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 to PCP to administer PHQ-9
- PCP performs warm handoff with SW when available or provides an appointment for BH

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 reduction in 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
- Helping 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
- Engaging a physician champion who understands the value of BH services is important

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 Count	12	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