

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

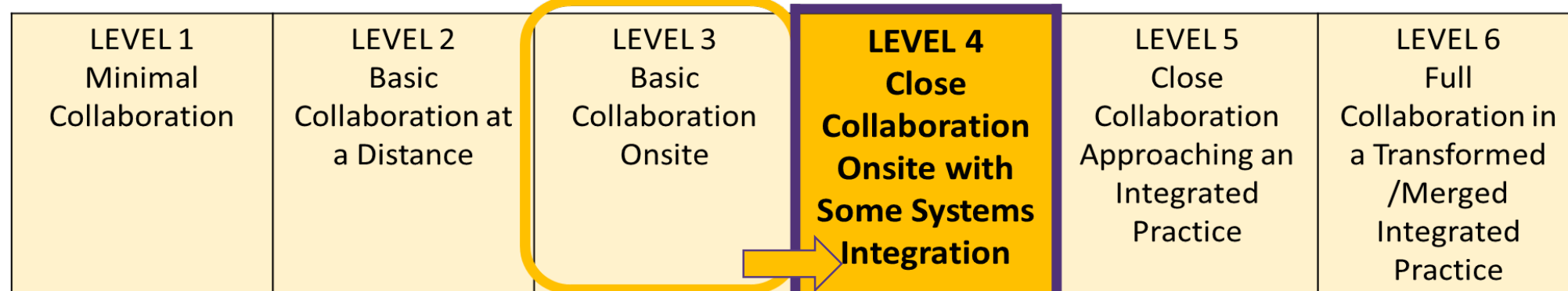
Management

- Monthly multi-service case conference meetings 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)	%Δ
Patient Engagement  PHQ Screening 457 patients screened with PHQ 54 patients connected to BH	71%	68%	-4.6%
 Patients Connected to BH	50%	30%	-20%
 Wait time at Center	5 hours	2 hours	-

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