No Going Back - Integrated Care Takes Hold in Western NH

Introduction – A Life Well Saved

It was Spring of 2019 when one of the integrated care teams announced that they had saved a life. We were all gathered in an old converted mill building along the Sugar River in Claremont NH that morning and that announcement picked up some chins and opened wide some eyes in a room filled with doctors, community health workers, mental health counselors, non-profit community organization leaders, psychiatrists, and county government leaders. For this was not heart surgery where a saved life is fairly easy to discern from one lost. This was integrated care, where the teams were addressing a whole range of factors impacting patient health, from chronic disease management to mental health care to substance use treatment to basic human need relief. Lifesaving in this part of healthcare is elusive and the fruits of change show up on a time scale of decades not days.

But that day, an integrated care team had gotten out just ahead of a certain teen suicide. The two possible futures were standing starkly side by side and were clear as day for everyone in the room. The avoided future was one of near unbearable grief for family and friends. It was a future of school interventions and grief counselors and hundreds, maybe thousands of hard conversations among parents and their kids as a community wraps around the tragic loss of a child. But not today. The future that actually happened was one where a teenager and a family were quickly, calmly, and expertly supported from crisis to safety.

Comprehensive Screening – An Opening Signal for Care

The integrated care team credits a comprehensive assessment for saving this life. This inexpensive patient questionnaire is taking hold in Western NH as a new 'vital sign' to be gathered at primary care and behavioral health appointments, as simply and routinely as height, weight, and blood pressure are gathered. The questions are far ranging and take patients an average of 12 minutes to complete prior to a medical appointment. Some patients complete the questions through a patient portal at home the day before the appointment while others fill out questions on a tablet or clipboard in the waiting room before non-emergent visits. Since patients arrive an average of 16-17 minutes early to their appointments, most have time to complete the questions.[1]

The questions themselves uncover patient need for support in five important areas:[2]

- Physical health questions provide a patient with an opportunity to self-identify issues with physical health and chronic disease management.
- Mental health questions provide a patient a chance to identify symptoms of anxiety and depression.
- Substance use questions help a patient identify concerning use of alcohol, drugs, and nicotine.
- Social determinants of health questions provide an opening for a patient to identify gaps in basic human needs such as housing, food, financial support, employment, education, and others.

[1] Time study of Comprehensive Core Standardized Assessment completion at two Dartmouth Hitchcock Clinic primary care locations. March-April 2019.

[2] Region 1 IDN Protocol for Comprehensive Core Standardized Assessment, 2018., Region 1 IDN website resources, http://region1idn.org/resources/

- Safety questions help a patient send up a bright flag for help with an unsafe home, inter-partner violence, and suicidal thoughts.

Many of the questionnaires include a "health confidence" question and a "courtesy" question. The health confidence question asks "How confident are you that you can control and manage most of your health problems?" and the response choices are "very confident," "somewhat confident," "not very confident," and "I do not have any health problems." The health confidence question provides an opening for a conversation about getting more help to manage health. The answer to this question is also predictive of health outcomes and use of hospital and emergency department care.[3] The courtesy question asks the patient if they want any help. This question lets the patient indicate if they are already getting the help they need and puts the patient in control of asking for additional help.

As of December 2020, 22,686 comprehensive assessments had been administered reaching a rate of ~1,000 screens per month across the Region 1 Integrated Delivery Network (IDN). Region 1 spans the western side of NH from lower Grafton County south to the Massachusetts border and eastward to the Monadnock region. 29,000 Medicaid members reside in Region 1 with roughly 2/3 presenting at a primary care or behavioral health visit during a given year. ~38% of presenting Medicaid Members are now being screened comprehensively in a semi-annual reporting period, up from near zero when care integration work began in 2017. Screening rates have been on a sharp upward incline and are on the way to becoming a routine part of patient care here.

Screening Follow Up – New Paths Opened

The comprehensive assessment 'vital sign' helps the integrated care team detect when something is amiss with a person's health and well-being. But what can an integrated team do with the new information? Among the Region 1 IDN integrated care projects, a "positive" screening result is providing the opening for a person-centered conversation where the clinician and patient discuss their health concerns and patient goals during the appointment. The screening and the goal setting together open up one or more care paths, each staffed with experts working together across organizations and disciplines:

- Intervention for Safety
- Introduction to Behavioral Health, and
- Engagement of Community Supports

Intervention for safety is a path opened with the discovery of suicidal thoughts or inter partner / domestic violence. This path is one of crisis, stabilization, and ongoing management and specialists from both healthcare and community support agencies are engaged seamlessly to help patients through each stage. Local experts are supported with training as part of the NH Zero Suicide Initiative.[4]

Introduction to Behavioral Health is a path opened with the discovery of mental health and/or substance misuse needs. There are a variety of models tested in Region 1 IDN, and each one includes a

[3] John Wasson, MD, and Eric A. Coleman, MD, MPH., Health Confidence: A Simple, Essential Measure for Patient Engagement and Better Practice, Asking patients this one question can lead to better outcomes. American Academy of Family Physicians., https://www.aafp.org/fpm/2014/0900/p8.html

[4] NH Zero Suicide Initiative, NH Department of Health and Human Services, https://www.dhhs.nh.gov/dphs/bchs/spc/suicide-prevention-events.htm

"warm transition" to a behavioral health counselor. "Warm transition" means that the primary care clinician begins the goal setting and follow up intervention and then transitions the patient, often in person, to a behavioral health expert. That behavioral health counselor works closely with the patient and engages additional specialty resources as needed, such as a mental health counselor, a psychiatrist, or a substance use disorder treatment provider. With the emergence of the NH Doorways program in 2019, the integrated care teams now have additional resources to support NH residents with Opioid Use Disorder.[5]

Engagement of Community Supports is a path opened with discovery of unfulfilled basic human needs. The most common unfulfilled needs in Region 1 IDN that we know of to date are financial assistance, food, housing, health insurance, and transportation though there are many more. With the discovery of unfulfilled basic needs through comprehensive screening, a Community Health Worker (CHW) is prompted to reach out to the patient after the appointment. The CHW works with the patient to further understand the patient and family needs and goals for community supports and then partners with the patient and family to work through each one. In many cases, the CHW will engage expert resources from several local Community Support Organizations to help. In Region 1 IDN, the CHWs coordinate closely with over 60 Region 1 Partner organizations to meet the needs of the Medicaid population.[6]

With all three paths, the focus is on supporting the patient and family and on removing as much friction as possible while providing that support. This is the essence of the NH care integration work. Just a couple of years ago a patient and caregiver would have had to find and engage needed supports on their own. Given the number of specialized experts and organizations needed to support many individuals, many needs were going unmet and the hassle, inconvenience, and inefficiency of pulling together holistic care was untenable. The Region 1 integration work has focused on the intersections among organizations and the transitions of Medicaid Members across organizational boundaries. Organizations have been coming together for several years now to support those transitions so patients can get the support they need.

Multi-Disciplinary Core Team – Shared Care Planning for Those with Complex Care Needs

For a small number of NH Medicaid members, the screening and referral paths described earlier are not enough to support their complex care coordination needs. For these patients, the integrated care teams are now providing more intensive care coordination which comprises periodic "shared care planning" among a "multi-disciplinary core team."

Each month across the region, care team coordinators prepare several multi-disciplinary core teams to meet. The patient either attends the meeting or works with their provider on the goals to be discussed by the integrated care team and permission to do so. That team includes the care team coordinators, the primary care providers, and the mental healthcare providers who are currently working most closely with the patient. Some teams also include the behavioral health coordinator and Community Health Worker to maintain alignment with ongoing referral and follow up work. Since the meeting attendees work for separate organizations and may need to share sensitive information regarding mental health and/or substance use disorder treatment, the teams meet with the patient prior to the meeting to explain how it works and to gather appropriate consent for sharing information.

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[5] NH Doorways program, https://thedoorway.nh.gov/home

[6] Region 1 Integrated Delivery Network Partners. http://region1idn.org/partners/

The meetings are intense. Experts in primary care work closely with experts in behavioral health to try to figure out the best way to support the patients they together "share." There is a canyonlike historical divide in the U.S. healthcare system between the physical health and mental health disciplines, but here in Western NH that divide is closing in many places and today primary care and behavioral health medical colleagues are simply bringing their specialty expertise to help patients with complex needs.

A "Shared Care Plan" is a concise orchestrating plan developed among the integrated team to help guide ongoing care for the patient. The plan is intentionally simple and focuses on the valuable information that clinicians often struggle to share with each other through electronic health records and care summaries. The plans all include the following basic structure:

- Care Team: A list of current integrated care team members and their contact information
- Person-Centered Goals: A patient-defined outcome or condition to be achieved in the process of care. (e.g., alleviation of health concerns, desired/intended positive outcomes from interventions, longevity, function, symptom management, comfort, wellness, stability)
- Concerns: A Patient and/or Care Team-defined interest or worry that may require attention, intervention, or management. (e.g., Homelessness, Food insecurity, Domestic Violence, Schizophrenia, Diabetes)
- Plan: A Care Team plan for addressing Goals and Concerns. Forward looking plan that helps orchestrate actions of the Care Team and Community Support providers.

The Shared Care Plans reside in two places. The teams record the shared care plan fields in their electronic health record system for internal use and the teams copy the information to a secure platform for shared access among the Patient's care team. Excitingly, the shared care plans are also automatically pushed to hospital emergency department staff when a patient checks in during an emergency. The emergency department teams at Cheshire Medical Center, Valley Regional Hospital, Alice Peck Day, and Dartmouth Hitchcock Medical Center are now all getting critical information from the community primary care and behavioral health providers in real time.

What Is Left To Do – Spreading and Sustaining Best Practice

The clear work ahead is to share and spread and scale the integrated care projects that are underway throughout Western NH. This transformative work started out in 'pilot' form in many organizations and has already expanded outward quite some distance, but there is more to do and further to go to make sure best practices stick.

The NH Medicaid 1115 Waiver concluded in December of 2020 and the programmatic and funding support that helped implement this work is tapering off over the coming months. There is hope that new funding sources may be found in 2021 and beyond to complete the remaining work which includes:

- Expanding the comprehensive assessment 'vital signs' so we may accurately detect the needs of many more of our citizens
- Sustaining and scaling the work of the behavioral health coordinators and community health workers in line with the support needs discovered
- Identifying and engaging more complex patients in shared care planning
- Expanding the circle of primary care and behavioral health providers engaging in shared care planning with complex patients.

About Region 1 IDN

Region 1 Integrated Delivery Network is one of 7 IDNs that support the NH Medicaid 1115 Waiver. Region 1 IDN has completed a 5-year demonstration program to integrate primary care, behavioral health care, and community supports. Region 1 IDN successfully implemented care integration programs among large primary care provider organizations, 4 large behavioral health provider organizations, 5 hospitals, and multiple community supports organizations. All programs were supported with workforce funding and training as well as foundational health information technology services for shared care planning, event notification, patient privacy, and clinical quality reporting. The fiscal sponsors and administrative leads for Region 1 IDN are Dartmouth Hitchcock Medical Center and Cheshire Medical Center.