Lourdes Primary Care

Care Compass Network

Our Cohort

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

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

= 337 **1**

Our Actions

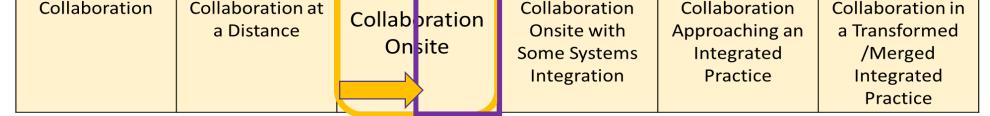
Patient Story

Thirty-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. Patient agreed to counseling with SW until she starts treatment at the LMH outpatient clinic.

Process Improvements

Patient Identification		Care Planning		Management		Follow-Up	
Implemented referral and warm handoff processes Implemented waiting room screening processes Expanded screening to include SBIRT	•	Implemented full-time SW Implemented integrated care plan Continuous provider education Data tracking and reporting EMR referral process		Brief intervention and connection facilitated by SW Collaborative care planning and management ("mini huddles") BH 'shadowing' of PCP to further embed BH into practice	•	Implemented ED follow-up process with Lourdes SW Implemented Health Home processes	
Level of Integrated Practice							

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	LEVEL 1	I EVEL 2		LEVEL 4	LEVEL 5	LEVEL 6
						220220
	Minimal	Basic	Racio	Close	Close	Full
			Basic			



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

	<i>Our Impact</i>	Baseline (Sept. '15 – Feb. '1	MAX Program 16) (Mar. '16 – Aug. '16)	
Patient Engagement	Presenter 1	0	1165	
142 patients received brief intervention with SW	PHQ Screening Compliance	0	156	
34 patients attended follow up session with the SW	Warm Handoff Count	0	245	
36 patients had improvement in PHQ score	Patients Connected to BH (patients with PHQ-9 >15)	0	36 showed an improvement of between 1-12 reduction in PHQ-9	
*Calculations are based on self-reported data from Action Team	Improvement in PHQ-9			