Medical Home DIY! Self-Guided Practice Transformation

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Medical Home DIY! Self-Guided Practice Transformation

Description: Many tools and resources have been developed to assist primary care practitioners in leading their own quality improvement efforts.

This session will include a panel of providers and experts who will each describe how they acquired the necessary skills to lead their staff in transforming the practice into a patient-centered medical home (PCMH).
Defining the medical home

The medical home is an **approach** to primary care that is:

- **Patient-Centered**
  Supports patients in managing decisions and care plans.

- **Comprehensive**
  Whole-person care provided by a team.

- **Committed to quality and safety**
  Maximizes use of health IT, decision support and other tools.

- **Coordinated**
  Care is organized across the ‘medical neighborhood’.

- **Accessible**
  Care is delivered with short waiting times, 24/7 access and extended in-person hours.

Source: www.ahrq.gov
National demand for healthcare transformation.
PCMH Population Stratification
Formerly within domain of payer, now within scope of care for PCMH

Targeted Patients with highly complex conditions (Top 1%)

Targeted Patients with unstable chronic conditions, barriers to behavioral change and or multiple co-morbidities

Targeted Patients with uncomplicated chronic conditions and preventative care needs

Medical Home contract established with population of focus

Acute Care Only

Usual Care: Diagnosis & Treatment Services

Informed Self Service: Education and Self Service Instructions

Supported Self Management: Proactive Outreach & Monitoring Services

Care Coordination: Patient/Family Coaching & Care Coordination

Case Management

0% Distribution of Services across the Population

Extended Care Team Focus

Practice Focus

Scope, Intensity & Cost of Services
Population Management
A new practice skill set

Program Management
- Identify and Stratify Target Patients
- Measure Program Results

Remote Patient Management
- Establish Goals & Treatment Plan
- Enrollee Health Management Services
- Create Care Action Plan
- Coordinate Care Team Activities
- Monitor Patient Outcomes, Outreach and provide transition management
Fully engaging our patients
How much should we expect from the consumer?

Discover
- Bio-Psycho-Social History
  - Goals, Wants, Needs

Activate
- Insurance Exchange
  - Primary Care Medical
  - Home
  - Patient Contract

Coordinate
- Identify and link resources:
  - Referrals
  - Transportation, Nutrition
  - Patient Peer Groups

Educate
- Primary and Secondary Prevention
- Self Monitoring
- Action Plans
- Urgent Care Guidelines
- Communication (Patient Portal)

Evaluate
- Assist with reporting outcomes to PCP

Monitor
- Functional Status
- Physical
- Social
- Cognitive
- Compliance
- Comorbidity

Patient Compliance
- Disease Self Mastery
- Learning Barriers
A patient’s perspective

• **Me:** 58 y/o male
• 5 physicians
• **3 chronic conditions** (diabetes, Hepatitis C, RSD)
• Comorbidity’s: Retinopathy, autonomic neuropathy
• Behavioral Health: PTSD, Chronic Depression
• Onset dates: Diabetes age 10, Hepatitis age 24, RSD age 55, retinopathy age 49, neuropathy age 55, PTSD age 33, chronic depression age 33.
• Meds = 7
• **Technology** includes CAGM
• **Functional status:** Retired SSDI due to RSD and autonomic neuropathy. Able to work at desk for periods up to 3 hours, able to drive for up to 3 hours
• **Social Status:** Married 20 years, no children.
• Education: BS Economics, AS Respiratory Therapy; RCVT, RPFT
• Former occupation: Director of High Risk Case Management; Director of Clinical Informatics Director of Cardio-Pulmonary Rehabilitation
• Recent Losses: Occupation and Avocational activity (Private Pilot)
• **Goals:** Control CD process and part time work in field of passion
Sorting, distributing, analyzing, paying, communicating, why the heck won’t my records synchronize?
2 hours later, 3 Starbucks, one fruit smoothie, 8 units of Apidra
How much more can we take!
PCMH at ❤ of “Medical Neighborhood”

- Community Centers
- Public Health
- Employers
- Schools
- Faith-Based Organizations
- Home Health
- Hospital
- Pharmacy
- Oral Health
- Mental Health
- Specialty & Subspecialty
- Skilled Nursing Facility

Health IT flows between these entities.
Without data interchange we are “dead in the water”
NCHICA Proposes Architecture
A long way from vision to reality
"Go to the people, live with them, learn from them....
Start with what they know, build with what they have...."

Lao Tzu

After ten years work with 3000 pulmonary and cardiac disease patients I learned some very simple lessons:

• We are an interdisciplinary workforce, our patients count on our ability and desire to share our treatment plans and assessments

• We may have individual treatment plans by sub-specialty or episode of care but we all share in the development of a “Life-Plan” engaging patients and families in their own self-defined “Plan of Care”

• Self mastery starts with understanding how the system works, who the cast of actors are and everyone's responsibility.
My PHR

Your personalized guide to health decisions

Organize your health information all in one place to get practical, personalized guidance that stays up to date as your needs change. Learn more

- Everything in one organized place
- Expert advice for your changing needs
- Better communication with your providers

Sign up. It's free!
Mayo Clinic Health Manager uses Windows Live ID to sign in to HealthVault.
(If you use Hotmail, Messenger, or Xbox LIVE, you have a Windows Live ID.)

Don't have a Windows Live ID?

Create new account

Or sign in with:

Facebook

OpenID

Windows Live ID:

jeffharris@untangledhealthcare.com

Password:

*********

Can't access your account?

Keep me signed in

Sign in

Not your computer?
Get a single use code to sign in with
How I connected my system

• Located physician with knowledge of health data interchange and motivation to heal
• Located surgeons who would treat me as equal
• Located tools online that worked and were interoperable
• Created my own accounts {HealthVault, Connected to

• Connected to CVS, SPINN secure Communication and LabCorp
Mayo Clinic Health Manager uses Windows Live ID to sign in to HealthVault.

(If you use Hotmail, Messenger, or Xbox LIVE, you have a Windows Live ID.)

Don't have a Windows Live ID?

Create new account

Or sign in with:

Facebook

OpenID

Windows Live ID:
jeffharris@untangledhealthcare.com

Password:

Keep me signed in

Can't access your account?

Not your computer?
Get a single use code to sign in with
My Family

Mayo Clinic Health Manager helps you organize, manage and understand your family’s health, and offers personalized guidance to help you make the right decisions at the right time.

Get a quick update on each family member here. For details, just click a person’s name.

**Add a family member**

**Alex Brother**
- Next appointment: None upcoming
- Action items:
  - Answer Starter Questions for more personalized action items
- Other recommendations
- View all

**Carol**
- Next appointment: None upcoming
- Action items:
  - Answer Starter Questions for more personalized action items
- Other recommendations
- View all

**Jeffrey**
- Next appointment: None upcoming
- Action items:
  - No action items
- Other recommendations
- View all

Mayo Clinic Health Manager uses Microsoft HealthVault to store your data [Learn more.]

Tell others about Mayo Clinic Health Manager
Decision Support
Details of record source

Change condition or symptom for Jeffrey

Condition name *
Diabetes mellitus

Status
Current: Currently has this

Date of onset (MM/dd/yyyy)  Date resolved (MM/dd/yyyy)
7/1/1998

Note
Insulin Pump since 1984

Show additional details

Save  Cancel
Medication Reconciliation

Who ordered drug?

Where did record come from?

Is this patient staying with medical home or Dr. Shopping?
Providers & Contacts

Who provides health care for Jeffrey? Keep track of health care providers, insurance plans, pharmacies and emergency contacts for Jeffrey.

Health Care Providers

Dr. Esther e Seo
7021 Harps Mill Road,
Suite 100
Raleigh NC 27603
United States

919-845-2125 (primary)

Note: Practice manager: Deborah Stark
Type of location: Duke Primary Care

Insurance Plans

FED Emp BC, Medical
Subscriber name: Carol Lolley-Harris
Subscriber ID: 59927051
Group number: 112
Expiration date: 1/17/2012

Pharmacies

There are currently no pharmacies on file for Jeffrey.

Emergency Contacts

Add a health care provider
Add an insurance plan
Add a pharmacy
Add an emergency contact
# Monitoring

Tools help you track progress toward your goals and get personalized health guidance. With some tools, you have the option to enter data electronically from HealthVault-connected monitoring devices. Learn more.

<table>
<thead>
<tr>
<th>Tool</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure Tracker</td>
<td>128/82, 3 months ago</td>
</tr>
<tr>
<td>BMI Calculator</td>
<td>Last used: 2 months ago</td>
</tr>
<tr>
<td>Cholesterol Tracker</td>
<td>LDL 100, HDL 40, Tri 100, Total 180, 4 months ago</td>
</tr>
<tr>
<td>Depression Risk Assessment</td>
<td>Last used: 2 months ago</td>
</tr>
<tr>
<td>Heart Disease Risk Calculator</td>
<td>10 %, Last used: 2 months ago</td>
</tr>
<tr>
<td>Height Tracker</td>
<td>6 feet 1 inches, 2 months ago</td>
</tr>
<tr>
<td>Hemoglobin A1C Tracker</td>
<td>7%, 2 days ago</td>
</tr>
<tr>
<td>Stress Tracker</td>
<td>High, 2 months ago</td>
</tr>
<tr>
<td>Weight Tracker</td>
<td>194 pounds 0 ounces, 2 months ago</td>
</tr>
</tbody>
</table>
Educating patients to select resources from published information.
Using process measures to make decisions when choosing providers

The rates displayed in this graph are from data reported for discharges January 2010 through December 2010.

*Top Hospitals 100%*

Surgery patients whose urinary catheters were removed on the first or second day after surgery.

- Average for all Reporting Hospitals in The United States: 91%
- Average for all Reporting Hospitals in North Carolina: 92%
- BETSY JOHNSON REGIONAL HOSPITAL: 84%
- JOHNSTON MEMORIAL HOSPITAL: 82%
- REX HOSPITAL: 92%

Top Hospitals represents the top 10% of hospitals nationwide. Top hospitals achieved a 100% rate or better.
Why Wouldn’t Patients Recommend

Bars below tell the percent of patients who reported YES, they would definitely recommend the hospital.

Would patients recommend the hospital to friends and family?

- Average for all Reporting Hospitals in The United States: 70%
- Average for all Reporting Hospitals in North Carolina: 71%
- BETSY JOHNSON REGIONAL HOSPITAL: 54%
- JOHNSTON MEMORIAL HOSPITAL: 62%
- REX HOSPITAL: 82%
If patients are readmitted is that the hospital issue or does it say something about the supporting community?

### Rate of Readmission for Heart Failure Patients

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Rate</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Betsy Johnson Regional Hospital</td>
<td>26.5</td>
<td>No Different than U.S. National Rate</td>
</tr>
<tr>
<td>Duke University Hospital</td>
<td>24.6</td>
<td>No Different than U.S. National Rate</td>
</tr>
<tr>
<td>Johnston Memorial Hospital</td>
<td>23.0</td>
<td>No Different than U.S. National Rate</td>
</tr>
</tbody>
</table>

U.S. National 30-Day Rate of Readmission for Heart Failure Patients = 24.9%

Number of Medicare Patients Admitted for Heart Failure:
- Betsy Johnson Regional Hospital: Based on 339 patients
- Duke University Hospital: Based on 927 patients
- Johnston Memorial Hospital: Based on 388 patients
Would you go somewhere with no reported data?

The rates displayed in this graph are from data reported for discharges January 2010 through December 21.

Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery.

- Average for all Reporting Hospitals in The United States: 94%
- Average for all Reporting Hospitals in North Carolina: 96%
- KERSHAW HEALTH: Not Available - No data is available from the hospital for this measure
- SAMPSON REGIONAL MEDICAL CENTER: Not Available - No data is available from the hospital for this measure
- WAKEMED, CARY HOSPITAL: Not Available - No data is available from the hospital for this measure

Top Hospitals represents the top 10% of hospitals nationwide. Top hospitals achieved a 99% rate or better.
Teaching patients and families to evaluate integration based on hospital readmission rates.
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Guiding Principles
- Patient-Centered
- Data Driven Decision Making
- Standardization
- Practice at Highest Level of Clinical License

**Sentara Medical Group**

**Care Model**

**Aim**
Improve the health of our patients
Deliver clinical and service excellence
that is cost effective and promotes an
optimal experience for all.

**Patient-Centered Medical Homes**
*Primary Care Teams*

- Standardization of patient experience
- Same Day Appointments
- 7 day hospital follow up
- EMR
- Patient EMR Portal
- Evidenced based guidelines
- Best practice alerts

**Care Management**
*RN/Social Worker/Pharm D*

- Hospital follow up
- Transitional contact after facility care
- Disease Management
- High Risk population management
- Managing psychosocial barriers
- Behavioral Health Integration
- Utilization analysis
- Coding optimization

**Integration between PCP, Specialty and Community Partners**
*Specialists/PCPs/Hospitalists/CSB/Community Health Centers*

- Clinically Integrated Network with community providers
- Hospitalists and PCP communication
- Specialist and PCP care agreements
- Health Plan collaborations

**Population Management**
*RN/LPN/MA/Secretaries*

- Preventive Care Telephonic Outreach
- Preventive Care and Screening Registries
- Health Maintenance review
- Chronic Disease Registries
- At Risk and Full Risk Patient populations with Payers

Supporting programs: Leadership and Professional Development, Safety and Regulatory, Quality Committee, IT and Analytics, Health System
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DIY Medical Home Transformation

SUZANNE BERMAN, MD, FAAP
Transformation takes time

No consultant can come in and do an "instant makeover" to PCMH-ify your practice.
Assemble your team

Team Leads:

- **Project manager (lead):** to assign, track, and check pieces for completion. Needs to 1) be OCD and 2) have nag power.

- **Provider (lead)** – to write/approve the clinical decision-making pieces, to provide input for clinical protocols, and to champion provider workflow changes.

- **Administrator (lead)** – to write/approve policies and procedures (clinical and nonclinical) and to champion front desk, clinical staff, and back office workflow changes.
Assemble your team

Team Supports:

- **Nonclinical and clinical staff (support)** – to provide feedback on current practices and proposed changes.

- **Patient/parent representatives (support)** – to provide feedback on current practices and proposed changes.

- **Computer geek (support)** – to prepare and analyze data for reporting. Needs familiarity with Excel, screen captures, PDF creation, etc.

- **Wordsmith (support)** – to proofread others’ materials; to draft protocols and/or find good ones to borrow on the Internet.
Assemble your tools

- **Web-based project management tool**
  - Dividing projects up into smaller tasks
  - Assigning people to tasks
  - Letting team members provide status reports
  - Collaborative document writing
  - Scheduling meetings and deadlines
  - Sending reminders

- **Spreadsheet software**

- **Screen capture and screen capture editor** – essential for documentation of computer-based workflow
Non-administrators MUST have protected time to work on transformation.

Even if they have some “interstitial downtime,” most staff have difficulty working on transformation in 5- and 10-minute pieces.

If you want transformation to be a priority, schedule (paid) blocks of time for each staff member to work on their pieces.

To prevent “playing” during protected time, use very short deadlines with frequent small deliverables; make it an active meeting/discussion with the transformation leader, rather than a self-paced activity.
Getting started is the hardest part

PICKING THE FIRST PROCESS TO IMPROVE CAN BE OVERWHELMING!
Your first change: choose something with $$$ benefit

- **Huddles**: reduce overtime
- **Better lab, x-ray, and referral tracking**: reduce overtime
- **Recall**: more remunerative schedule saturation
- **Same day appointments**: fewer no-shows
- **Team engagement**: better employee morale and lower turnover
Your second change: what bugs you?

- Find a common annoyance in your practice that **all** staff can rally around
  - Taming the telephone or fax?
  - Message tracking?
  - Patient wait times?
- Avoid “picking on” one department
Other longer-term or more expensive transformations: do later

- Extending evening/weekend hours
- Hiring, training, and implementing a care coordinator
- Formal comanagement agreements
- Hospital and ER tracking/coordination
- Empanelment matching
- Culturally and linguistically appropriate teaching
Medical Home DIY!
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Integrating Behavioral Health with PCMH Practices: An overview of Why, What, How

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University of Minnesota Medical School
cjpeek@umn.edu

Patient Centered Primary Care Collaborative (PCPCC)
Panel: Medical Home DIY--Self-Guided Practice Transformation
November 13, 2014 Washington, DC
Why should BH be part of the PCMH?
PCPCC slide decks
http://www.pcpcc.org/resource/behavioral-health-integration-pcmh

<table>
<thead>
<tr>
<th>PCPCC slide contents</th>
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<tbody>
<tr>
<td>Prevalence and burden</td>
</tr>
<tr>
<td>Unmet needs</td>
</tr>
<tr>
<td>Cost</td>
</tr>
<tr>
<td>Outcomes</td>
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<tr>
<td>Experience</td>
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</tbody>
</table>
A legacy of separate and parallel systems

Medical Care  
Mental Health Care

A forced choice between:
• 2 kinds of problems
• 2 kinds of clinicians
• 2 kinds of clinics
• 2 kinds of treatments
• 2 kinds of insurance

Integrated behavioral health leads to a better match of clinical services to the realities that patients and their clinicians face daily.

Original Source: CJ Peek 1996
What is integrated BH?
AHRQ Lexicon functional definition

“What”: (An ordinary two-sentence definition)

“How” functions:
1. A practice team tailored to the needs of each patient and situation (3 sub-clauses)
2. With a shared population and mission
3. Using a systematic clinical approach (6 sub-clauses)

“Supported by” functions:
4. Supported by 1) reliable office processes, 2) leadership alignment, and 3) sustainable business model
5. Ongoing QI and measurement of effectiveness (2 sub-clauses)
6. With a community or population expecting that BH and PC will be appropriately integrated as a standard of care
Illustration: A family tree of related terms used in behavioral health and primary care integration
See glossary for details and additional definitions

Integrated Care
Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Connotes organizational integration involving social & other services. “Altitudes” of integration: 1) Integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

Patient-Centered Care
“The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one’s person, circumstances, and relationships in health care”—or “nothing about me without me” (Berwick, 2011).

Coordinated Care
The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care” (AHRQ, 2007).

Shared Care
Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining 1 treatment plan addressing all patient health needs. (Kate et al, 1996; Kelly et al, 2011)

Collaborative Care
A general term for ongoing working relationships between clinicians, rather than a specific product or service (Dozerty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unützer et al, 2002)

Co-located Care
BH and PC providers (i.e. physicians, NP’s) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

Integrated Primary Care or Primary Care Behavioral Health
Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—"no wrong door" (Blount). BH professional used as a consultant to PC colleagues (Sabin & Bonis, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

Behavorial Health Care
An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

Patient-Centered Medical Home
An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient’s family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007).

Mental Health Care
Care to help people with mental illnesses (or at risk)—to suffer less emotional pain and disable—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

Substance Abuse Care
Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

Primary Care
Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Thanks to Benjamin Miller and Jürgen Unützer for advice on organizing this illustration.
Scope of Integrated BH

Condition-Centered and Person-Centered

Integrated care for MH conditions
- Depress / anxiety
- Substance abuse
- ADHD
- Other

Integrated care for Medical conditions
- Diabetes / BP / obesity
- Heart disease
- Childhood chronic illness
- Stress-linked phys sx

Integrated care for Persons: Social and care complexity
- Distress, distraction & readiness to engage in care
- Social safety, support & participation
- Understanding own health situation / health literacy
- Health behavior change
- Organization of care / relationships in health system

CJ Peek & Mac Baird, 2010; PCPCC 2014
Questions to ask early on with your consultant “hat” on

Who is your population—who do you serve? What are the BH aspect of their needs? How well are those needs met?

One way to get at that:
   “Who feels what kind of pain when it comes to the BH aspect of doing your job in your PCMH?”

What initial target for BH integration to start with?
Significant to the practice; can actually get it going

What financial arrangement at first? What payment or business models will you use to stay in business at first?

See this panel’s Berman and Carver presentations!
Only a **sample** of resources for action

**AHRQ Integration Academy**
integrationacademy.ahrq.gov

- Lit repository; lexicon (definitions); Atlas of integration measures; soon on-line community, “playbook”

**Center for Integrated Health Solutions (CIHS)**
www.integration.samhsa.gov

- Frameworks and models; guides and articles on financing, workforce, clinical, administrative

**AIMS Center—Advancing Innovative MH Solutions; U of Washington;**
aims.uw.edu

- Implementation guides, resource library, research; pieces on teams, roles, workflows, financing, examples

**PCPCC Behavioral Healh SIG**
pcpcc.org/resource/behavioral-health-integration-pcmh

- Slide decks; monthly phone calls or presentations on topics suggested by members

**Center for Integrated Primary Care.**
www.umassmed.edu/cipc/

- Training, literature, websites, reports, videos,

**Collaborative Family Healthcare Association:**
www.cfha.net

- Membership organization, journal, conferences, webinars, listserv, blog
References

- AHRQ Academy for Integrating Behavioral Health and Primary Care: integrationacademy.ahrq.gov/
- AIMS Center (Advancing Innovative Mental Health Solutions), Univ of WA. aims.uw.edu
- Center for Integrated Primary Care: http://www.umassmed.edu/cipc/
- Collaborative Family Healthcare Association: www.cfha.net
- Peek & National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration. AHRQ 2013: integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf
- National Alliance on Mental Illness. Integrating Mental Health & Pediatric Primary Care Resource Center: http://www.nami.org
- SAMHSA/HRSA Center for Integrated Health Solutions: http://www.integration.samhsa.gov
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