MaineCare Value-Based Purchasing Playbook
Based on the 2017 Data-Focused Learning Collaborative

Introduction

In the fall of 2011, Commissioner Mary Mayhew established a new direction for the management of the MaineCare program to focus on evaluating the value of services provided through the $2.6 billion annual budget and to incentivize models of care proven to improve health outcomes and better care coordination. The foundation of this work began with a statewide effort to support more effective management of MaineCare members with higher than average use of emergency room services through increased collaboration with hospitals throughout the state. This was followed by four major initiatives: Health Homes (HHs), Behavioral Health Homes (BHHs), Accountable Communities (ACs), and Opioid Health Homes. There are over 90,000 MaineCare members currently being served by these programs.

Health Homes are partnerships between an enhanced HH primary care practice and one of ten Community Care Teams (CCTs) around the state. Both organizations receive a Per Member, Per Month (PMPM) payment for HH services provided to MaineCare members who have two chronic conditions or one chronic condition and are at risk for another. HH services include care coordination, case management, individual and family support, and health promotion/education. Participation in HH services is entirely voluntary, and members can opt out of the service at any time.

Behavioral Health Homes are partnerships between a licensed community mental health provider (the "BHH organization"), one or more HH practices, and non-HH primary care practices to manage the physical and behavioral health needs of eligible adults and children. Both BHH and HH organizations receive a PMPM payment for HH services provided to enrolled members. BHHs build on the existing care coordination and behavioral health expertise of community mental health providers.

MaineCare's AC program contracts with groups of providers who volunteer to participate in the shared savings model. If an AC succeeds in reducing costs while meeting quality benchmarks, the AC shares in the savings it achieves for the MaineCare program in the form of a shared

savings payment, which is tied to the amount of the AC's savings and its quality performance.

The Data-Focused Learning Collaborative (DFLC) provides technical assistance to MaineCare BHHs and HHs who use outcome data to focus on quality improvement. The DFLC's focus for this guide is specific to the best practices derived from the partnerships between BHHs and HHs surrounding the Hemoglobin Glycosylated (HbA1c) test. This test is critical per the Antipsychotic Measures (AM) and Diabetic Care Measures (DCM), as set forth by MaineCare.

The DFLC Quality Measures, as determined through MaineCare claims data, are as follows:

- Number of members in BHH with two (2) fills of antipsychotic medication and an HbA1c test in the defined 12-month period
- Number of members in HH, 18 to 75 years old, with a diagnosis of diabetes and an HbA1c test in the defined 12-month period

This playbook will provide you with a step-by-step guide, recommendations, and examples for MaineCare BHHs and HHs working with members who are prescribed antipsychotics or members with diabetes. Documents in the Playbook may be used as tools to assist you in creating processes to manage your BHH or HH members.

Note: Materials in this Playbook created by providers have been de-identified.

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An HH is a primary care practice that provides care coordination services, as described in MaineCare Benefits Manual, Chapter II, Section 91.

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- MaineCare Benefits Manual - Chapter II, Section 91, Health Home Services
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- Definitions

Printable Playbook Materials

Connect and Contact

HH-BHH-Services.DHHS@maine.gov

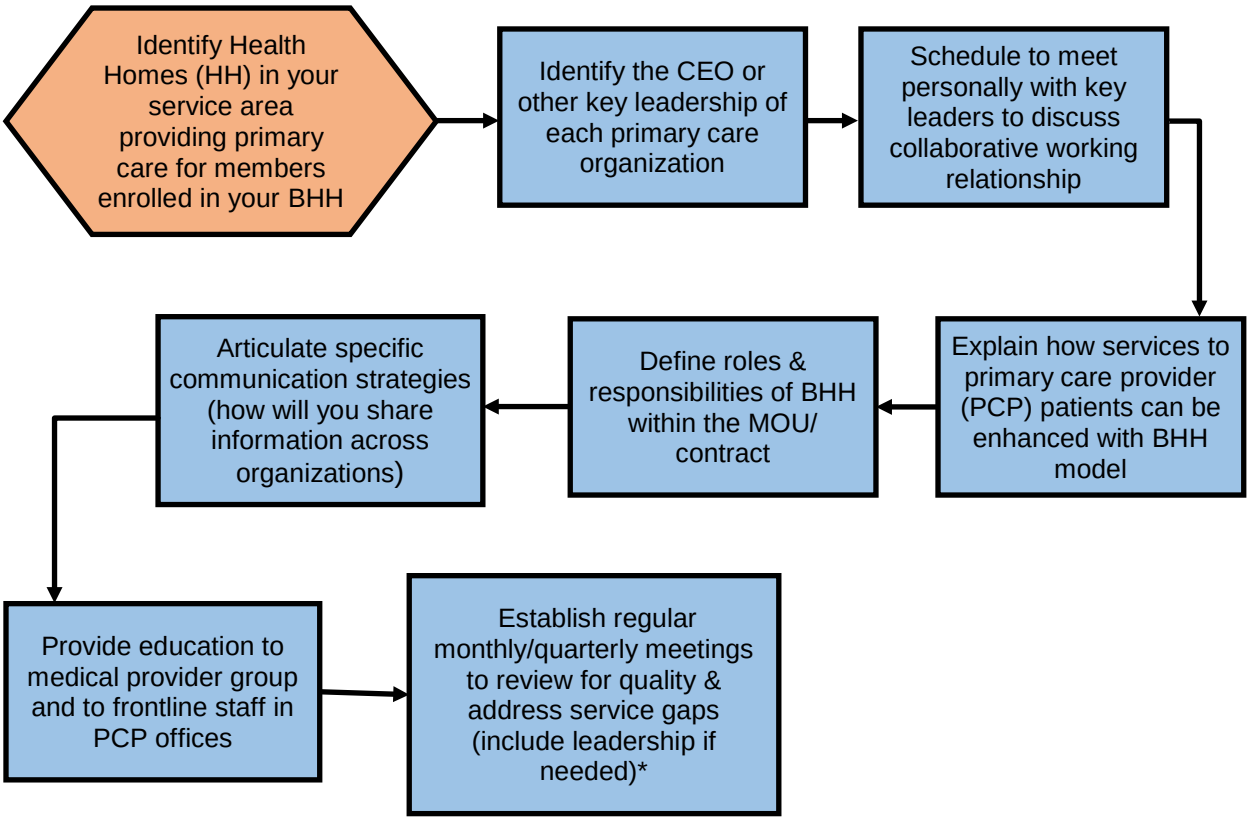
Memorandum of Understanding (MOU)

Memorandum of Understanding (MOU) Highlights

- MOUs are between Behavioral Health Home (BHH) and Health Home (HH) providers.
- An MOU should be a "blanket" agreement to discuss the healthcare of mutual patients between only those providers listed in the agreement.
- A release for information should be completed per member for providers not listed in the MOU; e.g., specialists, business partners, and non-HH providers.
- BHHs should have at least one MOU with an HH provider in each area they serve.
- MaineCare recommends that BHHs have MOUs with all HH providers in their service area(s) to include all shared members.
- MOUs are not an exclusive referral agreement; BHHs and HH practices may refer to a provider of the member's choice, even without an MOU.
- HH providers can have MOUs with multiple BHHs.
- MaineCare recommends MOUs being done at a pay-to/organization level to encompass all locations affiliated to the organization, instead of individual locations. This is helpful when organizations expand their service locations.
- MOUs must be signed by both BHH and HH providers before MaineCare can affiliate locations in the Value-Based Purchasing Management System (VMS) portal.
- Once the affiliations are made, HH providers will have access to shared members and their data in the VMS portal.
- MOUs should contain details of how the BHHO will make pass-through payments to affiliated HH providers, unless a separate contract has been created for this purpose.
- When a BHH is coordinating with primary care providers and an MOU is not present, releases are appropriate for the sharing of member information.
- All signed MOUs should be sent to HH-BHH-Services.DHHS@maine.gov
- MaineCare Benefits Manual Chapter II, Section 92.02-1(F) states:
    - The BHHO must have an executed contract or Memorandum of Agreement with at least one HHP in its area that describes procedures and protocols for regular and systematized communication and collaboration across the two agencies, the roles and responsibilities of each organization in service delivery, and other information necessary to effectively deliver all BHH services to all shared members without duplication. This may include names and contact information of key staff at BHHO and HHP, acceptable mode(s) of electronic communication to ensure effective and privacy-protected exchange of health information, frequency of communication at both leadership and practice levels (e.g., weekly, monthly, quarterly), procedures for bi-directional access to member plan of care and other health information, referral protocols for new members, collaboration on treatment plans and member goals and, as needed, Business Associate Agreement/Qualified Service Organization addenda.

Behavioral Health Home (BHH) Example:
Workflow for BHH/HH Memorandum of Understanding (MOU)/Contract

It is important to understand that communication and relationship building are critical when establishing your BHH MOU/contract. Primary care organizations want to coordinate with BHH providers. For initial contact, organizations appreciate and respect outreach made by phone, rather than email or fax. Regular communication is essential for ongoing referrals and quality care management.



Suggested program educational materials:

- Letters of introduction to the organization
- BHH program brochures, flyers, documents
- Frequently Asked Questions
- Identified BHH/HH key contacts

*For some organizations, it is leadership and not frontline staff who attends these meetings. They are the individuals with the authority to make necessary changes and they understand the infrastructure.

Example for creating a BHH/HH MOU

MEMORANDUM OF UNDERSTANDING
BEHAVIORAL HEALTH HOMES (BHH)

The parties to this agreement, [*BHH ORGANIZATION*] and [*HH ORGANIZATION*] enter into this agreement for the purpose of providing BHH services to eligible MaineCare members, made effective [*DATE*]. [*BHH ORGANIZATION*] and [*HH ORGANIZATION*] intend by this agreement to describe the mutual goals, objectives, and scope of their partnership in the MaineCare BHH program. The parties agree as follows:

I. MUTUAL GOALS AND OBJECTIVES

1. Provide BHH services to enrolled members, as described in MaineCare Benefits Manual Chapter II, Section 92, to include:
    a. Comprehensive care management services
    b. Care coordination
    c. Health promotion
    d. Comprehensive transitional care services
    e. Individual and family support services
2. Other goals and objectives as may be identified and agreed upon by the parties.

II. TARGET POPULATION

1. Adults with Serious and Persistent Mental Illness (SPMI) and children with Serious Emotional Disturbances (SED) who would benefit from a comprehensive system of care coordination from a BHH organization and the Health Home (HH) practice.

III. EXPECTED OUTCOMES, MEASURES, AND BENEFITS

1. Promotion of/improvement in key quality outcomes, as identified in MaineCare's BHH quality framework
2. Other outcomes, measures, and benefits as may be identified and agreed upon by the parties.

IV. POLICIES AND PROCEDURES

As described in the MaineCare BHH State Plan Amendment, the parties to this agreement shall further define mutually acceptable procedures for effective, ongoing communication and collaboration, such as:

1. Holding [*FREQUENCY*] meetings between organizational leaders to ensure that all components of the BHH program are operating as intended and that any implementation problems are resolved in a timely manner.
2. Using secure electronic communication to ensure the timely and privacy-protected exchange of health information

3. Bi-directional access to member plans of care and other health information that is in compliance with federal and state confidentiality laws applicable to individually identifiable health information;
4. Collaboration on treatment plans and member goals;
5. Interdisciplinary team meetings as needed to ensure that client/patient problems and needs are addressed in a timely manner;
6. Adherence to standard referral processes between organizations.

V. BHH RESPONSIBILITIES

1. [*To be decided and agreed upon by both parties*]

VI. HH RESPONSIBILITIES

1. [*To be decided and agreed upon by both parties*]

VII. REFERRALS

There is no requirement under this or any other agreement between the parties that either party refer any patients to the other party for products or services, and no payment made under this Agreement is in return for the referral of patients, or in return for the purchasing, leasing or ordering of any products or services for which MaineCare may make payment in whole or in part.

VIII. REIMBURSEMENT

The BHH shall be responsible for billing and collecting from MaineCare, in accordance with Chapters II and III, Section 92 of the MaineCare Benefits Manual, any applicable reimbursement for furnishing services to MaineCare members in connection with the BHH program. The BHH shall be responsible for collecting all Per Member Per Month (PMPM) HH reimbursement from MaineCare, and shall make payment to HH practice for such services. The BHH shall pay the HH practice the PMPM specified by MaineCare on the BHH pass-through payment summary in the Maine DHHS Value-Based Purchasing Management System (VMS) portal.

IX. COMPLIANCE WITH PRIVACY AND CONFIDENTIALITY

Parties to this agreement shall ensure compliance with all applicable federal and state laws, regulations, licensing, and accreditation requirements with regard to ensuring administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any information, in any format, that the parties may create, receive, maintain, or transmit pursuant to activities under this Agreement, including but not limited to Health Insurance Portability and Accountability Act (HIPAA) and/or Health Information Technology for Economic and Clinical Health (HITECH), 42 CFR Part 2, Maine confidentiality statutes, regulation, licensing requirements, DHHS contract.

X. INDEMNIFICATION

The parties shall protect, defend, and indemnify one another, one another's Board members, officers, agents, volunteers, and employees from any and all liabilities, claims, liens, demands, costs, and judgments, including court costs, costs of administrative proceedings, and attorney's fees, which arise out of the occupancy, use, service, operations, performance or nonperformance of work, or failure to comply with federal, state, or local laws, ordinances, codes, rules and regulations, or court or administrative decisions, negligent acts, intentional wrongdoing, or omissions by either party, its officers, employees, agents, representatives, or subcontractors in connection with this Agreement. Nothing herein shall be construed as a waiver of any public or governmental immunity.

XI. TERMINATION

Either party may terminate this agreement by giving thirty (30) days written notice to the other party.

XII. AUTHORITY TO SIGN

The persons signing below certify by their signatures that they are authorized to sign this Agreement on behalf of the party they represent, and that this Agreement has been authorized by said party.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date written below.

Signature:

_____Date:_____
[*Printed Name and Title*]
[*Organization*]
[*Contact Information*]

Signature:

_____Date:_____
[*Printed Name and Title*]
[*Organization*]
[*Contact Information*]

Behavioral Health Home Resources

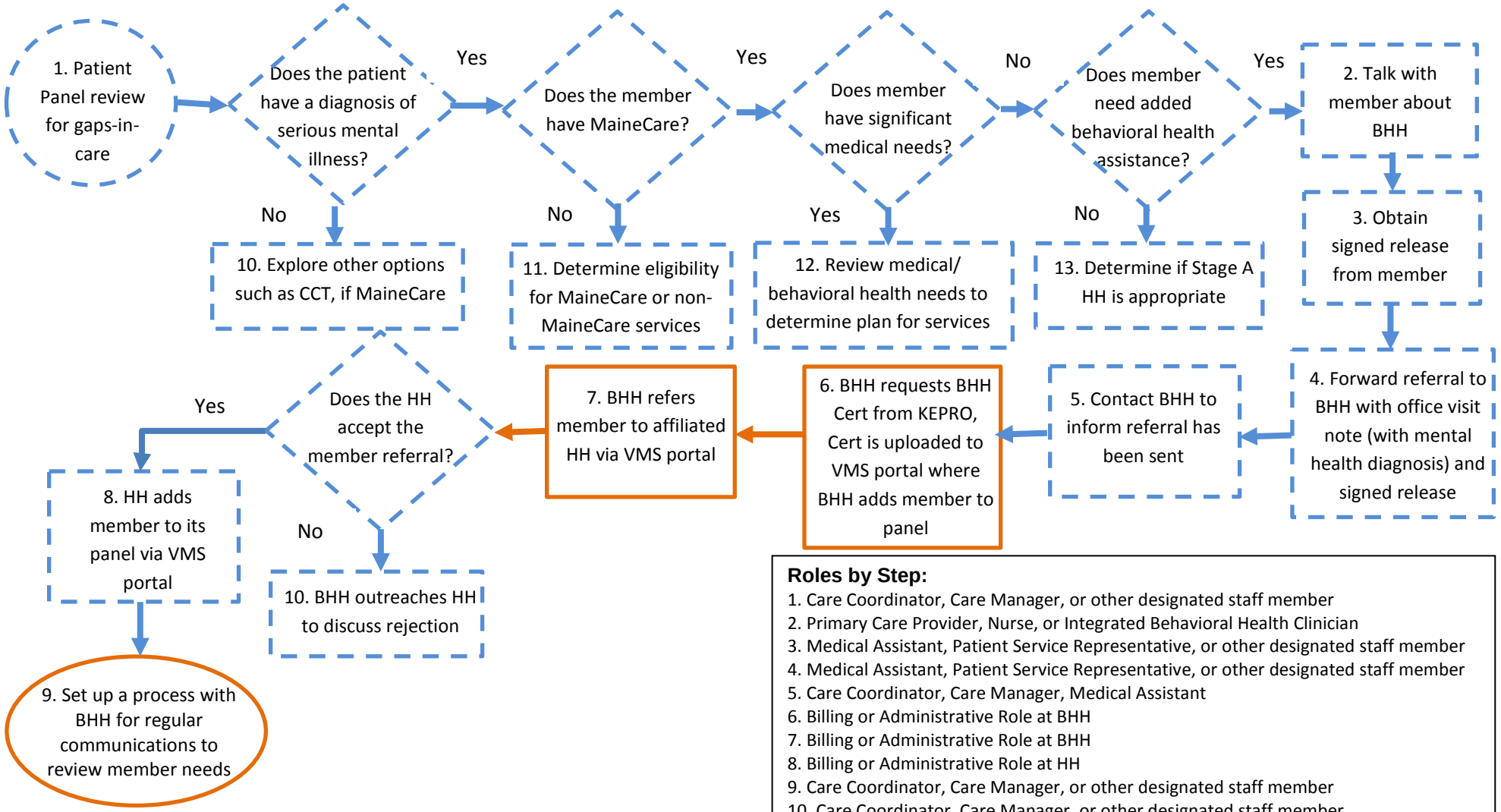
Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Ricker Hamilton, Acting Commissioner

Referring a Member to BHH Services

Legend:
- Behavioral Health Home (BHH) Role
- Health Home (HH) Role

Acronyms:
CCT – Community Care Team
VMS – Value-Based Purchasing Management System



Roles by Step:

1. Care Coordinator, Care Manager, or other designated staff member
2. Primary Care Provider, Nurse, or Integrated Behavioral Health Clinician
3. Medical Assistant, Patient Service Representative, or other designated staff member
4. Medical Assistant, Patient Service Representative, or other designated staff member
5. Care Coordinator, Care Manager, Medical Assistant
6. Billing or Administrative Role at BHH
7. Billing or Administrative Role at BHH
8. Billing or Administrative Role at HH
9. Care Coordinator, Care Manager, or other designated staff member
10. Care Coordinator, Care Manager, or other designated staff member
11. Medical Assistant, Patient Service Representative, or other designated staff member
12. Primary Care Provider, Nurse, or Integrated Behavioral Health Clinician
13. Care Coordinator, Care Manager, or other designated staff member

Welcome to Children's Behavioral Health Home Services. Things You Should Know About Us…

We are honored that you chose _____ to be the service provider for your child. We take great pride in our service and we want you to be satisfied with the work we do for your family.

When you come to _____, you don't get just one person supporting you – you get a whole team. Care/Case Management is the only thing we do and we are experts. It is our specialty and we have a whole team of people here for you.

We believe in having a personal touch, so when you call _____, you will talk to a real person. If the person you are calling is not available, you will have the option to leave a voicemail or you can ask the receptionist to assist you with someone else. Your Care/Case Manager is your primary contact here, but you also have a Family Support Partner, Nurse Care Manager and a Clinical Supervisor who may be able to help you. Enclosed is an explanation of each of these roles along with a list of the people on your child's team and their contact information. Our office hours are ___am to ___pm and Care/Case Managers are able to meet families before/after work hours. If you have a crisis, please call the statewide crisis number: **1-888-568-1112**.

You can expect all members of your team at _____ to call you back within 24-36 hours. If you find it takes longer than that, please call us back and let us know so we can check on things for you.

We are working hard for your family and we want to do our very best. You can expect to be treated with respect, kindness, care and compassion. We are sending this welcome letter so that you know how much you matter to us. Please feel free to call us with comments or questions you might have. We are here for you. Please visit our Facebook page if you would like to follow us. At times, we will be sharing information there that you might find helpful or interesting. Again, thank you for choosing us; we are honored and proud to serve you.

The Children's Behavioral Health Home Team

Care/Case Coordinator (CC): This person was once called a Case Manager, but is now called a Care Coordinator. They have a specific job to do for your family, which is to:

- Discuss your child's needs and strengths to conduct a Comprehensive Assessment.
- Work with you to build a team that will help with any needs and barriers.
- Work with you and your team to develop a plan, called an Individual Plan of Care (IPC), that will address needs from the Comprehensive Assessment.
- Advocate for you; they support your voice, your ideas, and the choices you make.
- Find services and supports that might be used in the IPC, and make referrals for those supports.
- Coordinate services and supports for you.
- Monitor referrals and existing services to ensure you are happy with the services being provided to your family.
- Attend meetings with you; school meetings, medication management meetings, treatment team meetings, etc.
- Work with you to decide if the services are right for your family and adjust the IPC as necessary.

Family Support Partner (FSP): These are parents of children with special needs who have worked through the mental health and other systems with their own children. The support they provide can be adjusted to meet a family's specific needs. This role can help with many things that parents need, which could include:

- Offering emotional support.
- Helping to find resources and other supports for you.
- Listening; they can simply listen or be a shoulder to cry on.
- Being a cheerleader when things are going well.
- Brainstorming ideas together.
- Helping to think about and build a natural support team.
- Attending meetings if a Care Coordinator is unable to be there.

The FSP is assigned to more families than the Care Coordinators. They do not work with all families at once, only those who reach out to them for support or who they are actively supporting.

Nurse Care Manager (NCM): The NCM works as a medical consultant to the team. They are available to the FSPs, the CCs, and to families who have questions about medical issues and needs. They work with primary care practices for families. Our NCMs can be reached by phone and can attend some meetings, though their availability is limited.

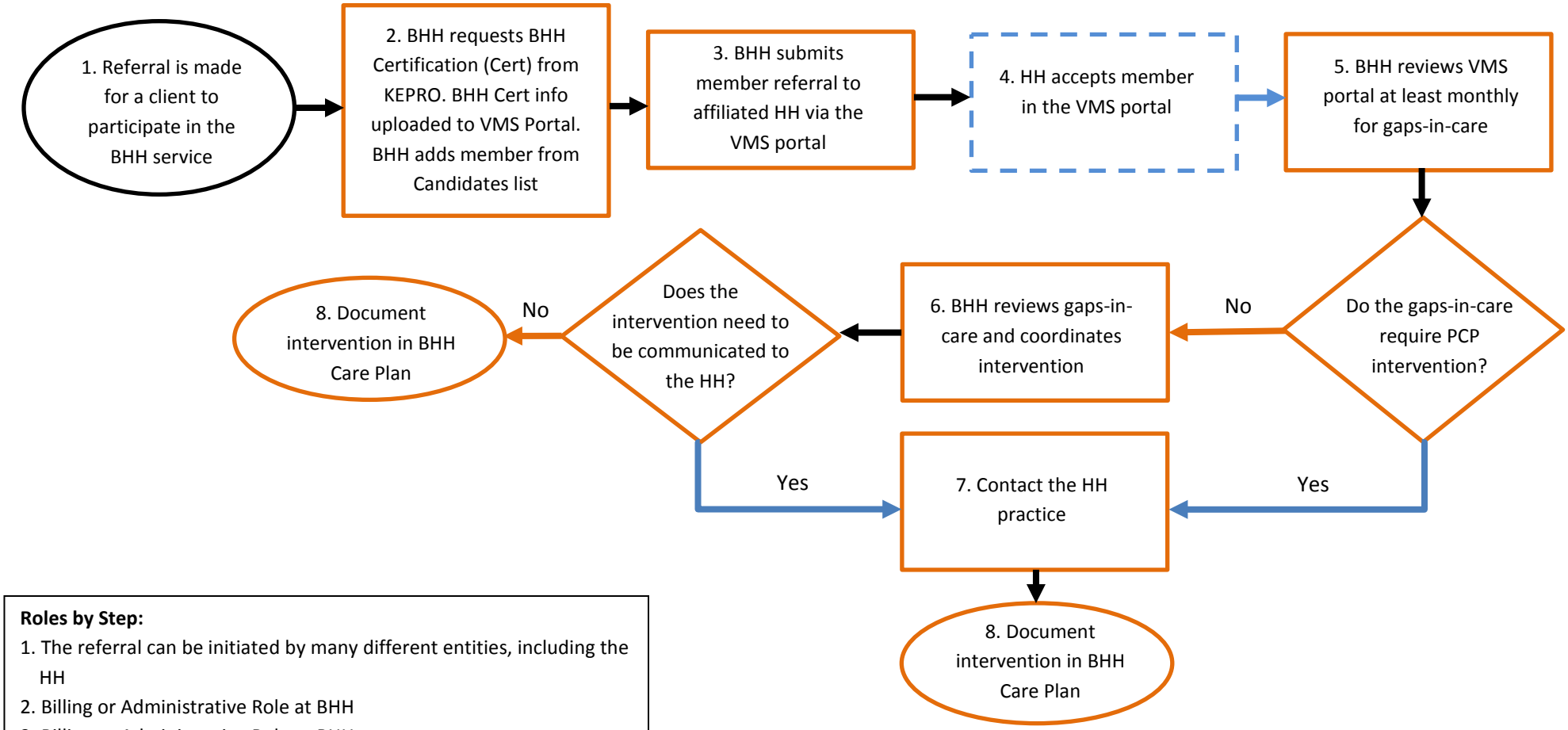
Clinical Supervisor: The clinical supervisor supervises the FSP and CC. They offer clinical insight into the work that we do and they help brainstorm solutions to issues. Review and approval of all Comprehensive Assessments and Individual Plan of Care (IPC) is completed by the clinical supervisor, who makes sure they follow all rules and regulations and agency values.

Other Support Staff: We have several other support staff available to families in need of assistance. These include a program manager, psychiatric consultant, medical consultant, executive director, administrative coordinator, operations manager, referral specialist and a receptionist. All staff are dedicated to helping your family. Our office hours are _____. If you urgently need someone, make sure you let the receptionist know and she will find someone to assist you.

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor — Ricker Hamilton, Acting Commissioner

Member-Level Care Coordination Workflow
From the Behavioral Health Home (BHH) Perspective



Roles by Step:

1. The referral can be initiated by many different entities, including the HH
2. Billing or Administrative Role at BHH
3. Billing or Administrative Role at BHH
4. Billing or Administrative Role at HH
5. Nurse Care Manager at BHH
6. HH Coordinators and entire BHH Team
7. Nurse Care Manager or HH Coordinator at BHH to a Care Coordinator or Nurse Care Manager at the HH Practice
8. Nurse Care Manager or HH Coordinator at BHH

Legend:

- Behavioral Health Home (BHH) Role
- Health Home (HH) Role

Acronyms:

PCP – Primary Care Provider
VMS – Value-Based Purchasing Management System

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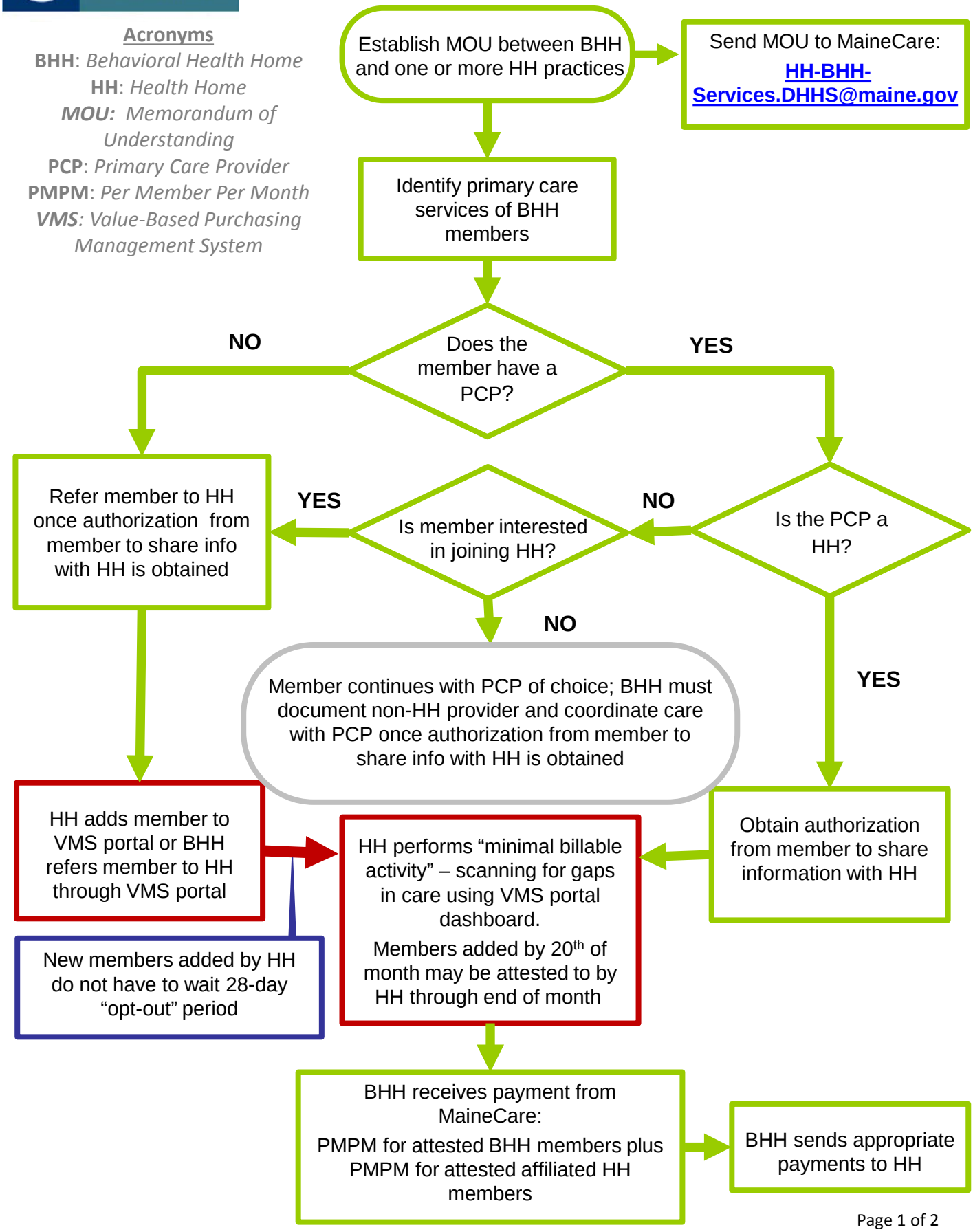
An Office of the Department of Health and Human Services

Steps to enroll a BHH member in an HH

Acronyms

BHH: *Behavioral Health Home*
HH: *Health Home*
MOU: *Memorandum of Understanding*
PCP: *Primary Care Provider*
PMPM: *Per Member Per Month*
VMS: *Value-Based Purchasing Management System*



MaineCare Services
An Office of the Department of Health and Human Services

Steps to enroll a BHH member in an HH

1. Behavioral Health Home (BHH) organization sites (MIHMS NPI+3) in various areas of the state must have a memorandum of understanding (MOU) with at least one Health Home (HH) practice in each area of the state. A copy of the MOU must be sent to MaineCare at HH-BHH-Services.DHHS@maine.gov for the affiliations between each BHH site and HH to be entered into the Maine DHHS Value-Based Purchasing Management System (VMS) portal.

2. The BHH, in discussions with its members, identifies enrolled BHH individuals who receive primary care services at the partnering HH and non-HH providers. The BHH obtains proper authorization from those members to share information with the HH and non-HH providers.

3. The BHH refers members to the HH. This referral process should be developed through discussion between the two organization and pursuant to the process reflected in the MOU (for instance, via secure email, through identified referral staff, etc.).

   - Once the members have been referred to the HH, the HH adds these members manually via the VMS portal using the Stage B Additions menu page.

   - Members added to Stage B/BHH by the HHP do not need to wait the usual 28-day "opt-out" period. These member requests are reviewed by MaineCare and added immediately, once approved.

   - Members new to the HHP should be outreached to establish with the practice. Member panels should be monitored for changes.

4. The HH practice performs its "minimal billable activity" which is a scan for gaps in care using the MaineCare claims dashboard found on the VMS portal.

   - Members added by the 20th of the month may be attested to by the HH practice. BHHs receive payments from MaineCare, which include the BHH PMPM for its attested members plus the affiliated HH practice PMPM for its attested members. The BHH sends affiliated HH practices their payments within 30-days of receipt.

Behavioral Health Home Example: Communication to Primary Care – Shared Member

Date: _____

Primary Care Provider: _____

Your patient, identified below, is enrolled in the Behavioral Health Home service at _____. The patient has been assigned a Behavioral Health Home Care Coordinator. The Behavioral Health Care Coordinator, in conjunction with the Nurse Care Manager, will work closely with you to assess needs, develop care plans, and arrange additional supports and services to address the patient's overall health and wellness.

When coordinating care for this patient, please contact his/her Behavioral Health Care Coordinator or the Nurse Care Manager listed below. Also, please be aware the Behavioral Health Care Coordinator may accompany the patient to medical appointments to help facilitate the member's understanding of his/her health care and to enhance communication regarding treatment planning. We have attached a release of information form for your records.

If you have any questions about the Behavioral Health Home service, please call one of the providers listed below. We look forward to working with you.

Patient Name:

Date of Birth:

Behavioral Health Home Care Coordinator Name:

Behavioral Health Home Care Coordinator Phone Number:

Nurse Care Manager Name:

Nurse Care Manager Phone Number:

Provider Instructions and Template:
Primary Care and Behavioral Health Home Bi-directional Shared Member Communication Process

Purpose: Communication between healthcare providers is crucial to the safe and effective provision of care for the members we serve. It is the expectation that the Primary Care Providers (PCP) and Behavioral Health Home (BHH) organizations exchange important information about shared members on a regular basis.

Process:

1. Monthly- BHH identifies shared patients and notifies the PCP. The PCP may contact the BHH about a potential shared member who meets the MaineCare criteria.
    a. The BHH will send the list to the PCP Care Manager or the designated contact at the site.
    b. The PCP Care Manager, or contact, will distribute the information to the appropriate team members.

2. Annually or as needed- The BHH Care Manager and the PCP Care Manager, or designees, generate the *Bi-directional Shared Member Communication* template. It will be exchanged at least yearly, or if any of the following occur:

    a. Changes in medications
    b. Changes in or additional diagnoses
    c. Hospital event – admission, discharge, ED visit, transition of care
    d. Discharge from the BHH or the PCP
    e. Any life changing event

    The *Bi-directional Shared Member Communication* template will be faxed or securely emailed between the PCP and BHH. However, if there are multiple changes at any time this will prompt a conversation between the care managers. The *Bi-directional Shared Member Communication* template will be scanned into the individual member's chart.

3. Ongoing-The BHH Care Manager and the PCP Care Manager, or designees, will coordinate the mental health or primary care needs (gaps in care).

4. Ongoing-Practices will develop their own tickler file or calendar to review members and share information.

Best Practice Guidance for use of the *Bi-directional Shared Member Communication* template:

- Template can be completed electronically with permanent information pre-filled (i.e. member name, DOB, PCP, Care Manager names & phone numbers)
- Electronic Medical Record documents can be attached to the form (i.e. problem lists, med lists, annual physical exam notes)
- Key lab and biometric measurements may include blood pressure, HbA1c, TSH, Microalbumin, liver function, weight, and BMI
- Ordering provider should copy lab results to the PCP or BHH
- Current and previous treatment history information may include recent office visits for PE, diabetes check, ED visits, hospitalizations, other specialist visits, or other community agencies involved in care of the member.
- Summary section may include goals of care, barriers to care, progress toward goals, medication changes/reason, or explanation of significant events (i.e. loss of housing, death or illness of friend or family member)

Template:
Primary Care/Behavioral Health Home: Bi-directional Shared Member Communication

DATE:
PATIENT NAME:
D.O.B.:

Release of Information Effective Dates:

Provider Type	Provider Name	Telephone	FAX
HH Nurse Care Manager			
PCP			
BHH Nurse Care Manager			
BHH Care Coordinator			

Medication List: ☐ None ☐ Attached
Problem List: ☐ None ☐ Attached

CURRENT AND PREVIOUS TREATMENT HISTORY (PCP, ED, Inpatient, Outpatient):

Description	Date

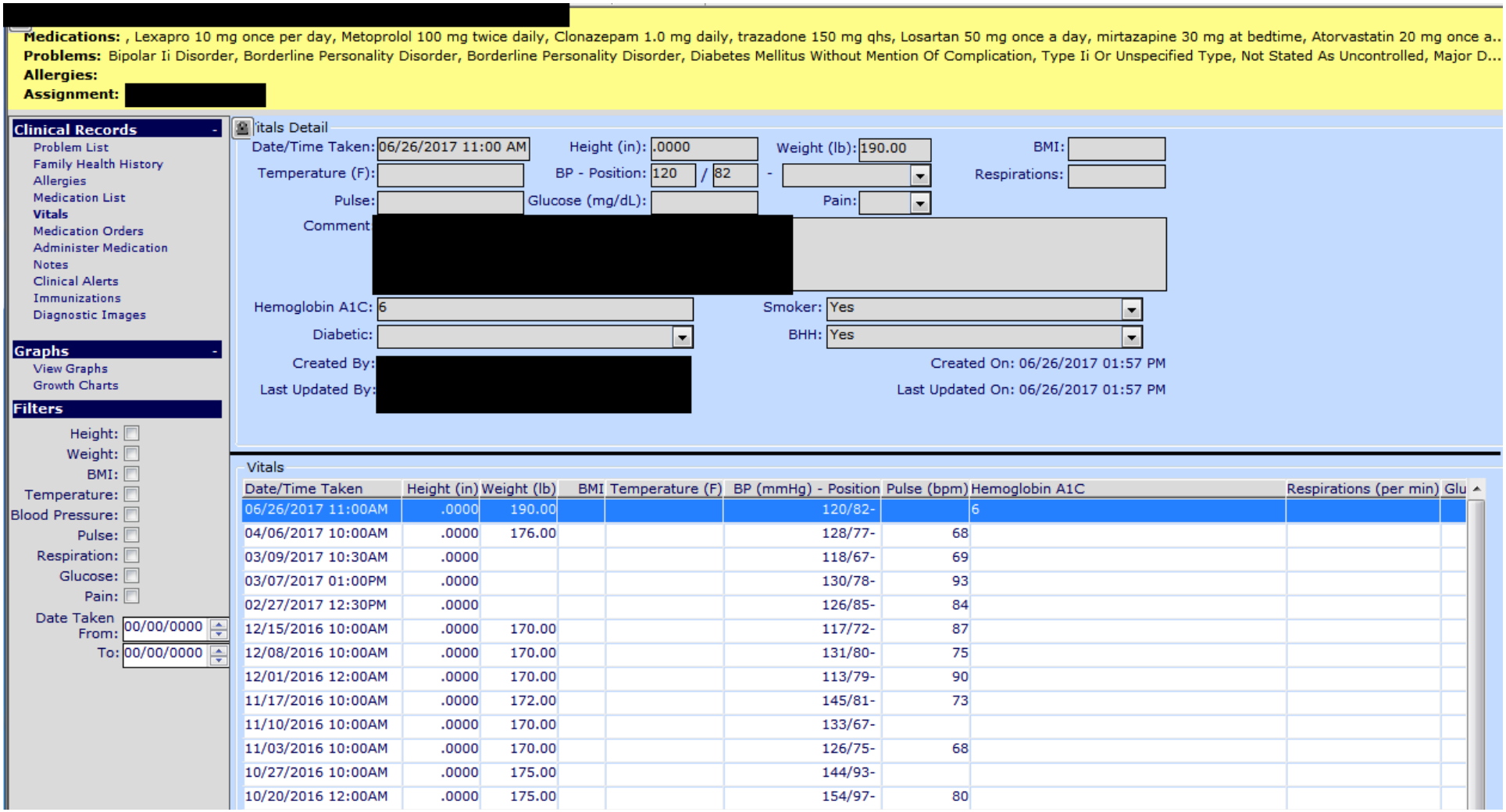
LABS/PHYSICAL EXAM:

Description	Date Of Most Recent
Physical Exam	
Metabolic Syndrome Screening	
HbA1c	

SUMMARY (shared goals, gaps in care, progress toward goals, medication changes/reason, adverse medication events):

Behavioral Health Home Example: Electronic Health Record Detail

Electronic Health Records (EHR) collect a lot of valuable information, but tailoring this information can provide a lot of insight into the population that an agency serves. The screenshot below is from the clinical record screen in the PsychConsult EHR, used by a Behavioral Health Home (BHH) provider. The purpose of this section is to track and collect physical health data. When staff updates physical health data, they can quickly review the various areas (listed in the top left) contained in clinical records and are able to enter/update any allergies, medications, vitals, etc. The BHH team added the HbA1c and BHH fields to the vitals section. When staff is entering physical health measurements such as height, weight, blood pressure, etc., they can quickly add in the HbA1c number when a test has recently been taken and note whether or not the member is in BHH.



Behavioral Health Home (BHH) Core Standards - Provider Best Practices

#1 Demonstrated Leadership	The established Clinical Team Leader is carefully tracking the micro-steps leading to achieving the Core Standards.
	Our team leader meets twice monthly with team members to review quality and performance of our BHH. Additionally, we meet as a larger team once monthly to oversee the processes and structure of our care practices. And finally, the clinical team lead meets with our case manager for weekly supervision to monitor cases and progress.
	The clinical team leader is present in all meetings that involve the BHH. We have a weekly memo to all members of the BHH team to pick up a variety of issues, updates, ideas, etc.
#2 Team-Based Approach to Care	Clinical coordinators, care coordinators, and nurse care manager completed a four-week course on the principles of and approach to Trauma-Informed Care. Certified Intentional Peer Specialists (CIPSS) facilitate workshops such as 'Getting the Most of Your Doctor's Visits' and others related to integrating physical and mental health recovery.
	CIPSS create and conduct ongoing trainings for staff during and outside of regular team meetings about intentional peer support, role of intentional peer support specialists within the BHH team as well as topics relevant to the consumer/survivor movement and voice.
#3 Population Risk Stratification and Management	We have developed a chronic disease registry and data tracking system to identify clients with chronic diseases and risk factors that are known to be highly prevalent within the population of adults with Severe Mental Illness (SMI) (diabetes, COPD, hypertension, hyperlipidemia, BMI > 25 and tobacco use), leveraging data in HealthInfoNet (HIN) and the Value-Based Purchasing Management System (VMS) portal & relationships with primary care partners, in addition to care coordinator knowledge of their member panels. We have begun utilizing this registry to target clients for nurse care manager outreach and education, support chronic disease self-management, and develop wellness activities that address the needs of these vulnerable, high-risk members.
#4 Enhanced Access	We have office staff available 24/7. If a message is generated, that message is immediately sent by email to the care coordinator with a copy to the office manager and another copy to the clinical director. This also represents the line of response. We strive to return contact with the client within an hour or less. All care coordinators remain on-call to provide coverage for each other. We do not provide crisis services, however, all clients have a detailed "Crisis Plan" when warranted
	As mentioned, we have office staff available 24/7. In addition, each client receives a text message the day before any scheduled appointments; they can reply to that text with one digit to represent (a) confirm, (b) reschedule, (c) cancel, (d) detail reply. We also use our monthly "BHHO Re-cap" to carefully monitor utilization of services.

#5 Comprehensive Consumer/Family Directed Care Planning	Plans of Care are ALWAYS co-constructed with the client. The tenants of Recovery-Oriented Model of care are replete across our clinical documentation and our policies and procedures. All care coordinators have a copy of the practice manual for the Recovery-Oriented Model and are asked to consult with it often and when updating Plans of Care
#6 Behavioral- Physical Health Integration	Completed the assessment early; within the first six months.
	We have developed a process for proactive identification of clients who are currently prescribed atypical antipsychotics to assess risk for developing diabetes and provide the appropriate education regarding risk, timely screening & lifestyle intervention(s). We continue to monitor and identify people with chronic diseases.
#7 Inclusion of Members and Families	We continue to hold seasonal membership gatherings. All BHH members are encouraged to attend the wellness fair-style gathering, where they receive programmatic updates since the last gathering and provide suggestions to improve service delivery within the BHH. We implemented a "suggestion box" so members could provide feedback. Within the peer wellness programming, continuous feedback is gathered and utilized to inform workshop development to reflect the needs and interests of the population served.
	Our clients are surveyed twice a year, which allows for the submission of comments regarding what they liked best and suggestions for improvement to our BHH services. We appreciate our clients' comments and strive to continue improving our results.
	Our survey results are reviewed at our BHH meeting and reported to the Board of Directors. Examples of utilizing feedback from our survey results: For any appointment made with our BHH staff greater than two weeks prior to the appointment, we would make a reminder call. We try to maintain continuity for our clients with their HH coordinator by only changing staff when necessary (staff resignations and geographical issues).
#8 Connection of Community Resources and Social Support Services	Several BHH members participated in a six-week Cooking Matters group, facilitated by Good Shepard Food Bank. BHH staff members are now trained to offer Cooking Matters to our clients, and we plan to continue to work with Good Shepard to run the group independently going forward. CIPSS offer quarterly workshops, Getting to Know Your Community, to facilitate knowledge of traditional and non-traditional community resources, identify barriers and ways to overcome them, and foster community inclusion.
#9 Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-effective Use of Healthcare Services	Through our collaboration with HealthInfoNet and the State Innovation Model program, our BHH has been utilizing HealthInfoNet as well as the VMS data to identify high utilizers of emergency and hospital services. This allows us to respond to factors contributing to this high use and provide education about accessing routine or preventative care and other more appropriate resources. We are involved in an ongoing ED utilization initiative among our other quality improvement efforts.
#10 Integration of Health Information Technology	We use an Electronic Health Record, by which we can run many different types of reports. We also have a "Monthly Re-Cap" of units used for a client so that we can look at appropriate level of care and utilization. This also helps us spot trends in utilization; these trends can be presented to the client when updating the Plan of Care and presented to the Board of Directors and the Clinical Team to prompt questions and proactive discussion.

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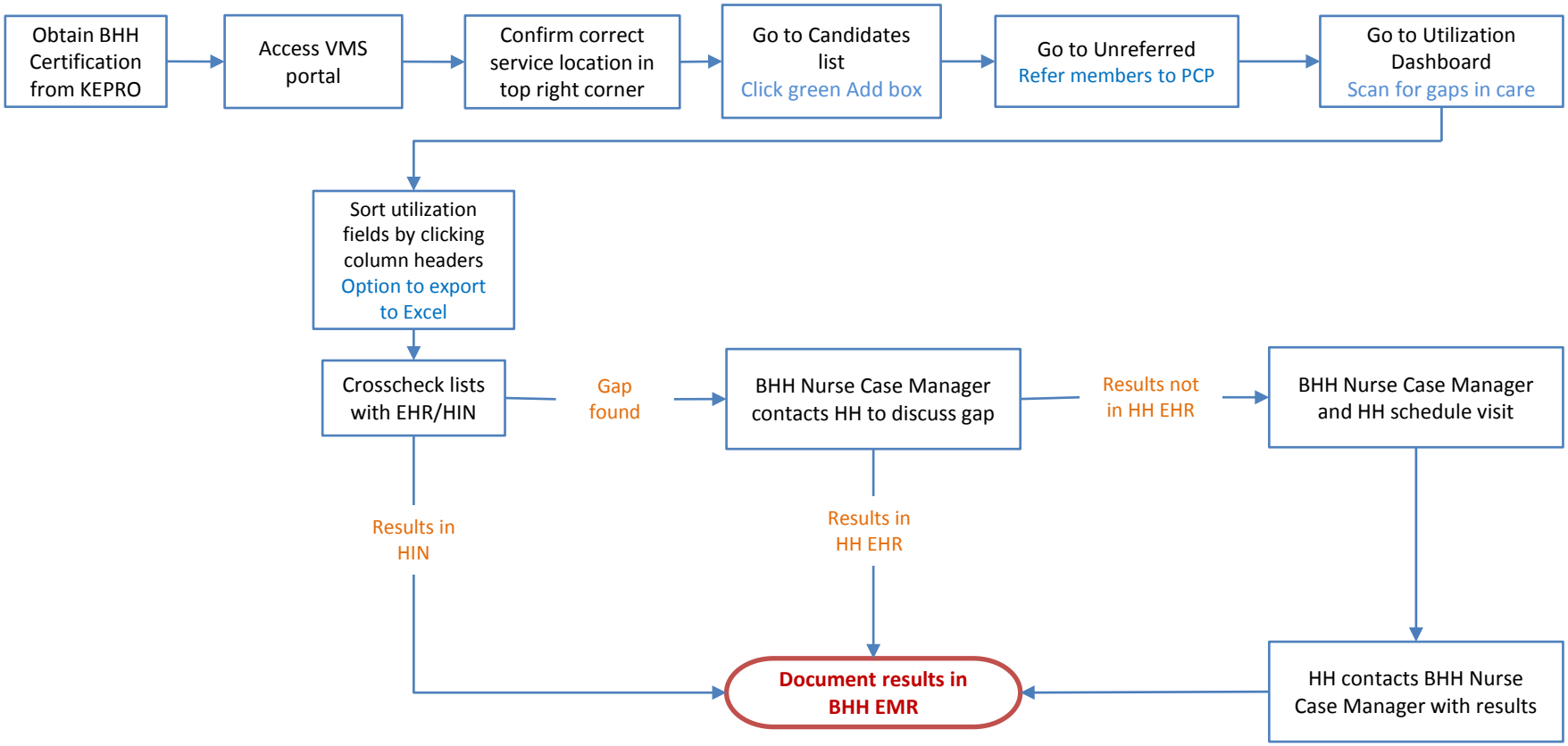
Behavioral Health Home VMS Portal Workflow



Acronyms:
BHH – Behavioral Health Home
EHR – Electronic Health Record
EMR – Electronic Medical Record
HH – Health Home
HIN - HealthInfoNet
PCP – Primary Care Provider
VMS – Value-Based Purchasing Management System

Utilization Dashboard

- Displays member-level MaineCare claims, including prescriptions, by clicking Go next to the member's name
- Identifies members who are considered high-utilizers of certain services
- Based on 12 months of claims; updated monthly
- Allows providers to determine which members are and are not receiving certain screenings and services

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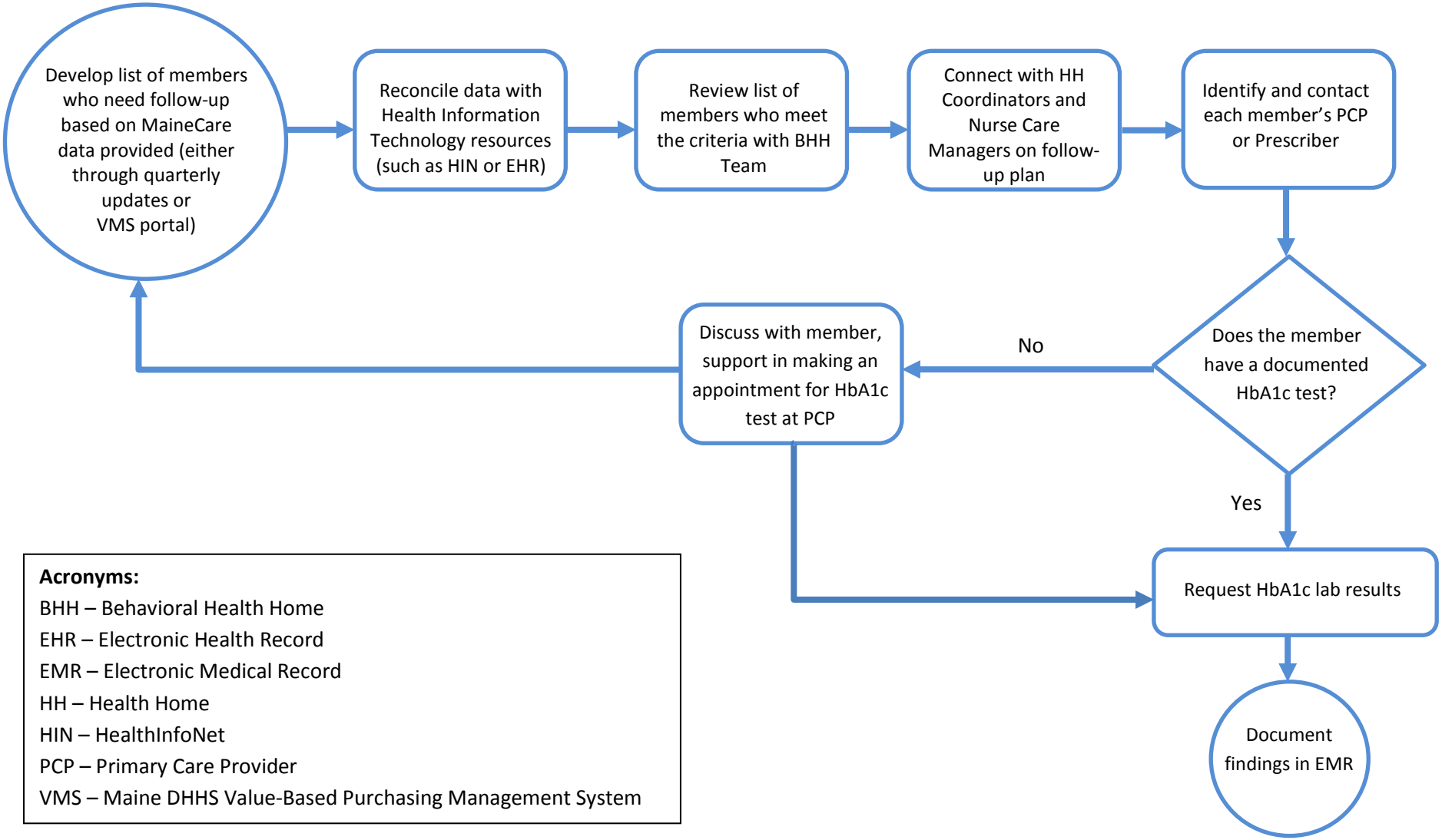
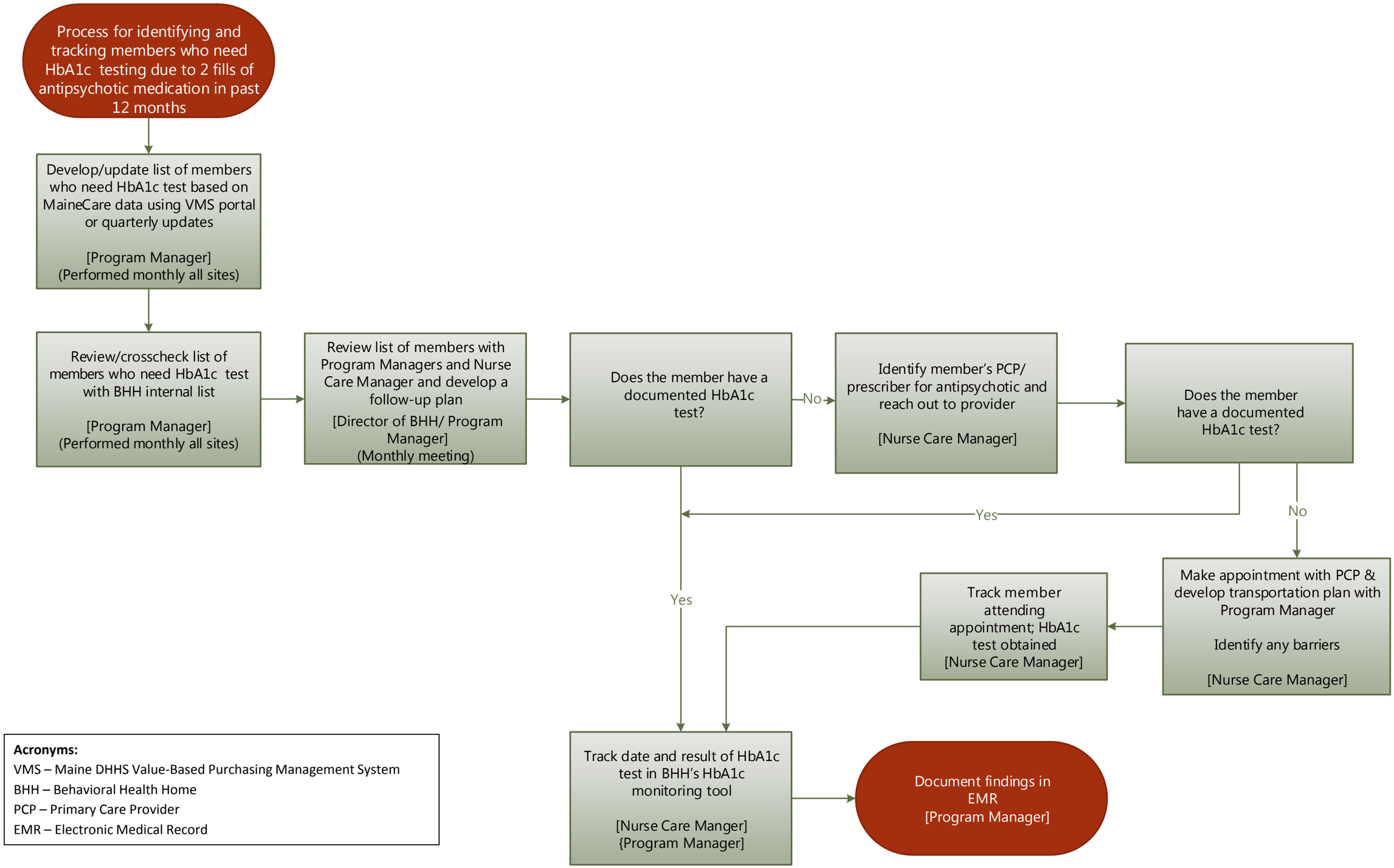
HbA1c Antipsychotic Measure
Behavioral Health Home Intervention Workflow



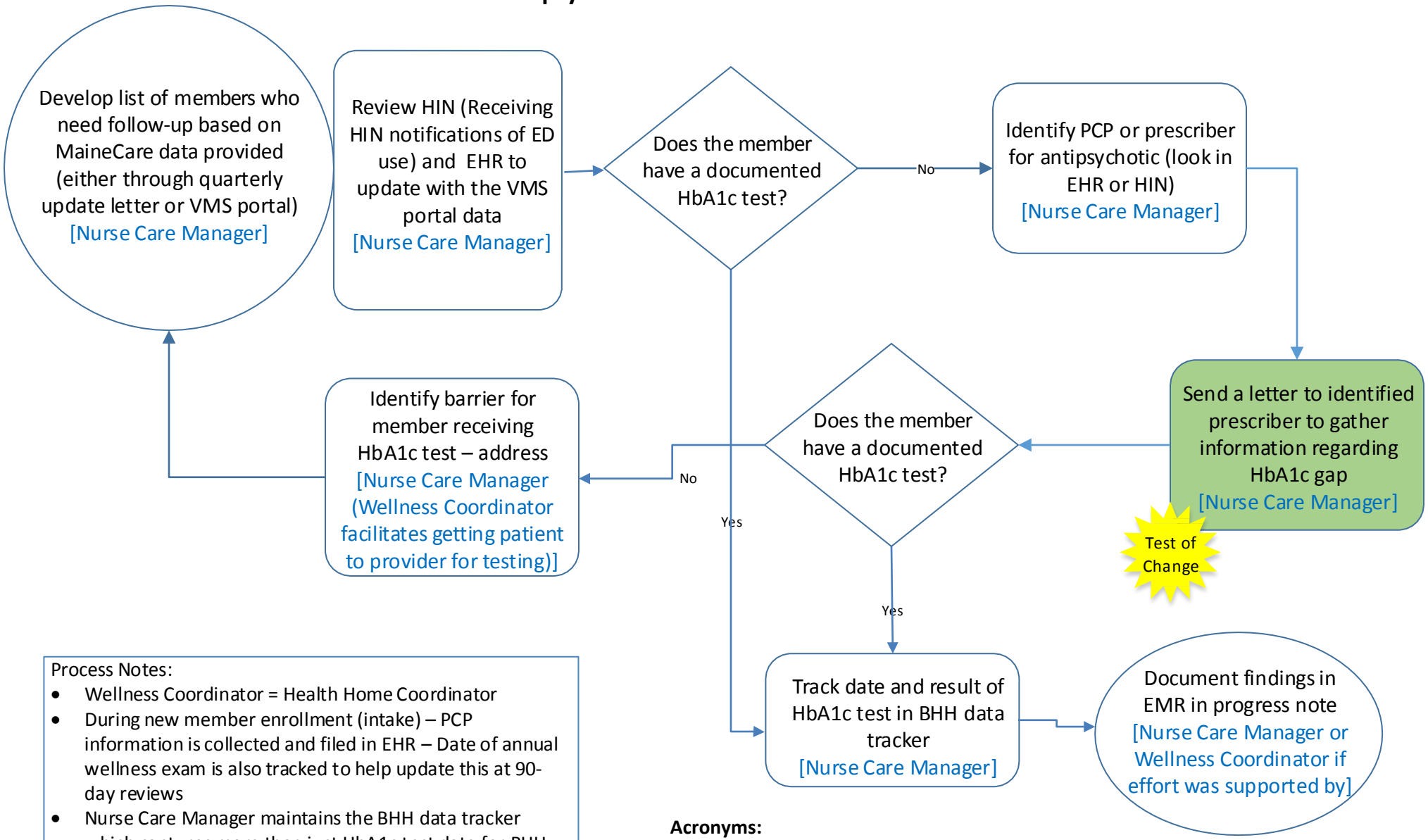
Acronyms:
BHH – Behavioral Health Home
EHR – Electronic Health Record
EMR – Electronic Medical Record
HH – Health Home
HIN – HealthInfoNet
PCP – Primary Care Provider
VMS – Maine DHHS Value-Based Purchasing Management System

Behavioral Health Home Example 1: Less Than Five Sites
HbA1c Antipsychotic Review and Intervention Workflow



Acronyms:
VMS – Maine DHHS Value-Based Purchasing Management System
BHH – Behavioral Health Home
PCP – Primary Care Provider
EMR – Electronic Medical Record

Behavioral Health Home Example 2: Single Site
HbA1c Antipsychotic Review and Intervention Workflow



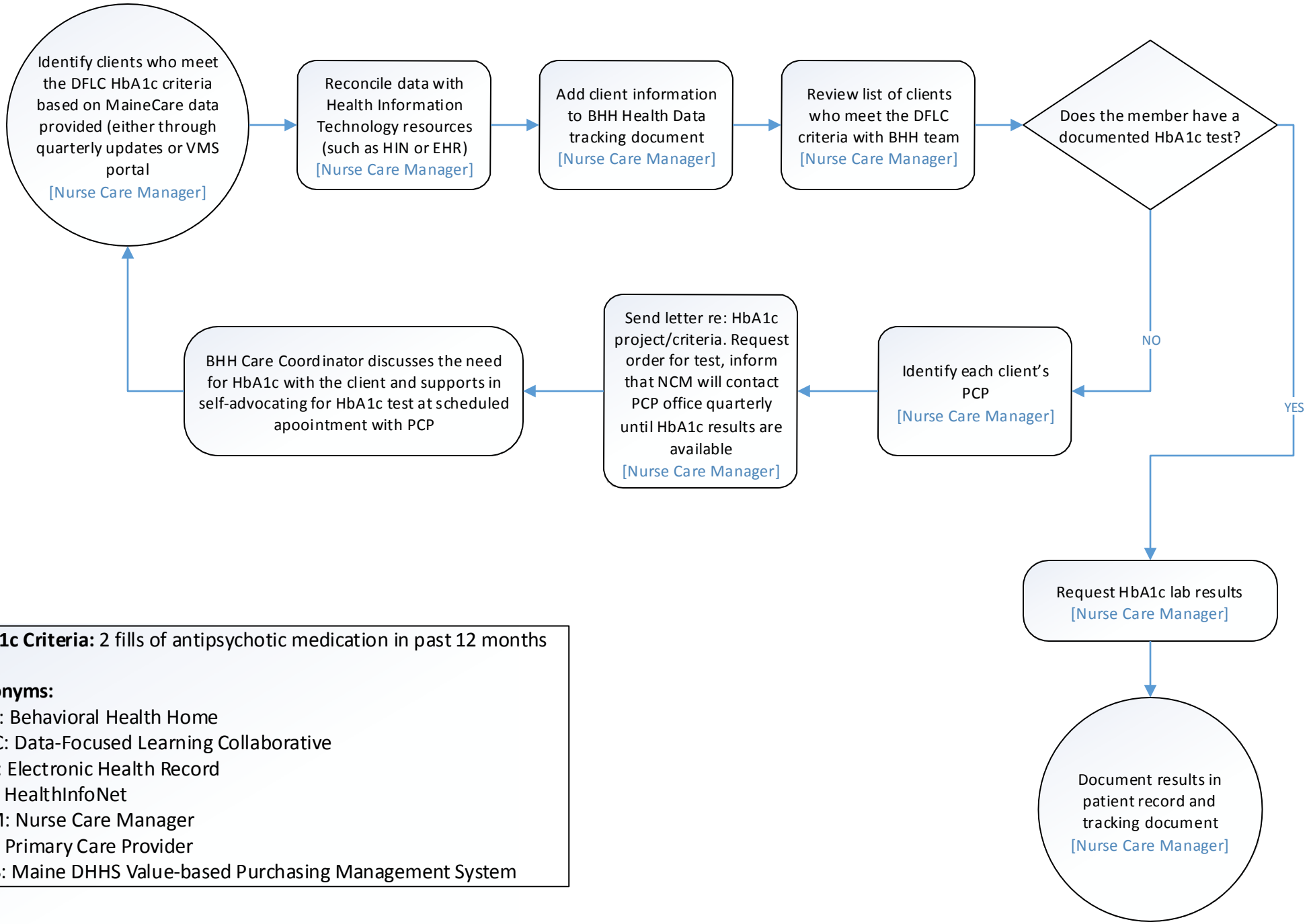
Process Notes:

- Wellness Coordinator = Health Home Coordinator
- During new member enrollment (intake) – PCP information is collected and filed in EHR – Date of annual wellness exam is also tracked to help update this at 90-day reviews
- Nurse Care Manager maintains the BHH data tracker which captures more than just HbA1c test date for BHH members (e.g. annual physical, ED visits, lipid panels, 2 or more antipsychotics fills)
- Receipt of lab results occurs when Nurse Care Manager requests from practice – if result is high, this is brought up at one of the 2x monthly BHH clinical case reviews

Acronyms:

BHH – Behavioral Health Home
EHR – Electronic Health Record
EMR – Electronic Medical Record
HIN – HealthInfoNet
PCP – Primary Care Provider
VMS – Maine DHHS Value-Based Purchasing Management System

Behavioral Health Home Example 3: Multiple Sites Statewide
HbA1c Antipsychotic Review and Intervention Workfow



HbA1c Criteria: 2 fills of antipsychotic medication in past 12 months

Acronyms:
BHH: Behavioral Health Home
DFLC: Data-Focused Learning Collaborative
EHR: Electronic Health Record
HIN: HealthInfoNet
NCM: Nurse Care Manager
PCP: Primary Care Provider
VMS: Maine DHHS Value-based Purchasing Management System

Behavioral Health Home Example: Tracking Sheet – HbA1c Tests for MaineCare Members Prescribed Antipsychotic Medication

First Name	Last Name	ID Number	Have HbA1c (from MaineCare Qtly Report or VMS Portal)	Health Home Coordinator Assignment	Antipsychotic Medication	Prescriber, Office	Primary Care Provide, Office	Last: HbA1c/FBS/LDL (result)	Next Draw	Comments
			Y		Perphenazine (Trilafon) & Abilify	Dr. Sally Sue, HH	Pediatrics, Dr. Clough	HbA1c: 2/7/17 (4.9)	2/7/18	
			N		Geodon (Discontinued, see comment)	Dr. Sally Sue, HH	Harry Mo (FNP-C), Family Medicine	**No HbA1c** FBS: 11/16/16 (97)	Not Scheduled	Antipsychotic discontinued November 2016
			Y		Olanzapine (Zyprexa)	Dr. Don Health, BHH	Dr. Olga Hill, Pediatrics	HbA1c: 9/15/16 (5.02) LDL: 4/26/16 (115)	9/15/17	Living in residential facility since July 2016
			N		Abilify & Risperidone	Dr. Val Awesome, HH	Dr. Val Awesome, HH	**No HbA1c** FBS: 12/23/16 (79) LDL: 4/26/16 (86	12/23/17 4/26/17	Communicated with Dr. Awesome on 3/29/17. May order HbA1c with other blood work

HbA1c Tracking Template

Member on Antipsychotic	Care Coordinator (CC)	PCP/HH	PCP/HH Release?	Date Release Expires	CC Notified of Release Need	HbA1c in last year?	HbA1c Date	Comments

Behavioral Health Home Example: Communication to Primary Care – Antipsychotic Measure

(Date)

(Address)

Dear (Provider),

Our mutual member, (Name & DOB), is part of the Behavioral Health Home (BHH) program here at (Organization Name). MaineCare is requiring BHH providers to track and confirm HbA1c testing for MaineCare members receiving two or more fills of an antipsychotic prescription within the last 12 months. (Member name) was identified by MaineCare as being part of the tracking program based upon the two fills of (Name of Antipsychotic(s)).

Our records indicate that the client last had a HbA1c test on (date). We are reaching out to see if you can help us coordinate efforts with the member to have this test completed. If you have any questions regarding the BHH or MaineCare requirements, you can contact (Name, Title, Phone Number, Email of contact person). You may also contact MaineCare directly at HH-BHH-Services.DHHS@Maine.gov .

Thank you,

Name

Title

Organization Name

Address

Phone

Fax

Email

The Relationship between Antipsychotics and Increased HbA1c Levels

In the United States, close to 19 million adults have severe mental illnesses (SMI) and die approximately 25 years earlier than those who do not have SMI, usually from cardiovascular disease (2). Twenty percent of this population has diabetes, and it is estimated that seventy percent of those on antipsychotic medications are not screened and remain untreated (2). Antipsychotic medications were introduced 50 years ago, helping many patients manage their mental illness symptoms (1). Their use can make the difference to leading more productive and fulfilling lives for these patients (1).

In 2003, the American Diabetes Association, the American Psychiatric Association, the American Association of Clinical Endocrinologist and the North American Association for the Study of Obesity hosted the consensus development conference where recommendations were made for baseline screening before, or as soon as possible after, the initiation of antipsychotic medication (1). In 2004, the Food and Drug Administration (FDA) issued a warning about hyperglycemia and metabolic dysregulation related to antipsychotic medication treatment (3). In 2010, the ADA added the hemoglobin A1c as a diagnostic test (3). Despite these recommendations and the FDA warnings, monitoring has not significantly improved for this population (3).

The metabolic side effects of antipsychotic treatment include weight gain, dyslipidemia, and increased risk of diabetes which is especially evident within weeks of the initiation of treatment (1). Monitoring for these risks falls within the scope of the primary care provider and the mental health provider, but often, patients with mental illness have many barriers to developing and maintaining a relationship with their primary provider, such as cognitive impairment, symptoms management, and access to services (3). Barriers for the providers may include communication barriers between the primary office and the mental health office, a lack of designated staff for referral and follow-up to outside services, and Electronic Health Record capability (4).

What is an HbA1c?

In 2009, an international expert committee recommended this as one of the tests that is available to help diagnose diabetes and prediabetes. This blood test provides information about the patient's average level of blood glucose over the previous three months and is reported as a percent average. The test is based on the attachment of glucose to hemoglobin which is the

protein in red blood cells that carries oxygen. Since the lifespan of a red blood cell is approximately three months, the test reflects an average over the last three months. The accuracy of the test can be .5% higher or lower than the given value. An inaccurate reading can happen for patients of African, Mediterranean, or Southeast Asian descent; family history of sickle cell anemia or thalassemia; anemia, blood or hemoglobin issues such as heavy bleeding, anemia; and kidney failure, and liver disease.

The following are the procedure codes for HbA1c testing and the diagnosis that can be used for antipsychotic screening: (Please note that 83036 is the only procedure code that MaineCare will cover for HbA1c)

HbA1c Procedure Codes	**Code if Dx is needed**
3044F	Z79.899
3045F	
17856-6	
4548-4	
4549-2	
83036	
83037	

The following table from the National Institute of Diabetes and Digestive and Kidney Diseases provides the percentages that indicate diagnoses of normal, diabetes, and prediabetes according to A1C levels.

Diagnosis*	A1C Level
Normal	below 5.7 percent
Diabetes	6.5 percent or above
Prediabetes	5.7 to 6.4 percent

*Any test for diagnosis of diabetes requires confirmation with a second measurement unless there are clear symptoms of diabetes.

References

1. Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes

http://care.diabetesjournals.org/content/27/2/596.full

2. Diabetes and Cardiovascular Care Among People with Severe Mental Illness: A Literature Review (Abstract)

http://link.springer.com/article/10.1007/s11606-016-3712-4

3. Metabolic Monitoring for Patients on Antipsychotic Medications

http://www.psychiatrictimes.com/cme/metabolic-monitoring-patients-antipsychotic-medications/page/0/3

4. Self-Efficacy and Hemoglobin A1C Among Adults With Serious Mental Illness and Type 2 Diabetes: The Roles of Cognitive Functioning and Psychiatric Symptom Severity (Abstract)

http://journals.lww.com/psychosomaticmedicine/Abstract/2016/04000/Self_Efficacy_and_Hemoglobin_A1C_Among_Adults_With.3.aspx

https://www.niddk.nih.gov/health-information/diabetes/overview/tests-diagnosis/a1c-test

Handouts for patients – American Diabetes Association print on demand website: http://professional.diabetes.org/search/site/a1c%2520testing?f[0]=im_field_dbp_ct%3A32&retain-filters=1

Resources	Websites
Academy of Nutrition and Dietetics	http://www.eatright.org/
AHRQ Clinical Summary-Behavioral Programs for Type 1 Diabetes Mellitus: Current state of the evidence	http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=1917
AHRQ Clinical Summary-Behavioral Programs for Type 1 Diabetes Mellitus: A review of the research	https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2346
American Association of Diabetes Educators	https://www.diabeteseducator.org/
American Diabetes Association	http://www.diabetes.org/
American Diabetes Association – Standards of Medical Care in Diabetes-2017	http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf
Canadian Diabetes Association	www.diabetes.ca
Maine Diabetes Prevention & Control Program	http://www.maine.gov/dhhs/mecdc/population-health/dcp/
Maine Health Learning Resource Center	http://www.mainehealthlearningcenter.org/topics/nutrition-and-exercise/
Maine's National Diabetes Prevention Program (NDPP) Information Portal	http://rethinkdiabetes.org/
Medicare Diabetes Prevention Program	https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/
National Diabetes Education Program	https://www.niddk.nih.gov/health-information/health-communication-programs/ndep/pages/index.aspx
NIH National Diabetes Information Clearinghouse (NDIC)	https://healthfinder.gov/FindServices/Organizations/Organization.aspx?code=HR0005
Prevent Diabetes STAT	https://preventdiabetesstat.org/

Quarterly Antipsychotic Measure Report – Including List of Antipsychotic Medications

MaineCare Value-Based Purchasing Data-Focused Learning Collaborative (DFLC) Quarterly Report – SFY 2017 Q4

[PAY TO] [SERVICE LOCATION]

Executive Summary: On September 30, 2016, Health Home (HH) and Behavioral Health Home (BHH) practices were sent a service location ranking for the MaineCare Value-Based Purchasing Data-Focused Learning Collaborative initiative. The purpose of this report is to update each provider on their diabetes screening rate among members with two or more fills of antipsychotic medications. The time period for this report is the 12-month period through the end of the quarter – SFY 2017 Q4 (for example: SFY 2017 Q2 is data from January 1, 2016 though December 31, 2016)

About this measure: The enclosed report includes MaineCare members assigned to your Behavioral Health Home who filled at least two prescriptions for an antipsychotic medication during (see list below) the 12-month period through the end of the quarter (for example: SFY 2017 Q2 is data from January 1, 2016 though December 31, 2016). The report also notes whether the member had a paid claim for a blood glucose (HbA1c) test during the time period. This measure was designed based upon the American Diabetes Association's (ADA) recommendation: "Annually screen people who are prescribed atypical antipsychotic medications for prediabetes or diabetes." The ADA and the American Psychiatric Association's consensus guidelines appear below.

Table 1 – Metabolic monitoring parameters based on American Diabetes Association/ American Psychiatric Association consensus guidelines[4]

	Baseline	Week 4	Week 8	Week 12	Every 3 months thereafter	Annually
Medical history[a]	X			X		X
Weight (BMI)	X	X	X	X	X	X
Waist circumference	X			X		X
Blood pressure	X			X		X
Fasting glucose/hemoglobin A_{1c}	X			X		X
Fasting lipids	X			X		X

[a] Personal and family history of obesity, diabetes, hypertension, and cardiovascular disease.

Source: *Diabetes Care* 2004 Feb; 27(2): 596-601. http://dx.doi.org/10.2337/diacare.27.2.596 / as amended 2010

The measure focuses on HbA1c testing as it gives more comprehensive data about the patient than a fasting blood glucose test. The HbA1c test has the further advantage of being less burdensome, since the patient does not have to fast, which may be especially difficult for people taking these medications. For these reasons, the ADA added the HbA1c test to its consensus guidelines in 2010. Though the ADA's recommendation specifies atypical antipsychotic

medications, we have included first generation medications also. The first generation medications are also linked to higher risk of diabetes.

HEDIS List of Antipsychotic Medications

Amitriptyline Hydrochloride/Perphenazine	Haloperidol	Paliperidone Palmitate
Aripiprazole	Haloperidol Decanoate	Perphenazine
Asenapine	Haloperidol Lactate	Perphenazine-Amitriptyline
Brexpiprazole	Iloperidone	Pimozide
Cariprazine	Loxapine Succinate	Prochlorperazine Maleate
Chlorpromazine Hydrochloride	Lurasidone Hydrochloride	Quetiapine Fumarate
Clozapine	Molindone Hydrochloride	Risperidone
Fluoxetine Hydrochloride-Olanzapine	Olanzapine	Thioridazine Hydrochloride
Fluphenazine Decanoate	Olanzapine Pamoate	Thiothixene
Fluphenazine Hydrochloride	Paliperidone	Trifluoperazine Hydrochloride
		Ziprasidone Hydrochloride

Behavioral Health Home providers ranked as a Beginner or Improver will work with the technical assistance vendor and other BHH practices to ensure that all of their patients with two or more fills of a prescribed antipsychotic medication are receiving at least one HbA1c test per year.

Billing a HbA1c Test for a Medicare Member at Risk for Diabetes
For MaineCare members on antipsychotic medications who have Medicare as their primary payer, providers can bill a HbA1c test (procedure code 83036) with the diagnosis code Z79.899, other long term (current) drug therapy. (Reference: page 1,756 of the Medicare coverage manual available at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/Downloads/manual201704_ICD10.pdf)

For MaineCare members who do not have Medicare (or other coverage), the HbA1c test is billed directly to MaineCare and no diagnosis codes are specifically required.

Health Home Resources

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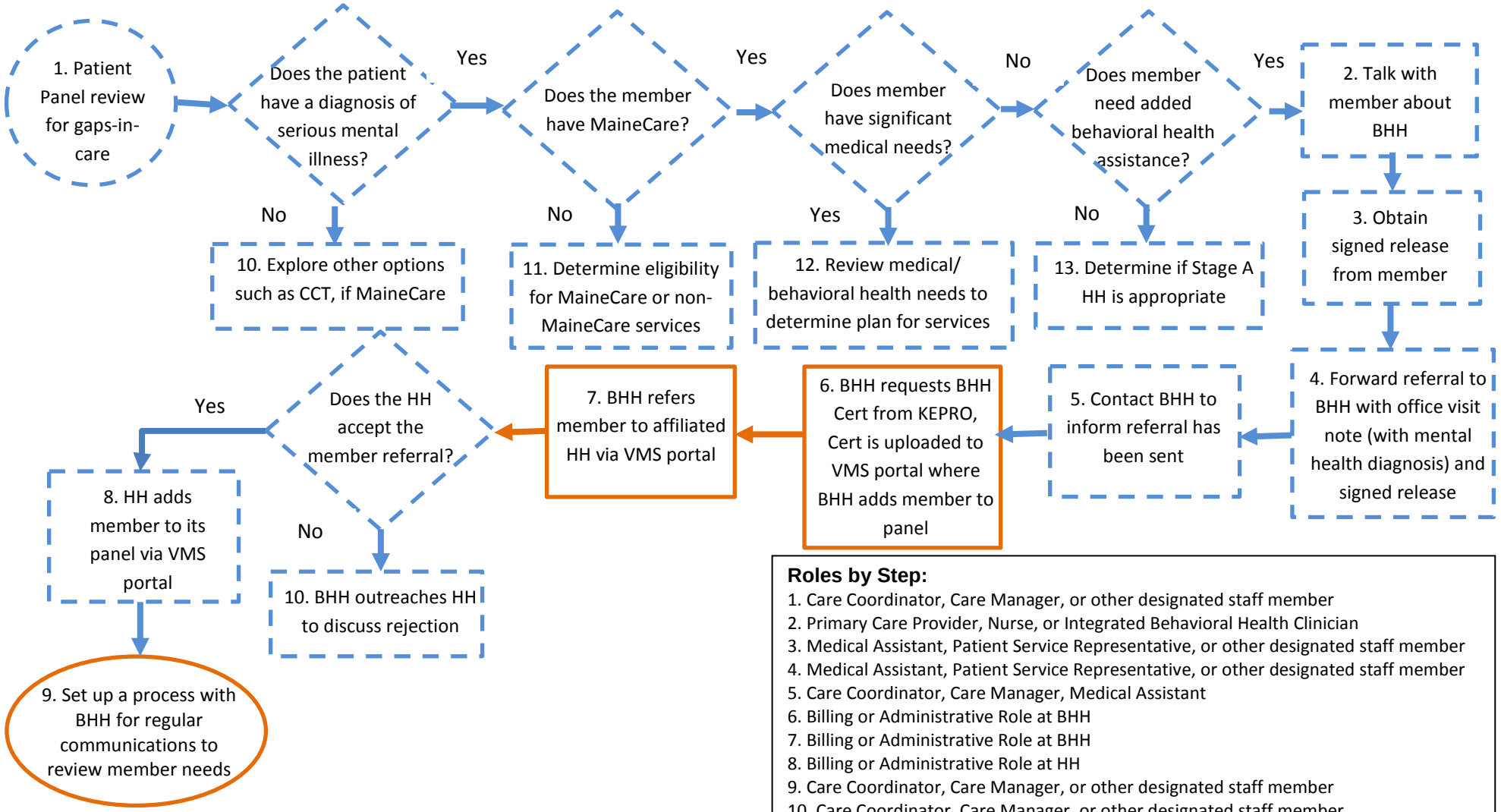
Referring a Member to BHH Services

Legend:
- Behavioral Health Home (BHH) Role
- Health Home (HH) Role

Acronyms:
CCT – Community Care Team
VMS – Maine DHHS Value-Based Purchasing



Roles by Step:

1. Care Coordinator, Care Manager, or other designated staff member
2. Primary Care Provider, Nurse, or Integrated Behavioral Health Clinician
3. Medical Assistant, Patient Service Representative, or other designated staff member
4. Medical Assistant, Patient Service Representative, or other designated staff member
5. Care Coordinator, Care Manager, Medical Assistant
6. Billing or Administrative Role at BHH
7. Billing or Administrative Role at BHH
8. Billing or Administrative Role at HH
9. Care Coordinator, Care Manager, or other designated staff member
10. Care Coordinator, Care Manager, or other designated staff member
11. Medical Assistant, Patient Service Representative, or other designated staff member
12. Primary Care Provider, Nurse, or Integrated Behavioral Health Clinician
13. Care Coordinator, Care Manager, or other designated staff member

Provider Instructions and Template:
Primary Care and Behavioral Health Home Bi-directional Shared Member Communication Process

Purpose: Communication between healthcare providers is crucial to the safe and effective provision of care for the members we serve. It is the expectation that the Primary Care Providers (PCP) and Behavioral Health Home (BHH) organizations exchange important information about shared members on a regular basis.

Process:

1. Monthly- BHH identifies shared patients and notifies the PCP. The PCP may contact the BHH about a potential shared member who meets the MaineCare criteria.
    a. The BHH will send the list to the PCP Care Manager or the designated contact at the site.
    b. The PCP Care Manager, or contact, will distribute the information to the appropriate team members.

2. Annually or as needed- The BHH Care Manager and the PCP Care Manager, or designees, generate the *Bi-directional Shared Member Communication* template. It will be exchanged at least yearly, or if any of the following occur:

    a. Changes in medications
    b. Changes in or additional diagnoses
    c. Hospital event – admission, discharge, ED visit, transition of care
    d. Discharge from the BHH or the PCP
    e. Any life changing event

    The *Bi-directional Shared Member Communication* template will be faxed or securely emailed between the PCP and BHH. However, if there are multiple changes at any time this will prompt a conversation between the care managers. The *Bi-directional Shared Member Communication* template will be scanned into the individual member's chart.

3. Ongoing-The BHH Care Manager and the PCP Care Manager, or designees, will coordinate the mental health or primary care needs (gaps in care).

4. Ongoing-Practices will develop their own tickler file or calendar to review members and share information.

Best Practice Guidance for use of the *Bi-directional Shared Member Communication* template:

- Template can be completed electronically with permanent information pre-filled (i.e. member name, DOB, PCP, Care Manager names & phone numbers)
- Electronic Medical Record documents can be attached to the form (i.e. problem lists, med lists, annual physical exam notes)
- Key lab and biometric measurements may include blood pressure, HbA1c, TSH, Microalbumin, liver function, weight, and BMI
- Ordering provider should copy lab results to the PCP or BHH
- Current and previous treatment history information may include recent office visits for PE, diabetes check, ED visits, hospitalizations, other specialist visits, or other community agencies involved in care of the member.
- Summary section may include goals of care, barriers to care, progress toward goals, medication changes/reason, or explanation of significant events (i.e. loss of housing, death or illness of friend or family member)

Template:
Primary Care/Behavioral Health Home: Bi-directional Shared Member Communication

DATE:
PATIENT NAME:
D.O.B.:

Release of Information Effective Dates:

Provider Type	Provider Name	Telephone	FAX
HH Nurse Care Manager			
PCP			
BHH Nurse Care Manager			
BHH Care Coordinator			

Medication List: ☐ None ☐ Attached
Problem List: ☐ None ☐ Attached

CURRENT AND PREVIOUS TREATMENT HISTORY (PCP, ED, Inpatient, Outpatient):

Description	Date

LABS/PHYSICAL EXAM:

Description	Date Of Most Recent
Physical Exam	
Metabolic Syndrome Screening	
HbA1c	

SUMMARY (shared goals, gaps in care, progress toward goals, medication changes/reason, adverse medication events):

Health Home (HH) Core Standards - Provider Best Practices

#1 Demonstrated Leadership	Identify primary care provider (PCP) who champions.
	PCP models the team-based approach to care, participates in daily huddles and de-briefs, and engages the staff through Plan-Do-Study-Act (PDSA) cycles for continuous improvement.
	PCP participates in monthly Health Home updates and learning sessions and shares knowledge, ideas, and resources among the practice team.
#2 Team-Based Approach to Care	Our front desk, medical assistants and medical records staff take part in reviewing our patient panel, gap summaries and rising risk reports. Our front desk and medical assistants contact patients to address gaps in care.
	The practice team works together to improve access and efficiency through pre-visit planning, integrated care management that is embedded in the practice, task delegation to ensure that everyone is working to the top of their licensure, and improved emphasis on patient education. In addition, the practice's care coordinator provides critical data support on quality and utilization to help reduce costs while improving outcomes.
#3 Population Risk Stratification and Management	We do Emergency Department (ED)/hospital discharge follow-ups over the phone and in the clinic, as needed. Care management assists patients, who are at risk (as evidenced by social determinants), with accessing community resources.
#4 Enhanced Access	Same day appointments are built into our providers' schedules. We have an after hours answering service which routes calls to the on-call provider. The answering service creates a follow-up e-mail message to our clinic. These messages are then assigned to the appropriate team through our Electronic Health Record (EHR).
	The practice tracks time to third next available appointment on a monthly basis and continuously works to identify ways to improve access for all appointment types.
#5 Practice Integrated Care Management	The care coordinator, in collaboration with the provider and clinical staff, helps facilitate appropriate care management services for patients who meet the criteria for Community Care Team (CCT) services that are provided by the practice's community partner.
	The care coordinator functions in the full capacity of a care management staff member and has clearly defined roles that are directly related to care management services for the patients within the practice. The care coordinator attends care management training on a monthly basis.
	The care coordinator uses Meridios (data registry), as well as the MaineCare VMS portal, to track patient outcomes for patients receiving care management resources. Both data resources provide information on outcomes, utilization, and cost.

#6 Behavioral-Physical Health Integration	This is done on an annual basis for re-assessment.
	The practice has fully integrated behavioral health into the practice and performs routine depression screening (PHQ02 and PHQ-9) per protocol. The practice has a licensed clinical social worker co-located within the practice who sees patients for support of chronic condition management.
#7 Inclusion of Patients and Families	The practice has active members who volunteer on the patient advisory council, which holds monthly meetings to gather input from patients. The meetings take place in the evenings for convenience.
	The practice participates in the National Research Corporation/Picker patient-satisfaction survey tool. This feedback helps educate the practice on what areas are needed for improvement, and everyone on the practice team works with patient experience coaches to make improvements.
#8 Connection of Community Resources and Social Support Services	We have a case management team that makes sure that our patient's medical and social needs are met. They work with local area agency on aging, food pantries, transportation, CCT nurses, Behavioral Health Home teams, housing, Home Energy Assistance Program (HEAP) and Goold.
#9 Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-effective Use of Healthcare Services	We review all of our patients who have been discharged from the ED/hospital and make sure patients have a follow-up with our providers or a referral, if recommended. We work with DHHS ED project for patients who frequent the ED. We refer to CCT and instruct patients to call the clinic with any questions or concerns.
#10 Integration of Health Information Technology	We utilize our EHR reports, HealthInfoNet, Sisense (chart prep), gap summaries, rising risk reports, and care managers utilize our EHR to document/communicate to team.

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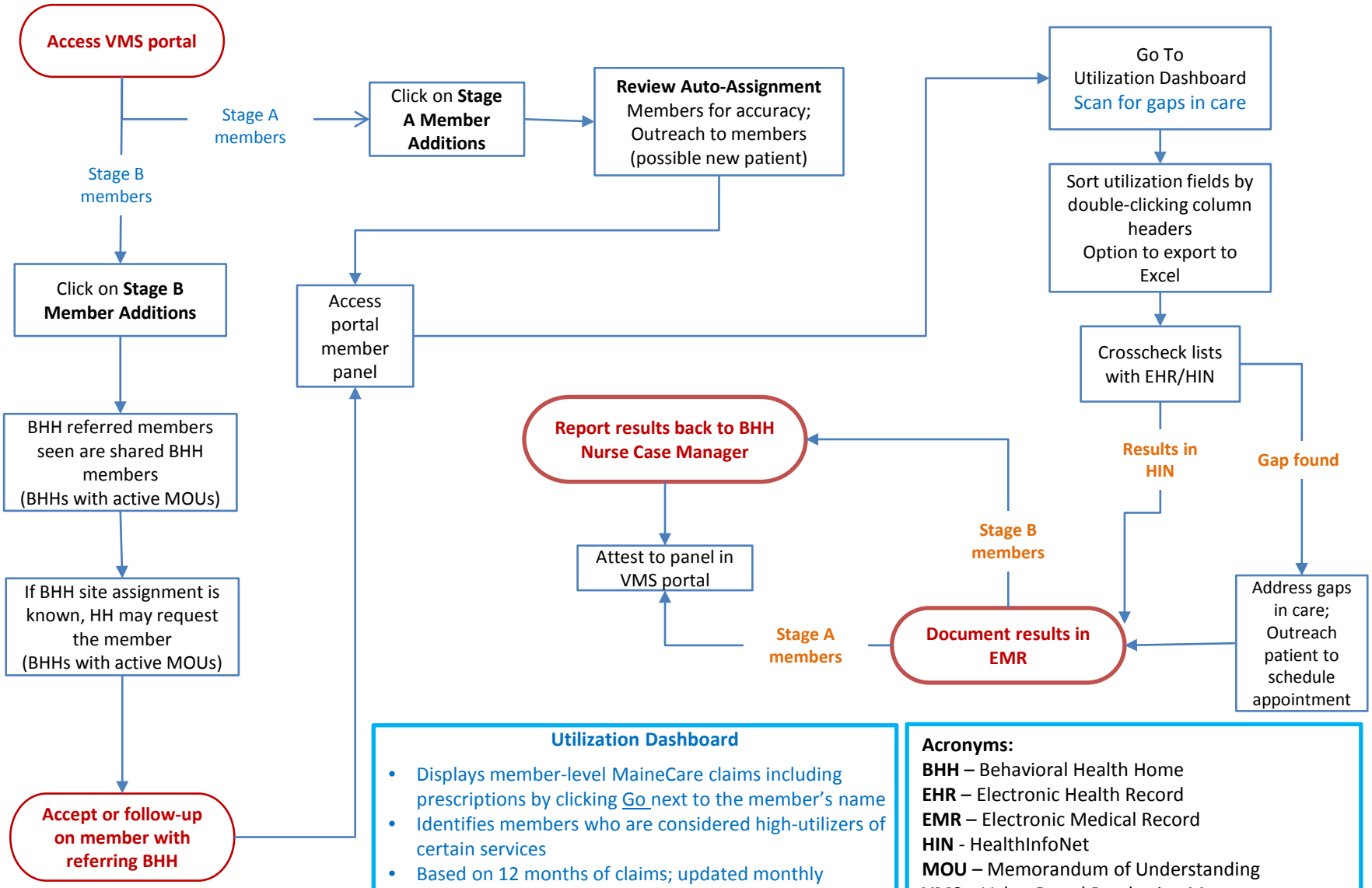
Health Home VMS Portal Workflow



Utilization Dashboard

- Displays member-level MaineCare claims including prescriptions by clicking Go next to the member's name
- Identifies members who are considered high-utilizers of certain services
- Based on 12 months of claims; updated monthly
- Allows providers to determine which members are and are not receiving certain screenings and services

Acronyms:
BHH – Behavioral Health Home
EHR – Electronic Health Record
EMR – Electronic Medical Record
HIN - HealthInfoNet
MOU – Memorandum of Understanding
VMS – Value-Based Purchasing Management System

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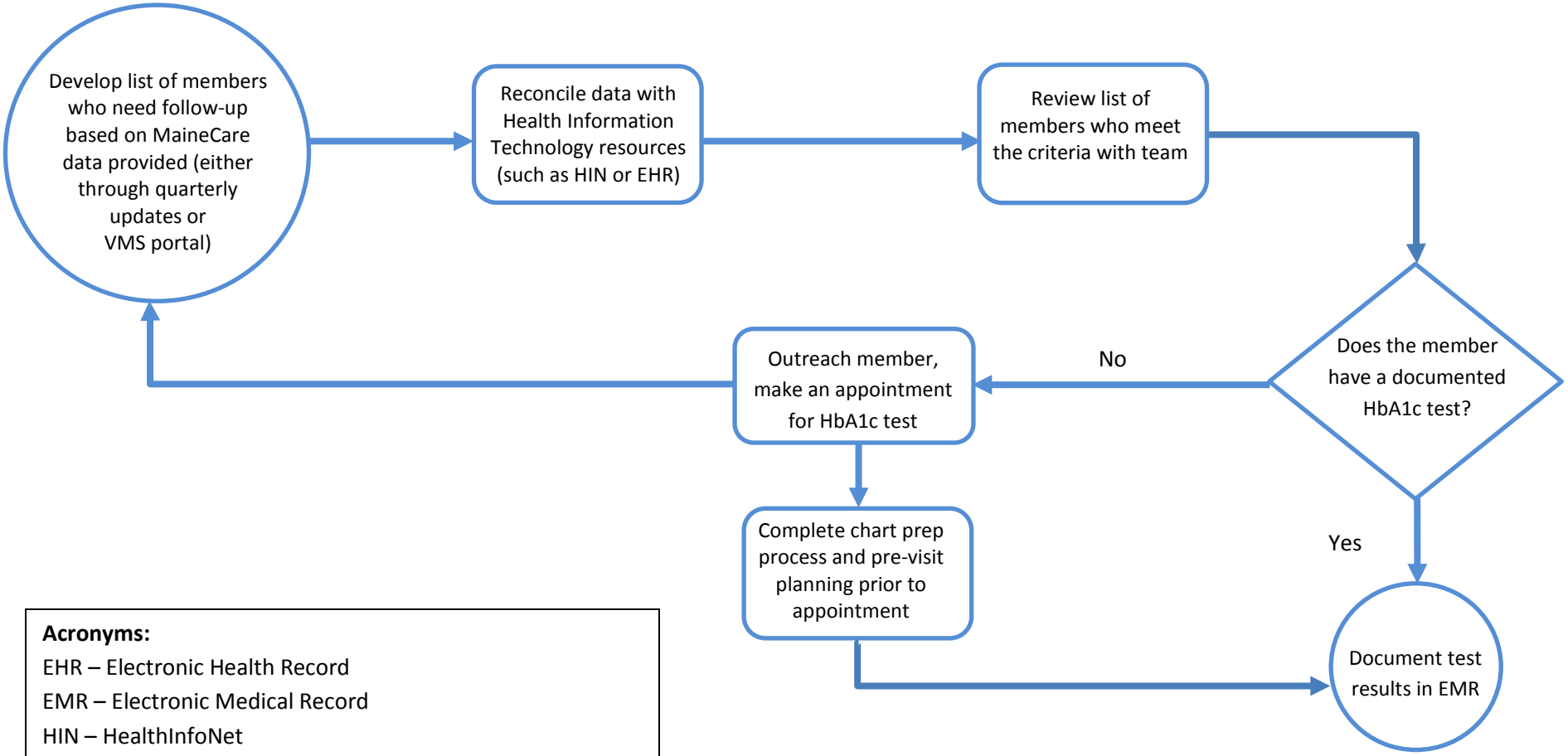
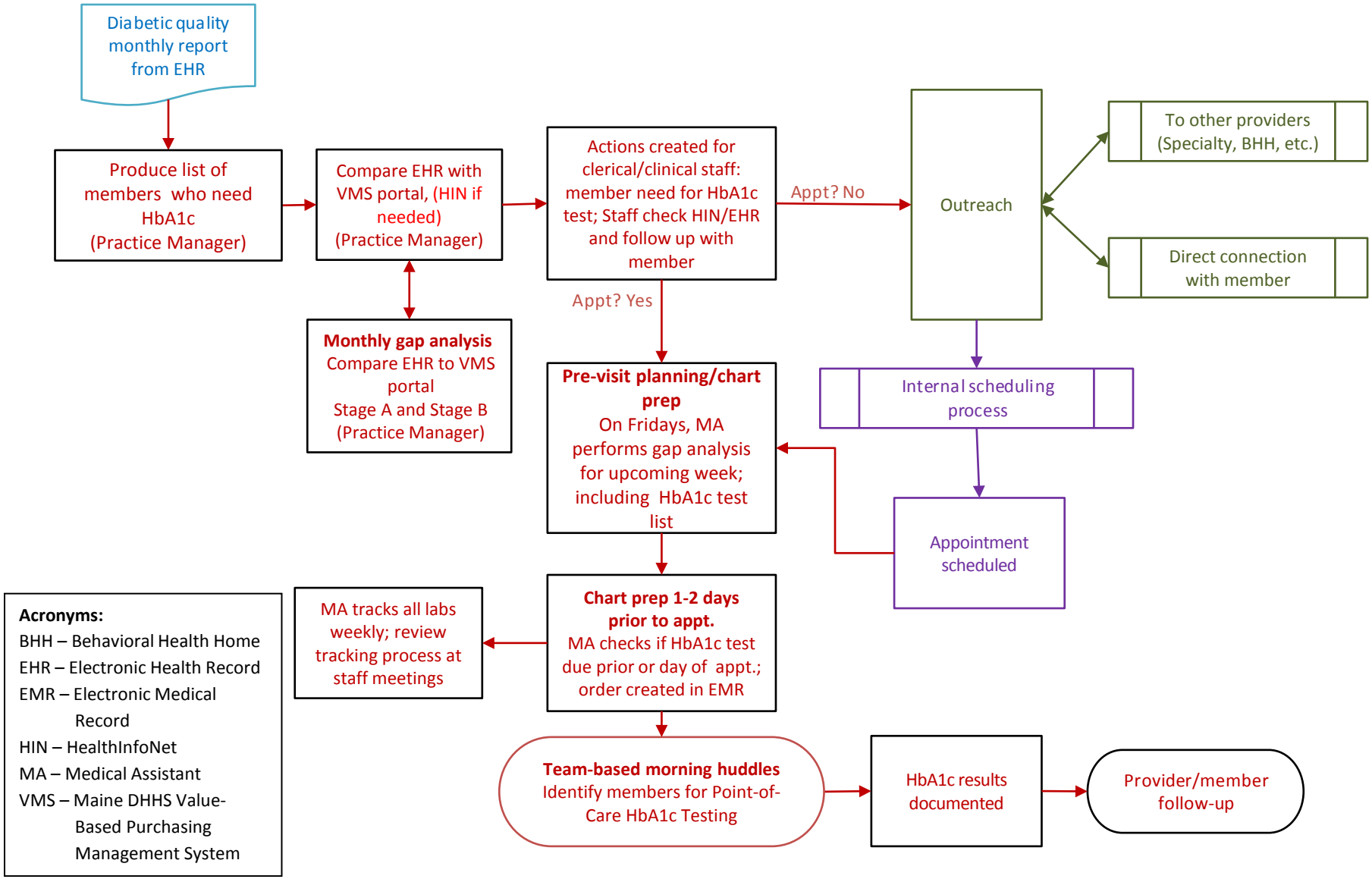
HbA1c Diabetes Measure
Health Home Intervention Workflow



Acronyms:

EHR – Electronic Health Record
EMR – Electronic Medical Record
HIN – HealthInfoNet
VMS – Maine DHHS Value-Based Purchasing Management System

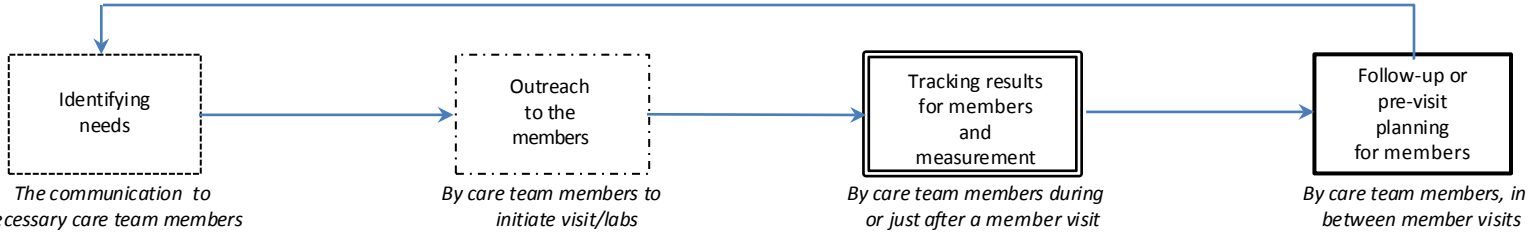
Health Home Example 1: Rural Family Practice
Diabetes Review and Intervention Process



Acronyms:
BHH – Behavioral Health Home
EHR – Electronic Health Record
EMR – Electronic Medical Record
HIN – HealthInfoNet
MA – Medical Assistant
VMS – Maine DHHS Value-Based Purchasing Management System

Health Home Example 2: More Than Ten Sites
Diabetes Review and Intervention Process

(Including BHH relationship elements)



The communication to necessary care team members

By care team members to initiate visit/labs

By care team members during or just after a member visit

By care team members, in between member visits

1

Shared Elements

- Use of daily or weekly team huddles
- Same day of visit pre-screens for health conditions includes diabetes
- EMR has "Protocols" tab including information on HbA1c
- "Tough" individual diabetes cases at each site

Differing Elements

- Number of HH members
- Staff roles in process may vary slightly at different sites
- Degree of team's attention to population health data

2

Shared Elements

- Multiple levels of staff reaching out to members and other providers (specialty)
- Regular meetings conducted with BHH & care coordination

Differing Elements

- Comfort level of understanding diabetes by frontline staff (front desk or MA levels)
- Local BHH may not be connected to site or system
- Onsite testing (different billing details?)
- Number of HH members
- Onsite blood draws
- Geographic region and panel demographics impact

3

Shared Elements

- Standard protocols for HbA1c tests for diabetic members
- Quality measures (including HbA1c) shared with provider teams
- No standard notification of BHH built into the process

Differing Elements

- May or may not have standing orders for ordering HbA1c test
- Onsite Phlebotomist for draws that tracks labs sent out and returned
- Onsite blood draws
- Onsite testing

4

Shared Elements

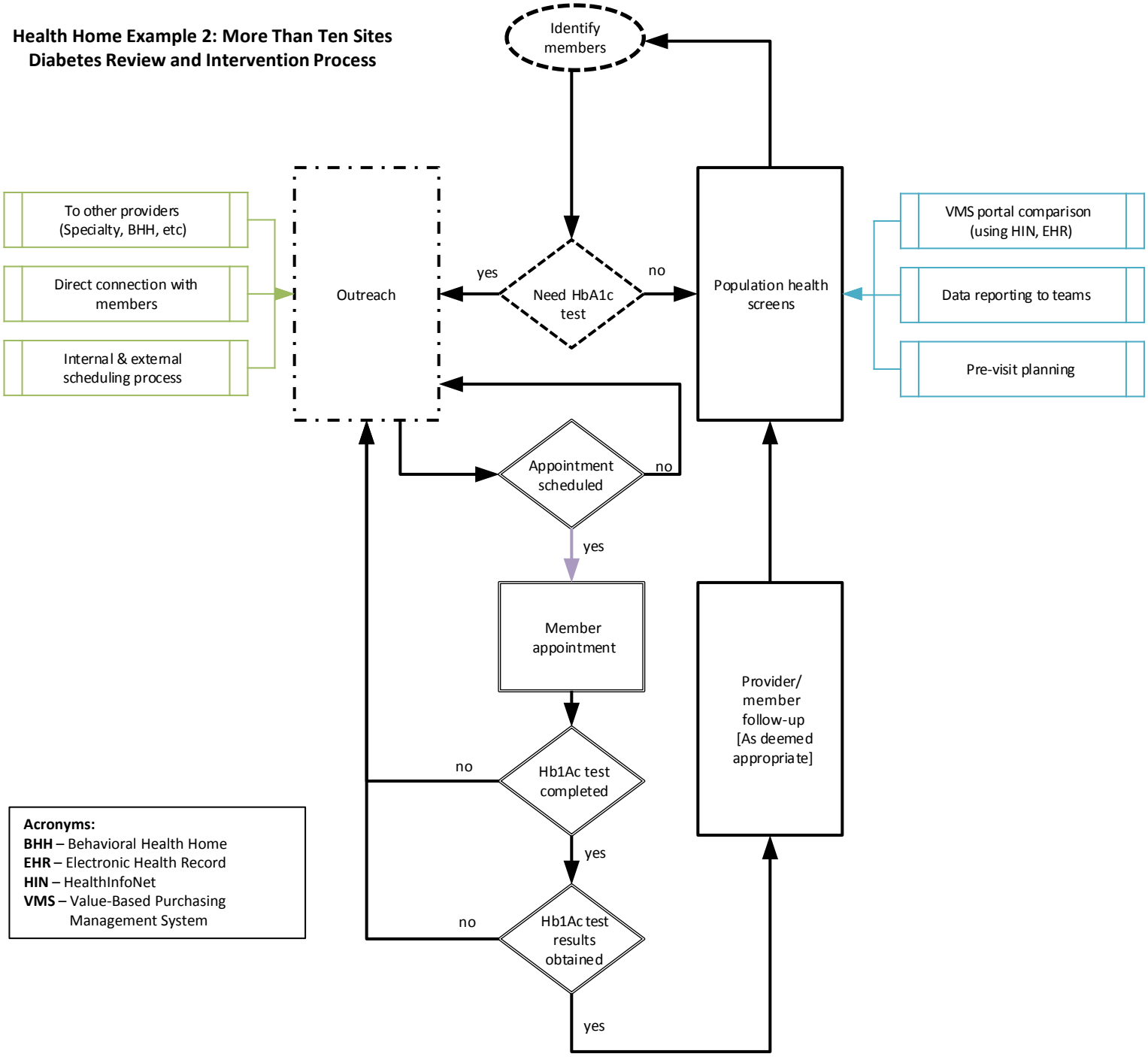
- Care Coordinators regularly reviewing VMS portal Protocol for follow-up on abnormal HbA1c test results
- "Tough" individual diabetes cases at each site

Differing Elements

- Use of, and familiarity with, the VMS portal
- Capability of sites to use EHR/ registry to pull members who are in need of HbA1c testing
- Pre-visit planning process
- Capacity for pre-visit planning work
- Managing the VMS panel consistently to ensure accuracy

Acronyms:
BHH – Behavioral Health Home
EHR – Electronic Health Record
EMR – Electronic Medical Record
HH – Health Home
MA – Medical Assistant
VMS – Value-Based Purchasing Management System

Health Home Example 2: More Than Ten Sites
Diabetes Review and Intervention Process



Acronyms:
BHH – Behavioral Health Home
EHR – Electronic Health Record
HIN – HealthInfoNet
VMS – Value-Based Purchasing Management System

Health Home Example 3:
Diabetes Review and Intervention Process
Pre-visit Planning Workflow -
Point-of-Care for Members

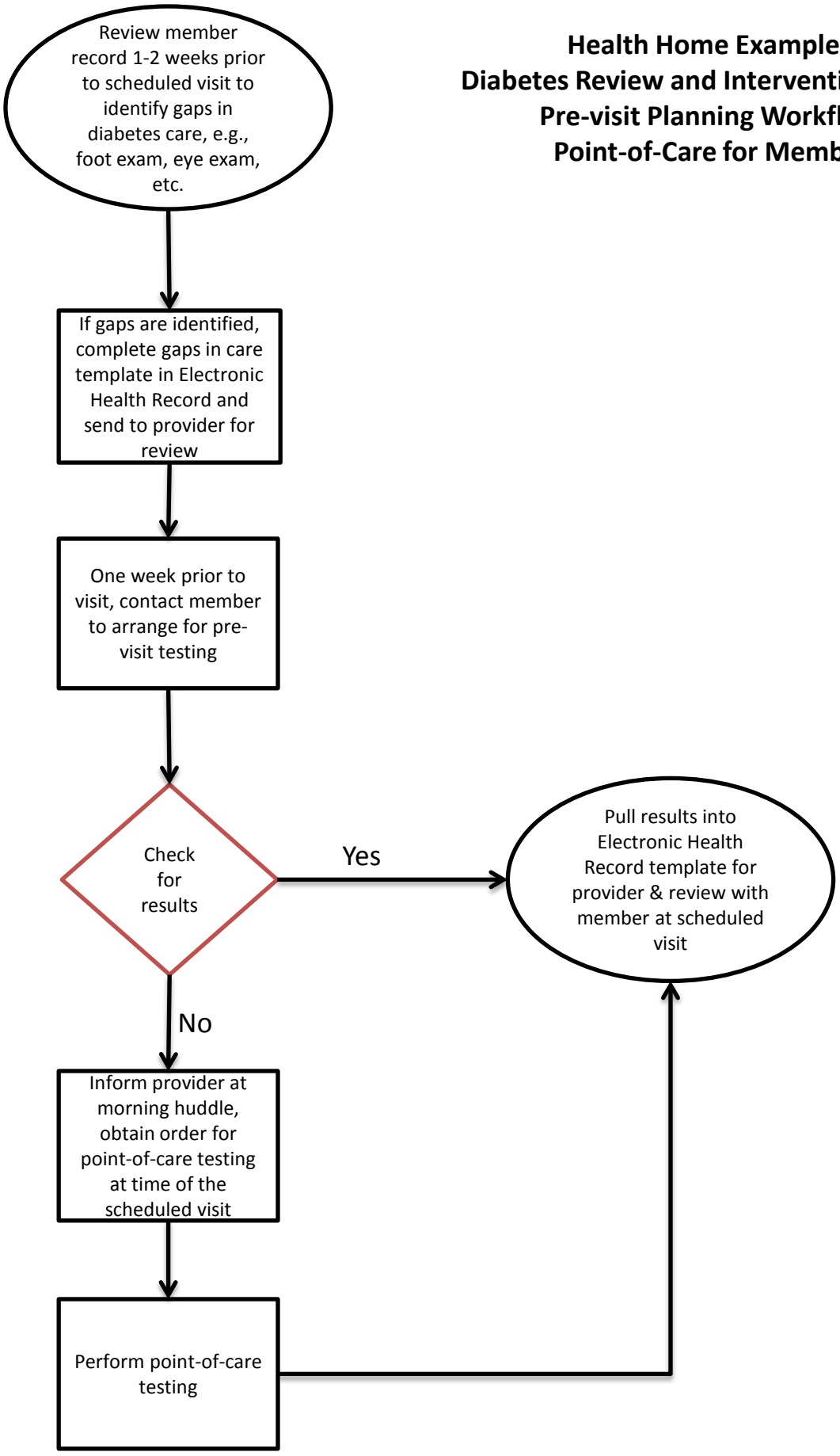


Chart Prep Template

Member Name:		
Reason for Visit:		
Last Lipid:		
Diabetic:		
Last HbA1c:		
Diabetic Foot:		
Diabetic Eye:		
Last Physical:		
Last Mammogram:		
Last PAP:		
Specialists/Referrals:		
Member Name:		
Reason for Visit:		
Last Lipid:		
Diabetic:		
Last HbA1c:		
Diabetic Foot:		
Diabetic Eye:		
Last Physical:		
Last Mammogram:		
Last PAP:		
Specialists/Referrals:		
Member Name:		
Reason for Visit:		
Last Lipid:		
Diabetic:		
Last HbA1c:		
Diabetic Foot:		
Diabetic Eye:		
Last Physical:		
Last Mammogram:		
Last PAP:		
Specialists/Referrals:		
Member Name:		
Reason for Visit:		
Last Lipid:		
Diabetic:		
Last HbA1c:		
Diabetic Foot:		
Diabetic Eye:		
Last Physical:		
Last Mammogram:		
Last PAP:		
Specialists/Referrals:		

Health Home Example: Diabetes Tracking

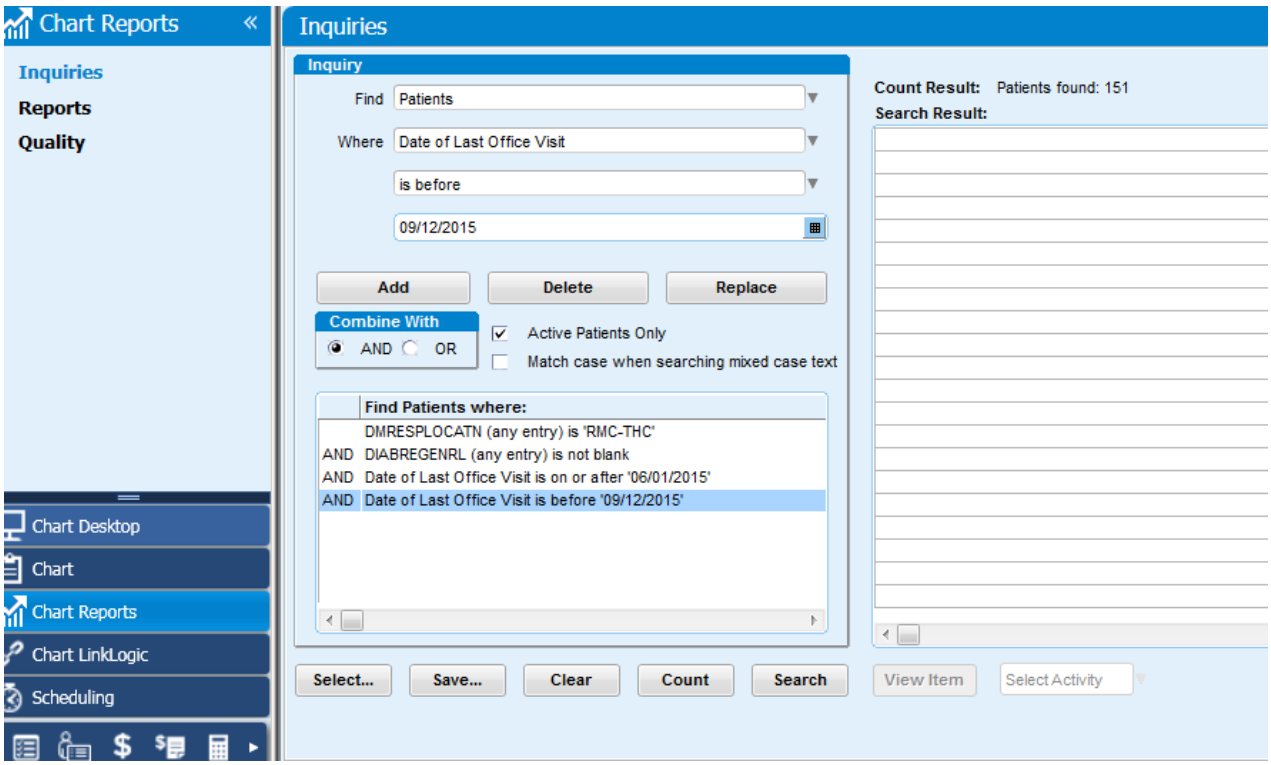
PURPOSE: Tracking diabetic members who are due for office visits and sending recall letters.

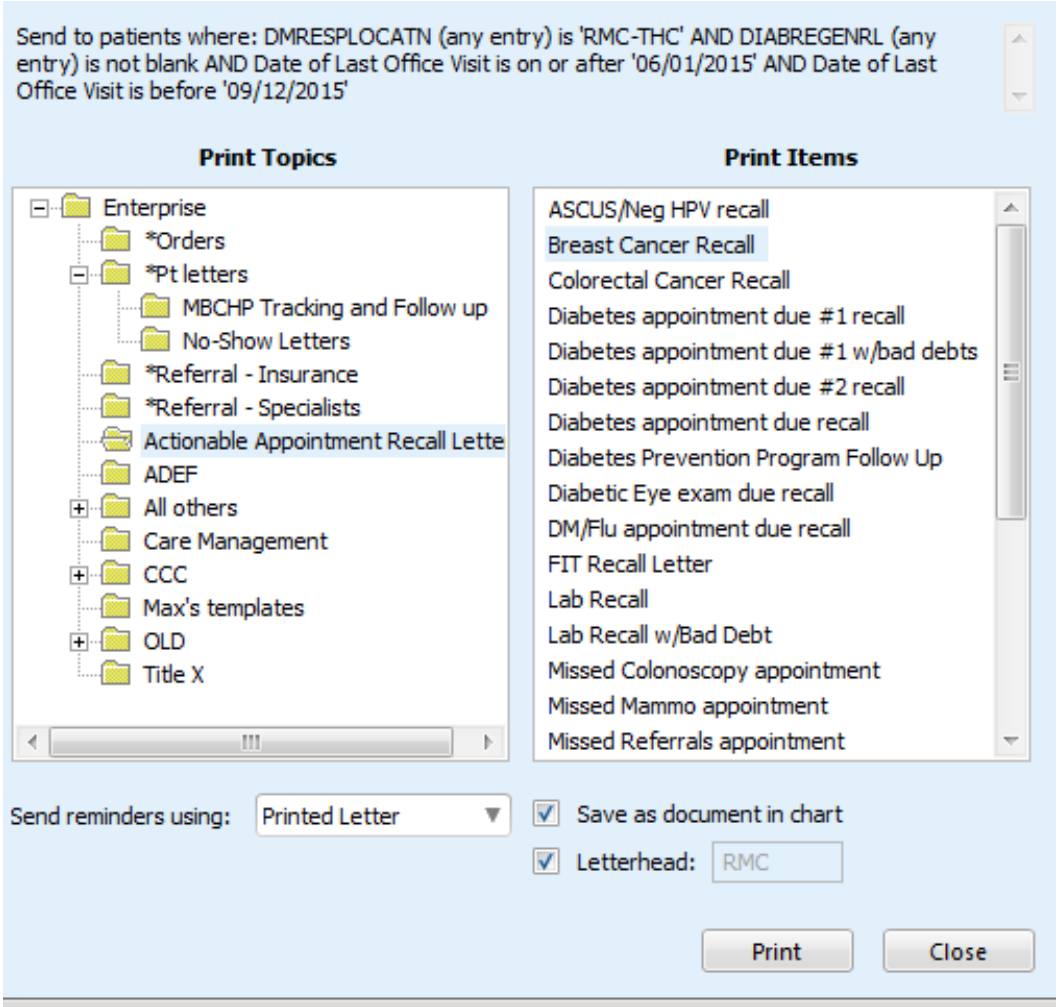
PROCEDURE: The designated staff member will run a report of their provider's diabetic members who have not been in for a diabetic visit in the last four (4) months. This staff member will send a recall letter to members who are due for a diabetic visit.

Running Diabetic Recall Reports and Sending Reminders – Recall Letters

1. Go to Centricity Chart Reports. Select report: **"DM APPT REPORT"**
2. Click on the "Date of Last…" line. Change the date to: "…is before '4 months prior to current date'"
3. Click "Search." A list of patients will display
4. Choose "Send Reminder…" from the "Select Activity" dropdown.

***See "Preventive Care –Recall Patient Search (Reminder) Letters document."**





5. One month after the letter was sent, check referrals tracking.
6. If there is still no response, make two (2) attempts to call the patient (48-72 hours apart from one another), documenting attempted calls as " ___ RECALL" in the patient's chart.
7. If you are still unsuccessful in reaching patient or if the patient has still not made an appointment, flag the primary provider for further directions to -
    a. Stop tracking
    b. Continue to reach patient via certified letter.
    c. Convert to a document once action has been taken. Sign off in the chart.

Health Home Example: Diabetes Standing Order/Protocol

The following standing order/protocol will be implemented in order to ensure that our diabetic members receive optimal care.

1. Use the diabetes template or drop down menu on the History of Present Illness (HPI).
2. The following will be performed and recorded in the Electronic Medical Record (EMR) for each visit:
   - Blood pressure, pulse, height, weight, Body Mass Index (BMI)
   - Reconciliation of all medications
   - Ranges or averages of Self Blood Glucose Monitoring (SBGM)
   - Any **problems or questions about their diabetes, exercise program or diabetic diet (**and alert physician in the HPI to those issues).
   - The provider will ask the member to remove shoes and socks for a foot exam. Perform the foot exam and:
     - Screen and identify if his/her feet are at risk (swelling, poor circulation, sores, etc.)
     - Palpate the dorsalis pedis and posterior tibial pulses
     - Inspect the skin of the feet for abnormalities
     - Check the sensation of the feet using monofilament testing protocol at least yearly
     - Alert the physician to any abnormalities and document findings in the EMR
3. If an **HbA1c** test has not been done in the previous six (6) months, then perform Point-of-Care (POC) HbA1c test and document results in EMR.
4. If **Microalbumin** has not been tested in previous 12 months, obtain a spot urine for microalbumin and put order in EMR.
5. If a **lipid profile** was not done in the past 12 months, complete an order for lipid profile or Cardiac 1 profile. This should be done fasting or, at the physician's discretion, it may be obtained non-fasting.
6. If a **metabolic profile** has not been done in the previous 12 months, complete an order for a Complete Metabolic Profile (CMP) or, at the physician's discretion, a Basic Metabolic Profile (BMP).
7. If a **dilated eye exam** was not done in the previous 12 months, complete a referral for a dilated eye exam by an optometrist/ophthalmologist.
8. Every member with diabetes should have at least one **pneumococcal vaccine** and should be assessed after five (5) years to determine the need for a booster. Every member with diabetes should have an annual **influenza vaccine**. Document the vaccine status in the EMR.
9. **Smoking status** should be documented on all diabetic members and if smoking, a referral to the Maine Quit Smoking Hotline or behavioral counselor should be offered and documented in the EMR. Progress toward smoking cessation should be documented at every visit.

Health Home Example: Communication to Member with Diabetes

(Date)

(Address)

Dear _____,

Happy Birthday! We, at _____, hope you have many things to celebrate as your birthday approaches and throughout the coming year.

_____ knows how important it is for you to take care of yourself. Many health issues can worsen if not found and taken care of. It is important for you to get regular health checkups to help find and treat problems early and keep you on a path of good health.

We follow the latest national guidelines to give the best possible care to our patients. Our records show that you are due for your annual health checkup. You may also need the following health care as part of to your yearly care plan:

DM Eye Exam Due Now – Last Done: _____

Microalbumin Due Now – Last Done: _____

Lipid Panel should be done once yearly. Your Lipid Profile was last done: _____

Total Chol: _____

TG: _____

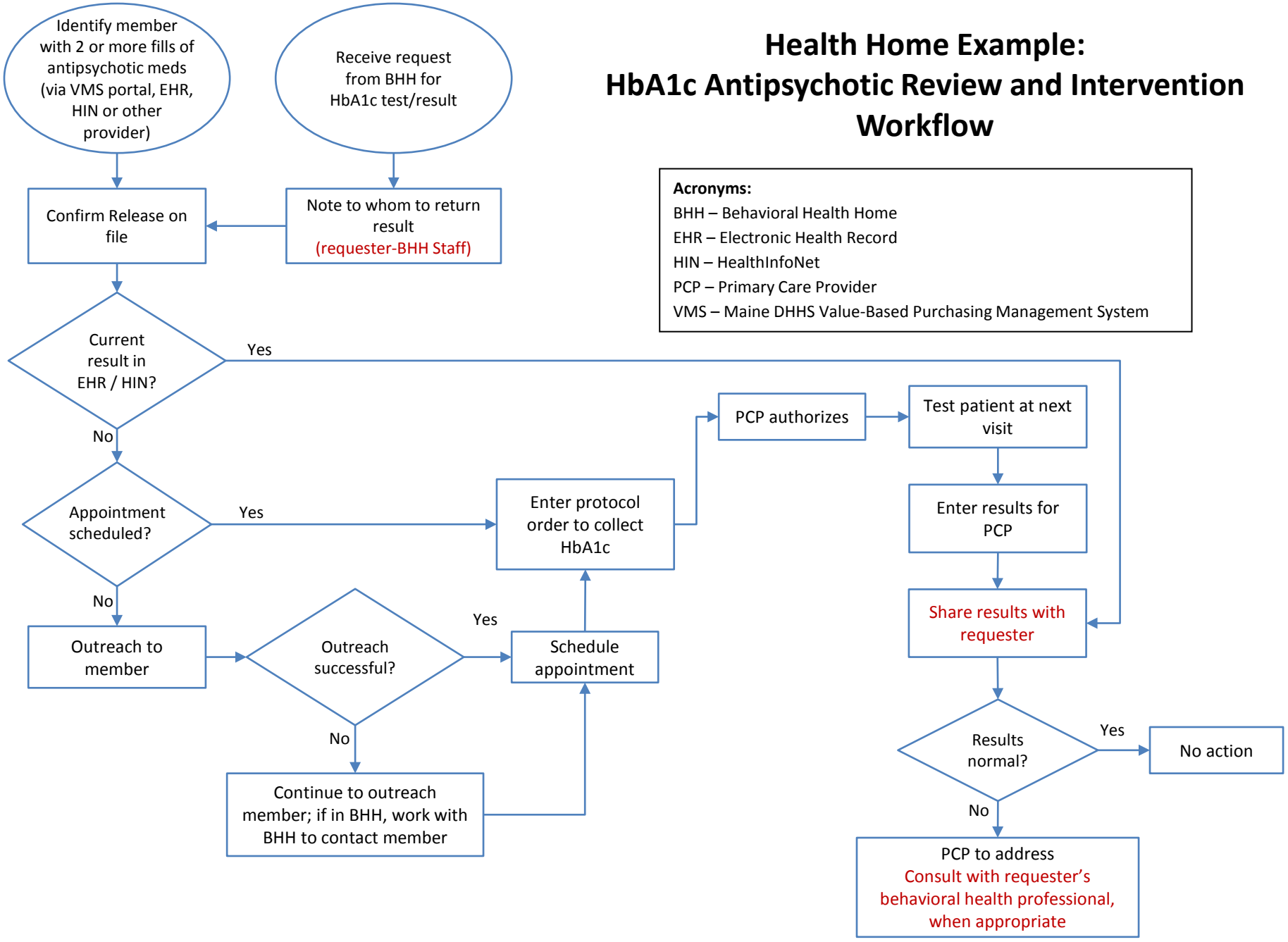
HDL: _____

LDL: _____

This is a letter created from your chart to be used as a guideline for preventive health. Your provider may adjust these guidelines based on your age, gender, race, allergies, or other healthcare conditions. As your provider, we strongly suggest calling for a health checkup to maintain your overall good health and well-being. To schedule your appointment, call _____ between ___am and ___pm.

May the coming year bring you good health.

Health Home Example: HbA1c Antipsychotic Review and Intervention Workflow



Acronyms:

BHH – Behavioral Health Home
EHR – Electronic Health Record
HIN – HealthInfoNet
PCP – Primary Care Provider
VMS – Maine DHHS Value-Based Purchasing Management System

Provider/Practice Takeaways

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Maine Quality Counts
Better Health Care. Better Health.

Key Highlights from the DFLC Regional Forums 2017

- Value-Based Purchasing Management System (VMS) Portal:
  - Ensure all necessary staff have access to the VMS portal.
  - Cannot rely solely on HealthInfoNet (HIN); need to use VMS portal as well.
  - Ensure contacts within portal are correct.
  - Use portal for secure messaging.

- Communication:
  - Identify contacts and obtain contact info for better bi-directional communication.
  - Have face-to-face meetings with all necessary parties.
  - Invite Behavioral Health Home (BHH) to the practice and develop a way to coordinate to support members.
  - Work with MaineCare to address any data concerns; continue to review data and submit corrections.

- Education:
  - Increase provider knowledge of skills and services BHHs and Health Homes (HH) have to offer.
  - Need to better educate the members and their families on how BHH and HH teams can work together to provide services.
  - BHH Health Home Coordinators can support clients to access their online primary care patient portal.
  - BHH and HH acronyms can be barriers.
  - Need to better educate members and providers on diabetes.

- Tools:
  - Establish a process to set up standing orders for HbA1c testing. This seems to be working well in some practices.
  - Process of sharing medication lists between BHH and HH.
  - BHH and HH would like an updated antipsychotic prescription list.
  - It would be helpful to have a list of shared patients between the BHH and HH; It is a barrier not knowing which patients are shared between BHH and HH.
  - Develop a process to establish more Memorandums of Understanding (MOU) with neighboring organizations.
  - Advocacy – at the end of the day, the patient/client is a person. They have needs. We are here to meet those needs.

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Data-Focused Learning Collaborative (DFLC)

Success Stories of Health Homes (HH) and Behavioral Health Homes (BHH)

Working Together

Kennebec Behavioral Health and Kennebec Region Health Alliance have connected to develop processes for bi-directional communication and patient management of shared clients. Their work together has resulted in:

- Improved communications
- Timely responses to requests for tests and documentation
- Clarity around processes for managing shared clients

Victory Calls

HealthReach – Bethel Family Health Center was proud to announce:

"We received our first call today from a BHH requesting an HbA1c. Our process worked great!"

Technological Updates

Cornerstone Behavioral Healthcare made changes to their Electronic Health Record (EHR) in order to capture HbA1c data.

Collaboration at its Best

Aroostook Mental Health Services is a BHH that attends monthly HH meetings to actively discuss overlapping, high needs cases.

Right on Track

Wings for Children & Families developed a process to ensure compliance regarding HbA1c requirements. Their process monitors future test needs and allows the HbA1c test results to be easily tracked.

Know Your Resources

Aroostook Mental Health Services created a summary sheet of BHH Resources to share with HHs to raise awareness of the different services they offer.

Quality Improvement Guidance

Institute for Healthcare Improvement

Improving Health and Health Care Worldwide

Resources »

How to Improve

Measures »

Changes »

Improvement Stories »

Tools »

Publications »

IHI White Papers »

Case Studies »

Audio and Video »

Presentations »

Posterboards »

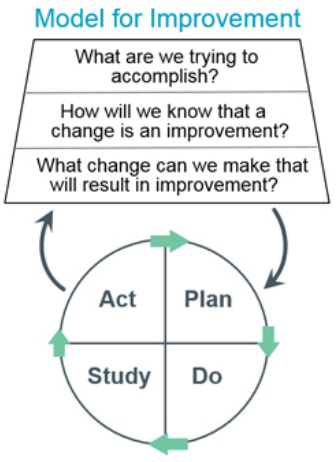
Other Websites »

How to Improve

How to Improve

IHI uses the Model for Improvement as the framework to guide improvement work.

The Model for Improvement,* developed by Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement. This model is not meant to replace change models that organizations may already be using, but rather to accelerate improvement.



Learn about the fundamentals of the Model for Improvement and testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles.

- Introduction
- Forming the Team
- Setting Aims
- Establishing Measures
- Selecting Changes
- Testing Changes
- Implementing Changes
- Spreading Changes

*Source:
Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

Visit the Improvement Capability Topic page >>

UPCOMING PROGRAMS

Breakthrough Series College »
October 17–19, 2017 | Cambridge, MA

Improvement Advisor Professional Development Program »
October 23, 2017 | Boston, MA

2017 IHI National Forum »
December 10-13, 2017 | Orlando, FL

RELATED IHI WHITE PAPERS

A Framework for Spread: From Local Improvements to System-Wide Change »

Comparing Lean and Quality Improvement »

Engaging Physicians in a Shared Quality Agenda »

HOW TO IMPROVE

Introduction

Forming the Team

Setting Aims

Establishing Measures

Selecting Changes

Testing Changes

Implementing Changes

Spreading Changes

FEATURED CONTENT

Comparing Lean and Quality Improvement »

Plan-Do-Study-Act (PDSA) Worksheet »

Project Planning Form »

The Model for Improvement (Part 1) »

The Science of Improvement on a Whiteboard! »

TAKE A FREE QI COURSE

Learn the fundamentals of improvement with this online course, free with registration on ihi.org:

QI 102: How to Improve with the Model for Improvement

IMPROVEMENT SCIENCE AT IHI NATIONAL FORUM

December 10-13, 2017 | Orlando, FL

Improvement Science is a featured topic at the **2017 National Forum**, with topic-related sessions offered in a special track.

Execution of Strategic Improvement Initiatives to Produce System-Level Results »

Planning for Scale: A Guide for Designing Large-Scale Improvement Initiatives »

Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition) »

Sustaining Improvement »

The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement »

Whole System Measures »

Example: Quality Improvement Implementation Plan

BHH/HH Name:	
QI Project Title:	**Increasing Awareness of Alternative Options to the Emergency Department for BHH members**
BHH/HH Team Leader:	
QI Team Leader:	
QI Project Duration:	*April 1, 2015 through January 1, 2016*
QI AIM Statement:	By January 2016, only 18% of BHH's members visited the Emergency Department (ED) at least once for a low to moderate severity reason. **SUB AIM:** 60% of BHHO's BHH members who have visited the ED at least once for a low to moderate severity reason in 2014 will report being more aware of their alternative ED options by January 2016.

PDSA Cycle	Objective	Actions	Person(s) Responsible	Start Date	Completion Date	Team Meeting Date	Resources Needed (if applicable)	Success Measures (if applicable)	Notes
Indicate which PDSA Cycle the actions are supporting	What are you trying to achieve?	What steps need to be done to meet your objective?	Who is responsible for completing the action?	When will the action start?	When should the action be done?	When will your team meet to talk about this action?	Are there resources you need to complete the action?	How will you know your action was a success?	Mark additional actions needed, missed deadlines, etc.
Cycle 1									
Plan	Baseline Data Collection	Distribute survey to BHH members to collect baseline on awareness levels	All Health Home Coordinators	4/1/2015	4/30/2015	5/4/2015	Printed Surveys	30 surveys distributed	
		Collect surveys from BHH members	All Health Home Coordinators	4/1/2015	4/30/2015	5/4/2015		30 surveys collected	
		Develop database and analyze survey data	Nurse Care Manager	4/1/2015	5/8/2015	5/11/2015		Database developed	
Do	Increase Awareness #1	Research member's nearby resources for alternative ED options	All Health Home Coordinators	5/1/2015	8/1/2015	8/3/2015	Research on member's nearby resources	30 specific info sheets for members	
		At member's Plan of Care discussion, refer to the Health Guidebook and specific resources as alternative ED options	All Health Home Coordinators	5/1/2015	8/1/2015	8/3/2015	Health Guidebooks	30 Plan of Care visits	May need to print extra Health Guidebooks
Study	Comparison Data Collection	Distribute survey to BHH members to see if there was a change in awareness levels	All Health Home Coordinators	8/1/2015	8/31/2015	9/7/2015	Printed Surveys	30 surveys distributed	
		Collect surveys from BHH members	All Health Home Coordinators	8/1/2015	8/31/2015	9/7/2015			
		Analyze survey data and compare to baseline	Nurse Care Manager	8/1/2015	9/4/2015	9/7/2015		Comparison report on awareness data	
Act **Cycle 2**									
Plan	Increase Awareness #2								

Instructions on Utilizing the PDSA Cycle through Model for Improvement: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Template: Quality Improvement Implementation Plan

This template is designed to help your team have a successful QI project. It incorporates the "Plan-Do-Study-Act" cycle steps and provides a structure for you and your team to complete key tasks within the timeframe of your project.

BHH/HH Name:	
QI Project Title:	
BHH/HH Team Leader:	
QI Team Leader:	
QI Project Duration:	
QI AIM Statement:	

PDSA Cycle	**Objective**	**Actions**	**Person(s) Responsible**	**Start Date**	**Completion Date**	**Team Meeting Date**	**Resources Needed** (if applicable)	**Success Measures** (if applicable)	**Notes**
Indicate which PDSA Cycle the actions are supporting	What are you trying to achieve?	What steps need to be done to meet your objective?	Who is responsible for completing the action?	When will the action start?	When should the action be done?	When will your team meet to talk about this action?	Are there resources you need to complete the action?	How will you know your action was a success?	Mark additional actions needed, missed deadlines, etc.
Cycle 1									
Plan									
Do									
Study									
Act Cycle 2									
Plan									
Do									
Study									

Additional Resources

Additional Resources

MaineCare Benefits Manual:

http://www.maine.gov/sos/cec/rules/10/ch101.htm

MaineCare Benefits Manual, Chapter II, Section 92, Behavioral Health Home Services:

http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s092.docx

MaineCare Benefits Manual, Chapter III, Section 92, Behavioral Health Home Services:

http://www.maine.gov/sos/cec/rules/10/144/ch101/c3s092.docx

MaineCare Benefits Manual, Chapter II, Section 91, Health Home Services:

http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s091.docx

MaineCare Benefits Manual, Chapter III, Section 91, Health Home Services:

http://www.maine.gov/sos/cec/rules/10/144/ch101/c3s091.doc

MaineCare Value-Based Purchasing Website:

http://www.maine.gov/dhhs/oms/vbp/

Maine Center for Disease Control and Prevention - Maine Division of Disease Prevention:

http://www.maine.gov/dhhs/mecdc/population-health/dcp/educationprogram.htm

DSMT Site Directory link is contained within this page (dated with most recent update)

Model for Improvement: Plan-Do-Study Act (PDSA) Cycles:

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

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Maine DHHS VMS Portal Dashboard Data

The Maine Department of Health and Human Services (DHHS) Value-Based Purchasing Management System (VMS) portal contains two dashboards of specific measure data: Utilization and Quality. These dashboards were created to give providers medical claims information for the members they serve through the Health Home (HH) and Behavioral Health Home (BHH) programs.

The Utilization Dashboard:

- Displays specific member healthcare claims information, including prescriptions
- Allows providers to determine which members are and are not receiving certain screenings and services
- Identifies members who are considered high utilizers of certain services
- Presents member claim costs

The Quality Dashboard:

- Displays practice-level healthcare claims information
- Allows comparison of performance to peers for each measure
- Presents historical trends for each measure, within a practice

Providers' goals for using the dashboards:

- Understand where your organization is performing well on specific measures compared to your HH or BHH peers
- Identify areas of increased focus and opportunity for your HH or BHH team
- Use the dashboard in coordination with other member data sources
- Use dashboards to affect individual member and practice outcomes
- Verify the impact of services you are providing

MaineCare's Expectations:

- Providers will review the Utilization Dashboard to determine which members require outreach and coordination. Upon this review, MaineCare expects providers to:
    - Schedule primary care visits for members with no PCP visit within the last year
    - Monitor/impact inpatient utilization, as appropriate; two (2) or more hospitalizations in the last quarter and/or three (3) or more hospitalizations in the last year
    - Reduce Emergency Department overutilization; two (2) or more Emergency Department visits in the past quarter and/or three (3) or more Emergency Department visits in the last year
    - Review and monitor member claims data to determine which core cost services over $10,000 are impactable
    - Increase monitoring of diabetic members who have **not** had:
        - HbA1c test in the last year
    - Increase screening/monitoring of members with two (2) antipsychotic prescription fills for diabetes:
        - HbA1c test in the last year

- Providers will review the Quality Dashboard to improve overall practice performance in the following areas, at a minimum:
    - Number of members not receiving appropriate diabetes-related care
    - Percentage of members in the practice who have had a primary care visit
    - Children, of varying age levels, who have not received well-child services
    - Number of members being prescribed non-evidence based anti-psychotic medications
    - Use of appropriate medications for asthma
    - Alcohol and other drug dependency treatment
    - Follow-up after hospitalization for mental illness
    - Number of members using high-risk medications

If you have any suggestions regarding additional measures that could be helpful to your practice, please contact: HH-BHH-Services.DHHS@maine.gov .

Utilization and Quality Dashboard Measure Listings may be found on the Maine DHHS VMS Portal within the Help menu, or found on the MaineCare Value-Based Purchasing webpage.

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DHHS VMS Portal Utilization Measures

ID	Measure Name	Description
1	Hospitalizations in the last quarter	Count of hospitalizations with a paid claim service date in the past three (3) months - Excludes hospitalizations related to substance use disorders from those hospitals that have specialized substance abuse treatment units
2	Hospitalizations in the last year	Count of hospitalizations having a paid claim with a service date in the past 12 months - Excludes hospitalizations related to substance use disorders from those hospitals that have specialized substance abuse treatment units
3	ED visits in last quarter	Count of outpatient Emergency Department (ED) visits with a paid claim service date in the past three (3) months
4	ED visits in last year	Count of outpatient ED visits with a paid claim service date in the past 12 months
5	Pts AC total Core paid claims	Total Accountable Community (AC) Core cost (acute medical, behavioral health and pharmacy) in the past 12 months. AC Core Costs include Acute Medical and Behavioral Health Care Services
6	Pts total AC Optional paid claims	Total AC Optional cost in the past 12 months; AC Optional services include dental, nursing homes, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), Home and Community Based Waivers, Private Duty Nursing and other long term care services and supports
7	Pts total AC Excluded paid claims	Total AC Excluded cost in the past 12 months; AC Excluded services include Private Non-Medical Institutions (PNMIs), non-emergency transportation, targeted case management provided by the state and other related conditions waiver
8	Number of Rx in last quarter (Number of Distinct NDC Codes)	The number of different prescription NDC codes with a paid claim with a service date in the past three(3) months (substance abuse and HIV have been excluded)
9	Pts with no PCP visit in the past year	Members with no paid claim for a primary care visit with a service date in the past 12 months. No Primary Care Provider (PCP) visit = “Y”
10	Pts with an HbA1c test in the last year (Diabetes)	Members with diabetes diagnosis and a paid HbA1c test claim with a service date in past 12 months. Diabetic member with HbA1c test = “Y”; diabetic member with no HbA1c test = “N”; non-diabetic member = blank
11	Pts with an LDL panel in the last year (Diabetes)	Members with diabetes diagnosis and a paid LDL panel claim with a service date in past 12 months; Diabetic member with LDL = “Y”; diabetic member with no LDL = “N”; non-diabetic member = blank
12	Pts with an LDL panel in the last year (CVD)	Members with Cardiovascular Disease (CVD) diagnosis and a paid LDL panel claim with a service date in past 12 months; CVD member with LDL = “Y”; CVD member with no LDL = “N”; non-CVD member = blank
13	Pts with two antipsychotic prescription fills and an HbA1c test in the last year	Members receiving at least two antipsychotic prescription fills and a paid claim for an HbA1c test with a service date in the past 12 months. Members with two antipsychotic fills with HbA1c = “Y”, those that do not have an HbA1c test = “N” and those not having two antipsychotic prescription fills = blank

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Ricker Hamilton, Acting Commissioner

DHHS VMS Portal Quality Measures

ID	*Measure Name/Description*
Preventive Health	
10	Well-Child Visits - Age - 1st 15 Months of Life (% of Members w/6 or more visits)
20	Well-Child Visits - Age - 15 Months - 3 Yrs (% of Members w/1 or more visits)
30	Well-Child Visits - Age 3-6 Yrs
40	Well-Child Visits - Age 7-11 Yrs
50	Adolescent Well-Care Visits 12–21 years of age
60	Developmental Screening in 1st 3 Years of Life
80	Percent Members with Primary Care Provider visit
Care Coordination	
100	Pediatric Quality Chronic Composite - Ambulatory Care Sensitive Admissions (Pediatric)
110	Prevention Quality Chronic Composite - Ambulatory Care Sensitive Admissions (Adult)
120	Non-emergent ED Use *
130	Plan All-Cause Readmissions*
140	Use of High Risk Meds in the Elderly - At least 1 high-risk medication *
150	Use of High Risk Meds in the Elderly - At least 2 different high-risk medications *
At-Risk Populations	
160	Use of Appropriate Meds for people with Asthma - Age 5-11 Yrs
170	Use of Appropriate Meds for people with Asthma - Age 12-50 Yrs
180	Non Evidence-Based Antipsychotic Prescribing *
200	Cardio-Metabolic Screening for Adults and Children who are prescribed Antipsychotic Medications
220	Diabetes: Adult - Hemoglobin A1c (HbA1c) Testing
230	Diabetes: Adults Dilated Retinal
240	Diabetes: Adults Lipid Control
250	Diabetes: Adults Nephropathy
260	Cholesterol Management for Patients with Cardiovascular Conditions
270	Use of Spirometry Testing COPD
300	Follow-up after Hospitalization for Mental Illness – 7 Day
310	Follow-up after Hospitalization for Mental Illness – 30 Day

Measure for only Behavioral Health Home (BHH) Providers
Measure for only Health Home (HH) Providers
Measure for both HH and BHH

* indicates a lower rate is better performance for this measure

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DFLC Use of the VMS Portal:

Using the Quality and Utilization Dashboards on the Value-Based Purchasing Management System (VMS) Portal to Impact the Data-Focused Learning Collaborative (DFLC) HbA1c Measures

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Quality Dashboard Overview:

The Quality Dashboard allows Health Home (HH) and Behavioral Health Home (BHH) providers to view specific quality measures and compare their progress against their HH/BHH peers. These measures, updated every three months, are based on 12 months of paid MaineCare claims data with nine months of claims run out. Measure data will populate once qualifying members have been on the practice panel at least six months.

- The HH quality measure 220: *Diabetes: Adult - Hemoglobin A1c (HbA1c) Testing* aligns with DFLC data sent to HH providers.

- The BHH quality measure 200: *Cardio-Metabolic Screening for Adults and Children who are prescribed Antipsychotic Medications*, does not align with the DFLC measure sent to BHH providers. The portal quality measure denotes members with both HbA1c and Low Density Lipoproteins (LDL) testing. The DFLC data for BHH providers regarding antipsychotic medications is not displayed in the Quality Dashboard.

To prevent future gaps in care, providers can go to the Utilization Dashboard to identify and develop an action plan for those current panel members who have not had the HbA1c test in the most recent 12 months.

Utilization Dashboard Overview:

The Utilization Dashboard assists HH and BHH providers in tracking specific utilization measures and affiliated MaineCare paid claims for members on their panels. Measure data is based on 12 months of claims, updated monthly, and is available for each member, with affiliated claims, as soon as the member is added to the practice's panel. The Utilization Dashboard provides the ability to view HbA1c test claims.

- **The Utilization Measure of *HbA1c test in the last year (Diab)* labels panel members as follows:**
  - **Y -** member has a diabetic diagnosis and a claim for an HbA1c test in the past 12 months
  - **N -** member has a diabetic diagnosis and no claim for an HbA1c test in the past 12 months
  - Blank field - member does not have a diabetes diagnosis in the past 12 months

- **The Utilization Measure of *HbA1c for Antipsy. meds in last year* labels panel members as follows:**
  - **Y -** member has two antipsychotic medication fills and a claim for an HbA1c test in the past 12 months
  - **N -** member has two antipsychotic medication fills and no claim for an HbA1c test in the past 12 months
  - Blank field - member does not have two fills of antipsychotic medications in the past 12 months

Tracking member utilization of antipsychotics and diabetes, and reacting to this data, assists in DFLC measure improvements in member care. This will also impact future quality measure outcomes.

If assistance is needed for either of these dashboards, additional guides are available on the VMS portal within the *Help* tab. The guides are titled *Quality Dashboard Guide* and *Claim Utilization and Dashboard Measure Definitions***.** Also visit http://www.maine.gov/dhhs/oms/vbp/index.html and select Utilization and Quality Dashboard Overview and Utilization and Quality Measure Listings for more information.

Department of Health and Human Services
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MAINE DIABETES UNIT
DIABETES SELF-MANAGEMENT TRAINING (DSMT) SITE DIRECTORY
August 17, 2017

BLUE HILL MEMORIAL HOSPITAL, BLUE HILL			
Satellite site	None		
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Phys. Adv.	Michael G. Murnik MD	374-3010	michael.murnik@emhs.org

BRIDGTON HOSPITAL, BRIDGTON			
Satellite site	None		
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	Linda Russell MA RD LD CDE	647-6062	Russelll@cmhc.org
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CARY MEDICAL CENTER, CARIBOU			
Satellite site	Saint John Valley Health Center, Van Buren		
Site Coordinator	Erica Ouellette RN BSN CDE 163 Van Buren Rd. Suite 1 Caribou, ME 04736	498-1283	eouellette@carymed.org
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	Erica Ouellette RN BSN CDE	498-1283	eouellette@carymed.org
	Marthe Pelletier MS RD LD CDE	498-1211	mpelletier@carymed.org
Phys. Adv.	Carl Flynn MD	498-2356	cflynn@pineshealth.org

CENTRAL MAINE MEDICAL CENTER, LEWISTON Central Maine Endocrinology and Diabetes Center			
Satellite site	Rumford Hospital, Rumford		
Site Coordinator	Maylene Peralta MD FACE 287 Main St. Suite 301 Lewiston, ME 04240	795-7520	peraltma@cmhc.org
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EASTERN MAINE MEDICAL CENTER, BANGOR			
Satellite site	None		
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	Heather Leclerc RD CDE	973-7334	hleclerc@emhs.org
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Phys. Adv.	Dr. K Sadurska MD	973-7334	ksadurska@emhs.org

EASTPORT HEALTH CARE, INC., EASTPORT			
Satellite sites	Eastport Health Care, Machias Calais Regional Hospital, Calais		
Site Coordinator	Debbie Pottle RN, CDE 30 Boynton St. P.O. Box H Eastport, ME 04631	853-0136	dpottle@eastporthealth.org
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FRANKLINHEALTH, FRANKLIN MEMORIAL HOSPITAL, FARMINGTON			
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	Jeannine Lake RN	779-2225	jlake@fchn.org
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	Eileen Caffrey RN	778-3326	ecaffrey@fchn.org
Phys. Adv.	Kristine Sanden DO	778-3326	ksanden@fchn.org

HOULTON REGIONAL HOSPITAL, HOULTON			
Satellite site	None		
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INLAND HOSPITAL, WATERVILLE Diabetes & Nutrition Wellness at Inland Hospital			
Satellite site	Sebasticook Valley Health, Pittsfield		
Site Coordinator	Ev Jackson, RDN LD Diabetes & Nutrition Wellness 180 Kennedy Memorial Dr. Suite 101 Waterville, ME 04901	861-7150	efjackson@emhs.org
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INTEGRATED OPTIMAL HEALTH, AUBURN			
Satellite sites	Integrated Optimal Health, Conway NH Carroll County Diabetes, Nutrition & Wellness Center, Wolfeboro NH Every Day Nutrition Associates, Brunswick ME Integrated Optimal Health (2 Auburn Maine locations)		
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	Marie L. Veselsky MS RD BC-ADM	1-603-770-4586	mveselsky@roadrunner.com
	Patty Walker RD CDE	1-603-520-3176	patty@ccdnwc.com
Phys. Adv.	Dr. Roy Nakamura	1-207-725-8079	

LINCOLNHEALTH, DAMARISCOTTA Diabetes & Nutrition Program			
Satellite site	St. Andrews Campus, Boothbay Harbor		
Site Coordinator	Patricia Brewer RN 35 Miles St. Damariscotta, ME 04543	563-4902	patricia.brewer@lchcare.org
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MAINEGENERAL MEDICAL CENTER, AUGUSTA			
Satellite site	MaineGeneral Diabetes & Nutrition Center, Waterville		
Site Coordinator	Kathleen Harger RN BSN 6 East Chestnut St. Suite LL 120 Augusta, ME 04330	621-9320	kathleen.harger@mainegeneral.org
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MAINE COAST MEMORIAL HOSPITAL, ELLSWORTH			
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MAINE MEDICAL PARTNERS, SCARBOROUGH **Endocrinology & Diabetes Center**			
Satellite sites	Maine Medical Partners Endocrinology & Diabetes at Lewiston		
Site Coordinator	Susanne D'Angelo-Cooley MS RD LD CDE 175 U. S. Route 1 Scarborough, ME 04074	396-7515	danges@mmc.org
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MAINE MEDICAL PARTNERS, PORTLAND **Specialty Care**			
Satellite sites	Maine Medical Partners Pediatric Specialty Care, Oakland Maine Medical Partners Countdown to a Healthy Maine, Portland		
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Phys. Adv.	Jerrold Olshan MD	662-5522	olsha@mmc.org

MAYO REGIONAL HOSPITAL, DOVER-FOXCROFT **Mayo Practice Associates Diabetes Education**			
Satellite sites	Corinth Medical Associates, Corinth Dexter Internal Medicine, Dexter Guilford Medical Associates, Guilford Milo Family Practice, Milo		
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MERCY HOSPITAL, PORTLAND **The Mattina R. Proctor Diabetes Center**			
Satellite sites	Mercy Primary Care South, South Portland Gorham Crossing Primary Care, Gorham Portland Internal Medicine, Portland West Falmouth Primary Care, Falmouth Windham Family Practice, Windham Yarmouth Primary Care, Yarmouth		
Site Coordinator	Hillary O'Donnell MS RD LD CDE 144 State St., 4th Floor Portland, ME 04101	400-8500	odonnellh@emhs.org
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MID COAST MEDICAL GROUP, BRUNSWICK **Center for Diabetes & Endocrinology**			
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Instructor	Alison Fernald RD LD CDE	406-7290	afernald@midcoasthealth.com
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MILLINOCKET REGIONAL HOSPITAL, MILLINOCKET			
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MOUNT DESERT ISLAND HOSPITAL, BAR HARBOR			
Satellite sites	Community Health Center, Southwest Harbor Trenton Health Center, Trenton		
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	Sherry Rogers RN	(multiple sites)	Sherry.rogers@mdihospital.org
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NORTHERN MAINE MEDICAL CENTER, FORT KENT			
Satellite site	Acadia Health Center, Madawaska		
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	Linda Russell RN	834-1964	linda.russell@nmmc.org
Phys. Adv.	Dr. Paul Pelletier MD	444-5973	ppelletier@ffrh.org

PEN BAY MEDICAL CENTER, ROCKPORT Diabetes and Nutrition Care Center			
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	Marcia Kyle RDN LD CDE FAND	921-3999	mkyle@penbayhealthcare.org
	Eileen MolloyRDN LD CDE	921-3999	emolloy@penbayhealthcare.org
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REDINGTON FAIRVIEW GENERAL HOSPITAL, SKOWHEGAN			
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	Laurie Sweet RD LD	858-2257	lsweet@rfgh.net
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ST. JOSEPH HOSPITAL, BANGOR Diabetes & Nutrition Center			
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STEPHENS MEMORIAL HOSPITAL, NORWAY			
Satellite site	None		
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THE AROOSTOOK MEDICAL CENTER, FORT FAIRFIELD			
Satellite site	A. R. Gould, Presque Isle Caribou Health Center, Caribou Mars Hill Health Center, Mars Hill Presque IsleFamily Practice, Presque Isle		
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Phys. Adv.	Mary Coffin FNP CDE MSN	768-4753	mcoffin@tamc.org

WALDO COUNTY GENERAL HOSPITAL, BELFAST Diabetes Services			
Satellite site	None		
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YORK HOSPITAL, YORK			
Satellite site	None		
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	Barbara Moriarty RD LD CDE	351-3702	diabetesed@yorkhospital.com
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Data-Focused Learning Collaborative Acronyms

AM – Antipsychotic Measure

BHH – Behavioral Health Home

CCT – Community Care Team

CS – Core Standards

DCM – Diabetic Care Measure

DFLC – Data-Focused Learning Collaborative

DHHS – Department of Health and Human Services

DSMT – Diabetes Self-Management Training

EHR – Electronic Health Record

EMR – Electronic Medical Record

HbA1c – Hemoglobin Glycosylated Test

HH – Health Home

HIE – Health Information Exchange

HIN – HealthInfoNet

MOU – Memorandum of Understanding

NCM – Nurse Care Manager

OMS – Office of MaineCare Services

PCP – Primary Care Provider

PDSA – Plan-Do-Study-Act

PHD – Public Health District

PMPM – Per Member, Per Month

QI – Quality Improvement

TA – Technical Assistance

VMS – Maine DHHS Value-Based Purchasing Management System

Data-Focused Learning Collaborative Definitions:

Antipsychotic Measure (AM): The number of members in BHH with two (2) fills of antipsychotic medication and an HbA1c test in the defined 12-month period.

Behavioral Health Home (BHH): A partnership between a Behavioral Health Home organization and one or more Health Home (HH) practices, as defined in MaineCare Benefits Manual, Chapter II, Section 92, to manage the physical and behavioral health needs of eligible adults and children. Both organizations receive a Per Member, Per Month (PMPM) payment for Health Home Services, as described in MaineCare Benefits Manual, Chapter III, Section 92, provided to enrolled members. BHHs build on the existing care coordination and behavioral health expertise of community mental health providers.

Continuous Quality Improvement Principles: A quality management process that encourages all health care team members to continuously ask the questions, "How are we doing?" and "Can we do it better?"

Core Standards: A set of process measures that HH and BHH providers are required to meet and maintain, as described in MaineCare Benefits Manual, Chapter II, Section 91, for HHs and as described in MaineCare Benefits Manual, Chapter II, Section 92, for BHHs.

Diabetic Care Measure: The number of members in HH, 18 to 75 years old, with a diagnosis of diabetes and an HbA1c test in the defined 12-month period.

Data-Focused Learning Collaborative (DFLC): Technical assistance for MaineCare HHs and BHHs using outcomes data to focus on quality improvement.

Diabetes Self-Management Training (DSMT): Training on how to cope with and manage diabetes. It includes tips for eating healthy, being active, monitoring blood sugar, taking medication, and reducing risks.

Electronic Health Record (EHR): An official health record for an individual that is digitized and shared among multiple facilities and agencies. EHRs are expected to improve efficiency and quality of care and, ultimately, reduce costs.

Electronic Medical Record (EMR): An EMR is a digital version of a paper chart that contains all of a patient's medical history from one practice. An EMR is mostly used by providers for diagnosis and treatment.

Health Home (HH): A partnership between a primary care HH provider and a Community Care Team, as defined in MaineCare Benefits Manual, Chapter II, Section 91, to manage specific chronic physical health needs of eligible members. Both organizations receive a Per Member, Per Month (PMPM) payment for Health Home Services, as described in MaineCare Benefits Manual, Chapter III, Section 91, provided to enrolled members.

Health Information Exchange (HIE): The transmission of healthcare-related data among facilities, health information organizations and government agencies according to national standards.

Hemoglobin Glycosylated (HbA1c): A blood test that provides a result for the average blood sugar control for an individual person over the past two (2) to three (3) months. Through an HbA1c test, clinicians obtain an overall picture of average blood sugar levels over a period of weeks/months.

Memorandum of Understanding (MOU): An MOU is a signed agreement between BHH and HH providers for the purpose of care coordination of shared members.

Practice Team: A group of individuals from an organization, practice or provider that meet together to build effective care teams by expanding roles, providing training, developing trust and teamwork, and using standing orders so staff can act independently.

Technical Assistance (TA): Assistance provided to HH and BHH providers to achieve goals and standards set forth by MaineCare.

Value-Based Purchasing Management System (VMS) Portal: An internet-based portal used by HH and BHH providers to manage members enrolled within the programs.