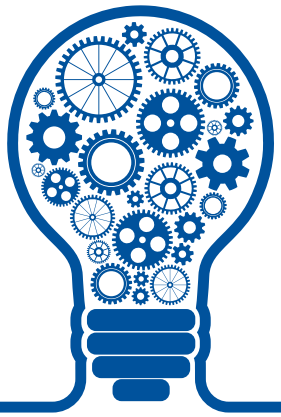
Michigan Health Council

Building Best Practices With Teamwork



Agenda and Annotated Bibliography

November 10, 2015 • University Club of MSU • Lansing, MI

Michigan Health Council

Dear Colleague,

Thank you for joining us for lunch to discuss ways to Build Best Practices with Teamwork.

Since teamwork or "interprofessional collaboration" can be defined in different ways, the Michigan Health Council has adapted this definition from Health Canada:

> Interprofessional collaboration is a process for communication and decision making that enables the separate and shared knowledge and skills of different care providers to synergistically influence the care provided through changed attitudes and behaviors, all the while emphasizing person-centered goals and values.

We hope you use today's informal dialogue with three teamwork experts to imagine ways in which interprofessional collaboration can transform health care in our state. As I engage with our speakers, I encourage you to think about the questions you want to ask during our discussion following lunch.

The annotated bibliography included in this booklet ensures you leave today with resources recommended by our experts. We plan to continue advancing teamwork best practices online at Education2Practice.org—our clinical practice consulting service.

How do you envision building best practices with teamwork? We hope you share your ideas with us and your colleagues.

Warm regards,

Melanie Brim

Melanie Brim
President and CEO
Michigan Health Council

Speakers

Ingemar Johansson

Chief Operating Officer & Director, Northern Michigan Health Coalition & Centra Wellness Network

The Northern Michigan Health Coalition currently involves 14 organizations comprehensively serving the health needs of individuals across ten counties in northwest Michigan by vertically integrating primary care, acute care, and behavioral health with substance abuse treatment, dental care, elder care, public health, and social work.

Ruth Clark

Executive Director, Integrated Health Partners

Integrated Health Partners is a Physician Hospital Organization with 170 affiliated physicians representing 34 specialties using a learning collaborative model across their region to set goals, train together, and share best practices with each other to address community health needs like chronic disease management and promoting preventative care.

Stacey Gedeon

Director, Behavioral Health & Integrated Primary Care, MidMichigan Community Health Services

MidMichigan Community Health Services is a Federally Qualified Health Center based in Houghton Lake that established an integrated primary care program in 2012 using a team of primary care and behavioral health clinicians.

Agenda

11:00 Opening remarks

11:10 Moderated discussion with experts

11:55 Lunch

12:25 Your opportunity to ask the experts

12:55 Closing remarks

1:00 Adjourn

Annotated Bibliography

Our research staff compiled this annotated bibliography as a "thank you" for participating in the discussion.

This information will also be available on the Michigan Health Council's Education to Practice website at education2practice.org.

Today's experts recommend you consult these resources as you consider ways to Build Best Practices with Teamwork.

Agency for Healthcare Research and Quality Lexicon for Behavioral Health and Primary Care Integration

http://integrationacademy.ahrq.gov/lexicon

Expert consensus developed the set of concepts and definitions contained in the Lexicon for what is meant by behavioral and primary care integration—a functional definition—of what things look like in practice. The report defines integration as, "The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."

Cherokee Health Systems

http://www.cherokeehealth.com

Located in Tennessee, the Cherokee Health Systems possess a blended behavioral health and primary care clinical model. Features of the model include: embedded behavioral consultant on the primary care team, real time behavioral and psychiatric consultation available to primary care providers, and a behavioral medicine scope of practice.

Collaborative Family Healthcare Association
Primary Care Behavioral Health Frequently Asked Questions

https://cfha.site-ym.com/?PCBHFAQs

Q: What can a behavioral health consultant do if there is a medical provider who is resistant or reluctant to work with a behavioral health consultant?

A: Communicating in a concise, jargon-free way, accentuating only the most pertinent information of a case is a good way to gain respect and have successful interactions while working with often overstretched primary care providers.

Chronic Care Model (Improving Chronic Illness Care)

http://improvingchroniccare.org

Improving Chronic Illness Care was a national program of the Robert Wood Johnson Foundation launched in 1998 with The Chronic Care Model (CCM) at its conceptual core. The model depicts Community Resources and Policies existing alongside Health Systems and the Organization of Health Care that collectively influence the productive interactions between informed, activated patients and prepared, proactive teams. All of these factors impact improved outcomes related to chronic conditions defined as “any condition that requires ongoing

adjustments by the affected person and interactions with the health care system."

Community Care of North Carolina

https://www.communitycarenc.org

Community Care is public-private partnership that brought together regional networks of physicians, nurses, pharmacists, hospitals, health departments, social service agencies and other community organizations. These professionals work together to provide cooperative, coordinated care through the Medical Home model. An independent evaluation found that Community Care saved nearly a billion dollars between 2007 and 2010.

Education to Practice

http://www.education2practice.org

E2P is a nonprofit clinical practice consulting service offered by the Michigan Health Council. With the help of a co-occurring chronic health conditions expert, E2P helps its clients implement interprofessional collaboration by focusing on eight steps. These steps include: establishing support, mapping organizational support, developing core competencies, training the facilitator, forming the team, creating/customizing tools, calibrating team performance, and measuring progress.

Evolving Models of Behavioral Health Integration in Primary Care

http://www.milbank.org/uploads/documents/10430Evolving-Care/EvolvingCare.pdf

The Milbank Memorial Fund published this report by Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade. The authors provide a summary of the existing evidence supporting integration as a way to deliver quality, effective physical and mental

health care. Included in the report are descriptions of eight different delivery models, representing different approaches to integrating or coordinating care across a continuum. The report also describes four quadrants of clinical integration based on an assessment of the complexity of the patient's physical and behavioral health needs.

Model for Improvement

http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

The Institute for Healthcare Improvement (IHI) uses the Associates in Process Improvement's Model for Improvement to accelerate progress. The model has two interrelated parts—three fundamental questions that can be addressed in any order and the Plan-Do-Study-Act (PDSA) cycle testing change in real work settings. The initial three questions are:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

Patient-Centered Primary Care Collaborative

https://www.pcpcc.org

PCPCC is a not-for-profit membership organization with over 1,200 stakeholder organizations representing health care providers across the care continuum, payers and purchasers, and patients and their families. The Centers for Medicare and Medicaid Services awarded PCPCC a Transforming Clinical Practice Initiative award on 9/29/15 for up to $566,433 in the first year to provide technical assistance support to help equip clinicians across the country with tools, information, and network support needed to expand their quality improvement capacity.

Substance Abuse and Mental Health Services Administration (SAMHSA)-Health Resources and Services Administration (HRSA)

Center for Integrated Health Solutions

http://www.integration.samhsa.gov/resource/quick-start-guide-to-behavioral-health-integration

The SAMHSA-HRSA Center for Integrated Health Solutions developed the Quick Guide to Behavioral Health Integration for Safety-Net Primary Care Providers to assist organizations that are thinking of moving to an integrated delivery model. This interactive flowchart was designed to help primary care organizations think through the process of integrating behavioral health services into a primary care system. Successful integration involves more than simply adding the availability of behavioral health services. It requires that an organization think about how the integration of mental health and substance abuse services will impact the workforce, clinical practice and administrative operations.

Substance Abuse and Mental Health Services Administration (SAMHSA)-Health Resources and Services Administration (HRSA)

Six Levels of Collaboration/Integration (of Behavioral Health and Primary Care)

http://www.integration.samhsa.gov/integrated-care-models/CIHS_Framework_Final_charts.pdf

The Six Levels include:

1. Minimal Collaboration-in separate facilities with communi cation about cases only rarely and under compelling circumstances
2. Basic Collaboration at a Distance-in separate facilities with communication periodically about shared patients
3. Basic Collaboration Onsite-communicate regularly about shared patients, by phone or email

4. Close Collaboration Onsite with Some System Integration-communicate in person as needed

5. Close Collaboration Approaching Integrated Practice-communicate frequently in person

6. Full Collaboration in a Transformed/Merged integrated Practice-communicate consistently at the system, team, and individual levels

University of Michigan School of Social Work

Web-based Certificate in Integrated Behavioral Health and Primary Care

http://ssw.umich.edu/offices/continuing-education/certificate-courses/integrated-behavioral-health-and-primary-care

The Certificate is designed for direct clinical practitioners—social workers, nurses, care managers, psychologists, and physicians—who deliver or plan to deliver integrated health services and who serve populations often presenting with complex needs in physical health, mental health, and substance use. Participants gain assessment, intervention, and consultation skills, learn to apply these skills in the workplace, and link with a peer distance learning community to practice new skills and discuss ideas.

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Education to Practice is a program of the Michigan Health Council, a 501(c)(3) non-profit committed to developing innovative health care solutions for educators, employers and communities.