

Organizational Leadership (All Respondents)

The majority of respondents indicated that organizational leadership strongly supports care integration (58%)

Nearly a third of respondents indicated moderate progress towards leadership strongly supporting care integration (35%)

Level of Support for Integrated Care amongst Organizational Leadership



- does not exist or shows little interest (no progress)
- is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care (early progress)
- is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings) (moderate progress)
- strongly supports care integration as a part of expected change in delivery strategy; provides support/resources for team time, staff education, info systems; integration project leaders viewed as organizational role models (regular part of care)

Q17

Organizational Leadership (By Home Types)

The majority of respondents indicated strong organizational leadership around care integration exists

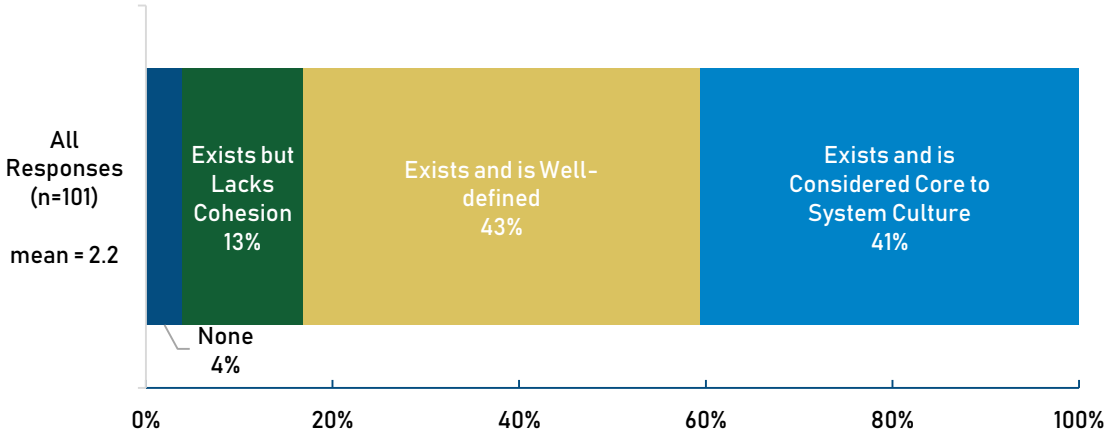
Behavioral Health Homes and Health Home respondents indicated the most room for improvement in this area

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.88			13%	88%
BHH n=14	2.64			36%	64%
HH n=19	2.58		5%	32%	63%
2 or more home types n=19	2.79			21%	79%

Integrating Care through Patient Care Teams (All Respondents)

Most respondents reported that the patient care teams charged with implementing care integration strategies are well defined (43%) and that integration is a concept embraced, supported, and rewarded by senior leadership (41%)

Existence of Patient Care Team for Implementing Integrated Care



- does not exist (no progress)
- exists but has little cohesiveness among team members; not central to care delivery (early progress)
- is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills (moderate progress)
- is a concept embraced, supported and rewarded by the senior leadership; teamwork is part of the system culture; case conferences and team meetings are regularly scheduled (regular part of care)

Q18

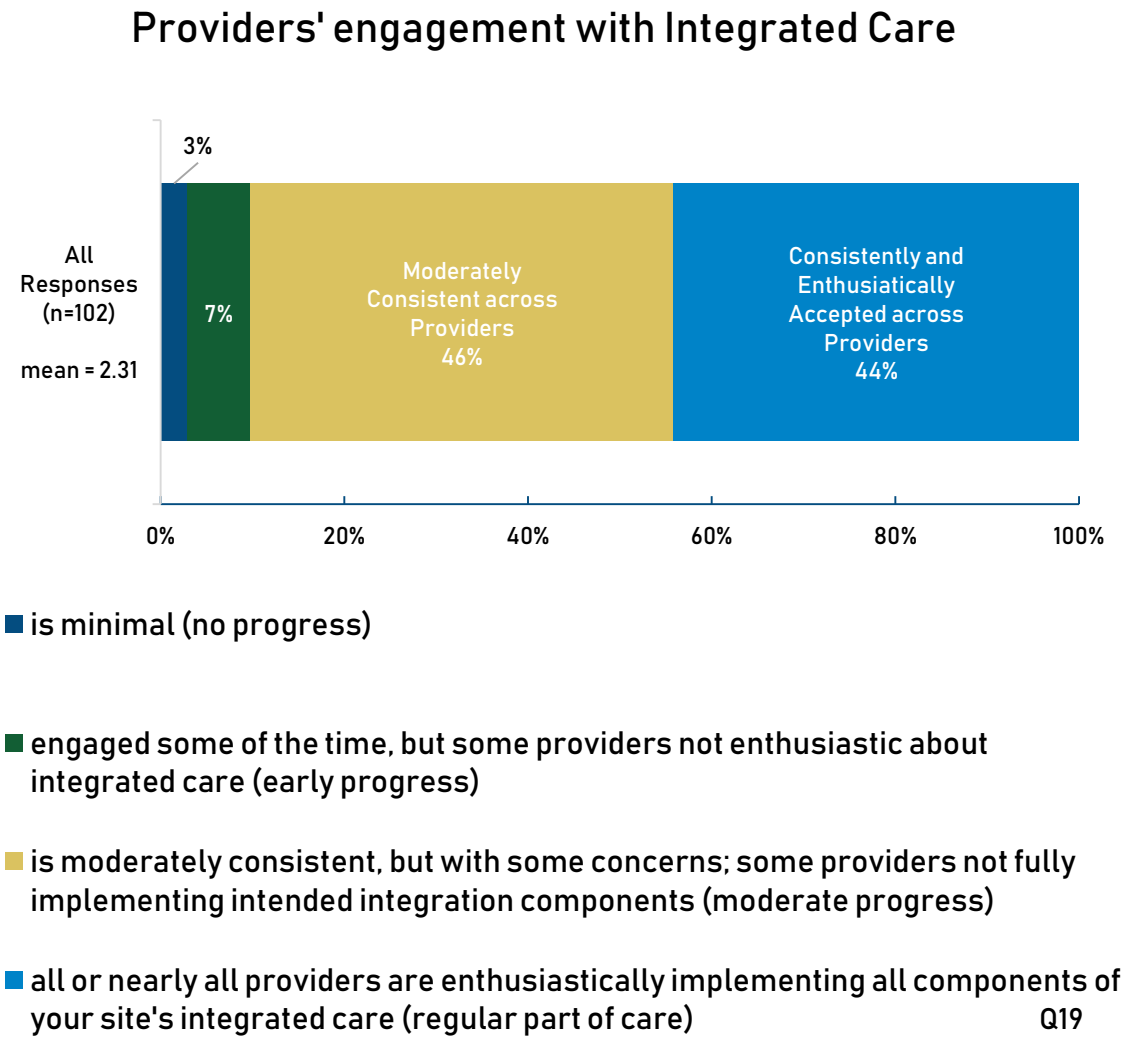
Integrating Care through Patient Care Teams (By Home Types)

With the exception Health Homes, most respondents indicated care is regularly integrated through patient care teams

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.75			25%	75%
BHH n=14	2.36	7%	7%	29%	57%
HH n=19	2.26		5%	63%	32%
2 or more home types n=19	2.32		16%	37%	47%

Providers' Engagement with Integrated Care (All Respondents)

The majority of respondents indicated providers' engagement with integrated care is moderately consistent (46%) or regularly consistent (44%) at their sites



Providers' Engagement with Integrated Care (By Home Types)

With the exception of Behavioral Health Home category, most respondents indicated all or nearly all providers are enthusiastically implementing integrated care at their sites (regular part of care)

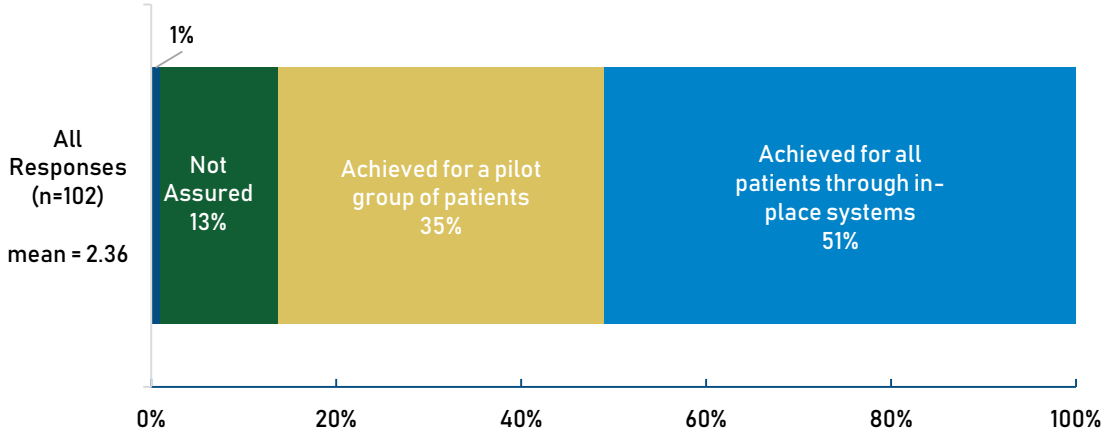
	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.88			13%	88%
BHH n=14	2.14		14%	57%	29%
HH n=19	2.74			26%	74%
2 or more home types n=19	2.37		11%	42%	47%

Continuity of Care (All Respondents)

Half of respondents felt that their organization had systems in place to support continuity of care between primary care and behavioral health

An additional 35% of respondents indicated continuity of care is achieved for some patients through a care manager or other strategy

Continuity of Care Between Primary Care and Behavioral Health



- does not exist (no progress)
- is not always assured; patients with multiple needs are responsible for their own coordination and follow-up (early progress)
- is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only (moderate progress)
- systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained (regular part of care)

Q20

Continuity of Care (By Home Types)

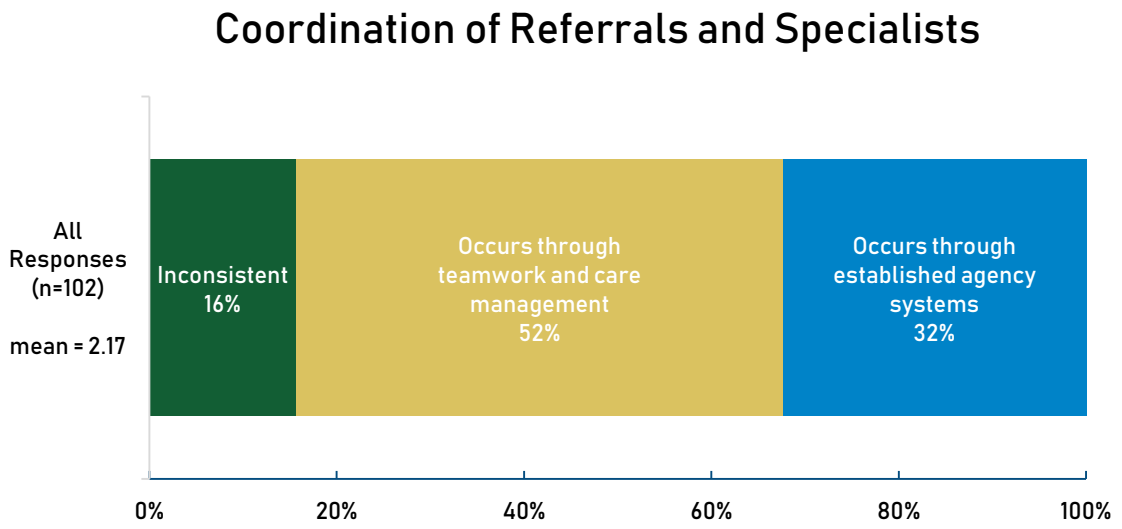
With the exception of Behavioral Health Home category, most respondents indicated systems are in place to ensure continuity of care for patients

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.75			25%	75%
BHH n=14	2.29		7%	57%	36%
HH n=19	2.79			21%	79%
2 or more home types n=19	2.53		5%	37%	58%

Coordination of Referrals and Specialists (All Respondents)

A third of respondents (32%) indicated coordination of referrals and specialists is accomplished through referral systems

Approximately half (52%) of respondents indicated the coordination of referrals and specialists occurs through teamwork and care management to recommended referrals



- is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team (early progress)
- occurs through teamwork & care management to recommend referrals; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care (moderate progress)
- is accomplished by having systems in place to refer, track incomplete referrals & follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training &QI (regular part of care)

Q21

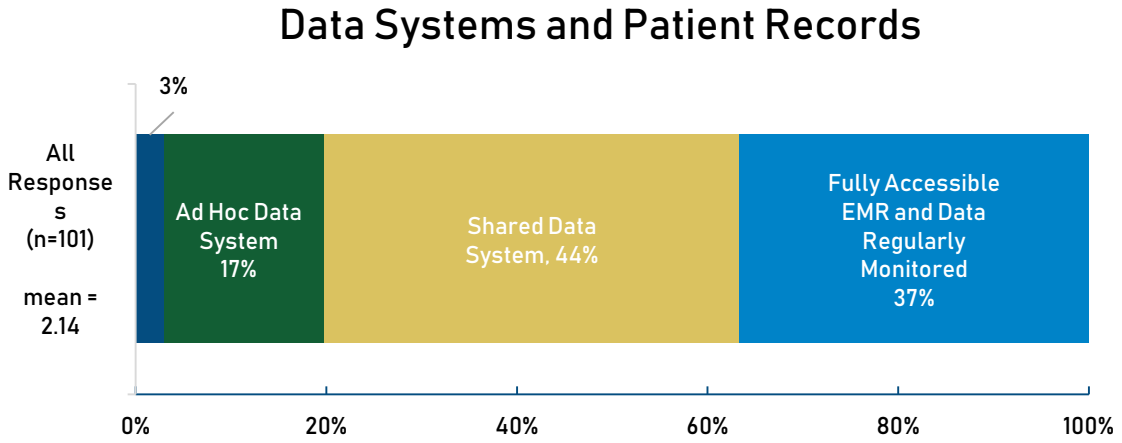
Coordination of Referrals and Specialists (By Home Types)

Respondents from Health Homes indicated the most progress towards the systematic coordination of referrals and specialists

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.50			50%	50%
BHH n=14	2.00		14%	71%	14%
HH n=19	2.58		5%	32%	63%
2 or more home types n=19	2.32		5%	58%	37%

Data Systems and Patient Records (All Respondents)

The majority of respondents had moderate (44%) or fully implemented (37%) data systems to support sharing of patient information to support care integration and coordination



- are based on paper records only; separate records used by each provider (no progress)
- are shared among providers on an ad hoc basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps (early progress)
- use a data system (paper/EMR) shared among the patient care team, who all have access to the med record, tx plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals (moderate progress)
- full EMR accessible to all providers; teams uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a CQI process (regular part of care)

Q22

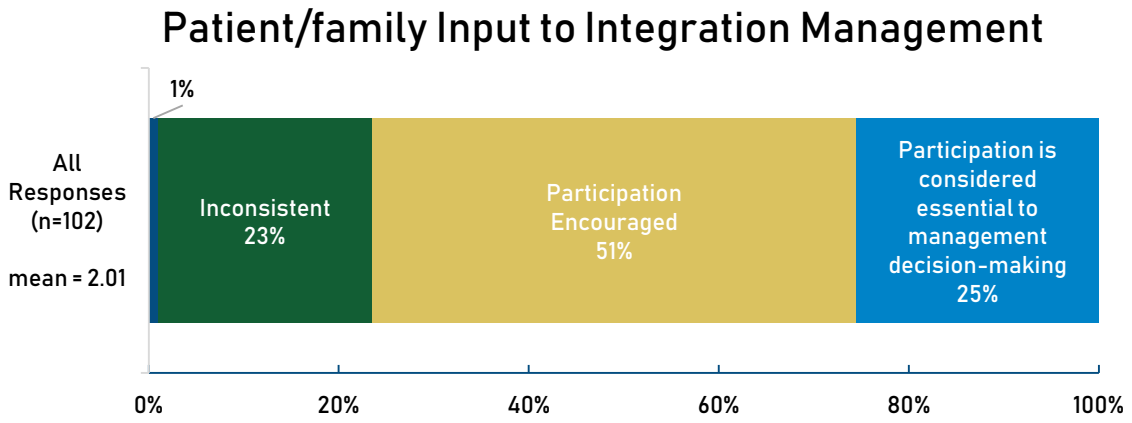
Data Systems and Patient Records (By Home Type)

Respondents from Health Homes indicated the most progress towards the systematic coordination of referrals and specialists

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.88			13%	88%
BHH n=14	2.14		14%	57%	29%
HH n=19	2.58		5%	32%	63%
2 or more home types n=19	2.21		21%	37%	42%

Patient/Family Input to Integration Management (All Respondents)

Half of respondents indicated that they have made moderate progress on implementing systems to solicit feedback from patients and family on integration efforts



- does not occur (no progress)
- occurs on ad hoc basis; not promoted systematically; patients must take initiative to make suggestions (early progress)
- is solicited through advisory groups, team members, focus groups, surveys,etc. for both current services & delivery improvements under consideration; patients/families are made aware of mechanism for input and encouraged to participate (moderate progress)
- is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information (regular part of care)

Q23

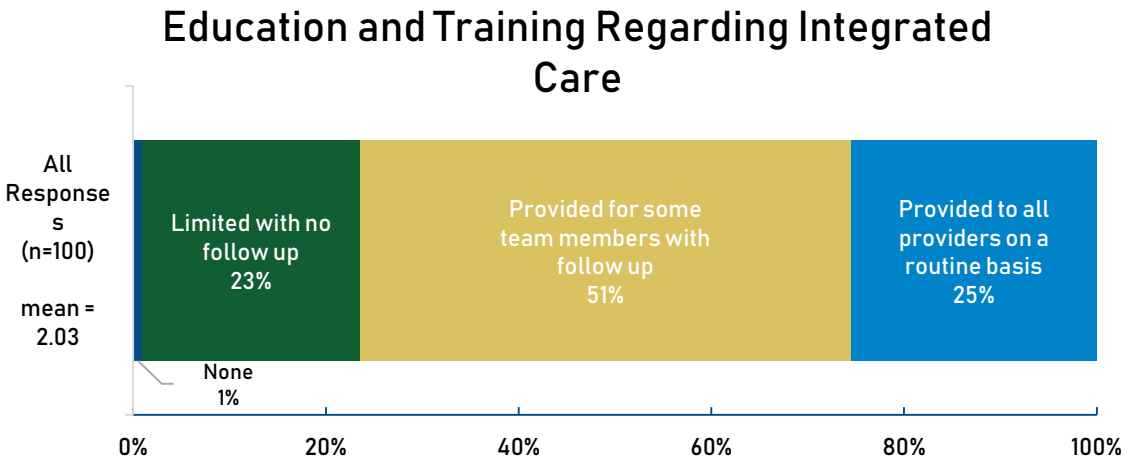
Patient/Family Input for Integration Management (By Home Type)

Respondents in each category were most likely to indicate they have made moderate progress towards implementing systems to solicit feedback from patients and family on integration efforts

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.25		13%	50%	38%
BHH n=14	2.07		21%	50%	29%
HH n=19	2.42			58%	42%
2 or more home types n=19	2.16		5%	74%	21%

Education and Training (All Respondents)

Half of respondents indicated that education and training is provided for some team members using established and standardized materials, protocols, or curricula



- does not occur (no progress)
- occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic (early progress)
- is provided for some team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation (moderate progress)
- supported + incentivized by the site for all providers; continuing ed about integration & evidence-based practice is routinely provided to maintain knowledge, skills; job descriptions reflect skills & orientation to care integration (regular part of care)

Q24

Education and Training (By Home Types)

<u>Respondents from Opioid Health Homes were most likely to indicate that</u>:

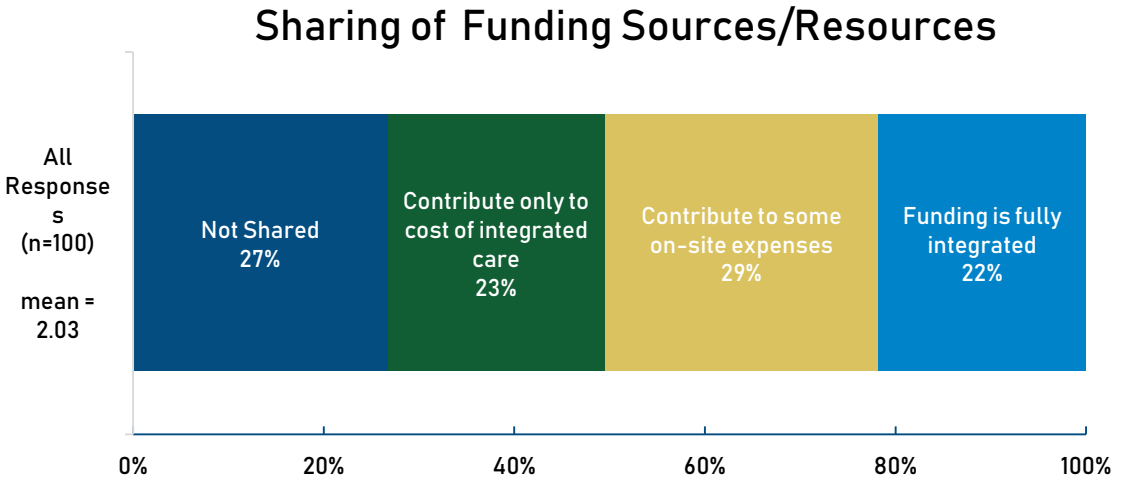
- education and training is supported and incentivized for all providers;
- continuing education about integration and evidence-based practice is routinely provided;
- job descriptions reflect skills and orientation to care integration

However, the number of responses in the "early progress" and "moderate progress" categories indicates there is room for improvement around support for education and training opportunities

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	2.75			25%	75%
BHH n=14	2.21		14%	50%	36%
HH n=19	2.42		5%	47%	47%
2 or more home types n=19	2.11		26%	37%	37%

Sharing of Funding and Resources (All Respondents)

Of all questions on the assessment, respondents indicated the lowest amount of progress around the sharing of funding and resources. Only 22% of respondents indicated that funding and resources are fully integrated or shared across providers



- no shared resource streams (no progress)
- separate primary care/behavioral health funding streams, but all contribute to cost of integrated care; few resources from participating organizations/agencies (early progress)
- separate funding streams, but some sharing of on-site expenses; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training (moderate progress)
- fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly (regular part of care)

Q25

Organization \ Practice

Sharing of Funding and Resources (By Home Types)

Respondents from organizations that have two or more homes were the least likely to indicate progress around the sharing of funding and resources

	Mean Score	No Progress	Early Progress	Moderate Progress	Regular Part of Care
OHH n=8	1.63	25%	25%	13%	38%
BHH n=14	1.43	29%	7%	57%	7%
HH n=19	2.21		16%	47%	37%
2 or more home types n=19	1.63	16%	32%	26%	26%

Appendix A:

Assessment Questions

Appendix A:

Assessment Questions

I. Integrated Services and Patient and Family-Centeredness

	(0) No Progress	(1) Early Progress	(2) Moderate Progress	(3) Regular Part of Care
Q7 Co-location of treatment for primary care and behavioral health care...	○ does not exist; consumers go to separate sites for services	○ is minimal; but some conversations occur among types of providers; established referral partners exist	○ is partially provided; multiple services are available at same site; some coordination of appointments and services	○ exists, with one reception area; appointments jointly scheduled; one visit can address multiple needs
Q8 Emotional/behavioral health needs (e.g., stress, depression, anxiety, substance use)... (ALTERNATE: If you are a behavioral health site, respond in terms of medical care needs)...	○ are not assessed (in this site)	○ are occasionally assessed; screening/assessment protocols are not standardized or are nonexistent	○ screening/assessment is integrated into care on a pilot basis; assessment results are documented prior to treatment	○ screening/assessment tools are integrated into practice pathways to routinely assess behavioral health/primary care needs of all patients; standardized screening/ assessment protocols are used and documented
Q9 Treatment plan(s) for primary care and behavioral health care...	○ do not exist	○ exist, but are separate and uncoordinated among providers; occasional sharing of information occurs	○ Providers have separate plans, but work in consultation; needs for specialty care are served separately	○ are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care

Appendix A:

Assessment Questions

Q10 Patient care that is based on (or informed by) best practice evidence for BH and primary care...

(0)	(1)	(2)	(3)
does not exist in a systematic way	depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases	evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence -based treatment depends on preferences of individual providers	follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently

Q11 Patient/family involvement in care plan...

(0)	(1)	(2)	(3)
does not occur	is passive; clinician or educator directs care with occasional patient/family input	is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with some patients/families and their provider(s)	is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources
No Progress	Early Progress	Moderate Progress	Regular Part of Care

Q12 Communication with patients about integrated care...

(0)	(1)	(2)	(3)
does not occur	occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style	occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/family cultures and learning styles is frequent	is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in how to communicate with patients about integrated care

Appendix A:

Assessment Questions

Q13 Follow-up of assessments, tests, treatment, referrals and other services

- ○ is done at the initiative of the patient/family members
- ○ is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up
- ○ is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments
- ○ is done by a systematic process that includes monitoring patient utilization; includes interpretation of assessments/lab tests for all patients; is customized to patients' needs, using varied methods; is proactive in outreach to patients who miss appointments

Q14 Social support (for patients to implement recommended treatment)...

- ○ is not addressed
- ○ is discussed in general terms, not based on an assessment of patient's individual needs or resources
- ○ is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs
- ○ is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources

Q15 Linking to Community Resources...

- ○ does not occur
- ○ is limited to a list or pamphlet of contact information for relevant resources
- ○ occurs through a referral system; staff member discusses patient needs, barriers and appropriate resources before making referral
- ○ is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and patients

Q16 Additional comments:

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Appendix A:

Assessment Questions

II. Practice/Organization

	(0) No Progress	(1) Early Progress	(2) Moderate Progress	(3) Regular Part of Care
Q17 Organizational leadership for integrated care...	○ does not exist or shows little interest	○ is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care	○ is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings)	○ strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models
Q18 Patient care team for implementing integrated care...	○ does not exist	○ exists but has little cohesiveness among team members; not central to care delivery	○ is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross -trained, have complementary skills	○ is a concept embraced, supported and rewarded by the senior leadership; teamwork is part of the system culture; case conferences and team meetings are regularly scheduled

Appendix A:

Assessment Questions

	(0) No Progress	(1) Early Progress	(2) Moderate Progress	(3) Regular Part of Care
Q19 Providers' engagement with integrated care ("buy-in")...	○ is minimal	○ engaged some of the time, but some providers not enthusiastic about integrated care	○ is moderately consistent, but with some concerns; some providers not fully implementing intended integration components	○ all or nearly all providers are enthusiastically implementing all components of your site's integrated care
Q20 Continuity of care between primary care and behavioral health...	○ does not exist	○ is not always assured; patients with multiple needs are responsible for their own coordination and follow- up	○ is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only	○ systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained
Q21 Coordination of referrals and specialists...	○ does not exist	○ is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team	○ occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care	○ is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement

Appendix A:

Assessment Questions

Q22 Data systems/patient records...

○ are based on paper records only; separate records used by each provider	○ are shared among providers on an ad hoc basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps	○ use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches quality improvement projects to achieve measurable goals	○ has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous quality improvement process

Q23 Patient/family input to integration management...

○ does not occur	○ occurs on an ad hoc basis; not promoted systematically; patients must take initiative to make suggestions	○ is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consideration; patients/ families are made aware of mechanism for input and encouraged to participate	○ is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information

Appendix A:

Assessment Questions

Q24 Physician, team and staff education and training for integrated care...

does not occur	occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic	is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation	is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration

Q25 Funding sources/resources...

no shared resource streams	separate primary care/behavioral health funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies	separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training	fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly

Q26 Additional comments:

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Appendix B:

Deployment Details

Deployment Details

Deployment List:

Several lists of providers from the Office of MaineCare services were compiled by the Cutler Institute to create an assessment mailing list to be used for electronic deployment via the Cutler Institute's iteration of Snap Survey.

Deployment Timeline:

10/14/2020- Initial deployment from Michelle Probert (10/30/2020 deadline)
10/27/2020- Reminder
10/30/2020– Reminder & deadline extension to 11/06/2020
12/08/2020– Reminder & deadline extension to 12/31/2020
12/15/2020- Reminder
12/22/2020– Final reminder
1/29/2021- Assessment closed to further responses

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