NEW YORK STATE | Department of Health

DSRIP – Medicaid Accelerated eXchange (MAX) Series Program

Final Report

Integrating Behavioral Health and Primary Care Services

New York State Department of Health in collaboration with Joan King, Emmeline Kunst, Jessica Logozzo, Kara Kitts, Dr. Douglas Woodhouse

January 2017

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Foreword from the New York State Department of Health

In Year 2 of our Delivery System Reform Incentive Payment (DSRIP) Program efforts, we continue to work diligently towards our goal of better health, better care, and lower costs for New York State's Medicaid enrollees. Together, we have made important strides towards our goal to improve the lives of over seven million Medicaid members.

Over the past 12 months, we have put an important focus on leading change at the front-line of patient care – where DSRIP becomes reality. The Department of Health has been proud to offer the opportunity for Performing Provider Systems (PPS) to participate in the Medicaid Accelerated eXchange (MAX) Series Program. The MAX Series Program has put front-line clinicians in a position to lead change. By enabling change at a grass-roots level, PPSs have been able to generate impressive results – Including:

1. **Measurable increases in screening rates and connections to services** (as these relate to integrating behavioral health and primary care services)
2. **Capacity building in process improvement**
3. **Development of meaningful collaborations among partners**, both inside and outside of provider sites.

The MAX Series focus on the integration of behavioral health and primary care services is important as New York's behavioral health system is large and fragmented. The publicly funded mental health system serves over 600,000 Medicaid members, representing 12% of total Medicaid members across the State. This accounts for about $7 billion in annual expenditures or 13% of New York's total Medicaid spend[1]. With the overall goal to reduce avoidable hospital use by 25% through transforming the New York State health care system, DSRIP will focus on the provision of high quality, integrated primary specialty and behavioral health care in the community setting with hospitals used primarily for emergent and tertiary level of services.

This report highlights the work of 10 Action Teams who participated in the first year of the MAX Series Program, which focused on the Integration of Behavioral Health and Primary Care Services. Collectively, these 10 teams were comprised of over 100 clinicians, administrators and community providers. Over an eight month period, these individuals dedicated significant time to identify patients in need of behavioral health services; to develop innovative solutions to providing better care for these individuals; and to rapidly implement, test, and measure these improvements.

It is my hope that these examples of innovative Rapid Cycle Continuous Improvement and the lessons learned inspire you to accelerate change towards the integration of behavioral health with primary care services to provide better care for patients across the State.

To the 10 Action Teams who participated in the MAX Series Program focused on integrating behavioral health and primary care services, **thank you for your dedication to this important work**. Your work is meaningful and has a profound impact on changing the trajectory of human lives.

Sincerely,

Jason Helgerson, New York Director of Medicaid

[1] 1. A Plan to Improve Empire State's Medicaid Program. https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf

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Acknowledgment

The success of the first year of the Medicaid Accelerated eXchange (MAX) Series Program would not have been possible without the leadership and dedication of the 10 Action Teams who participated in this intensive effort focused on Integrating Behavioral Health and Primary Care Services. The good will, teamwork, perseverance, optimism, and creativity demonstrated by each one of the Action Teams is what brought this work to life – in theory and in practice.

Although this report will primarily focus on the patient-facing ways in which care processes and practices changed, we would be remiss if we did not acknowledge the improvement that occurred by bringing interdisciplinary, cross-departmental, and cross-continuum clinical, behavioral, and social service providers together – often for the first time – to work collaboratively. The diversity of perspectives and expertise, coupled with dedicated time to work on a specific challenge in a structured format, allowed locally-relevant solutions to emerge, be tested, and implemented in an incredibly compressed period of time.

To that end, we congratulate and thank the following Action Team participants for being pioneers in the MAX Series Program on Integrating Behavioral Health and Primary Care Services:

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About the MAX Series Program Team

The MAX Series Program was designed and facilitated by a team of individuals with experience in healthcare, process improvement, systems engineering, change management, and program management.

The KPMG MAX Series Program Team delivered the program on behalf of the Department of Health and included:

Joan Kenerson King, Senior Integrated Health Consultant at the National Council for Behavioral Health, provided content expertise and team-specific advisement. Joan has worked in behavioral health for more than 25 years and provided training and consultation on the development of recovery-oriented systems of care and practices, and on designing and developing integrated systems of care. At the National Council, Joan has led the development and dissemination of the Case to Care Manager training to nurture an integrated health workforce and consulted with behavioral health organizations across the country in their integration initiatives.

Douglas Woodhouse, MD, BScEng, practicing physician and system engineer. Dr. Woodhouse informed the design of the MAX Series Program and provided expertise in process improvement methodology. Dr. Woodhouse has expertise in LEAN, Theory of Constraints, Statistical Process Control and Change Management and has worked with over 100 healthcare teams throughout Europe and North America to improve clinical processes. Dr. Woodhouse is the Executive Director and Owner of Apix Performance based in Alberta, Canada.

Eveline van Beek, Managing Director at KPMG, served as the Engagement Director and Program Advisor. Eveline informed the design of the MAX Series Program and advised on process improvement methodology.

Emmeline Kunst, Director at KPMG, served as the Program Director focused on the program design and development. Emmeline led the design of the MAX Series Program and advised on ongoing program strategy.

Jessica Logozzo, MBA, Manager at KPMG, served as the Program Lead and Director of the MAX Series Program. Jessica led the program development and implementation and oversaw the programs focused on Integration of Behavioral Health and Primary Care, as well as Improving Care for Super Utilizers.

Kara Kitts, Manager at KPMG, served as the Topic Lead for the group of 10 Action Teams in the Integration of Behavioral Health and Primary Care series. Kara was also integrally involved in the ongoing program development.

Adin Shniffer, MBA, Manager at KPMG, served as the Topic Lead for the first group of six teams in the Improving Care for Super Utilizer series. Adin was also a facilitator within the Integration of Behavioral Health and Primary Care series.

Joshua Sorin, Manager at KPMG, served as the Topic Lead for the second group of seven teams in the Improving Care for Super Utilizer series. Josh was also a facilitator within the Integration of Behavioral Health and Primary Care series.

Joe Monastero, Senior Associate at KPMG, served as a Topic Analyst for the 10 Action Teams in the Integration of Behavioral Health and Primary Care series.

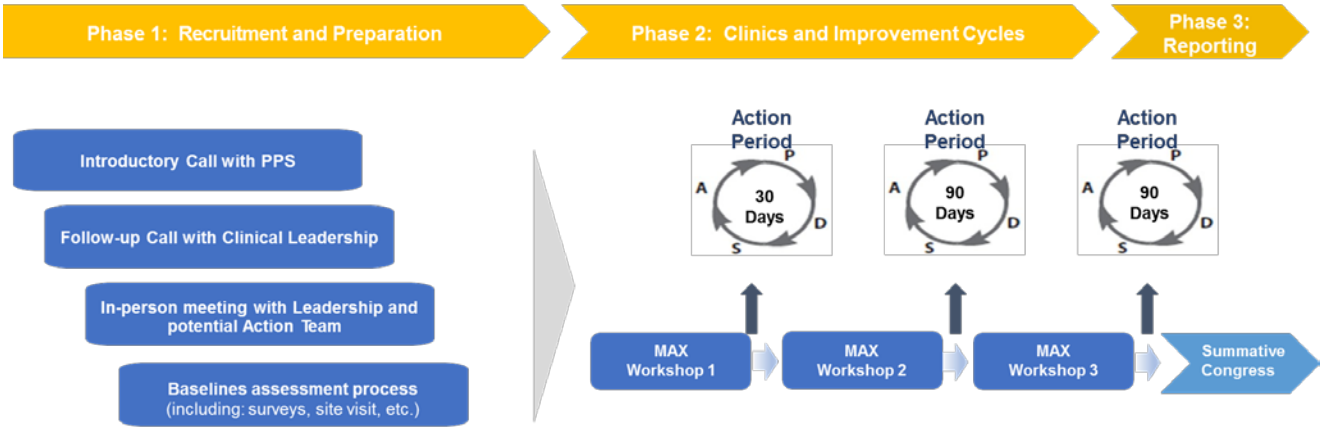
Introduction

The MAX Methodology

The MAX Series Program is a structured program of facilitated support offered to interdisciplinary, cross-setting teams to accelerate delivery system redesign and process improvement aimed at achieving DSRIP goals of reducing avoidable hospital use by 25% over five years. Through the offering of a series focused on the integration of behavioral health and primary care services, it supports the goal of transforming the system through the provision of high quality, integrated primary, specialty and behavioral health care in the community setting with hospitals used primarily for emergent and tertiary level of services.

The 2015-2016 MAX Series Program engaged 10 Action Teams who were committed to working on integrating behavioral health and primary care services. Each participating site was supported in bringing together an "Action Team" comprised of front-line clinicians, as well as leaders, administrators and key community partners who were central to the work of integrating behavioral health and primary care services. These Action Teams attended three facilitated in-person workshops, and were supported through three action periods during which time Action Teams tested and implemented prioritized process improvement plans developed during each workshop.

The MAX Series Program supported and accelerated change by creating structure and driving continuous improvement through off-site workshops, active facilitation, weekly coaching, content expertise, performance measurement, periodic virtual shared learning via online collaborative platforms and webinars. Each Action Team received one site visit during the recruitment and preparation phase and one on-site working session during one of the three Action Periods (Plan-Do-Study-Act (PDSA) cycles). The MAX Series Program was delivered over an eight-month period, according to the following sequence:



Phase 1: Recruitment and Preparation:

- ***Recruitment and Preparation,*** prior to launch of the Workshops, that included a site visit and survey to understand baseline processes and readiness for change

Phase 2: Clinics and Improvement Cycles:

- ***Workshops:*** Each workshop focused on a different topic and resulted in the development of three Action Plans
    - Workshop 1 – focused on quick wins
    - Workshop 2 – focused on detailed process redesign
    - Workshop 3 – focused on detailed process redesign and a Continuous Improvement Plan to sustain process improvement work

- ***Action Periods:*** Action periods followed each workshop and focused on the implementation of the Action Plans and was supported by weekly coaching calls

Phase 3: Reporting:

- ***Final Webinar:*** Included team to team sharing of results, lessons learned and next steps

The MAX Series Program is structured with a foundation based in process engineering, LEAN, root cause analysis, the Theory of Constraints, and Change Management. The approach for developing processes related to integrating behavioral health and primary care services was examined using four main categories:

1. Patient Identification
2. Planning
3. Management
4. Follow-up

In 2015-2016, the MAX Series Program was also implemented for a group of 13 Action Teams focused on improving care for super utilizers. A report on lessons learned and successes from that program is available in a separate document as well.

Applying the MAX Method to Integrating Behavioral Health and Primary Care Services

MAX Action Teams made progress in a short time period toward establishing processes that supported better integrated care and improvement in care for their behavioral health patients. Each Action Team started at a different stage of integration, as measured by the Integrated Practice Assessment Tool (IPAT)[2]. The IPAT measures stages of integration where level 6 represents a fully integrated practice. Teams ranged from a starting point of pre-collaboration (level 0) to close collaboration onsite with some systems integration (level 4).

The Action Teams invested effort in establishing a vision for integrated services for behavioral health patients, they worked at understanding how to better identify and meet their patients' needs, and they formed and functioned as an interdisciplinary, integrated Action Team, rapidly developing core required capabilities in data analysis, measurement systems, and innovation to develop new collaborative care processes and pathways to improve care for individuals within time and resource constraints.

MAX Action Teams accomplished all of this work by participating fully in the structure provided by the MAX Series Program, as described in the previous section.

As a testament to the "accelerator" impact of the MAX Series on the effort of these 10 teams to integrate behavioral health and primary care services, the following was achieved:

- ✓ **10 of 10 Action Teams** were able to create **more collaborative care processes** to better serve their behavioral health patients.
- ✓ **10 of 10 Action Teams** were able to report **progress along the continuum of integration**, where some teams **progressed within their existing level** of integration and others **progressed up to three levels** of integration.
- ✓ **10 of 10 Action Teams** were able to either **implement screening** for the first time, or **increase screening rates** to better identify patients needing behavioral health services.
- ✓ **10 of 10 Action Teams** implemented either **huddles or team meetings** that did not exist prior to the MAX Program.

[2] http://www.integration.samhsa.gov/operations-administration/assessment-tools#IPAT

- ✓ **6 Action Teams** reported an **increase in warm handoffs to behavioral health.**
- ✓ **6 Action Teams** reported an **improvement in screening scores for cohort patients.** *Given the relatively short period of time the teams were working, this improvement is particularly noteworthy.*

More specifically, Action Teams were able to:

1. **Improve identification and recognition of patient needs**
   As examples, Action Teams have learned the following:
   - Development of electronic tracking of the Patient Health Questionnaire (PHQ) administration and assessment of PHQ scores to monitor patient progress.
   - Standardization of PHQ screening process, resulting in the team being able to better identify patient needs and connect to behavioral health services during a patient appointment.
   - Standardization of a screening process for children with Attention Deficit Disorder (ADD) that is multi-focal (involving school, parents and prescriber) and consistent.

2. **Increase partnerships and working relationship with community based organizations**
   As an example, an Action Team implemented the following:
   - Connecting patients to specialized behavioral health services. In addition, they engaged with a neighboring behavioral health center to develop a memorandum of agreement for patients and a smooth flow between the two organizations.

3. **Improve collaboration between clinicians and providers**
   As examples, Action Teams have implemented the following:
   - Implementation of daily huddles to discuss patients who will attend clinic that day; instead of rearranging the primary care provider's schedules, one care team holds separate mini-huddles with each provider to discuss patients.
   - Implementation of monthly education sessions for all providers and practitioners on benefits of integrated services, on how integration improves patient care, and on key topics regarding either behavioral health or physical health issues.
   - Embedding social workers on the primary care floor to round and be available for warm handoffs.

4. **Establish better connection to health network**
   As examples, Action Teams have implemented the following:
   - Increased collaboration and development of standard processes with other ambulatory health network centers within their site.
   - Connection with department faculty and partners within their health network.
   - Increased collaboration and coordination with Health Homes. In several instances, Action Teams incorporated the Health Home care manager into daily huddles and/or into case conferences. In these organizations, the Health Home care managers can also complete the assessment and initiate Health Home services when the person is at the clinic.

5. **Improve patient access**
   As examples, Action Teams have witnessed the following:
   - Significant decrease in wait list for child psychiatry from six months to two months. This was accomplished by developing a more regimented screening process and increasing the comfort of the pediatricians in initiating treatment for ADD/ADHD.
   - Decrease in patient wait times; in one case, from five hours to two hours.

Structure of this Report

The next section of this report details five key insights from the work of the 10 MAX Action Teams in integrating behavioral health and primary care services:

1. Bringing primary care and behavioral health together is a culture change
2. Champions of change are critical to successful integration
3. Spotlight data to identify opportunities and facilitate change
4. Education for all staff is key
5. Integration requires knowledge, persistence and work

The subsequent section provides further detail on three concrete programs ("MAX in Practice") and the report concludes with a summary of eight key lessons learned.

Key Insights

Insight 1: Bringing Primary Care and Behavioral Health Together is a Culture Change

Adding behavioral health services to a primary care practice is not about "adding" a service; it is asking everyone who works in that setting to begin the process of thinking differently, of recognizing the complex interplay of mind and body.

When integration is successful it becomes the "way we do business," and creates an environment in which the team learns together, from each other, and from patients' experience with the ambition to design a seamless system of care. Within many of the MAX Action Teams, this meant the start of a transformation in culture, or cultures.

Establish a shared vision and goals

The first step to bringing providers together to think and deliver care differently, was to align on a shared vision for integrated services. The MAX Action Teams spent time together establishing a shared vision (guided by the question: "*what do you want to be true about the way patients receive care by your team*") and creating goals to move toward implementing this vision.

These statements were aspirational in nature, and at many points throughout the process, acted as the foundational touchstone for the work of the team. When times got tough, or the reason "why" they were integrating services became less clear, the vision provided clarity and inspiration to the team.

Examples of these vision statements include:

- *"To engage patients and staff in creating a patient-centered, seamless, holistic experience, resulting in improved health outcomes and increased satisfaction for ALL." (Translated to the motto: "Total wellness begins with you").*
- *"To create an interdisciplinary health and wellness environment for the community that can assess factors that impact health and wellness, overcome barriers to care, and provide care that achieves measurable outcomes and patient goals." (Translated to the motto: "Total care, no matter what").*
- *"Patients are treated as a whole person using a team based approach, incorporating an evidence-based patient-centric model which allows the patient to achieve their personal healthcare goals, that is accessible at all levels and is sustainable."*

This was the first step in having individuals think differently about their roles, as well as in adopting different mental models of their work.

Care planning and coordination as a first step

Building collaborative models for care planning and coordination was one of the first concrete steps that the Action Teams took in moving from their "vision" to reality and establishing a culture that would support the transformation.

Action Teams developed processes to coordinate services between all providers, including the establishment of processes for effective information exchange, such as integrated care plans, warm handoffs and huddles.

The development, implementation and testing of these processes were the first steps to begin to shift the culture towards (or create) one that supported integrated care for patients. As the teams implemented these processes, there were many lessons learned as cultures sometimes clashed between individuals (and disciplines) who had not worked together previously. In some cases, individuals became uncomfortable as they began to adopt different, more collaborative models of their work.

Two key lessons include:

1. ***Clarity of roles is important to help individuals feel comfortable within new models of care***. It is important for individuals to understand what their role is in the team, and what the roles of others are so that they know who can support them in this new way of working. In some cases, Action Teams found that primary care providers were uncomfortable treating or prescribing medication for behavioral health patients. In other cases, behavioral health practitioners were not comfortable talking to patients about their physical health issues. Education on roles and new care models went a long way to help individuals feel more comfortable in the new way of working together.
2. ***Communication is key.*** Being part of a team is one thing; feeling part of a team is another. Action Teams found that establishing communication processes – including huddles, case conferences, informal conversations in the hall, etc. – were critical to establishing a collaborative team culture focused on the whole patient.

Building trust does not just happen

Establishing a culture of integrated care does not happen overnight and does not happen by way of a prescribed approach. Action Teams demonstrated that trust builds over time, with persistence and patience. It is the culmination of various approaches – both formal and informal – that led to trust building over time.

MAX IN ACTION: Strategies for successful integrated care teams

Building trust through innovative approaches to the 'huddle'

Initially, the Action Team attempted to implement a daily morning huddle, and quickly learned that this timing and structure did not work for the primary care providers. Rather than trying to force the structure to work with the primary care providers, they thought innovatively about how they could accomplish the same goal of the huddle in a different format, to accommodate the entire team. The team structured 'mini-huddles' that came to the primary care providers when they were free. This good will has contributed to building a trusting relationship and has gone a long way to increasing provider engagement among the team.

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Monthly education sessions to build comfort in managing patients

One Action Team had both primary and behavioral health services co-located at the Center for years, but there was minimal interaction and collaboration between the two services. The Action Team implemented monthly sessions for each service to provide education and support on specific topics related to patients' diagnosis and management. This led to increased primary care provider comfort in managing behavioral health conditions and also increased the communication and collaboration between the two services to manage patients for the appropriate level of care.

Insight 2: Champions of Change are Critical to Successful Integration

Integration is complex for various reasons. As outlined in the previous section, creating a culture of collaboration and shared care is at the heart of integration and does not happen quickly or easily. Additionally, this change has to be accomplished within a fiscal and regulatory environment that still presents barriers to full integration.

Due to these complexities, among others, Action Teams have demonstrated the importance of having champions to lead through these complexities. Champions were those who were formal or informal leaders and who were willing to be persistent and persuasive through the integration journey. Champions saw barriers as opportunities to do things differently and in a better way, and saw resistance as an opportunity to engage and understand, and ultimately shift that resistance to support.

Two key lessons include:

1. ***Partnering behavioral health and primary care champions are a powerful force.*** Action Teams demonstrated that it was critical that the teams had champions of change from both the behavioral health and the primary care side. Teams were successful if they had partnering champions who could work together to clear barriers towards the overall vision and lead by example of what truly integrated care looked like.
2. ***Physician champions are key.*** Each provider has his/her own process and way of managing the patient's care. The integration of behavioral health requires the implementation of new processes and a different way of managing patients' care. Action Teams learned that this requires a physician to physician change management effort, with a physician champion in the lead.

MAX IN ACTION: Champions of change

Primary Care leadership and knowledge sharing

One Action Team had a strong Primary Care Provider who was engaged and dedicated to the change. She led the way by piloting new processes and performing PDSA cycles until she found what worked and then taught the other Primary Care Providers about the new process and how to implement it.

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An increase in referrals when the nurse Champion stepped in!

For one site, referrals picked up when they started using the nurse who understood how important this work was, who knew the patients, and could recruit new patients into their network.

Insight 3: Spotlight Data to Identify Opportunities and Facilitate Change

Data collection and measurement are critical components within Rapid Cycle Continuous Improvement work, and as such, are at the core of the MAX Series Program. In spite of this, many Action Teams found data to be a difficult tool to engage in their day-to-day work. This was due in part to poor data-related infrastructure (e.g., EMR's, unstandardized workflows, lack of dashboards, etc.) but also a lack of experience measuring care processes and using data to inform their day-to-day work and population health management.

Ultimately, through disciplined use of data in tracking and measuring the rapid cycle implementation of improvement ideas, data became the critical component of implementing ongoing process improvement. The teams demonstrated that data sheds light on areas for improvement that had possibly not been identified or

understood in the past. In this way "bad" data is as important as "good" data, because it shows areas that need attention.

Data informs care processes

Each Action Team selected a set of three to five performance metrics at the start of the first Action Period which would best inform their care processes. As the teams started to implement improvement ideas and more integrated care pathways, they utilized these data points as a way to determine whether these changes were improving care and moving them in the right direction.

Teams were guided to track and measure performance metrics along the lines of the following:

1. Number of screens completed
2. Number of warm handoffs
3. Number of patients connected to on-site behavioral health services
4. Number of patients with screening scores indicating clinical Improvement

Each performance metric had a baseline, a target, and a benchmark standard which acted as guideposts that staff could use to determine if the care process was being delivered efficiently and effectively, or required focused attention.

Performance metrics should be collected in the daily workflow of staff

In order for performance metrics to be useful in the day-to-day work of staff, the daily routine of staff (their workflow) needed to be understood. As part of the MAX process, Action Teams performed detailed process mapping to understand the current state of clinical workflows and to identify where improvements should be focused.

The performance metrics acted as one of the key ways to knowing if the process improvements for the identified patient cohort were working. As such, staff needed to understand how to reliably collect the performance metric data in the workflow. The degree to which staff can standardize clinical and administrative behaviors in their workflow to reduce variation/waste will eventually determine the quality of care provision and financial sustainability of the clinic.

Data is at the core of Plan-Do-Study-Act (PDSA)

MAX Action Teams used the Plan-Do-Study-Act cycle to implement their tests of change toward integrating behavioral health and primary care services. Data was integral to each step of this process, as reflected below:

- Gathering data specific to the question (PLAN): Action Teams pulled data for each performance metric to determine the baseline. This helped inform the starting point, as well as what part of the workflow needed to be adjusted to achieve benchmark targets.
- Assessing the current state (PLAN): teams leveraged their process maps to identify where in the daily workflow the performance metrics could be collected and reviewed (e.g., using dashboards in huddles, etc.) to develop a protocol for how the data could be collected, reviewed, and by whom.
- Implementing the improvement ideas or new protocols (DO): train staff and implement the processes!
- Collecting and reviewing the data (STUDY): on a weekly or monthly basis, teams compared the data to the baseline metrics to determine if there was improvement/movement toward the target/benchmarks.

- Determining next steps (ACT): if the data was found to be improving, teams continued with the processes as designed. If not, teams conducted another PDSA cycle to see where changes were needed. Action Teams demonstrated that if you do not succeed on the first attempt, keep testing new changes until you find what works!

Common pitfalls in data collection

Many staff talk about data as a "quality improvement activity." Historically, data has been handled by "special staff" and reported out, not used in day to day practice. In actuality, Action Teams demonstrated how using data is a process for knowing if a patient's health is improving or not, and a process for staff to change their everyday practices to make their jobs more predictable and less chaotic.

For data collection and use to be effective, all staff need to understand the "why" – why am I collecting this and why does it matter – and the "how" – what is the process for collection and frequency for monitoring. The why and the how apply not just to clinical staff but to all staff in the program, front door to back door, because everyone impacts and is impacted by the quality of service provided in a given clinic. Action Teams demonstrated that all staff needed to understand their scope of practice in the workflow protocols and that they need to understand performance metrics.

MAX IN ACTION: When data moves the wrong way…

One of the Action Teams (the Center) had placed significant efforts on developing a standard process for referring their patients to behavioral health services. When looking at their data for patients who attended their first behavioral health appointment from referral, it appeared to be a high percentage of patients attending. Initially, the Center inferred from this high rate of patients attending their first behavioral health appointment that they were effectively connecting their patients to behavioral health services and the process in place was working well.

As part of the MAX Series Program, the Center developed an Action Plan to better understand their utilization at the Center and how to engage their patients to effectively utilize the services the Center provided. The Action Team started by investigating their data availability and quality. During the data investigation, it was found that the baseline data being collected and reported were not being captured accurately. Specifically, the number of patients actually attending their first behavioral health appointment from referral was 20% lower than originally reported.

The Center did not interpret these data results as a failure, rather, an area for improvement that was identified through data. The Center is now focusing efforts on improving the process for patients to actually attend their behavioral health appointment after referral as a metric to 'connect their patients to care'.

Insight 4: Education for All Staff is Key

Integration of services is a full team commitment; from registration staff, to nursing, to providers. Despite this, disciplines often remain siloed in their education; physicians learn very little about behavioral health and behavioral health clinicians learn very little about physical health.

Through their efforts in the MAX Series Program, Action Teams demonstrated that education that goes beyond traditional scope of service is necessary and needs to be consistent and ongoing. Further, all staff must be

aware of the "why" and "what" for integrated services, which helped to ensure a consistent approach to patient care across teams. It was also important that all staff were educated on the importance of integrating services and how it improved both patient outcomes and staff satisfaction.

Examples of educational approaches and activities that Action Teams have implemented and tested, include:

1. ***Joint education sessions.*** Convene regular sessions to bring both primary care and behavioral health providers together to learn about the services that each provides and how they can better care for the 'whole person'. Some Action Teams scheduled monthly meetings and others did ad-hoc sessions (see "MAX IN ACTION" below for specific example).
2. ***Sessions with external speakers with experience in integration.*** Building on the concept of joint education sessions involve external individuals who have attempted integration in the past to share lessons learned – both successes and challenges.
3. ***Informal communication and education.*** Education does not always have to be delivered through a formal session or meeting. Action Teams demonstrated that sometimes the most effective way to share and build knowledge was through informal communication such as conversations in the hall between clinical sessions, over lunch, etc. Additionally, Action Teams demonstrated that the 'huddle' structure was a valuable educational platform, as all providers were in attendance.
4. ***Regular sharing of data and successes.*** Data can be a powerful tool to demonstrate, in an evidence-based way, the benefits of integrated care. Data that can show that more patients are screened, are being connected to services, and are seeing improvements in screening scores can help providers and staff understand the "why" and act as a motivator for change. Action Teams found it useful to share their performance metrics (in a format tailored to the respective audience) across the practice on a regular basis as both an education and communication tool.

MAX IN ACTION: Learning about each other, from each other

An Action Team had both primary care and behavioral health services on site but there was minimal to no interaction between the two services. As part of the MAX Series Program they implemented monthly, joint education sessions between behavioral health and the pediatricians to learn about each other's services and build processes together.

This approach lead to the pediatricians feeling confident enough to manage newly diagnosed, mild ADHD patients.

Insight 5: Integration Requires Knowledge, Persistence and Work

As has been discussed throughout this report, Action Teams have demonstrated that the integration of behavioral health and primary care services is complex. It requires a change in culture, driven by a shared vision for patient care. It requires finding new ways of working together and ways to determine whether those new processes are actually working towards the vision of better patient care. It requires time to ensure all team members understand their roles and are comfortable with the changes involved.

Through the eight month MAX program, Action Teams also demonstrated that there is no blueprint solution for how to integrate services successfully. Rather, through a structured approach – involving gathering knowledge/data to inform what needed to be done, prioritizing what needed be done, doing it, testing it and

measuring it – the Action Teams made progress in each of their integration journeys, at different paces given the individual environments and situations with which they were faced.

The structured process that each Action Team went through was key to furthering integration in a way that had not been done before. Framed within the requirements of knowledge, persistence and work, key elements of the structured process are highlighted below:

1. ***Knowledge.*** All Action Teams gathered knowledge on 'what' they needed to do to integrate services which were then implemented by way of Action Plans at each of the three MAX Workshops. First, Action Teams developed a current state process map to understand their baseline processes and to identify where they needed to focus to integrate services. To determine exactly what they needed to do to integrate services, Action Teams looked to: themselves (in many cases the knowledge lies within the team), colleagues and peers (including other Action Teams who may have been a bit further along in the integration journey or peers who had already integrated services and had lessons to share) and external subject matter professionals (all MAX Action Teams had access to a topic expert from the National Council for Behavioral Health who advised teams throughout the program). Knowledge sharing remained a key component of the program, for the duration of the program. Teams reported back at the start of each Workshop on what they accomplished, where there were successes, and where there were challenges. Throughout Workshops, Action Teams worked closely together to discuss lessons learned and share knowledge broadly.
2. ***Work.*** Action Teams identified improvement ideas at each Workshop and then implemented, tested and refined their ideas throughout the Action Periods. What was key to this was a structured and regular focus on this work – Action Teams met on a weekly basis, through a status call with the MAX Team, to check in on progress and identify areas where support may be needed. This regular 'touch base' ensured that teams stayed focus and accountable to what they committed to in the Workshops.
3. ***Persistence – try, try again!*** Action Teams learned that it takes time to find what works best for the team and for patients. Continuous improvement is at the core of the MAX process. Teams used Plan-Do-Study-Act (PDSA) cycles to continuously test and refine their processes until the right process for all staff was found. All Action Teams demonstrated the need for persistence – there will be failures and you will learn from them; the key is to not give up and to try again.

The next section of this report provides three examples of "MAX in Practice" – highlighting the work of three Action Teams and how they demonstrate the five insights discussed above in a very practical way.

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MAX in Practice: Integrating Behavioral Health into Primary Care (Model 1, Example 1)

Lourdes Primary Care – Care Compass Network PPS

"Provider engagement and education is critical to implementation. By educating providers on the goals and value of the integration, understanding where resistance was coming from, addressing barriers (both actual and perceived) and sharing success stories on the integration in order to motivate change, providers were able to become less change averse and open to the new processes."

– Action Team

Population of focus and Action Team composition

Lourdes Primary Care (Lourdes) now offers a full-time behavioral health consultant (social worker) at the primary care site to support the clinicians by providing brief interventions and addressing behavioral/social health needs.

Lourdes also offers behavioral health and psychiatry services at an affiliated Article 31 Lourdes Mental Health Center. The wait to access these services is approximately 2.5 months for an initial appointment.

Lourdes recognized that to better meet the behavioral health needs of their patients, fully integrating behavioral health and primary care services would help their patient population receive timely and coordinated care. The focus of the behavioral health consultant on site is to promote early detection and provide early intervention to patients' behavioral needs.

To support the targeted improvement efforts with people who scored positive for depression, a multidisciplinary Action Team was assembled with representatives involved in patient care across the continuum in primary care and behavioral health services, including:

- Social Workers (LMSW)
- Nursing staff
- Nurse Manager
- Operations Manager
- Primary Care Physician (PCP)
- Director of Clinical Operations
- Project Manager – Care Compass Network PPS

A new process for the integration of behavioral health and primary care services

Through the MAX program, the Action Team developed processes for the integration of behavioral health and primary care services, focused within four main categories: patient identification, planning, management and follow-up. The process is described below:

1. Patient Identification

Patients between the ages of 20-50 requiring behavioral health services are identified by use of the PHQ-9 screening tool. The team utilizes a threshold score of 15 or above, and/or a response of 'yes' on question #9 (identifying suicidal thought) as a trigger for automatic referral to behavioral health services. In cases where a patient scores below 15, providers use their clinical judgment to decide if a referral to behavioral health is warranted.

The team also implemented SBIRT (Screening, Brief Intervention and Referral to Treatment) practice for individuals who have been flagged by the nurses or clinicians. An initial SBIRT screening is administered to the patient via one to five pre-screen questions (utilizing questions from the National Institute on Alcohol Abuse and Alcoholism). A positive result from the pre-screen questionnaire then triggers additional assessments to be administered such as the AUDIT, DAST -10 or CRAFFT screening tools.

2. Planning

A social worker has been embedded within the clinic and has expanded her schedule to be available and co-located 5 days a week. Initially, the team started with one day a week but quickly identified the need for full time resources.

If a patient flags positive on the PHQ 9, the primary care provider or nurse then performs a warm handoff to the social worker to provide brief supportive interventions, enroll the patient in behavioral health services, and schedule an appointment for additional evaluation and needs assessment.

3. Management

To manage the care of patients connected to behavioral health services, the team developed a process to coordinate care by implementing "mobile mini huddles" to accommodate provider schedules and provide staff a forum to quickly discuss patient progress, issues, and success stories. The social worker has also started "shadowing" select primary care providers to further embed herself in the practice.

The team has also developed a robust care planning and management process, which utilizes an individualized care plan for each patient, focused on individual patient goals. This tool is used as the basis for the social worker to collaborate with the primary care provider to help patients reach specific goals and ultimately self-management. The team has implemented a process for transitioning patients back to primary care which is achieved when patients show an improvement in PHQ-9 score or achieve their specific self-management goals (i.e. losing weight or keeping follow up appointments with the primary care provider, outpatient mental health, managing their insulin, etc.).

4. Follow-up

The team actively manages patients through a defined follow-up process. The social worker actively follows up with patients through post-appointment phone calls to ensure patients attend their subsequent appointments and are following their care plan. These calls provide an opportunity to address barriers as they emerge and assist patients in continuing to increase their self-management skills.

The team has also established an emergency department follow up process in which the social worker receives a notification when patients within the MAX cohort are seen and discharged from the emergency department. Once the social worker receives the notification, he/she then reaches out to the patient to close the gap in care – this occurs either by phone call, attending their follow up primary care appointment at the site, or connecting the patient back to their outpatient mental health agency or Health Home(s).

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Summary of Process Improvements:

Patient Identification

- Implemented **referral** and **warm handoff processes**
- Implemented **waiting room screening processes**
- Expanded screening to include **SBIRT**

Care Planning

- Implemented **full-time SW**
- Implemented **integrated care plan**
- Continuous **provider education**
- **Data tracking** and **reporting**
- **EMR referral process**

Management

- **Brief intervention** and **connection** facilitated by SW
- **Collaborative care planning** and **management ("mini huddles")**
- **BH 'shadowing' of PCP** to further embed BH into practice

Follow-up

- Implemented **ED follow-up process** with Lourdes SW
- Implemented **Health Home processes**

Results: September 2015 – August 2016

**self-reported by the Action Team*

	Post-MAX Launch (Timeframe: Mar. '16 – Aug. '16)					
Data Element	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**
PHQ Screening Completed	63	70	314	292	164	262
Warm Handoff Count	5	9	21	18	6	14
Number of Patients Connected to Behavioral Health…via phone calls, onsite referrals, warm hand-offs, initial contacts…	20	19	80	71	31	24
Improvement in PHQ 9 Score	• 215 patients rescreened • 36 showed improvement of between a 1-12 point reductions in PHQ-9 score • 29 experienced an increase in PHQ-9 from initial assessment • 36 patients either refused screening initially or rescreening attempts					
Total Brief Interventions: SW provided emotional support, education, community resources and coping skills techniques…	142					
Total Follow-up Appointments – SW conducted a more structured session of brief counseling	34					

Key lessons learned include:

- **Integration is hard work and identifying champions is crucial for success**. Provider engagement and education is critical to implementation. Providers were able to become less change averse and more open to the new processes by, educating providers on the goals and value of the integration, understanding where resistance was coming from, addressing barriers (both actual and perceived), and sharing success stories on the integration in order to motivate change.
- **Communicating frequently will help to avoid deviations and miscommunications** on established plan/process and reduce additional confusion for the team, especially in a very busy clinic with seven fulltime primary care providers.
- **Be persistent**: transformation takes time and is hard work. It is important to remind the team and staff to not take failure personally. WORK the problem. There will be failures and you will learn from them.

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MAX in Practice: Integrating Primary Care into Behavioral Health (Model 1, Example 2)

Brightpoint Health – New York Presbyterian Queens PPS

"Data is the magnifying glass of clinic operations and patient population management to identify improvement opportunity."
– Action Team

Population of focus and Action Team composition

Brightpoint Health, Queens (the Center) serves a large homeless population. Although the Center offers both primary and behavioral health services and has a Health Home in the same site and location, the three services have worked in separate workflows with little information being shared between providers and practitioners. Additionally, the Center has suffered from a long wait time and high no-show rate (60% - prior to February 2016) for behavioral health appointments. As a result, patients' physical and behavioral health issues were not being managed effectively.

The Center identified that it had access to the right resources to serve the homeless patient population and could better integrate processes, workflows and information sharing between the Center's services to ultimately help patients manage their health and social needs.

To support the integration of services with the homeless patient population, a multidisciplinary team was assembled with representatives from primary care and behavioral health services including:

- Chief Clinical Officer
- Practice Manager / Nurse Practitioner
- DSRIP Project Manager
- Social Worker
- Health Home Liaison
- Business Development
- Care Manager

A new process for the integration of behavioral health and primary care services

Through the MAX program, the Action Team developed processes for the integration of behavioral health and primary care services, focused within four main categories: patient identification, planning, management and follow-up. The process is described below:

1. Patient Identification

Patients are identified for primary care services directly in the homeless shelter via Business Development (BD). Through partnership with the Health Homes, patient intake is performed in the shelter with a Health Home representative so that upon the patient's arrival at the Center, the patient is already registered in the system and a record has been created. Patients are also provided transportation from the shelter to the Center for their appointment(s). Upon arrival at the Center, the Medtech administers a PHQ-9 tool with the patient and

asks the patient, "what matters to you?" The Medtech then informs the primary care provider of the patient's PHQ score and what matters to the patient at that point of time. The primary care provider assesses the patient's severity of depression and makes the appropriate referral for behavioral health services. The primary care provider will also address "what matters most to the patient" and include the response in the patient's electronic record. If the patient requires an acute/mild type of intervention for depression, the social worker will be called upon for a warm handoff and the patient will be provided with an appointment for behavioral health before leaving. The "what matters most question" has been a critical shift in the method of care delivery, because the response quickly focuses the team on what is important to the patient, not what the team thinks is important to the patient.

2. Care Planning

Daily huddles are performed with each primary care provider and associated care team for the day. The patient list is reviewed before the huddle and if there is an identified need for behavioral health services that day, a behavioral health staff member will be included in the huddle.

The primary care staff, behavioral health staff and Health Home staff have 'read and write' access to the EHR and can all provide input or update the patient's care plan in one location.

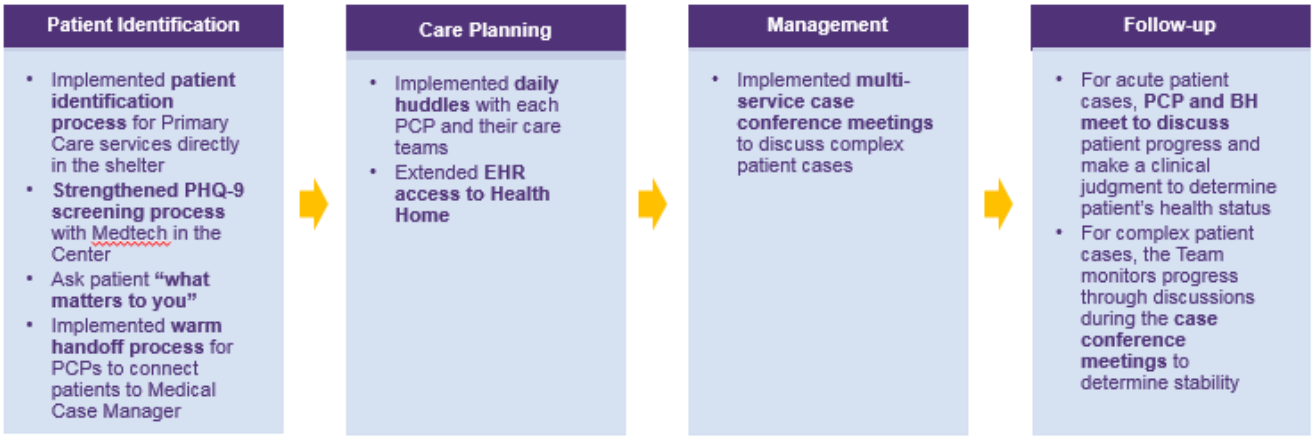
3. Management

On a monthly basis the Center holds a case conference with all provider services in attendance for complex patient cases. The team will discuss between four and five patients, highlighting the patient's current health status, course of action identified by each provider, and next steps for the patient's care plan.

4. Follow-up

For the mild/acute cases, the primary care provider and behavioral health staff use the PHQ score to track and monitor a patient's progress and to make a decision on when a patient is stable to transition back to primary care.

For complex patient cases, the team monitors a patient's progress through discussion in the case conference meetings, then as a team, makes a decision on when a patient is stable to be transitioned back to primary care.



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Results: September 2015 – August 2016

*self-reported by the Action Team

The table to the right outlines the overall impact of integrating primary care and behavioral health services. The baseline data was not correct as described in the case-study on page 16. Referrals were included in the 'Attended first BH Visit' numbers. The Action Team has created a specific action item to address this problem.

	Baseline (Timeframe: Sept. '15 – Feb. '16)		Post-MAX Launch (Timeframe: Mar. '16 – Aug. '16)	
Data Element	**Total Baseline**	**Rate (/month)**	**Total Post-MAX**	**Rate (/month)**
PHQ Screening Compliance	530	71.3%	457	67.7%
Attended first BH Visit	56	50%	54	29.6%
Wait Time for Patients in Cohort	Up to 5 hours		Maximum of 2 hours	
Future State: Stable BH Patients Returning to PC	Baseline information not available		Targeting top 15% of stable patients returning to PC	

Key lessons learned include:

- **Data is the magnifying glass of clinic operations** and patient population management to identify improvement opportunity.
- With support from Leadership and an Action Team, **a practice change agent can be the catalyst for change**.
- **Existing resources can be leveraged** to develop a creative response to a problem.

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MAX in Practice: Integrating Primary Care into Behavioral Health (Model 2)

Access Supports for Living & HRHCare – Montefiore PPS

"The dedication, persistence and willingness to change at the leadership level was the key factor that enabled the Team to overcome the initial barriers and succeed in integrating services."
– Action Team

Population of focus and Action Team composition

Access Supports for Living (Access) provides a spectrum of behavioral health services for their patients and is able to treat all types of behavioral health conditions. It was observed by Access that the majority of patients not only live with behavioral health conditions but also a co-morbid medical condition. Upon further analysis of Access' patient population, it was identified that diabetes is a common physical co-morbidity among the patient population.

Access has had a long standing partnership with HRHCare on other practice initiatives; when the time came to integrate physical health services they recognized that they needed the expertise that HRHCare would offer. HRHCare is a not-for-profit Federally Qualified Health Center (FQHC) that has experience in integrating services. As such, the team decided to co-locate a HRHCare primary care provider into the team at Access.

To support the integration of services for the population of patients with major mental illness, a multidisciplinary team was assembled including:

- Director of Multi-Specialty Services
- Behavioral Health Clinic Director - Access
- Medical Director/Psychiatrist - Access
- Support Staff Coordinator - HRHCare
- Primary Care Physician - HRHCare
- Vice President of Outpatient Physician Services - HRHCare
- Nurse Practitioner - HRHCare
- BH Registered Nurse - Access
- Care Coordinator - Access
- Senior Director of Behavioral Health - Access
- Senior VP of Clinical and Program Services - Access

A new process for the integration of behavioral health and primary care services

Through the MAX Program, the Action Team developed processes for the integration of behavioral health and primary care services, focused within four main categories: patient identification, planning, management and follow-up. The process is described below.

HRHCare's primary care team is located at Access' Middletown, NY site two days a week, with the primary care nurse practitioner on-site. Each person checking into the clinic is informed that there are primary care services available at the site and asked if he/she would be interested in learning more about the service or to meet the nurse practitioner. Each behavioral health practitioner has agreed to inform and engage new and existing

clients about the benefits of integrated care and introduce the person to the primary care provider team whenever possible.

The behavioral health and primary care provider teams continue to collaborate on the work flow issues and create a shared care plan that focuses on a manageable number of treatment goals as prioritized by each person. Access is in the process of establishing a contract with the same laboratory, which is used by HRHCare to allow one blood draw for the clients who have selected to have integrated care services. Processes are established to ensure that each behavioral health prescriber is also given the primary care provider ordered laboratory reports in a timely manner.

1. Patient Identification and Engagement

The behavioral health providers have been provided education and training to identify, in consultation with their patient, if the patient would be interested in enrollment to integrated primary care services. A warm handoff will be performed between the behavioral health provider and onsite primary care team to connect the patient to onsite primary care services. While the expectation is that this will grow over time, the Action Team quickly recognized they needed to have a more assertive approach to engagement and so identified an experienced nurse (within the practice) who could perform active outreach to patients in the waiting room. This approach resulted in a much more active uptake of new patients for the primary care provider.

Voluntary medical screenings are offered in the waiting room to help inform and bring awareness of physical health to patients, so that the patients may self-identify to enroll in integrated services.

2. Care Planning

The development of a shared care plan between the two services is underway and a concise 'treat to target' plan has been created for the patient to focus on his/her health over a 90-day period, followed by a reassessment. The behavioral health providers use motivational interviewing techniques to help the patient identify goals and prioritize them for action. The 'treat to target' plan allows patients to improve upon their health in manageable intervals of time. The nurse practitioner's progress notes and laboratory results are shared with the behavioral health provider via paper and distributed on lime green progress notes to "shout" integrated care. The sharing of the care plan allows the nurse practitioner and behavioral health practitioners to be aware and informed on their goals and progress for both physical and behavioral health.

3. Management

Case conference meetings are scheduled to discuss acute, chronic and preventive patient cases. The case conferences allow for collaborative discussion and decision-making with the patient and care team on a patient's next course of action to improve their health.

Additionally, through the sharing of progress notes and interactions between the nurse practitioner and behavioral health practitioners, the patients' care is collaboratively managed.

4. Follow-up

Through the case conferences, the care team will be able to track and monitor a patient's progress to be able to make the decision of when a patient has reached a stable state and can either decrease the patient's level of care or transition to a maintenance level of care.

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Summary of Process Improvements:

Patient Identification

- Performed **analysis of current patient roster**
- **Trained and educated BH Practitioners** to identify how a patient would benefit from PC services (a work in progress)
- Implemented **voluntary universal medical screening** processes

Care Planning

- Utilized **motivational interviewing** competence
- Implemented process to **share NP's progress notes** with the BH Practitioner
- **Implemented huddles** that include the BH Care Manager, PC team and the BH Clinic Director

Management

- Implementing **interdisciplinary care conference meetings**
- **Collaborative management of patients** through interactions between the NP, BH Specialist and BH Care Manager

Follow-up

- **Tracking and monitoring of a patient's progress** through interdisciplinary case conference meetings
- When improved health status is achieved, **monitoring and support plan is to be developed** to maintain health status

Results: September 2015 – August 2016

**self-reported by the Action Team*

The table to the right outlines the overall impact of integrating primary care and behavioral health services:

	Baseline; Pre-MAX Launch (Timeframe: Sept. '15 – Feb. '16)	Post-MAX Launch (Timeframe: Mar. '16 – Aug. '16)
Data Element	**Total Baseline**	**Total Post-MAX**
ED Utilization (Average # ED Visits per patient per month)	0.07	**0.08**
Primary Care visits within 6 months (% of Cohorts seen by PCP within the last 6 months)	49.3%	**64.4%**
Number of Patients Connected to Integrated Primary Care	-	**66**
7 Day Follow Up Appointment (% of Cohorts seen 7 days after hospitalization)	43.5%	**50%**
Smoking Cessation (% of Cohorts that smoke and engage in cessation counseling)	-	**6%**
Blood Pressure within Range (% of cohorts with blood pressure less than 140/90)	31.3%	**57.7%**

Key lessons learned include:

- It is **important to plan and achieve financial stability** by building enough volume and working across the organization to ensure an adequate flow of patients.
- **Culture change can be difficult** and requires consistent and real time communication and feedback between staff and leadership.
- A **shared care plan** will allow each treatment team member to embrace the treatment. It is essential to have one shared care plan, to allow every team member to focus on the prioritized treatment goals of each person.
- **Champions make a difference**. It is important to identify practitioner champions for integrated care who can talk about their own successes and create energy and optimism for everyone.

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Summary

Eight Lessons Learned About Integrating Behavioral Health and Primary Care Services

1. Integration of care is about creating a whole new way of delivering care…not just adding another service.

   For years, service systems have been siloed because of funding, regulations and educational preparation. The change, to focus on whole health and wellness, challenges long-held assumptions and some very real contextual barriers. As teams begin to work together, to learn from each other, and to work towards a seamless experience for the patient, preconceived notions begin to break down. Being conscious of this shift in thinking has been a critical success factor in integration.

2. Having a clear vision about why integration fits your mission will help you keep at it when the barriers arise.

   Vision is the stabilizing force when resistance and barriers arise. Organizations that identify the "why" of practice change, that commit to this as a way of delivering service, and make it part of the organizational mission, have the resilience necessary to overcome the resistance and barriers that will arise. The question then becomes, not "whether we will do this" but, "how we will do this?"

3. Recognize that culture drives practice.

   The transformation to an integrated practice requires creativity, courage and risk taking. In cultures where there is a top-down approach, where the contributions of everyone on the team (including the front desk, the medical assistants and others) are not recognized, the development of a team-based approach to care will be nearly impossible. A culture that recognizes the unique contribution of each team member is more likely to recognize the individuality of each patient, and to be engaging and inclusive in the care delivery system. This change requires new thinking and new practices, which in time create a culture of enhanced primary care.

4. Data is the magnifying glass to identify whether what you are doing is working…for the patient and for your processes (i.e. how integration supports keeping people out of crisis).

   Healthcare is a demanding field to work in and each day brings another change and another challenge. Without a planned approach to collecting real data that reflects real practice and outcomes, the practice will continue to do the same things over and over whether they work or not. Data causes us to ask questions; it is in the questions that ideas for improvement of care emerge.

5. Practice Champions are key and developing the overall functioning of the team cannot be overlooked.

   In an ideal world, everyone in a practice gets on board quickly and with enthusiasm about this change in the care delivery system. However, this is not reality and, as such, the role of early adopters and Champions becomes particularly important. The Champion is the one who keeps saying "yes we can" in the face of

doubts and who continues to work toward solutions when others only identify barriers. The Champion(s) are also the people who help the team come together, who call out conflict when it exists so it can be resolved, and who keep the project moving forward.

6. There is opportunity in understanding the effectiveness of leveraging staff outside of physicians and providers.

The patient experience begins at the front door with how they are greeted, continues with how they are roomed, and ends with how they are checked out. At each step there is an opportunity to engage patients or to have them disengage. Often the staff who are involved in these key processes are overlooked and/or underappreciated. They don't see their role as important and may not be treated as if it is. In an integrated practice they are critical in getting initial screenings completed, in communicating safety to patients, and in flagging for other staff when there may be an issue. They manage the waiting room and have a good sense of patient flow. For integrated care to be a success, these staff need to be included in huddles, in training and in process improvement.

7. Persistence is required and tackling obstacles with small tests of change will keep you moving forward.

Because there are so many moving parts with any integration effort, building a team and using data effectively to help you know what obstacle to tackle next, are key ingredients for success.

8. Integration is a continuous journey, not a destination.

One of the most critical hallmarks of a high-performing practice is the recognition that there is always more to do, always something to improve. The knowledge base in the field continues to expand, the team continues to improve, and the context changes – all of this requires continuous attention to growth, change and improvement.

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Appendix: Workshop Evaluation Questionnaire and Results

Questionnaire

DSRIP – MAX Series Program – Topic 2: Integrating Behavioral Health and Primary Care Services
Workshop 1 Evaluation

Thank you for participating in the MAX Series Program Topic 2 – Workshop 1. Please complete the following evaluation and **hand in to your Facilitator before you leave the session**.

1. Please provide name of your Action Team:

2. Please rate the overall value of the Workshop				
☐ 1 – Poor	☐ 2 – Fair	☐ 3 – Neutral	☐ 4 – Good	☐ 5 – Excellent
Comments:				

3. Please rate the effectiveness of the presenters during the Workshop				
Workshop Facilitator				
☐ 1 – Poor	☐ 2 – Fair	☐ 3 – Neutral	☐ 4 – Good	☐ 5 – Excellent
Topic Expert and Presenter				
☐ 1 – Poor	☐ 2 – Fair	☐ 3 – Neutral	☐ 4 – Good	☐ 5 – Excellent
Comments:				

4. Please rate the effectiveness of your MORNING FACILITATOR (check appropriate facilitator as per your Action Team)				
☐ *Facilitator 1* ☐ *Facilitator 2*		☐ *Facilitator 3* ☐ *Facilitator 4*		☐ *Facilitator 5* ☐ *Facilitator 6*
☐ 1 – Poor	☐ 2 – Fair	☐ 3 – Neutral	☐ 4 – Good	☐ 5 – Excellent
Comments:				

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5. Please rate the effectiveness of your AFTERNOON FACILITATOR (check appropriate facilitator as per your Action Team)				
☐ *Facilitator 1* ☐ *Facilitator 2*		☐ *Facilitator 3* ☐ *Facilitator 4*		☐ *Facilitator 5* ☐ *Facilitator 6*
☐ 1 – Poor	☐ 2 – Fair	☐ 3 – Neutral	☐ 4 – Good	☐ 5 – Excellent
Comments:				

6. Please rate your overall assessment of the following				
Confidence in your ability to **change the way you work**				
☐ 1 – Very Low	☐ 2 – Low	☐ 3 – Neutral	☐ 4 – High	☐ 5 – Very High
Confidence that you can provide **higher quality care** to your patients without additional resources (staff, equipment or facilities)				
☐ 1 – Very Low	☐ 2 – Low	☐ 3 – Neutral	☐ 4 – High	☐ 5 – Very High
Confidence that you can care for **more patients** without additional resources (staff, equipment or facilities)				
☐ 1 – Very Low	☐ 2 – Low	☐ 3 – Neutral	☐ 4 – High	☐ 5 – Very High
Comments:				

7. What did you find most valuable about the Workshop? In other words, <u>what do you want to see more of in the next Workshop</u>?
Comments:

8. What did you find least valuable about the Workshop? In other words, <u>what needs to change for the next Workshop</u>?
Comments:

9. Would you recommend this program to a colleague?	
☐ Yes	☐ No

10. Other comments or suggestions

Workshop Evaluation Results: Topic 2

	Metrics	Topic 2 Integrating BH and PC Services
Workshop 1	Average Overall Rating	4.4
	% Recommend program to a colleague	86%
	Average Facilitator Score	4.1
Workshop 2AB	Average Overall Rating	4.5
	% Recommend program to a colleague	97%
	Average Facilitator Score	4.4
Workshop 3AB	Average Overall Rating	4.5
	% Recommend program to a colleague	94%
	Average Facilitator Score	4.0
Average Overall Rating		**4.5**
Top 3 noted areas of value		▪ Structured brainstorming ▪ Focused Action Planning ▪ Sharing ideas with other Action Teams
Top 3 noted areas for improvement		▪ More interaction with DOH re: regulations ▪ Length of Workshops ▪ Location (travel time)