Integrating Primary Care, Oral Health and Behavioral Health for Older Adults

Health Center Information and Questionnaire

Section I. ECE Learning Collaborative Overview

Project Summary

In an effort to accelerate learning and collaboration within HRSA Health Center grantees across the U.S. that aim to improve the health outcomes for the ever growing older adult population in their communities, the National Center of Equitable Care for Elders (ECE) is launching a national learning collaborative.

The National Center ECE is funded by the Health Resources and Services Administration (HRSA) through a National Training and Technical Assistance Cooperative Agreement (NCA) that provides training and technical assistance (TA) to Community Health Centers, Federally Qualified Health Centers (FQHC) and look-alikes committed to improve health care delivery to the older adult population. The Learning Collaborative will take place from April to June 2018. The overall goal of the ECE Learning Collaborative is to provide health centers' workers with the tools they need to improve health equity among their older adult population by increasing access to care, improving health outcomes and serve as a resource or guide to social services to improve services for the elderly. This learning collaborative will achieve all of this by assessing the readiness for health centers' and providers' to provide integrated care including dental, behavioral services; and discussing evidence based integration strategies that are replicable.

Minimum Eligibility Criteria

ECE seeks responses from HRSA health center grantees.

Learning Collaborative Structure

● Identify a minimum of three individuals to serve as team members for the ECE Learning Collaborative (ie. medical champion, mental health champion, oral health champion or geriatric health champion), and a project lead, which can be one of the ECE Learning Collaborative team members.

● Between April and July 2018, participate in four (4), 1 hour, learning collaborative **video-conferencing calls** with ECE and the other participating health centers, to review and share strategies for implementing each of the four systems (assessment, training, clinical flow, evaluation) which must be developed to create medical-dental-behavioral health integration.

Evaluation Strategy

● Evaluations will be sent out at the end of each session to assess participants' knowledge, impact and satisfaction. Evaluation may also include interviews and additional data collection. ECE staff will document promising practices that participating health centers develop to address barriers in implementing medical/dental/behavioral health integration and that incentivize providers to engage in ECE projects, in order to develop resources to share these practices with other health centers nationwide.

Benefits of Participation

The ECE Learning Collaborative is an excellent opportunity for eligible health centers to:

● Learn strategies on increasing the number of elderly patients using health centers.

● Expand and enhance oral health and mental health integration with primary health care to create whole-person care.

● Gain knowledge on health integration programs with positive, rigorously evaluated and broadly replicable results

● Build relations with other organizations that will facilitate peer leaning experiences, both during this activity and beyond.

Section II. Questionnaire Form

Please complete the ONLINE APPLICATION by 5:00 PM EST on March 30, 2018

Applications can be sent through the online form or via email (ece@hsdm.harvard.edu)

1. Contact Person	
a. Name, credentials	
b. Title	
c. Email address	
d. Phone Number	

2. Health Center Information	
a. Organization Name	
b. Number of medical clinic sites	
c. Number of mental health clinic sites	
d. Number of co-located medical and mental health sites, if applicable	

3. Health services provided	Yes/No
a. Behavioral/Mental Health	
b. Oral Health services	

4. Staffing Information from 2016 UDS	#	%
a. Behavioral/Mental Health providers		
b. Geriatric Physicians		
c. Geriatric Dentists		

5. Health Information Technology Information	Yes/ No
a. Does every provider have access to EHR patient information?	

Section III. Questionnaire Form

What is the Current Level of Integrated Services at My Health Center?

Consider the following four areas of your Health Center and complete this self-assessment to quantitatively score your Health Center's level of integration

Health Center: _____

A. Mental/Behavioral and Oral Health Integration

1. Co-location of treatment for primary care and Mental/behavioral health care.
   - ☐ does not exist; consumers go to separate sites for services
   - ☐ is minimal; but some conversations occur among types of providers; established referral partners exist
   - ☐ is partially provided; multiple services are available at same site; some coordination of appointments and services
   - ☐ exists, with one reception area; appointments jointly scheduled; one visit can address multiple needs
2. Emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)
   - ☐ are not assessed (in this site)
   - ☐ are occasionally assessed; screening/assessment protocols are not standardized or are nonexistent
   - ☐ screening/assessment is integrated into care on a pilot basis; assessment results are documented prior to treatment
   - ☐ screening/assessment tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented.
3. Treatment plan(s) for primary care and behavioral/mental health care
   - ☐ do not exist
   - ☐ exist, but are separate and uncoordinated among providers; occasional sharing of information occurs
   - ☐ Providers have separate plans, but work in consultation; needs for specialty care are served separately
   - ☐ are integrated and accessible to all providers and care manager; patients with high behavioral health needs have specialty services that are coordinated with primary care
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care
   - ☐ does not exist in a systematic way
   - ☐ depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases
   - ☐ evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers

- ☐ follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently

5. Patient/family involvement in care plan
   - ☐ does not occur
   - ☐ is passive; clinician or educator directs care with occasional patient/family input
   - ☐ is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with some patients/families and their provider(s)
   - ☐ is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources
6. Oral health needs
   - ☐ are not assessed
   - ☐ are occasionally assessed; screening/assessment protocols are not standardized or are nonexistent
   - ☐ screening/assessment is integrated into care on a pilot basis; assessment results are documented prior to treatment
   - ☐ screening/assessment tools are integrated into practice pathways to routinely assess oral health needs of all patients; standardized screening/ assessment protocols are used and documented.

B. Practice/ Organization Current Level of Readiness for Integration

1. Organizational leadership for integrated care…
   - ☐ does not exist or shows little interest
   - ☐ is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care
   - ☐ is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings)
   - ☐ strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models
2. Patient care team for implementing integrated care …
   - ☐ does not exist
   - ☐ exists but has little cohesiveness among team members; not central to care delivery
   - ☐ is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills
   - ☐ is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences and team meetings are regularly scheduled
3. Data systems/patient records …
   - ☐ are based on paper records only; separate records used by each provider

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