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

64 Patients = 418 ED Visits

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)

39
Patients presented

27
Patients engaged by the Outreach Specialist

13
Health Home eligible patients enrolled

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

50 Patients = 3,195 ED Visits 270 IP Admissions

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)

15
Patients identified as eligible for Safe Haven beds

4
Eligible patients have presented in the ED

3
Patients who presented connected to a Safe Haven bed

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. '15)

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

105 Patients = 784 ED Visits, 472 IP Admissions

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)

58
Patients presented

33
Patients engaged at the hospital

22
Patients connected to services

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 approporate 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)

22
Patients presented

6
Patients admitted to the hospital

6
Patients connected to services (ex. HIV clinic)

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 ≥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)

51
Cohort patients contacted (33 presented to the hospital)

38
Patients contacted accepted services

28
Patients who accepted services are actively engaged

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.

109 Patients = 1,049 ED Visits 552 IP Admissions

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

91 Patients = 1,245 ED Visits — 243 IP Admissions

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

125 Patients = 909 ED Visits 637 IP Admissions

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

87 patients presented

28 patients engaged

19 patients connected to services

Including: Care Coordination, Housing, Drug Rehab, Immigration, Assisted Living

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

91 Patients = 1,226 ED Visits | 492 IP Admissions

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

1. 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
2. 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
3. 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

68 Patients = 578 ED Visits 48 IP Admissions

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.

114 Patients = 1,368 ED Visits 680 IP Admissions

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

1. Teams should take a broad look across services when building their team
2. Do not underestimate the related work flows needed to integrate health service providers into the ED and PCP practices
3. 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.

144 Patients = 891 ED Visits 680 IP Admissions

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	**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

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

Patient Engagement

527 patients stratified for level of care

250 shared patient case discussions

9 patients transitioned to PC

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

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

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

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

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

** All data reflects BH services co-located only 1 day/week

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

PRE-COORDINATION	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

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

Patient Engagement

414 patients screened with PHQ 2 & 9

154 warm handoffs conducted

9 patients had follow-up in August with BH

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

PRE-COORDINATION	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

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

Patient Engagement

76 patients screened positive

28 patients connected to BH

2 patients with improved PHQ score

	Baseline (Sept. '15 – Feb. '16)	MAX Program (Mar '16 – Sept. '16)
PHQ Screening Rate (# screens completed/total # patients)	30%	88% (76)
Warm Handoff Count	N/A	1
Patients Connected to BH	3	28
Improvement in PHQ Score	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

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

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

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

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

* 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

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

Patient Engagement

43 warm handoffs conducted

38 new patients managed by Pediatricians

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

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

Patient Engagement

32 patients connected to BH

19 patients with improvement in PHQ score

10 patients transitioned back to PC

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

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

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

PRE-COORDINATION	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

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

	Baseline *(Mar. '15 – Feb. '16)*	MAX Program *(Mar. '16 – Aug. '16)*	%Δ
ED Utilization Rate	.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

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

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

Patient Engagement

457 patients screened with PHQ

54 patients connected to BH

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

	Baseline (Sept. '15 – Feb. '16)	MAX Program (Mar. '16 – Aug. '16)
PHQ Screening Rate (# screens completed/total # patients)	71%	68% (457)
Patients Connected to BH	56	54
Wait time at Center	5 hours	2 hours

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 ≥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

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

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

Patient Engagement

1053 patients screened positive on PHQ

10 warm handoffs

132 patients connected to BH

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

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