

**Topic 1:  
Managing Care for Super  
Utilizers**

# Ellenville Regional Hospital & The Institute of Family Health Westchester Medical Center PPS

## Our Cohort

(Data reflects May '15 – Oct. '15)

Initial cohort was defined as patients with 5+ ED visits for chronic pain



## Our Actions

### Patient Identification

- Implemented a **Super Utilizer EMR flag** and created a **provider alert** process

### Planning

- Created a **Chronic Pain Policy** to decrease opioid medication use in the ED
- Created the **'Drivers of Utilization'** form to determine the underlying cause of visit

### Management

- Connected patients to the Institute for Family Health **Care Navigator** for **post-discharge telephonic outreach**

### Follow-Up

- Implemented an Institute for Family Health **integrated workflow for warm hand offs/referrals**
- Created a **pain contract** between the primary care provider and patient

### Lessons Learned

- Establishing **standardized practice guidelines** through the Chronic Pain Policy and gaining the support of Medical Staff and community providers were pivotal in sustaining and continuing the work of the Action Team
- Utilizing **non-medical staff** (hospital case management and Social Workers) is crucial for outreach and building patient relationships

### Patient Story

- 68 year old female lacked family support and transportation
- During the 6 months prior to program start, she had 37 ED visits; intervention occurred on 3/16/16, and she has had 6 ED visits in the 6 months post-intervention
- Patient was engaged by care team who identified mental health, housing, transportation and food service needs
- Care team facilitated Health Home enrollment and connected patient with mental health and primary care, transportation, respite stay, and local food pantry services

## Our Impact

### Patient Engagement

(Nov. '15 – Apr. '16)

24	Cohort patients came to the hospital since Care Navigator placed in ED
16	Patients have been engaged by the Care Navigator
12	Patients connected to services

### Hospital Utilization

	Before (May. '15-Oct. '15)	After (Nov. '15-Jul. '16)	%Δ Rate (/month)
ED Visits	69.7 /month	38 /month	-45.5%
Opioid Orders	63.6 /month	19.2 /month	-69.8%
Opioid Administered to General Population	167 /month	96 /month	-42.5%

self reported data up to July 31, 2016

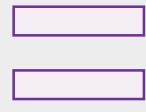
# Interfaith Medical Center Community Care of Brooklyn

## Our Cohort

(Data reflects Nov. '14 – Oct. '15)

Initial cohort defined as patients with 3+ psychiatric admissions in a 9-month period who the Action Team felt could be engaged

  
50 Patients



  
291 ED Visits

  
316 IP Admissions

## Our Actions

### Patient Identification

- Created a **Super Utilizer EMR flag** upon registration
- Implemented a **real time patient tracker** to locate the patient

### Planning

- Catholic Charities Outreach Specialist initiated a **care plan for Health Home connection**
- Hospital Care Manager helped **engage patients**

### Management

- Utilized the Catholic Charities **engagement model** to develop outreach work targeting clients post-discharge for engagement

### Follow-Up

- Catholic Charities made client calls and home visits using client medical information to increase the likelihood of care coordination enrollment

## Lessons Learned

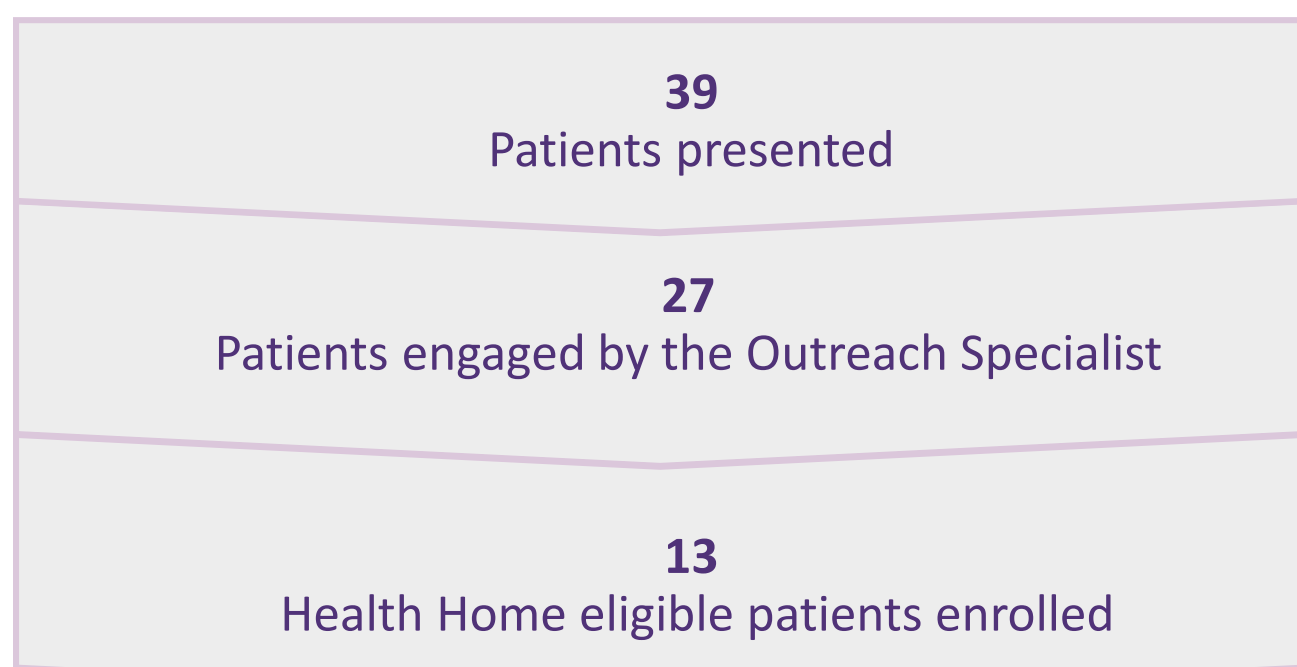
- Early, frequent, intensive, and repetitive engagement and education** are important for mitigating social barriers necessary to prevent hospital utilization
- Longitudinal tracking of patients** is essential for reviewing the effectiveness of interventions
- Strong leadership and interagency cooperation can help remove barriers and prevent duplication of efforts** – clinical and administrative leadership was necessary to support effective engagement of this population

## Patient Story



- 52 year old homeless male with behavioral health and substance abuse issues
- Intervention occurred Jan. '16; patient was engaged in the hospital and by Feb. '16 the care team began process for shelter assessment
- Patient was readmitted to another network hospital, but Care Manager connected to the client ensured continuity of care

## Our Impact

### Patient Engagement (Nov. '15 – Apr. '16)



### Hospital Utilization

	Before (May. '15- Oct. '15)	After (Nov. '15-Jul. '16)	%Δ Rate (/month)
 ED Visits	49.0 /month	19.8 /month	-59.6%
 IP Admissions	22 /month	25 /month	+13.6%

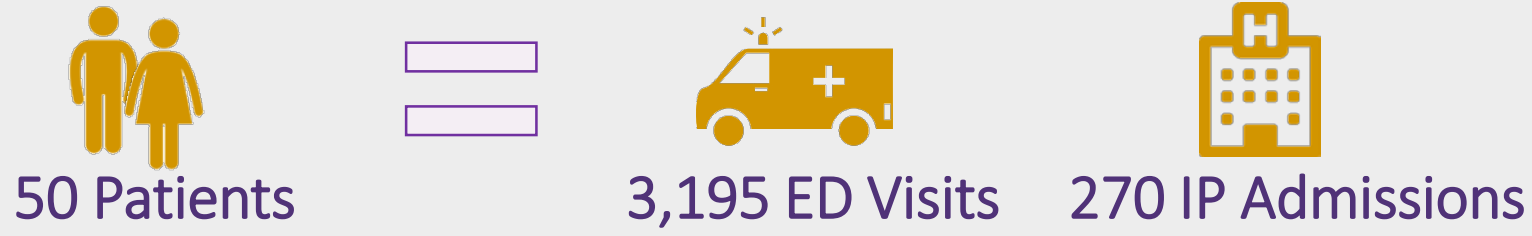
self reported data up to July 31, 2016

# St. Barnabas Health System Bronx Partners for Health Communities


## Our Cohort

(Data reflects May '15 – Oct. '15)

Initial cohort defined as the top 50 ED treat and release patients




## Our Actions




### Patient Identification

- Created a **Super Utilizer EMR flag** upon registration
- ED Registrars and Security Guards** notified Health Home Care Managers when a patient was avoiding registration




### Planning

- Performed a **patient assessment** in the ED or Bronx Works Living Room to determine **drivers of utilization**
- Implemented nightly, **direct transportation** from the ED to the Living Room




### Management

- Utilized Bronx Works partnership to determine and **track housing status**
- Used a **cross-team approach** to connect patients to services



### Follow- Up

- Offered **Case Management services** to patients



### Lessons Learned

- Real-time identification and intervention do not require technology** - Security staff were enthusiastic to help identify patients and connect them to the Homeless Outreach Team
- There is value in geographic proximity of services;** having a social service setting located close to the ED facilitates redirection of patients to settings better suited for case management



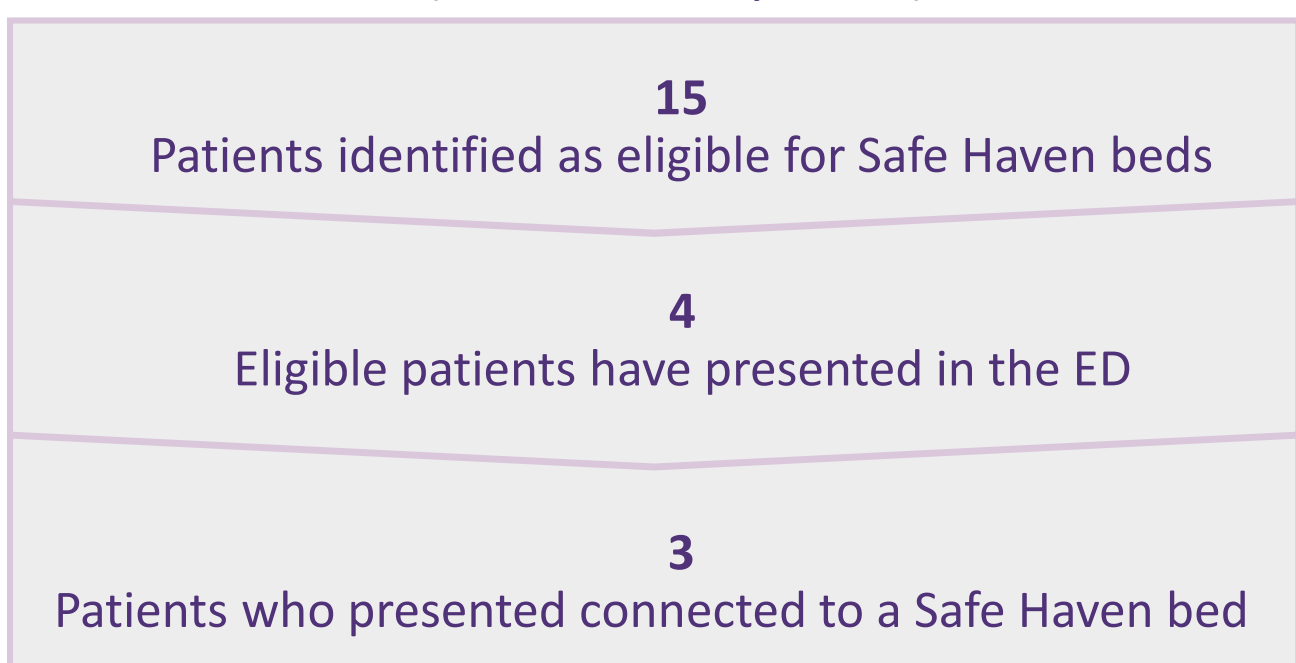
### Patient Story

- 21-year-old male with mental illness and metabolic disorder. Homeless for approximately 2-3 years since his aunt (with whom he was living in Yonkers) died. He reports that he has been riding the trains and that he comes into St. Barnabas frequently because he does not have anywhere else to stay. Previously he was living at a group home.
- From Jan '15 - Oct '15, he had 82 ED visits. Intervention occurred Nov. '15, and he has had 7 ED visits in the 9 months post-intervention
- Patient was engaged by Homeless Outreach Team, and transported to the Living Room
- Care team secured a Safe Haven bed, assigned a care manager, and HRA/housing application was initiated; SSI benefits – assistance provided to reinstate and patient was connected with appropriate behavioral health provider(s).

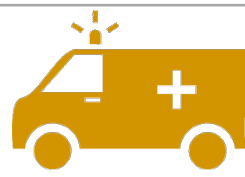
## Our Impact

### Patient Engagement

(Nov. '15 – Apr. '16)



### Hospital Utilization

	Before (May. '15-Oct. '15)	After (Nov. '15-Jul. '16)	%Δ Rate (/month)
 ED Visits	265.3 /month	165.5 /month	-37.6%

self reported data up to July 31, 2016

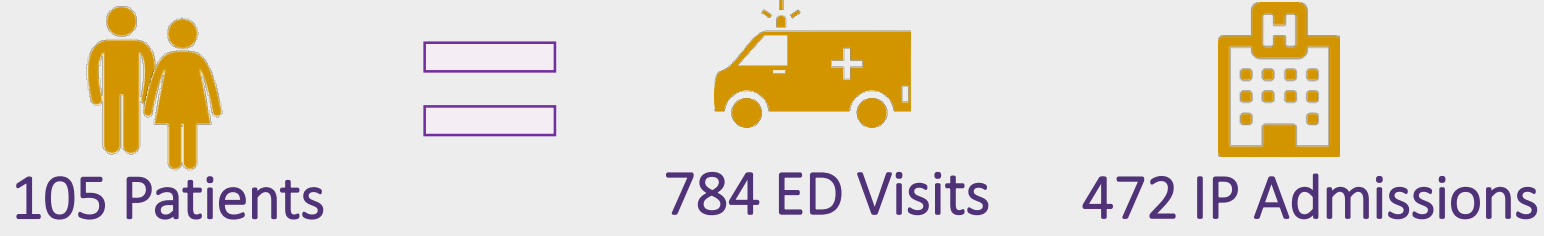


# Richmond University Medical Center Staten Island PPS

## Our Cohort

(Data reflects Jul. '15 – Jun. '16)

Initial cohort defined as patients with 6+ ED Visits or 3+ IP Admissions in a 2-year period with comorbidities of diabetes and behavioral health



## Our Actions

### Patient Identification

- Created a **Super Utilizer EMR flag** upon registration and an email notification **alert process**

### Planning

- Created an ED **Social Worker script** to engage the patient and initiate the **care plan**

### Management

- Connected patients to **CHASI (health home)**
- Evaluation and referral staff assisted service **connection, follow up, and off-hour communication**

### Follow- Up

- Transitioned patients to appropriate **community-based resources**

### Lessons Learned

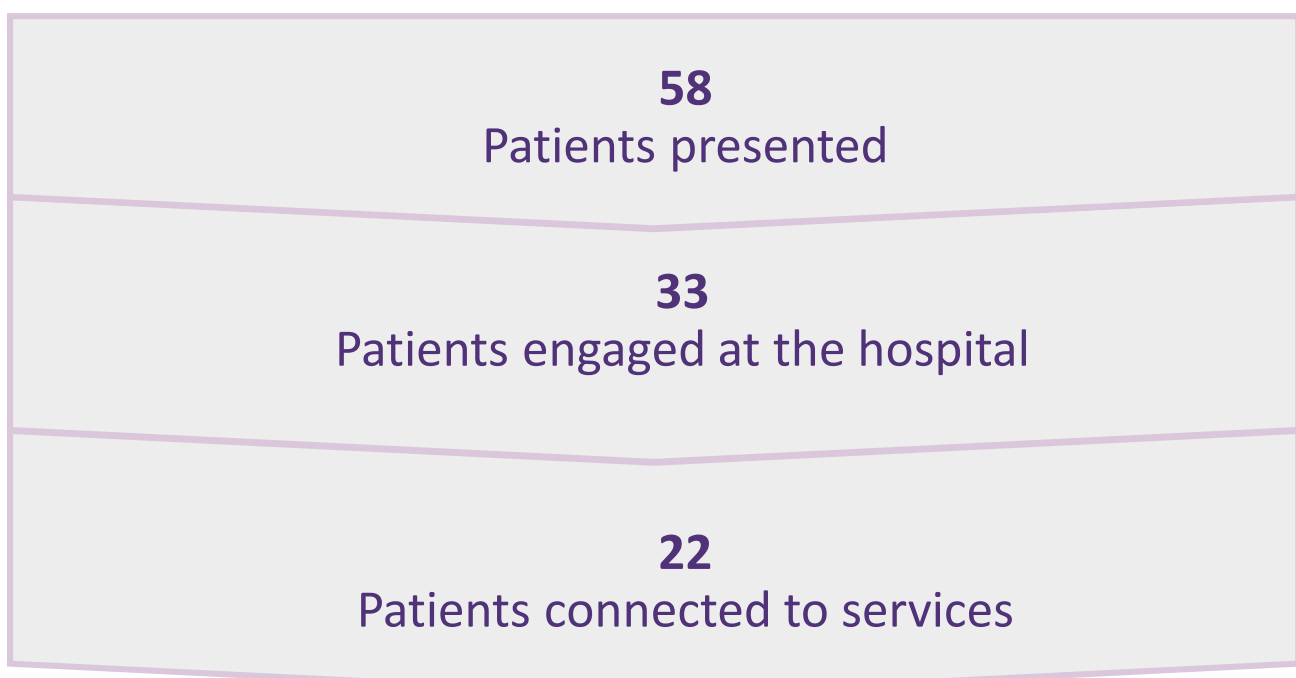
- Data Analyst was essential** for collecting and analyzing the data necessary to refine the Action Team's approach throughout the program
- Meetings between interdisciplinary providers and community organizations are important** for aligning goals/actions and often times lead to unexpected insights

### Patient Story

- 55 year old female with mental health issues
- During 6 months prior to intervention, she had 21 ED visits; 5 months post MAX intervention, she has had 3 ED visits
- Patient was engaged by the ED Social Worker who determined drivers of utilization and helped connect the patient with a visiting nurse and CHASI Strong Steps Domestic Violence Program

## Our Impact

### Patient Engagement (Nov. '15 – Apr. '16)



### Hospital Utilization

	Before (May. '15- Oct. '15)	After (Nov. '15-Jul. '16)	%Δ Rate (/month)
ED Visits	32.3 /month	27.7 /month	-14.2%
IP Admissions	19.8 /month	11.1 /month	-44.0%

self reported data up to July 31, 2016


# Staten Island University Hospital

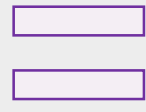
## Staten Island PPS

### Our Cohort

(Data reflects Apr. '15 – Mar. '16)

Initial cohort defined as patients with HIV/AIDS and 2+ IP Admissions in a 6-month period

  
99 Patients



  
273 ED Visits

  
131 IP Admissions

### Our Actions

#### Patient Identification

- Generated a **daily Super Utilizer report** and updated the patient registry with the patients who presented

#### Planning

- HIV Clinic performed **ED patient outreach**
- Developed **Social Worker Checklist** to uncover drivers of utilization
- Created a **Vision Board** to educate patients on appropriate use of the ED

#### Management

- Hospital Social Workers connected patients to **community services**
- Provided **personalized care management** through the HIV Clinic and CHASI (health home)

#### Follow-Up

- Patients continue to be **managed by Care Managers** at the HIV clinic, or community agency
- SW is working with subspecialty clinics to **decrease barriers to appointments**

#### Lessons Learned

- Data analysis is important in highlighting gaps in care** and can be used to inform resource decisions
- Understanding the patients' drivers of utilization** is critical in developing programs and initiatives that meet patient needs
- There is high value in infrastructure development**, ex. the Action Team established channels that facilitated communication between the hospital and outpatient settings to increase program impact
- Super Utilizers experience barriers to specialty care**; through the support of leadership, the Action Team developed an action plan to create awareness and collaborate on expedited appointment policies with subspecialty clinics

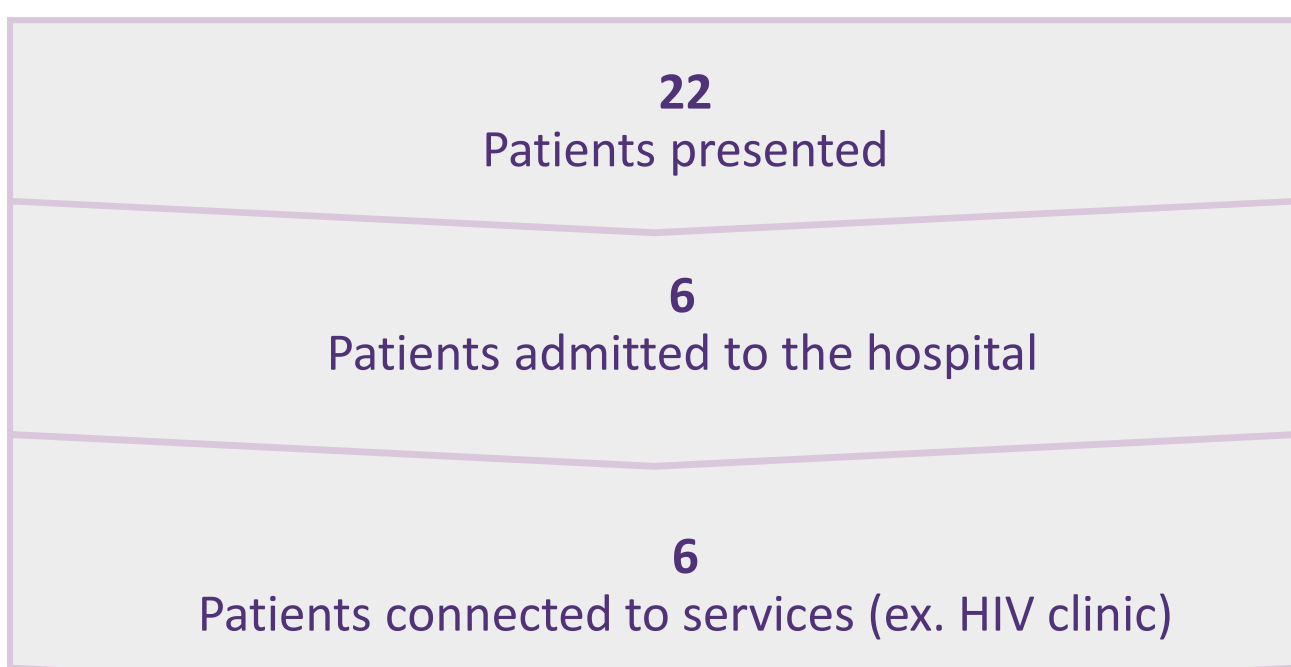
#### Patient Story

- 41 year old male with history of non-compliance
- During the 5 months prior to intervention, he had 9 ED visits and 1 IP admission, intervention occurred 4/14/16, and he has had 8 clinically related ED visits and 3 IP admissions in the 5 months post-intervention
- Patient was engaged by the ED Social Worker who educated the patient on a community care coordination agency
- A warm-handoff was made to the Health Home and patient is compliant at home
- Team continues to decrease barriers to timely specialty appointments through the next Action Plan "Breaking Down Barriers to Specialty Care"


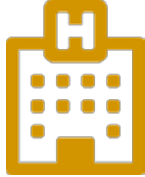
### Our Impact

#### Patient Engagement

(Jan. '16 – Apr. '16)



#### Hospital Utilization

	Before (Oct. '15- Mar. '15)	After (Jan. '15-Jul. '16)	%Δ Rate (/month)
 ED Visits	45.5 /month	13.3 /month	-70.8%
 IP Admissions	21.8 /month	4 /month	-86.7%

self reported data up to July 31, 2016

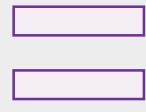
# Brookhaven Memorial Hospital Medical Center Suffolk Care Collaborative

## Our Cohort

(Data reflects May. '15 – Oct. '15)

Initial cohort defined as patients with  $\geq 3$  ED Visits and/or  $>1$  IP admission in a 6-month period with a primary or secondary diagnosis of COPD

  
61 Patients



  
394 ED Visits

  
93 IP Admissions

## Our Actions

### Early Initiatives

- Patient identification via **Super Utilizer EMR flag** and email notification process
- Staff Education
- Opened a COPD unit
- Started Pulmonary Rehab
- Better Breathers Club

### Planning

- Created a **Social Worker checklist needs assessment** to uncover 'Drivers of Utilization'
- Developed a **resource toolkit** to assist providers with risk mitigation activities

### Management

- Social Worker performed **home assessments and telephonic outreach, and coordinated community resources**
- Established **interdisciplinary meetings** between care team and patient
- Health Home Enrollment

### Follow up/ Ongoing Initiatives

- Developed **graduation criteria** for patients no longer needing high touch care
- **Transitioned care management services** from Social Worker to Health Home

### Lessons Learned

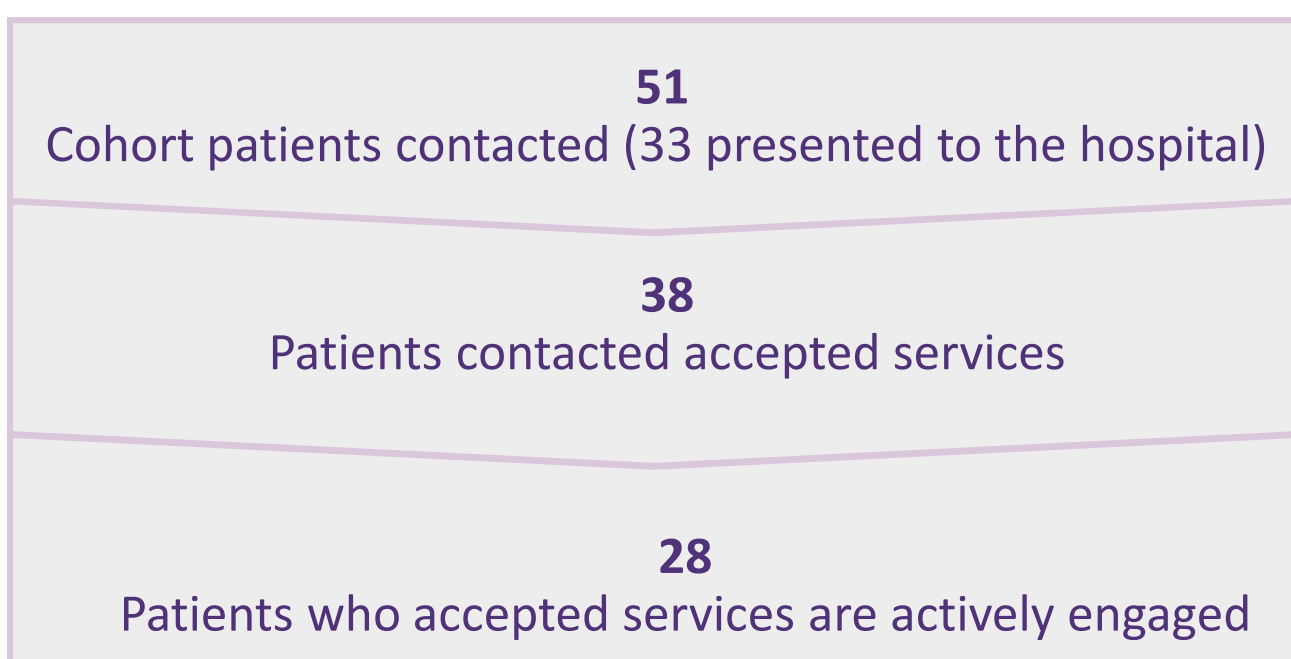
- **Frequent, high touch contact by a consistent resource helps build patient relationships**, and is critical for supporting the 'never give up, and keep trying!' culture
- **Mitigating capacity overload through patient "graduation" protocol was critical** in matching patients to appropriate levels of care and alleviating the patient caseload among the team
- **Process maintenance** is as critical as **process generation**
- Super Utilizers often have **unmet behavioral health needs that require a personalized approach**

### Patient Story


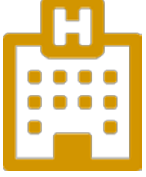
- Middle aged female with multiple chronic conditions including depression
- During the 6 months prior to program start, she had 14 ED visits and 5 IP admissions; 6 months after program start, she has had 8 ED visits and 4 IP admissions
- Patient was administered a needs assessment and care team identified a need for education and support for follow-up appointments
- Patient was connected to care coordination services, primary care, and Medicaid transportation

## Our Impact

### Patient Engagement (Nov. '15 – Apr. '16)



### Hospital Utilization

	Before (May. '15- Oct. '15)	After (Nov. '15-Jul. '16)	%Δ Rate (/month)
 ED Visits	65.7 /month	32.3 /month	-50.8%
 IP Admissions	15.5 /month	11.0 /month	-29.0%

self reported data up to July 31, 2016



**Topic 3:  
Managing Care for Super  
Utilizers**



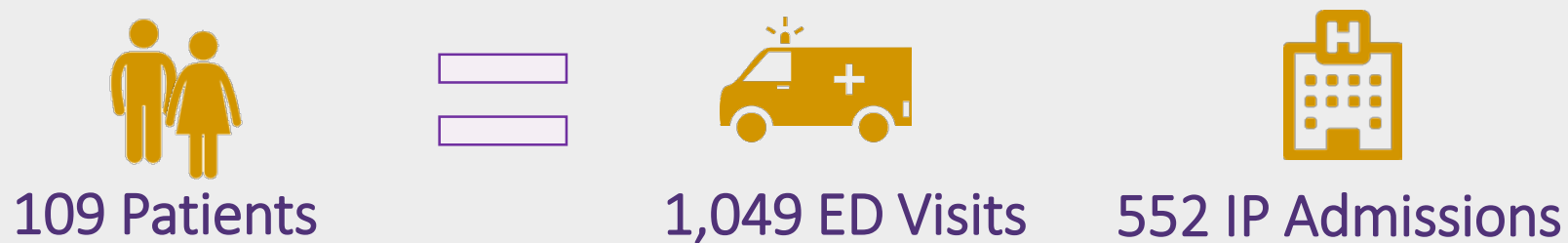
# Bronx Health Access

## Bronx Lebanon Hospital Center

### Baseline

(Data reflects Jan. '15 – Dec. '15)

Initial cohort was defined as patients with 4+ IP Admissions and/or 16+ ED visits in a 12-month period.



### Patient Success Story

Patient is a 57 year old female with multiple comorbidities whose personal fear of death was driving her hospital utilization. The patient had 8 ED Visits and 2 IP Admissions in the 6 months before her index visit (Jan. 1 – Jun. 12) and has had 3 ED visits in the 3 months since her index visit (Jun. 13 – Aug. 9).

#### ACTIONS

- Care Transitions identified the patient through an EMR alert
- Patient was screened for Care Coordination by the BLHC Clearinghouse
- Care Coordinator completed a multidisciplinary visit at bedside, revealing the patient was confused about which seizure medications to take and had a personal fear of death
- Medications were modified, patient was educated, and referred to Doctors on Call
- Care Coordinator escorted the patient to pulmonary, PCP, psychiatrist and neurologist appointments, advocated for extended home care hours and conferenced with patient's daughter who is now more involved in the patient's care
- Care Coordinator was also present at all subsequent ED visits

#### LESSON LEARNED/BRIGHT IDEA

- Patients need more than hospital interventions in order to solve for the patients' key drivers of utilization
- Intensive and extensive Care Coordination upon discharge is critical

### Impact

(Mar. '16 – Sep. '16)

#### Patient Engagement

30 patients presented

13 patients engaged

13 patients connected to services

Including: Doctors on Call, specialist appointments, Health Home, food services, wellness education

#### Process Improvements

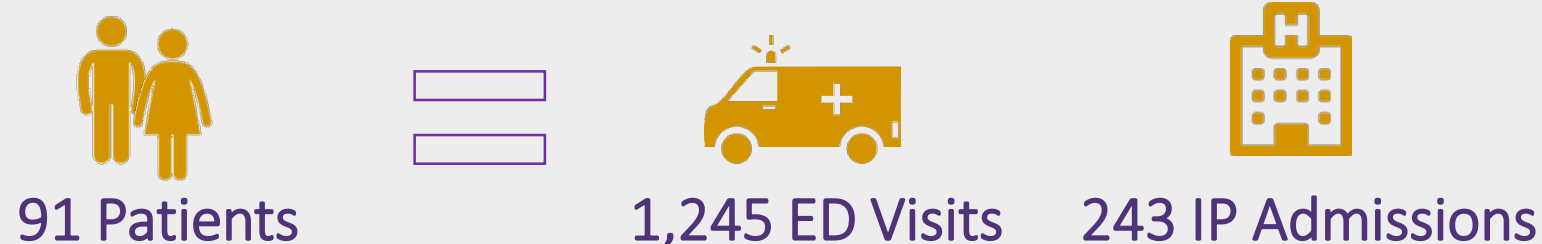
- Implementation of EMR alerts system
- Development and implementation of ED Care Transitions Team
- Integration of HealthFirst Care Manager
- Enhanced communication among hospital teams and community partners

# Adirondack Health Institute Champlain Valley Physicians Hospital

## Baseline

(Data reflects Jan. '15 – Dec. '15)

Initial cohort was defined as patients with 10+ ED visits in a 12-month period



## Patient Success Story

Patient is a 39 year old male who suffers from anxiety and had 9 visits in the 3 months (Apr. 11 – Jun. 11) prior to his index visit on Jun. 11 and has had 3 visits in the 3 months since his index visit (Jun. 12 – Aug. 12).

### ACTIONS

- Patient was flagged in the ED and alerts were received by the care team
- Typically patient was provided anxiety meds and discharged, but care team performed a needs assessment instead and discovered unmet social and behavioral health needs
- Patient was prescribed new meds, had a psychiatrist appointment made, and connected with BHSN for behavioral health services
- The Care Manager is working to enroll patient in Medicaid and connecting him to money management services, transportation services, and a food pantry



### LESSON LEARNED/BRIGHT IDEA

1. It can be difficult and time consuming to address the needs of Super Utilizers
2. Community resources are a critical element of successfully assisting these patients and the team was able to effectively leverage resources within the community
3. Collaboration is necessary to be successful in assisting these patients

## Impact

(Mar. '16 – Sep. '16)

### Patient Engagement

88 patients presented

32 patients engaged

8 patients connected to services

Including: BHSN, NAMI, Meals on Wheels, Medicaid, HCR

### Hospital Utilization

Note: Only includes patients with an Index visit and at least 90 days of post-index visit data (n = 9)

	Before 3 mo. Pre-Index Visit	After 3 mo. Post-Index Visit	%Δ
ED Visits	53	12	-77%
IP Admissions	3	1	-67%
Total	56	13	-77%

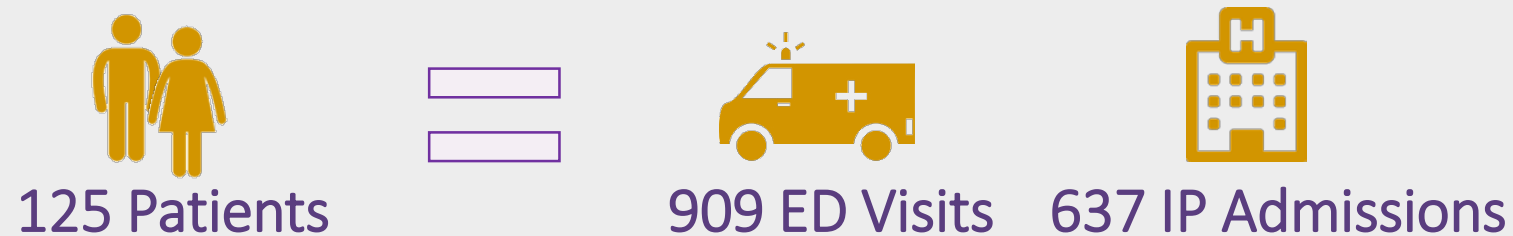
\*Calculations are based on self-reported data from Action Team

# Montefiore Hudson Valley Collaborative Saint Joseph's Medical Center

## Baseline

(Data reflects Jan. '15 – Dec. '15)

Initial cohort was defined as patients with 4+ IP Admissions in 2015



## Patient Success Story

Patient is a homeless male who suffers from end stage liver disease who had 7 inpatient visits in the year prior to his index visit on Apr. 12 and has had 5 visits in the 3 months since his index visit (Apr. 13 – Jul. 13). Although the visit volume did not significantly change, the key driver of the visit changed from social to medical in nature.

### ACTIONS

-  Health Home and multiple hospital departments worked together to locate and enroll patient in critical services
-  Patient contacted Care Manager before going to the ED; Care Manager contacted ED physician
-  Patient was treated at the hospital and then connected to Montefiore for additional treatment
-  Patient placed in permanent housing and reported feeling "really good about himself"



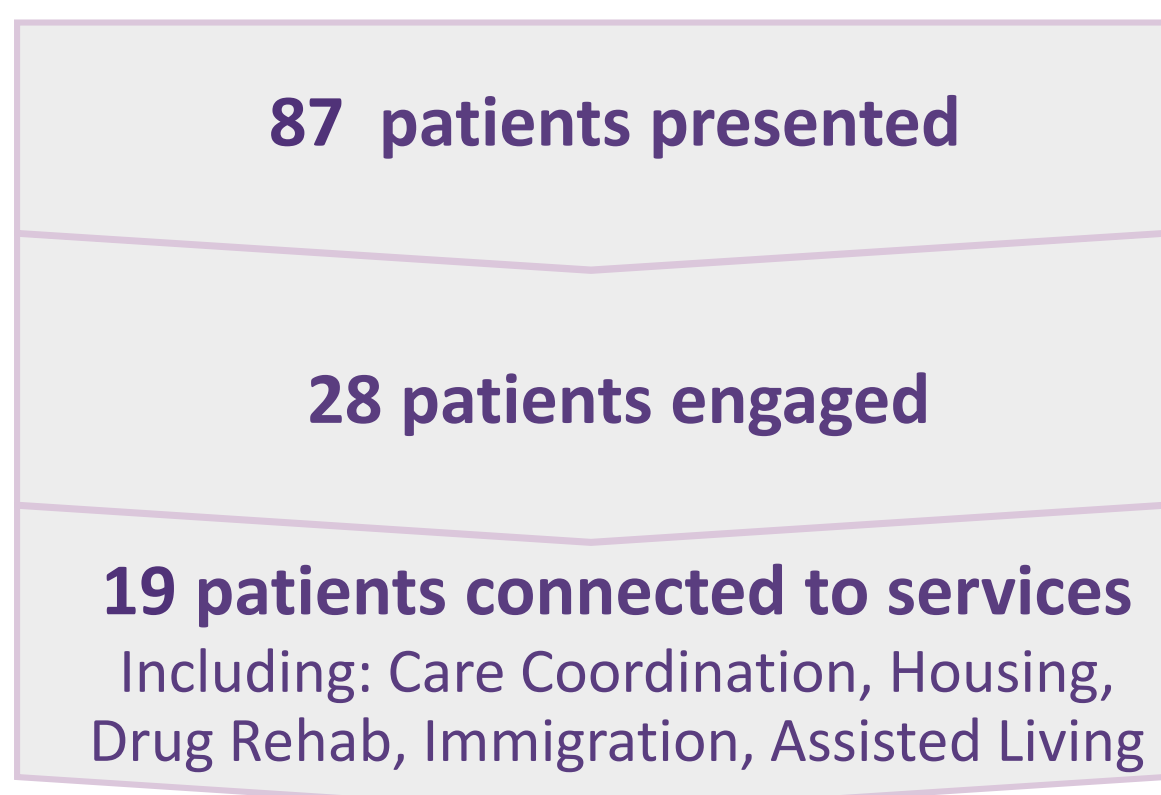
### LESSON LEARNED/BRIGHT IDEA

Involving organizations and physicians, that care for patients in the community, to collaborate with intensive care strategies based upon the patients' unique needs, strengthens and impacts the entire community we serve.

## Impact




(Mar. '16 – Sep. '16)

### Patient Engagement



### Hospital Utilization

Note: Only includes patients with an Index visit and at least 90 days of post-index visit data (n = 15)

	Before 3 mo. Pre-Index Visit	After 3 mo. Post-Index Visit	%Δ
 ED Visits	129	103	-20%
 IP Admissions	33	4	-88%
 Total	162	107	-34%

\*Calculations are based on self-reported data from Action Team

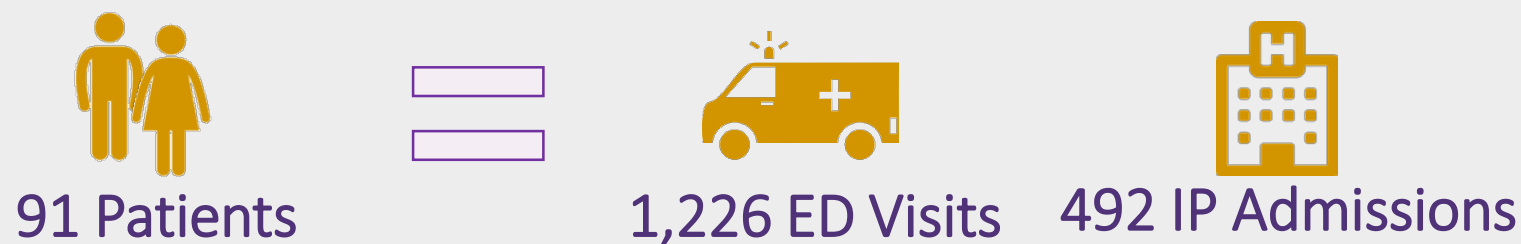


# Montefiore Hudson Valley Collaborative St. Luke's Cornwall Hospital

## Baseline

(Data reflects Jan. '15 – Dec. '15)

Initial cohort was defined as patients with 6+ ED visits and 3+ IP admissions in a 12-month period



## Patient Success Story

Patient is a female with a chief complaint of pain who had 8 ED visits and 6 IP Admissions in the 3 months (Mar. 3 – Jun. 3) prior to her index visit, and has had 2 ED visits and 2 IP Admissions since her index visit (Jun. 4 – Aug. 4)

### ACTIONS

- Care team received alerts upon the patient's presentation to the ED
- Care Manager performed a needs assessment revealing behavioral health and substance abuse problems as the driver of utilization
- "Quarterback" (QB) was assigned and patient was connected to an Insurance Case Manager and a diabetes educator
- Care Manager continued to perform frequent telephonic outreach
- Patient connected to Health Home (HVCS)
- Patient set goals of taking care of her son and having her own apartment. She also calls the QB before presenting to the ED and successfully avoided a non-emergent visit by being connected to therapy instead

### LESSON LEARNED/BRIGHT IDEA

- In order to be successful, the patient must be connected to his/her "quarterback" (care coordinator / manager) who can connect the patient to services that address medical, behavioral, and social needs
- Patient must be invested in his/her plan of care and must see that there is adequate support to assure that the plan of care does not make them susceptible to failure
- Super Utilizers have grown accustomed to utilizing the ED whenever they need something; they need to trust that "plan B" is a solid alternative and will address their needs

## Impact

(Mar. '16 – Sep. '16)

### Patient Engagement

62 patients presented

47 patients engaged

33 patients connected to services  
Including: PCP, Health Home, Hospice, Horizon, HVCS, Drug Rehab, Asthma Coalition

### Hospital Utilization

Note: Only includes patients with an Index visit and at least 90 days of post-index visit data (n = 24)

	Before 3 mo. Pre-Index Visit	After 3 mo. Post-Index Visit	%Δ
ED Visits	118	119	1%
IP Admissions	43	12	-72%
Total	161	131	-19%

\*Calculations are based on self-reported data from Action Team



# Leatherstocking Collaborative Health Partners (Bassett) PPS Little Falls Hospital

## Baseline

(Data reflects Jan. '15- Dec. '15)

Initial cohort was defined as patients with 6+ ED visits in a 12-month period



## Patient Success Story

Patient is a 24 year old female with multiple medical and behavioral health conditions. In 2015 she had 33 visits. Although the patient continues to visit the hospital frequently, the Team has developed a strong relationship with the patient who has taken steps to improve her situation.

### ACTIONS

- Patient was flagged upon presenting to the ED
- Social Worker and Case Manager met with patient uncovering multiple potential drivers of utilization including depression and anxiety
- Care Manager and the hospital developed a care plan
- Social Worker and Care Manager worked to get patient surgery for medical condition, referred her to BH counselor and psychiatrist, arranged home medications, developed daily living routine contract, referred patient to a diabetes educator, and kept in frequent contact with the patient.



### LESSON LEARNED/BRIGHT IDEA

- Leverage the broader care network, including internal resources, community organizations, and the PPS
- Seek to understand patients from a different perspective with more of an emphasis on their psychosocial issues
- Super Utilizers require a greater level of attention, advocacy and management in order to connect them to critical social services and support

## Impact

(Mar. '16 – Sep. '16)

### Patient Engagement

45 patients presented

30 patients engaged

20 patients connected to services

Including: Primary care, specialist, education, mental health services, social services

### Hospital Utilization

Note: Only includes patients with an Index visit and at least 90 days of post-index visit data (n = 15)

	Before 3 mo. Pre-Index Visit	After 3 mo. Post-Index Visit	%Δ
ED Visits	33	20	-39%
IP Admissions	10	7	-30%
Total	43	27	-37%

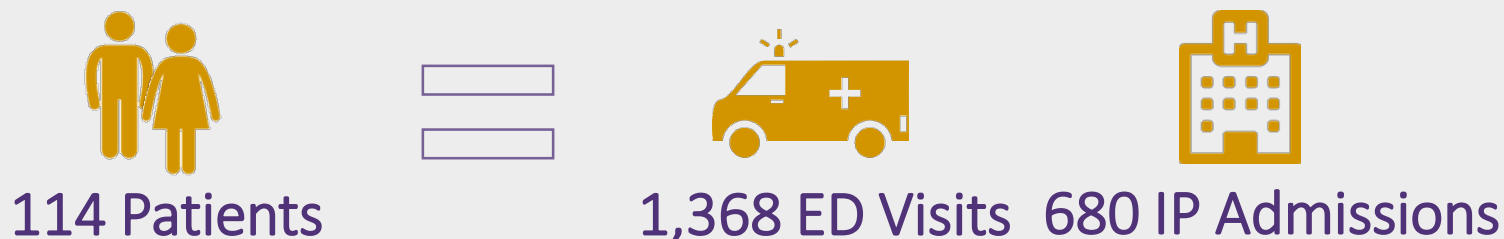
\*Calculations are based on self-reported data from Action Team

# Millennium Care Collaborative Erie County Medical Center

## Baseline

(Data reflects Jan. '15 – Dec. '15)




Initial cohort was defined as patients with 6+ ED visits and 1+ primary care visit in a 12-month period.



## Patient Success Story

Patient is a 60 year old female with multiple co-morbidities (CHF, COPD, Diabetes, etc.). The patient lacked an understanding of how to manage her illnesses. The patient has had 4 visits in the months before the program and only 1 ED visit since her index visit.

### ACTIONS

- 
 Patient was flagged upon presenting to the ED, which triggered a visit from the ED Care Manager
- 
 ED Care Manager linked the patient with the Catholic Health Home, set up appointment with Pain Management Doctor (PMD) and instructed the patient to call PMD before visiting the ED
- 
 Patient attended two follow up visits with the PMD; at the PMD appointment a Social Worker set her up with Meals on Wheels and linked the patient with the "Going Place" van to take her to the grocery store



### LESSON LEARNED/BRIGHT IDEA

- Teams should take a broad look across services when building their team
- Do not underestimate the related work flows needed to integrate health service providers into the ED and PCP practices
- Teams have to continually make efforts to keep the MAX Series Team members energized and engaged

## Impact

(Mar. '16 – Sep. '16)

### Patient Engagement

99 patients presented



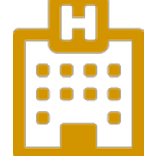
26 patients engaged

24 patients connected to services

Including: Care Management, Health Home (Evergreen), financial counseling, physician follow up, drug rehab

### Hospital Utilization

Note: Only includes patients with an Index visit and at least 90 days of post-index visit data (n = 6)

	Before 3 mo. Pre-Index Visit	After 3 mo. Post-Index Visit	%Δ
 ED Visits	23	18	-22%
 IP Admissions	8	2	-75%
 Total	31	20	-35%

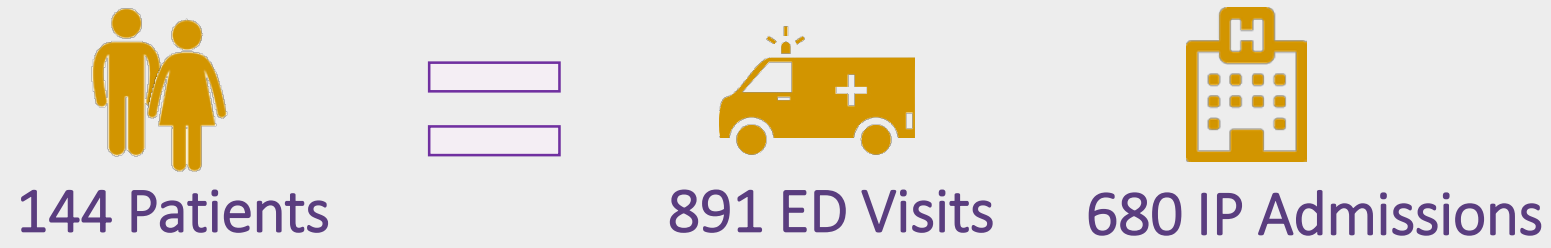
\*Calculations are based on self-reported data from Action Team

# Suffolk Care Collaborative Southside Hospital

## Baseline

(Data reflects Jan. '15 – Dec. '15)

Initial cohort was defined as patients with 4+ Inpatient Admissions in a 12-month period.



## Patient Success Story

Patient is a 79 year old male with CHF and HTN who was facing significant financial issues that were obstructing his ability to address his medical needs. The patient had 4 IP Admissions in the 6 months prior to his index visit on Jun. 3 and has not had any visits in the 3 months since his index visit.

### ACTIONS

- Patient identified in the ED via EMR flag triggering a Social Worker (SW) needs assessment
- SW met with patient at bedside revealing that the patient was facing significant financial issues preventing him from addressing his medical needs
- SW researched and worked with Diabetic educator to identify discounted diabetic supplies and investigate financial aid opportunities on the patient's behalf
- Patient connected to Home Health Care, Chronic Disease Management, and food pantry.

### LESSON LEARNED/BRIGHT IDEA

- Using a truly integrated, multidisciplinary approach is critical to solving the drivers of utilization for patients with complex medical and psychosocial problems
- There is a need for great utilization of outpatient resources available both inside and outside of the health system
- It is important to monitor the outpatient activities of these patients to make certain their needs are addressed
- **Moving from "frequent flyer" moniker to a "guides toward better health" way of thinking**

## Impact

(Mar. '16 – Sep. '16)

### Patient Engagement

45 patients presented

37 patients engaged

30 patients connected to services

Including: Physician follow up, home oxygen, home health care, Family Service League, education, SBIRT referral

### Hospital Utilization

Note: Only includes patients with an index visit and at least 90 days of post-index visit data (n = 21)

	Before 3 mo. Pre-Index Visit	After 3 mo. Post-Index Visit	%Δ
ED Visits	13	5	-62%
IP Admissions	41	20	-51%
Total	54	25	-54%

\*Calculations are based on self-reported data from Action Team

**Topic 2:**  
**Integrating Behavioral  
Health and Primary Care**




# CHONY 6 Pediatric Psychiatry Clinic and Audubon Pediatric Medical Clinic New York-Presbyterian

## Our Patient Cohort

(Data reflects Sept. '15 to Feb. '16)

Shared pediatric patient population between the CHONY 6 and Audubon clinics

≡ 56 

## Our Actions

### Patient Story

4 year-old male in short-term therapy who experienced heart attack and stroke requiring a heart transplant. Patient transferred to BH services for more intensive treatment. With new established lines of communication and collaboration with PC and BH providers, patient was able to seamlessly transition to BH and then back to PCP upon achieving stable status.

### Process Improvements

#### Patient Identification

- Enhanced BH screening by Pediatrician: Vanderbilt & SNAP IV
- Pediatrician determines level of care
- Implemented referral process from Pediatrician to Audubon psychiatric NP for complex cases

#### Care Planning

- Implemented BH medication management document for Pediatricians to reference
- Implemented "Welcome Package" at CHONY 6 to be administered to incoming patients

#### Management

- Implemented a "point-person" at CHONY 6 to manage patient care plan
- Implemented the sharing of provider handoff sheet when transferring cases between clinics

#### Follow Up

- Implemented CHONY 6 Graduation criteria document to help determine stable BH status to transition care back to PC

### Level of Integrated Practice

LEVEL 1 Minimal Collaboration	<b>LEVEL 2 Basic Collaboration at a Distance</b>	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice
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### Lessons Learned

- Face-to-face communication is important in order to enhance service collaboration
- Developing standardized processes, workflows and reference documents increases collaboration among providers
- Expanding concept of a treatment team to encompass PC and BH providers helps facilitate patient flow across settings and changes the culture of care delivery

## Our Impact

**Baseline**  
(Sept. '15 – Feb. '16)      **MAX Program**  
(Mar. '16 – Aug. '16)

### Patient Engagement

527 patients stratified for level of care

250 shared patient case discussions

9 patients transitioned to PC



#### Screening Rate

(# screens completed/total # patients)

40%

78%



#### Pediatrician Comfort Level

70%

89%



#### Transitions in Care

0

12



#### Number of Shared Patient Case Discussion

N/A

250

\*Calculations are based on self-reported data from Action Team

# Lutheran Family Health Center NYU Lutheran Medical Center

## Our Cohort

(Data reflects Mar. '16 to Sept. '16)

Behavioral health members with a chronic condition of diabetes

≡ 230 

## Our Actions

### Patient Story

67 year old male patient with chronic diabetes and multiple hospitalizations was identified and connected to BH services on the same day. Patient is now engaged in care, has improved A1c levels, **significant reduction in PHQ score** and has received certificate of improved health.

### Process Improvements

#### Patient Identification

- Patient screened with PHQ-2 and if positive, a blue card is given to the patient to signal PCP to administer PHQ-9
- PCP performs warm handoff with Social Worker (when available) or schedules BH appointment

#### Care Planning

- Daily multidisciplinary huddles
- PCP/SW share care plans and PCP will sign off on SW care plan

#### Management

- PCP/SW track/monitor progress through consultation
- ED Psychiatrist is also available for consultation
- Level of Care guidance used to support management

#### Follow-Up

- Patient's PHQ score is monitored over 30 day periods for improvements
- A patient is determined stable when scores <10 on PHQ-9 or decreases by 5 points from moderate depression

### Level of Integrated Practice

LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice
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### Lessons Learned

- Executive level support at the Clinic is critical to success
- Help staff understand that the model of care with SW embedded in PC is different than in a BH Clinic setting
- Meeting on a weekly basis to track progress is important for building Team and collaboration
- Engage a physician champion who understands the value of BH services

## Our Impact

Baseline (Sept. '15 – Feb. '16)      MAX Program (Mar. '16 – Jul. '16)

### Patient Engagement

134 patients with positive PHQ screen
32 warm handoffs conducted
9 patients connected to BH
11 patients with 50% improvement in PHQ score

  
**PHQ Screening Rate**  
(# screens completed/total # patients)

27%

95% (134)

  
**Warm Handoff Count**

N/A

32

  
**Patients Connected to BH**

N/A

45%

  
**Improvement in PHQ Score**

5 patients

11 patients



# Community Memorial Hospital – Hamilton Leather Stocking Collaborative Health Partners

## Our Cohort

(Data reflects Mar. '16 to Sept. '16)

Adult Behavioral health members with a PHQ 10+

≡ 80 

## Our Actions

### Patient Story

61 year old female with a history of medication non-adherence and missing appointments required a heart procedure. PCP invited BH provider to participate in the patient's care and after 2 sessions with the BH provider, the patient was able to manage anxiety levels to obtain the heart procedure.

### Process Improvements

#### Patient Identification

- PHQ-2/9 is administered and inputted in EHR
- PC determines if patient requires BH and performs warm handoff
- BH provides consults for both patient and provider following warm handoff

#### Care Planning

- BH huddles with each provider separately
- BH develops treatment plan in consultation with PC and shares progress notes in EHR

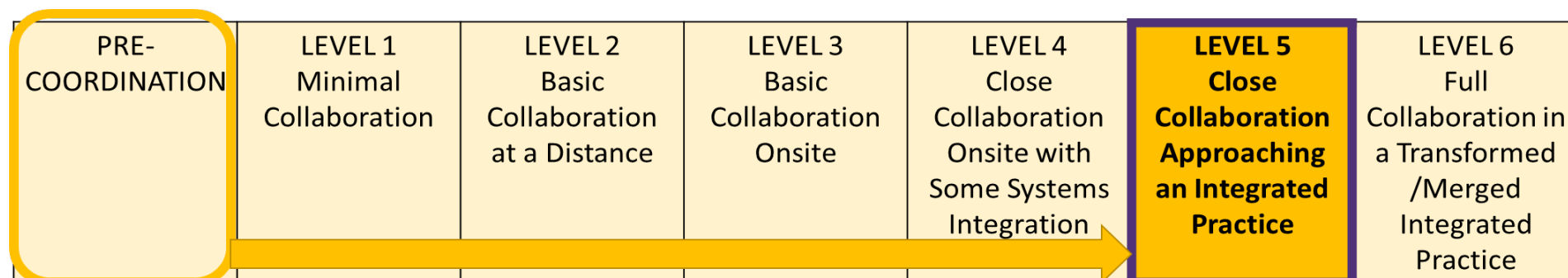
#### Management

- BH and PC consult on patient treatment plans and monitor and track patient progress

#### Follow-Up

- BH services remain part of the PC treatment until consultation concern is resolved or patient requires a higher level of care

### Level of Integrated Practice



### Lessons Learned

- Developing plans are important but need to be tested through trial and error to find what works
- Persistent communication and provider engagement contribute to overall success
- Be flexible to allow providers and clinicians the space to learn how to work together as a team

## Our Impact

Baseline (Sept. '15 – Feb. '16)      MAX Program (Mar. '16 – Sept. '16)

### Patient Engagement

414 patients screened with PHQ 2 & 9

154 warm handoffs conducted

9 patients had follow-up in August with BH



PHQ Screening Rate  
(# screens completed/total # patients)

59%

78% (414)



Warm Handoff Count

0

154



Patients Connected to BH for follow up

0

9

\*Calculations are based on self-reported data from Action Team

\*\* All data reflects BH services co-located from Jul. - Aug.'16

# Planned Parenthood Mohawk Hudson Central New York Care Collaborative

## Our Cohort

(Data reflects Mar. '16 to Sept. '16)

Females aged 18-34 with a PHQ 10+

≡ 1,228 

## Our Actions

### Patient Story

A young female was identified for BH services during a PC consult appointment. Patient is now engaged with BH services and has seen immediate improvement. Patient will continue BH therapy via telehealth.

### Process Improvements

#### Patient Identification

- Increased PHQ-2 and 9 screening rate
- Warm handoff performed when BH available
- Electronic referral made when BH not available

#### Care Planning

- Morning huddles before appointments
- BH assesses patient goals and creates treatment plan

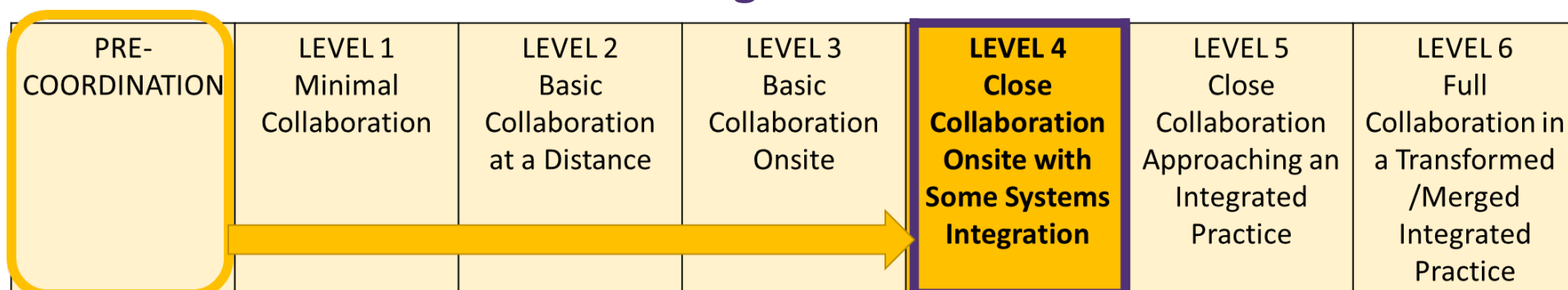
#### Management

- BH and PC share care plans and progress notes

#### Follow-Up

- Treatment plans are monitored and tracked by BH and PC to measure patient progress and determine next steps based on health status

### Level of Integrated Practice



### Lessons Learned

- Effectively maintain communications through a group e-mail address and weekly team meetings
- Involve staff from other departments as soon as possible so “behind the scenes” processes and workflows are not left to the last minute
- Leverage the PDSA cycle to test new processes and make changes as needed

## Our Impact

Baseline      MAX Program





(Sept. '15 – Feb. '16) (Mar '16 – Sept. '16)

### Patient Engagement

76 patients screened positive

28 patients connected to BH

2 patients with improved PHQ score

 <b>PHQ Screening Rate</b> (# screens completed/total # patients)	30%	88% (76)
 <b>Warm Handoff Count</b>	N/A	1
 <b>Patients Connected to BH</b>	3	28
 <b>Improvement in PHQ Score</b>	N/A	2

\*Calculations are based on self-reported data from Action Team

\*\*Data represents measurement period of May. '16 to Aug. '16 with BH 1 day/week




# Lourdes Primary Care Care Compass Network

## Our Cohort

(Data reflects Mar. '16 to Aug. '16)

Adults 20-50 years old with mild/acute depression scoring 10+ on the PHQ-9

≡ 337 

## Our Actions

### Patient Story

30 year old female diagnosed with Type 1 Diabetes with a history of hospitalizations due to depression and neglecting insulin. Patient had an appointment with SW, filled out the paperwork for LMH outpatient clinic. Patient agreed to counseling with SW until she starts treatment at the LMH outpatient clinic.

### Process Improvements

#### Patient Identification

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

#### Care Planning

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

#### Management

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

#### Follow-Up

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

### Level of Integrated Practice

LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice
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### Lessons Learned

- Identifying **champions** is crucial for success
- Provider buy-in and education** is critical
- Small tests of change** lead to big improvements
- Data drives change** and provides motivation

## Our Impact

**Baseline**  
(Sept. '15 – Feb. '16)      **MAX Program**  
(Mar. '16 – Aug. '16)

### Patient Engagement

142 patients received brief intervention with SW

34 patients attended follow up session with the SW

36 patients had improvement in PHQ score

  
PHQ Screening Compliance

0

1,165



Warm Handoff Count

0

73



Patients Connected to BH  
(patients with PHQ-9 >15)

0

34



Improvement in PHQ-9

0

36\*

\*Calculations are based on self-reported data from Action Team

\* Showed an improvement of between 1-12 reduction in PHQ-9

# Refuah Health Center

## Refuah PPS

### Our Cohort

(Data reflects Sept. '15 to Aug. '16)

Pediatric patients with a diagnosis of ADHD

≡ 351 

### Our Actions

#### Patient Story

9 year old female screened positive on Vanderbilt for both ADHD and oppositional defiant. Pediatrician identified need for BH services. Patient was connected through a warm handoff alleviating the patient's mother's concerns on the spot. Patient was provided with a follow up BH appointment to manage condition, as well as follow-up with the Pediatrician for ADHD.

#### Process Improvements

##### Patient Identification

- Patient identified via school referral and/or by parent
- Vanderbilt assessment used to diagnose ADHD
- If needed, warm handoff performed and patient immediately connected to BH

##### Care Planning

- For acute ADHD, Pediatrician manages care and medication
- Higher complexity ADHD is referred to BH

##### Management

- Pediatrician uses level of care guidelines to manage ADHD symptoms and medication
- Child prescribed to an after school physical activity program

##### Follow-Up

- Pediatrician and BH monitor/track patient progress on 2-3 month interval and consult to determine treatment plan

#### Level of Integrated Practice

LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice
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#### Lessons Learned

- Regardless of the level of integration there is always room for process improvement
- Team based communication to listen, learn and develop processes together is critical
- Educate at every step of the process from patient identification to treatment to follow up to help all providers and practitioners feel comfortable managing care

### Our Impact

**Baseline**  
(Sept. '15 – Feb. '16)

**MAX Program**  
(Mar. '16 – Sep. '16)

#### Patient Engagement

43 warm handoffs conducted

38 new patients managed by Pediatricians

Vanderbilt Screening 

N/A

38

Warm Handoff Count 

0

43

Patients Connected to BH 

44

29

Child Psychiatrist Wait List 

51 patients

14 patients

\*Calculations are based on self-reported data from Action Team

# Stony Brook Medicine Suffolk Care Collaborative PPS

## Our Cohort

(Data reflects Jan. '16 to Aug. '16)

**Adult Medicaid behavioral health members with a PHQ -9 score  $\geq 10$**

≡ 76 

## Our Actions

### Patient Story

Patient presented for PC visit and declined PHQ-9. PC identified that patient was presenting signs of depression and in the moment performed a warm handoff to care coordination to connect patient to SW. Patient was seen by SW within 24 hours who consulted with Psychiatry and NP and connected the patient to the appropriate level of care.

### Process Improvements

#### Patient Identification

- PHQ-9 administered during registration
- If patient scores  $\geq 10$  on PHQ the PCP will perform a health assessment and perform warm handoff or refer for Specialty services

#### Care Planning

- PC and SW collaborate on med. management and therapy intervention
- The SW may administer a psychosocial assessment and connect patient to Care Coordination Team

#### Management

- Live confirmation calls 24 hours prior to appointment
- PC and SW track patient progress with med. management and PHQ-9 reassessment scores

#### Follow-Up

- The PCP and SW assess patient progress with treatment plan and by clinical discretion
- Stable patients are transitioned back to PC for monitoring and maintenance

### Level of Integrated Practice

LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice
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### Lessons Learned

- Education and engagement of patients on what therapy is and how it can help are important
- Using data can help identify a disparity in different patient population needs
- Embedding BH providers and Care Coordinators allows for continuity of care

## Our Impact

**Baseline**      **MAX Program**  
(Sept. '15 – Dec. '15)      (Jan. '16 – Aug. '16)

### Patient Engagement

<b>32 patients</b> connected to BH
<b>19 patients</b> with improvement in PHQ score
<b>10 patients</b> transitioned back to PC



**PHQ Average Screening Rate** (# of patient in MAX cohort with screening/total # in MAX cohort)

N/A

**100% (39)**



**Medication Management**

N/A

**57%**



**Patients Connected to BH**

N/A

**32**



**Improvement in PHQ Score**

N/A

**19**

\*Calculations are based on self-reported data from Action Team



# Access Supports for Living & HRHCare Montefiore Hudson Valley Collaborative PPS

## Our Cohort

(Data reflects Sept. '15 to Feb. '16)

Adult Behavioral Health members diagnosed with diabetes

≡ 67 

## Our Actions

### Patient Story

Male BH patient with **very high blood pressure** developed **trust in the NP** through multiple brief visits and is **now compliant with medication** to control his blood pressure.

### Process Improvement

#### Patient Identification

- Identified eligible patients
- Educated BH Practitioners to identify how a patient would benefit from PC
- Voluntary universal medical screenings

#### Care Planning

- Use motivational interviewing to identify patient goals
- Share PC progress notes with BH Practitioners
- Multidisciplinary huddles

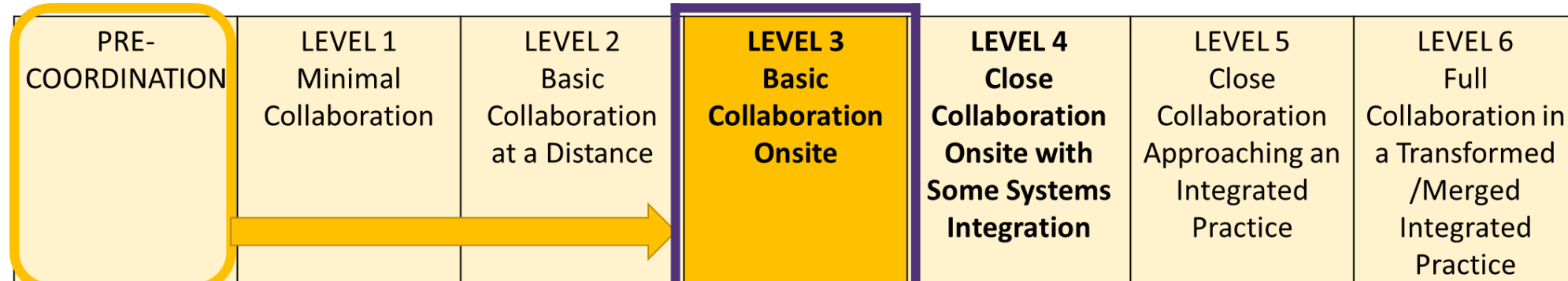
#### Management

- Multidisciplinary case conferences to track/monitor patient progress

#### Follow-Up

- Collaborative management of patients and support to maintain health status

### Level of Integrated Practice



### Lessons Learned

- Leveraged PPS' clinical depth and best practice knowledge to support integration effort through active conversation
- Well-established partnership allowed freedom for front line practitioners to work together
- Communication needs to transcend importance of integration to increase BH Practitioner comfort level to talk about Primary Care with patients

## Our Impact

### Patient Engagement

72 patients connected to PC

271 Total PC visits



ED Utilization Rate

Baseline

(Mar. '15 – Feb. '16)

MAX Program

(Mar. '16 – Aug. '16)

%Δ

.07

.08

14%



PC Visit rate within 6 Months

49%

64%

31%



Number of Patients Connected to PC

-

72

-



7-Day Follow-Up rate

44%

25%

-43%



Smoking Cessation\*

-

6%

-



BP within Range

31%

58%

84%

\*Calculations are based on self-reported data from Action Team

\*(# engaged in cessation counselling/total # in cohort who smoke)

# Brightpoint Health

## New York Presbyterian Queens

### Our Cohort

(Data reflects Mar. '16 to Sept. '16)

Homeless population transported to Brightpoint from 2 'premium account' shelters

≡ 90 

### Our Actions

#### Patient Story

What mattered most to one mother in primary care was not that she needed a well-woman visit but her son's behavioral health needs. That was a barrier to her care, and it was discovered because of morning huddles.

#### Process Improvements

##### Patient Identification

- Patients identified in shelter for PC services
- Strengthened PHQ-9 screening processes
- Patients asked "what matters to you?"

##### Care Planning

- Daily huddles with each PCP
- Increased EHR access to Health Home to share care plans and progress notes

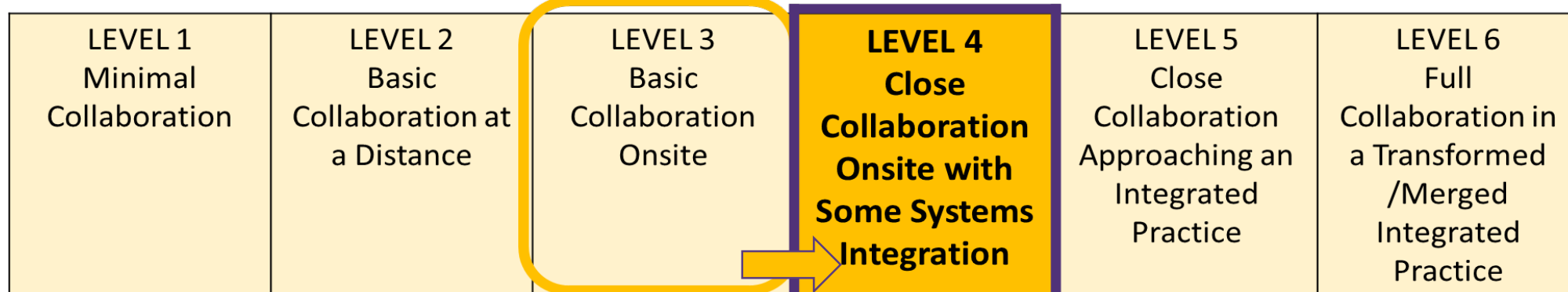
##### Management

- Monthly multi-service case conferences to discuss and monitor patients

##### Follow-Up

- Acute patient health status determined via PCP and BH collaborative clinical judgment
- Complex patients monitored via case conferences to determine health status




#### Level of Integrated Practice



#### Lessons Learned

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

### Our Impact

	Baseline (Sept. '15 – Feb. '16)	MAX Program (Mar. '16 – Aug. '16)
<h4>Patient Engagement</h4> <div style="border: 1px solid gray; padding: 10px; margin-bottom: 10px;"> <p>457 patients screened with PHQ</p> <p>54 patients connected to BH</p> </div>  <p><b>PHQ Screening Rate</b> (# screens completed/total # patients)</p>	71%	68% (457)
 <p><b>Patients Connected to BH</b></p>	56	54
 <p><b>Wait time at Center</b></p>	5 hours	2 hours

\*Calculations are based on self-reported data from Action Team

# Long Island FQHC – Roosevelt Center Nassau Queens PPS

## Our Cohort

(Data reflects Mar. '16 to Aug. '16)

Adult Behavioral health members with a PHQ-9 score  $\geq 10+$

≡ 255 

## Our Actions

### Patient Story

A 30 year old female who was 2 months postpartum presented to the center complaining that she had difficulty sleeping. She scored positive on the PHQ and received warm handoff for same day BH services. She now sees a therapist regularly and has decreased to a score of 0 on PHQ.

### Process Improvements

#### Patient Identification

- Increased PHQ-9 screening rate via patient self-administration
- PC performs electronic referral in the moment as warm handoff to BH

#### Care Planning

- Implemented daily multidisciplinary huddles
- Implemented level of care algorithm and developed workflows to manage mild to complex patient cases

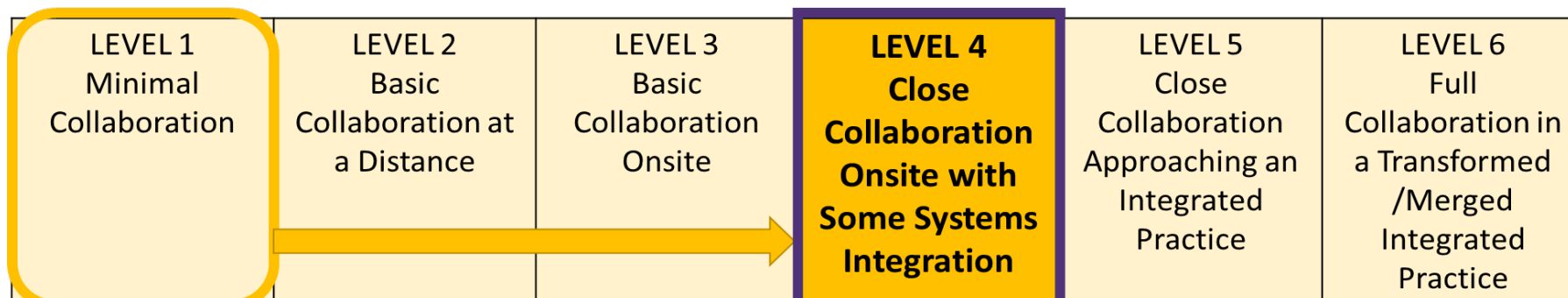
#### Management

- Patient tracker tool is used in monthly case conferences to discuss and monitor complex patient cases
- Refined daily huddle discussions

#### Follow-Up

- Lower acuity patients are assessed every 90 days using the PHQ screening tool to monitor patient progress

### Level of Integrated Practice



### Lessons Learned

- Taking small steps to educate staff and change the workflow had a positive impact on change efforts
- Creating different opportunities to collaborate between the two services encouraged staff to improve
- Communicating key messages, process changes and progress updates helped facilitate improvements

## Our Impact

**Baseline**  
(Sept. '15 – Feb. '16)

**MAX Program**  
(Mar. '16 – Aug. '16)

### Patient Engagement

**1053 patients** screened  
positive on PHQ

**10** warm handoffs

**132 patients** connected to  
BH

  
**PHQ Screening Rate**  
(# screens completed/total # patients)

98%

85%  
(11,485)

  
**Warm Handoff Count**

0

8

  
**Patients Connected to BH**

0

132

  
**Improvement in PHQ**

N/A

1

\*Calculations are based on self-reported data from  
Action Team