Welcome to our poster exhibit!

These posters highlight the accomplishments of provider-led workgroups, organized by MBHP, to address barriers to substance use disorder (SUD) care pathways and to improve quality and integration of SUD services.

MBHP is sharing these posters today to highlight the outstanding efforts providers have made to improve the health and wellness of our Members. Their collective work is the foundation of the conference themes you will hear today.

Thank you to all of those who participated in these projects.
We are grateful for your commitment.

The NIATx Process Improvement Model

Simple Process Improvement for Behavioral Health

1. What is NIATx?

Background: NIATx is a model of process improvement designed for behavioral health care settings.

Complete a Walk-Through: Understand the patient experience to determine his/her needs.

Choose an Aim: When beginning a NIATx project, the agency(ies) chose at least one of the four NIATx aims that will improve outcomes for the organization.

- **Reduce waiting time**
- **Reduce no-shows**
- **Increase admissions**
- **Increase continuation**

Appoint a Change Team:
Executive Sponsor: Senior leader authorizing project
Change Leader: Staff member who organizes and conducts the project
Change Team: 5-9 staff members who roll out project

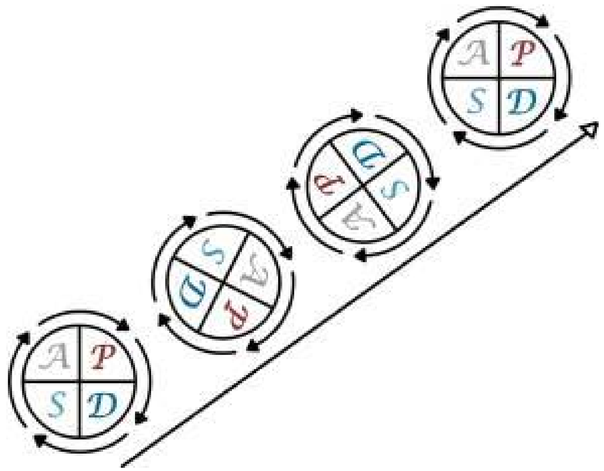
Select a Change Project to Test: Define a process improvement project that the team can implement quickly using resources available.

Choose Metrick and Gather Baseline Data: Determine how the team will evaluate progress.

Select and Test Changes: Plan-Do-Study-Act cycles

2. Using Plan-Do-Study-Act (PDSA) Cycles

- NIATx follows a Plan-Do-Study-Act cycle to rapidly test and refine changes.
- The goal is to test a change **on a small scale**, learn, and improve in the next application.
- Results of each change cycle are compared to pre-test measurements to ensure that the change is an improvement.



- **PLAN the Test**: Determine how to test the change on a small scale. Limit the test to a few work areas, levels of care, or particular types of clients, etc. Prepare a detailed plan for the test.
- **DO the Test**: Implement the test plan. Document any changes you have to make if you are unable to follow the plan.
- **STUDY the Results**: Evaluate the data. Use data to determine if the change was successful and which intervention had the most success.
- **ACT on the New Knowledge**: Use results to decide next steps. Determine if change should be **adopted** in the organization, **adapted** (e.g., in scope, target a different population), or **abandoned**.

3. Sustaining Improvements

Ten Factors for Sustaining Change

1. Change improves efficiency, making jobs easier.
2. Benefits are immediately obvious and supported by evidence.
3. Changes can be adapted when organizational changes are made.
4. Create a system to identify and monitor progress, act on it, and communicate the results.
5. Get staff invovled and adequately trained to sustain a new process.
6. Staff will feel empowered as part of the change process and believe the imprvemenet will be sustained.
7. Organizational leaders take responsibility to sustain the change process.
8. Clinical leaders take responsibility to sustain the change process.
9. History of successful sustainability and improvement goals are consistent with the organizaiton's strategic aim.
10. Staff, facilities, equipment, job descriptions, policies, procedures, and communication systems are appropriate for sustaining change.

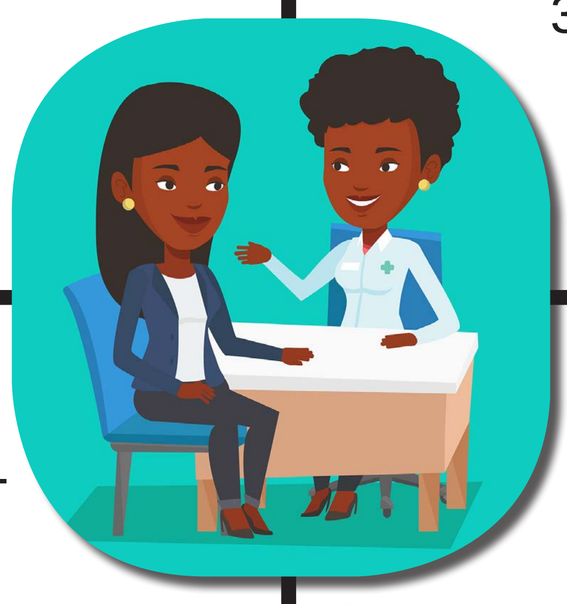
NIATx™

Project A

Plan

Goal:
To increase the retention of new Members in treatment by streamlining intake and providing short, supportive “check-ins.”

Target Population:
Members 18 and older with an opioid primary diagnosis



Study:
- Quantitative: Compared retention rates pre- and post-project
- Qualitative: Conducted Member interviews to identify barriers

Lessons Learned:
- Nurture and treat Members with respect at engagement.
  - Communicate importance of natural and family supports in recovery.

Do

Procedures:
1. Scheduled appointment for new Members at walk-in
2. Identified potential barriers to engagement at intake and created treatment plan for new Members
3. Used “buddy system” to orient and support new Members

Act

Next Steps:
- Developing a focus group to understand why Members drop out of treatment within the first 90 days
- Providing mutual supportive “check-ins” to support Member engagement in program

Study

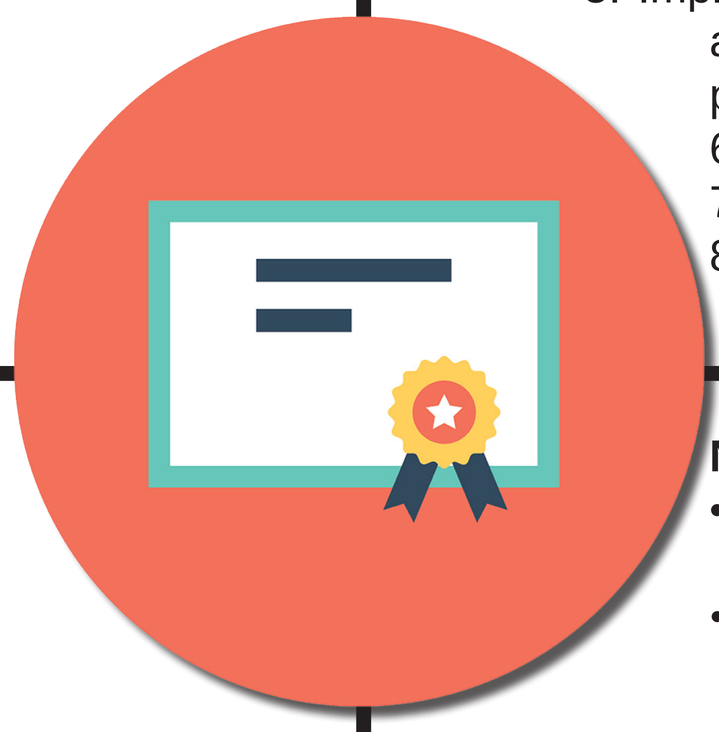
Project B

Plan

1. Improve overall access to clinical pathways for patients with substance use disorders
2. Improve patient engagement and overall program compliance

Do

1. Developed Project Charter
2. Performed a walk-through to understand current organizational process and Member experience
3. Simplified process for initiating treatment to decrease wait times
4. Defined Scope of practice, from time of intake to orientation to program completion.
5. Implemented Welcome to Orange, an on-boarding group for all new patients in Suboxone treatment
6. Collected baseline data
7. Determined targets
8. With each group cycle, made incremental improvements



Study

- Performed a timed study of the process
- Collected baseline data by measuring:
  - Time to intake
  - Time to induction
  - Time to group
  - Percentage Completion rate for Welcome to Orange
- Tripled the number of patients attending Welcome to Orange (increased from 7 to 14-21 patients per group)
- Improved Welcome to Orange completion rate to 82 percent
- Reduced intake and induction times by 50 percent and eliminated the wait list

Act

Next Steps:

- Reducing length of program curriculum
- Developing workflow with front desk staff to schedule consecutive appointments
- Engaging patients in treatment through Patient Navigators
- Piloting nursing intake and using “smart phrases” at induction
- Implementing Referral project
- Implementing alumni program and a Welcome to Subutex program

Project C

Plan

Goal:
Increase direct admissions to Medication Assisted Treatment (MAT)

Measures: Track direct admit data and compare admissions pre- and post-implementation

Do

Procedures:
- Educated staff on efficacy of MAT
- Educated Members on MAT options
- Influenced practices that support use of MAT in residential treatment

Study

Study:
Tracked the number of direct admits to MAT in eligible population

Data:
Increased number of direct admits to methadone treatment from 30 to 54 from pre- to post-measurement period

Act

Next Steps:
- Using motivational interviewing among Members with multiple detox admissions to support direct admit to MAT
- Revising strategy to influence practices around direct admits to MAT and residential treatment

Project D

Plan

Goals:
- Increase counseling attendance rates among those clients who were present <25% of the prior month
- Focus on subgroup of clients who indicated an onset of drug use <18 years of age at time of admission

Measures:
- Created a brief survey to identify client barriers to attending counseling
- Survey 21 identified clients

Benchmark Percentages:
Average (January–April 2017): 51.58%

Do

Changes implemented:
1. Developed and implemented compliance program in late April/ early May
2. Used Direct Services Analysis (DSA) report to identify Members with < 25% attendance
3. Scheduled meeting with clinic director or clinical director for clients identified in the DSA report
4. Client participated in program for four weeks to increase attendance
5. Dispensed medication after attendance to counseling improved

Study

Observations:
- Overall attendance and subgroup attendance improved.
- Two clients in the sub-group left treatment for unknown reasons.
- NIATx team needs to meet more consistently to assess progress and make timely changes.
- Staff consistency in adhering to compliance program operations helped to improve attendance.
- Improvement percentages below indicate significant improvement in client attendance.

Improvement:
- Average (May–August 2017): 57.70 percent
- 11.88 percent improvement from benchmark

Act

Next Steps:
- Compliance team will continue
- Program to be assessed for areas that might require improvement in clinical approach (i.e., developing engagement skills)
- Explore incentives that can be integrated into the clinic services (e.g., coffee in every office, snacks, water)
- Assess current incentive program (September/early October) as part of effort to enhance consistent attendance in counseling
- Sub-group: identify those clients who might be most at risk for dropping out of treatment

Improving Communication Across Providers Using a Shared Referral Form

Greater Boston Region

Mission Statement

Improve referral pathways and access to care by creating and piloting a brief, standardized referral form for Clinical Stabilization Services (CSS)

Barriers

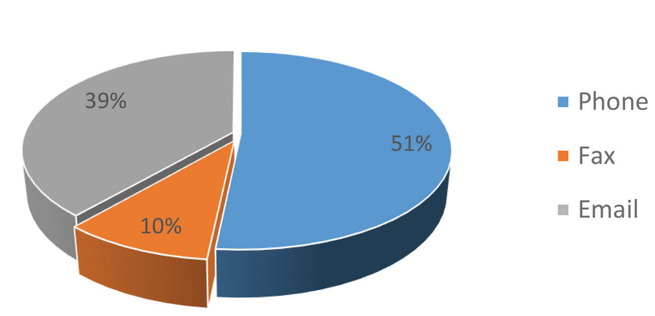
- Providers have multiple referral forms to complete when handing off Members to next level of care.
- Referral forms are unique to each organization, and no standard form exists across agencies.
- Multiple forms complicate referral processes for both the receiving and referring providers.

Findings/Outcomes

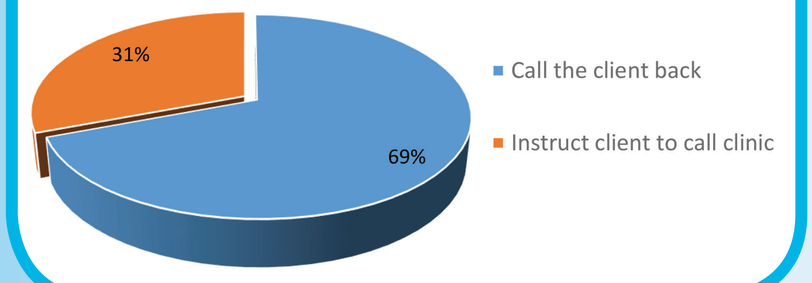
Results of Provider Survey (N=37):

- Essential Member information to collect on referral form included: medication lists, insurance information, and substance use disorder (SUD) history.
- Common barriers to receiving and referring Members to next level of care included: insurance, transportation, lack of ROI, bed availability, and inaccurate Member contact information.

What is your preferred mode of communication for referrals and follow up?



How do you communicate status of your waitlists with clients?



Target Population and Activities

Target Population: Providers referring to and accepting Members into SUD treatment programs

- Created a Provider Survey to collect data about:
  - Information required for referrals
  - Admissions
  - Barriers in receiving and referring Members
- Created a standardized referral form for CSS to reduce burden of paperwork.
- Sent form to CSS providers for feedback.

Next Steps

- Inviting CSS providers to next Workgroup meeting
- Piloting the referral form with CSS providers statewide
- Collecting and analyzing initial feedback and evaluate the acceptability and implementation of form
- Adapting form to meet needs, making changes, and continuing to use with CSS
- Expanding to other levels of care

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Clarifying Care Management (CM) Services to Ensure High-Risk Members Have Access to Appropriate Services

Southeast Region

Mission Statement

To increase Member access to appropriate care management services by educating providers, stakeholders, and Members on CM resources

Barriers

- Providers and Members may not be aware of current CM services offered by MBHP or through their organizations.
- Challenge distinguishing medical necessity criteria that makes Members eligible for CM

Target Population and Activities

Target Population: Providers treating high-risk Members and Members self-referring with SUD who would benefit from CM services

- Developed activities to educate providers, stakeholders, and Members on CM services:
  - Created CM Resource List describing all care management services available to Members
  - Developed Member-friendly definitions of care management services for clarification

Lessons Learned

- ACO implementation is reducing the number of Members in MBHP's CM program.
- Using existing resources to educate providers rather than adding additional resources will decrease paperwork and administrative burden.

Next Steps

- Updating CM Resource List in real-time to reflect changes in CM services
- Including Recovery Support Navigators and Recovery Coaches in CM guide
- Developing Decision Tree to direct Members to appropriate CM services
- Disseminating Decision Tree using annual Member letter, provider email, and MBHP's Member Engagement Center
- Involving the support of PCC Plan Support Managers to provide education to PCC providers
- Collaborating with and educating ACOs and Community Partners on available case management services

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Establishing Best Practices for Warm-Hand Offs in Behavioral Health (BH) and Substance Use Disorder (SUD) Treatment

Southeast Region

Mission Statement

Increase rates of referral to BH and SUD treatment by defining expectations of what a warm hand-off is and sharing results with providers, Members, and stakeholders

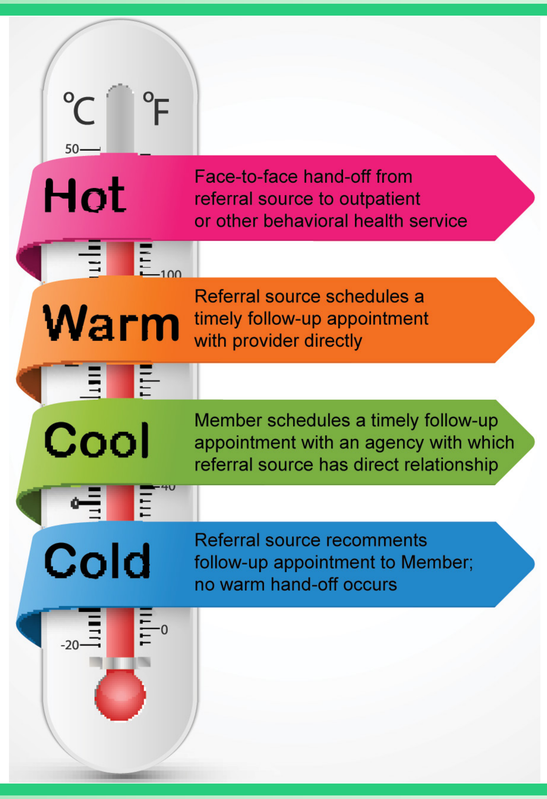
Barriers

- Providers often face challenges connecting Members to timely follow-up treatment after discharge.
- There is a lack of standardized definition of a warm hand-off, which complicates efforts to share and implement best practices for successful referrals across organizations.
- Waitlists and inaccurate referral contact information pose challenges to successful warm hand-offs.
- Payment options provided by insurance companies are lacking for true warm hand-offs; grants run out.
- Member-centered models are critical to drive effective process improvement.

Target Population and Activities

Target Population: Providers treating Members with BH and/or SUD

1. Workgroup defined warm hand-off at a provider-level:
   a. Researched clinical definitions of a warm hand-off
   b. Shared best practices for current operational warm hand-offs
   c. Brainstormed definitions of operational warm hand-off from a provider perspective
2. Developed standard for a warm hand-off definition
3. Brainstormed strategies to strengthen warm hand-offs at a provider-level
4. Determined that Member input is critical to defining a warm hand-off
5. Developed and disseminated a Member survey to collect information on how Members define the warm hand-off



Results/Changes

Services that Improve Hand-Offs:

- Open access
- Morning huddles
- Bridge groups
- CSP
- ICMP
- Client Advocates
- On site outpatient services (internal or external provider)
- Direct off site outpatient referral relationship

Best Practices for Community Health Centers:

- Short-term billable services if Member is wait-listed for referral
- Make direct contact with referring agency for transfer
- Encourage Member to see PCP for care or potential bridge prescriptions with consultation of MCPAP or available agency psychiatrist
- Once members are stabilized on Psychiatric medications, utilize PCPs for ongoing care on stable clients with Psychiatrist available for consult if needed (or MCPAP)

General Best Practices:

- Establish direct contacts at referral agencies
- Make follow-up appointment for Member with referral agency
- Follow-up after referral with agency and with Member, confronting Member on no shows
- Sign Release of Information for referral agency immediately
- Use bridge visit for acute levels of care
- Connect Members to PT1s, cab vouchers, and bus passes
- Send Members appointment reminders

Process for Creating and Distributing a Member Survey Across Agencies

1. Developed survey for Members
2. Provider leader wrote draft and disseminated to group for review
3. Group responded with edits and revised survey
4. Provider leader shared with consumer group, collected feedback, and used feedback to revise survey
5. Group responded with edits to revise survey and developed a final document
6. Group created a cover letter with directions and developed a plan to distribute surveys
7. Voluntary workgroup providers had one month to distribute survey in their practice and then return to Workgroup

Next Steps

1. Resend survey again with English and Spanish translations
2. Request Member feedback to develop a measure of Member Experience that can be included in surveys
3. Create and disseminate best practice tip sheet from Member feedback
4. Promote tip sheet on *masspartnership.com* website and during RNM site visits

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Facilitating Communication to Improve Access to Care and Reduce Wait Lists

Central Region

Mission Statement

To strengthen communication among providers and support families and individuals seeking substance use disorder (SUD) services

Barriers

Communication between and across the provider network poses a challenge to successful warm hand-offs at time of referral:

- Lack of consistent referral contacts hinders timely referral
- Members and their families do not know where to find information on appropriate treatment options.
- Lack of an accessible resource to identify information on SUD treatment in the Central region, particularly for youth

Target Population and Activities

Target Population: Providers across levels of care (behavioral health and PCC) who are treating youth and adolescent patients with SUD and Members and their families or natural supports

Activities:

- Created a referral contact list document for providers
- Contacted sites to compile contact information and preferred mode of communication for performing hand-offs
- Developed plan for resource dissemination and brainstormed options for regularly updating information
- Discussed resource list with providers in region during provider meetings
- Created two-sided resource document with treatment options and information to be used by families and youth seeking treatment:
  - Shared contact list with the larger work group to obtain feedback
  - Finalized document

Findings/Outcomes

- Added providers to the outpatient access report that MBHP will update monthly and distribute to Members
- Providers have increased access to information on wait lists status for outpatient treatment.

Lessons Learned

Real-time contact information is critical for referral process, but is challenging to maintain due to lack of infrastructure supporting shared resources.

Next Steps

Creating and implementing a sustainability plan to update resources in real-time:

- Use existing resources (i.e., Regional Provider Guide, Care Pathways Decision Tree) to share the contact list and resource guide
- Determine where to post the contacts list for easy access
- Incorporate resource guide and contact list into MBHP's Regional Provider Guide
- Update resources quarterly to account for staff turnover
- Promote resources in provider community

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Identifying and Increasing Effective Use of Substance Use Disorder (SUD) Screening Tools for Youth and Adolescents

Central Region

Mission Statement

To increase use of SUD adolescent screening tools across agencies, levels of care, and provider specialties

Barriers

- Although SUD is commonly linked to other co-occurring behavioral health (BH) disorders, SUD and BH are often treated independently of each other.
- Providers outside of SUD treatment system may not be aware of and/or comfortable using screening tools to detect SUD.
- Primary care providers report insufficient time, limited knowledge, and access to substance use treatment programs as barriers to screening and referring to treatment for youth and adolescents (Harris et al., 2012).

Source: Harris, S. K., Csemy, L., Sherritt, L., Starostova, O., Van Hook, S., Johnson, J., … Knight, J. R. (2012). Computer-facilitated substance use screening and brief advice for teens in primary care: an international trial. Pediatrics, 129(6), 1072–1082.

Target Population and Activities

Target Population: Behavioral health and primary care providers treating youth and adolescent Members

1. Compiled universe of SUD screening tools
2. Identified a diverse set of SUD screening resources that incorporated the key components of an effective screening process:
   a. Screening and Assessing Adolescents for Substance Use Disorders, a SAMHSA manual
   b. Screening, Brief Intervention, Referral to Treatment (SBIRT)
   c. Bureau of Substance Abuse Services (BSAS)
3. Explored using the S2BI Screening Tool developed by the Massachusetts Child Psychiatry Access Program (MCPAP). MCPAP developed a Toolkit with research-informed practices to address SUDs that have been successfully implemented in primary care and might be transferable for behavioral health providers.

Next Steps

1. Developing a training tool for staff on how to screen, treat and refer youth to SUD services
2. Working to increase use of screening tool across agencies, levels of care, and provider specialties
3. Incorporating resources related to treatment following a positive SUD screening. Will explore using Adolescent Community Reinforcement Approach (A-CRA) as behavioral intervention.

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Identifying Opportunities to Enhance Substance Use Disorder (SUD) Treatment by Addressing Unique Needs of Adolescents and Transitional Aged Youth (TAY)

Central Region

Mission Statement

Increase access to SUD treatment by educating providers and community stakeholders on referral pathways for adolescents and TAY

Barriers

- Adolescent and TAY populations do not consider their substance use to be a problem.
- Recently, courts have been making fewer referrals for TAY to mandated treatment compared to previous years so fewer youth are connected to the treatment system to address issues early.
- SUD treatment are designed for adults and often do not meet the needs of adolescents and TAY.
- Providers, Members, and stakeholders might lack education or awareness of available services.

Target Population and Activities

Target Population: Central MA TAY population, families, providers, state agencies, and school systems.

- Identified gaps in adolescent and TAY SUD resources
- Surveyed providers to understand their current knowledge about SUD services for adolescents and TAY
- Identified LOC needs and treatment approaches that work for this population
- Connected with regional resources to involve schools, treatment facilities, Department of Youth Services (DYS), and local district attorney's office in improving referral processes
- Developed a multi-pronged strategy to educate providers and stakeholders on SUD referral pathways

Findings/Outcomes

The Workgroup distributed survey to mental health providers and Community Workers.

- 65% were **not aware of TAY programs and services**.
- 55.36% would be **not be likely to refer youth to SUD services**.
- 71.10% had **never referred youth to SUD services**.
- 46% were **unsure if they worked with a "high-risk" youth who is currently using ETOH and drugs**.
- 87.5% had **never had training in treating TAY for SUD**.
- 94.9% would like more information on programs and training for TAY with SUD.

Lessons Learned

- Most programs that treat adolescent and TAY for SUD follow an adult model.
- 46% of treaters were not sure if they were working with a high-risk SUD TAY Members.

Next Steps

- Developing communication plan to educate provider and stakeholder community using results from survey
- Developing a quarterly newsletter to bring SUD TAY treatment and awareness to providers and committees with updates on programs and success stories from TAY in recovery
- Developing a central resource where Members, families, and providers can access information related to SUD referral pathways and continuously update materials with real-time information
- Educating schools (nurses) to identify youth with SUD and make referrals when appropriate
- Engaging the Recovery High School in the Central region
- Using existing resources to educate. For example, educational materials from "Learn to Cope" can serve as resources for Member's natural and/or family supports.

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Engaging Providers in Process Improvement

Western Region

Mission Statement

1. To develop a partnership with the Massachusetts Department of Public Health (DPH) to collaboratively offer NIATx (Network for the Improvement of Addiction Treatment) training to clinicians
2. To train agencies in using NIATx model of process improvement

Target Population and Activities

Target Population: Outpatient clinic workforce treating co-occurring SUD and BH disorders

- MBHP developed a partnership with the Western Massachusetts DPH to provide NIATx training for up to eight provider organizations.
- Five provider agencies committed to attending training and implementing a NIATx project.

Barriers

- Clinicians lack familiarity and comfort treating co-occurring substance use disorder (SUD) and behavioral health (BH) disorders.
- Current BH graduate school curriculum does not provide adequate training about treating SUD.
- While licensed alcohol and drug counselors (LADCs) are trained in SUD treatment, they are less comfortable treating other co-occurring BH disorders.
- Changing BH graduate school curriculum could improve how SUD treatment is delivered in the long-term opioid crisis.

Next Steps

- The Workgroup's goal is to use NIATx training to develop a Learning Community in the Western region to increase efficiencies in treating and managing co-occurring disorders.
- Initiating NIATx training and projects in five agencies
- Sharing lessons learned from NIATx implementation
- Defining pre- and post-data metrics before initiating NIATx projects helps organizations determine whether to adopt, adapt, or abandon a project.

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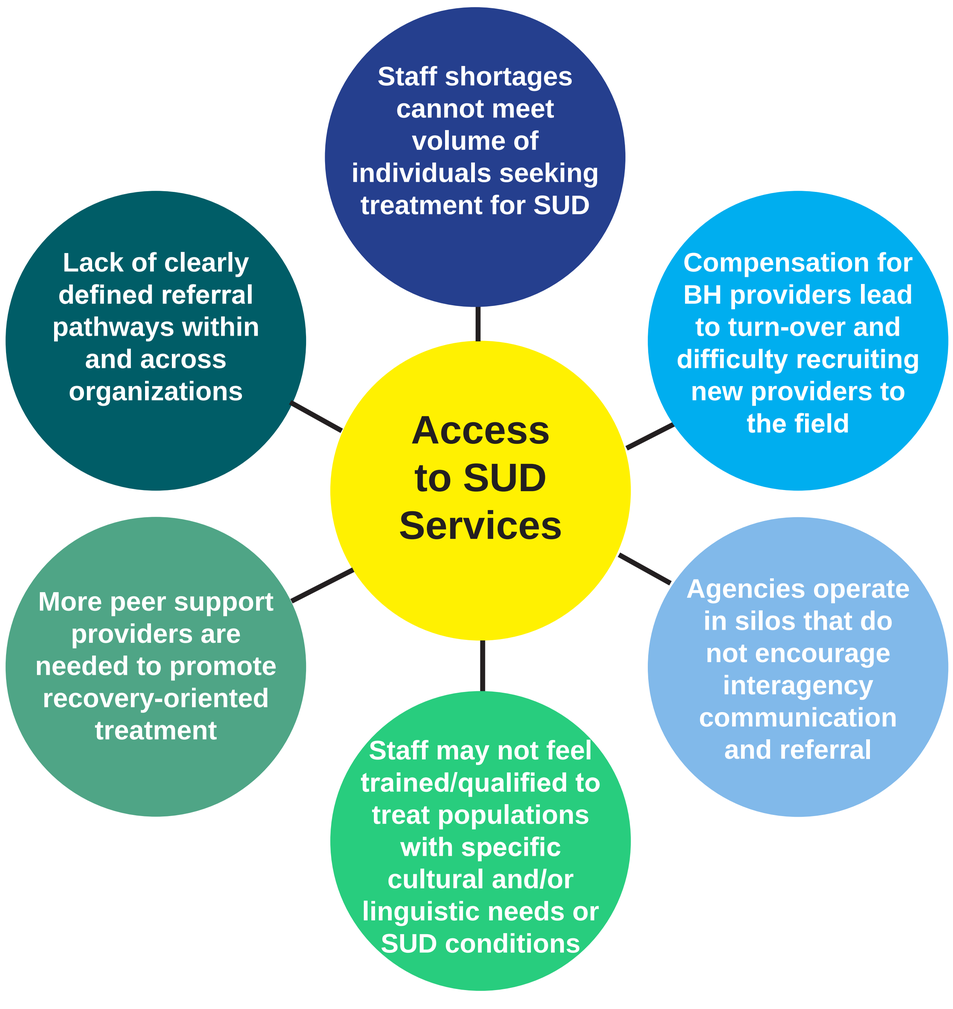
Establishing a Regional Workgroup to Develop Best Practices for Integrated Care

West Region

Mission Statement

1. Increase access to care by focusing on staff recruitment, retention, and training
2. Identify a champion in each agency to lead improvement process for integrated care practices

Barriers



Target Population and Activities

Target Population: Behavioral health, substance use disorder, and primary care providers treating Members with substance use disorders (SUD) and/or co-occurring disorders

- Identified a provider in region who has demonstrated best practices for integrating care by:
  - Implementing SUD screening at all sites
  - Training central intake staff on screening and identifying SUD
  - Identifying a champion to lead integration activities
  - Training behavioral health (BH) staff on SUD programs and access to SUD services
  - Identifying and including SUD diagnoses in claims department
  - Hiring peer and recovery coaches
  - Providing supervision to new/ existing staff treating co-occurring SUD and BH disorders
  - Engaging state agencies, internal resources, and/or community resource to provide staff SUD education
  - Developing career paths for advancement and reimbursement
  - Recruiting, training, and supervising interns in SUD programs
- Workgroups suggested that each agency identify a champion to lead improvement efforts and implement best practice list.

Lessons Learned

Standardized measurement allowed the agency to detect that SUD diagnoses were not consistently being reported. Integrated care requires that SUD history is shared across providers for quality and safety.

Next Steps

- Identifying SUD champions
- Identifying the scope of “SUD champion” role within each organization
- Identifying metrics to evaluate the effectiveness of SUD champion and actions to improve integration

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