NEW YORK STATE | Department of Health | Medicaid Redesign Team

DSRIP Annual Learning Symposium

# The MAX Series Journey Towards Integrated Behavioral Health and Primary Care Services…

September 22, 2016

# The Journey Towards Integrated Behavioral Health and Primary Care Services…

# The MAX Series Journey Towards Integrated Behavioral Health and Primary Care Services…

## Project 3a.i

DSRIP Project 3.a.i focuses on the integration of behavioral health with primary care services to ensure coordination of care for both services


## MAX

MAX is designed to put clinicians in the lead to redesign the way care is delivered in support of the DSRIP goals

## 10 Action Teams

>100 clinicians and administrators have been working for 8 months to improve care for behavioral health patients

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## Teams were able to achieve significant successes, including:

Improved identification and **recognition of patient needs**

**Increased partnerships** and working relationships with community based organizations

**Improved collaboration** between clinicians and providers

**Better connection** to health network

Improved **patient access**

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## Overall, Teams have been able to begin moving the dial on a number of measures, including:

9 Teams were able to either **implement screening** where it did not occur before, or **increase screening rates**

6 Teams reported **increase in warm handoffs to Behavioral Health**

3 Teams reported an **improvement in PHQ scores for cohort patients**

A focused effort on integration of services over the past eight months has led to **five key insights**…

1. **Data** acts as a spotlight that shines light into places for change
2. **Bringing primary care and behavioral health together is a culture change**
3. **Champions of this change** are critical for successful integration
4. **Education** for all staff is key…
5. Integration requires **knowledge, persistence and work**

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Lourdes Primary Care

*Care Compass Network PPS*

**Bouakham Rosetti**

*Project Manager* – Integration of Behavioral Health in Primary Care*, Care Compass Network*

# Action Team: **Care Compass Network – Lourdes Primary Care**

## Our Journey

Patient Population: **337 adults 20-50 years with mild/acute depression scoring 10+ on the PHQ**

Integration Model: **Integrating behavioral health into primary care**

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**

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# Action Team: **Care Compass Network – Lourdes Primary Care**

## Our Impact and Results

### Patient Success Story

PCP **"warm hand-off"** and **introduction of SW** to patient in exam room!

### Quantitative Results

| | **Baseline (Timeframe: Sept. '15 – Feb. '16)** | **Post-MAX Launch (Timeframe: Mar. '16 – Aug. '16)** |
|---|---|---|
| **Data Element** | **Total Baseline** | **Total Post-MAX** |
| **PHQ Screening Compliance** | 0 | **1,297** |
| **Warm Handoff Count** (Patients received brief intervention with SW and attended a follow up session with SW) | 0 | **156** |
| **Number of Patients with a score of 15 or higher who were connected to Behavioral Health** | 0 | **85** |
| **Improvement in PHQ Score** | **36 showed an improvement of between 1-12 reduction in PHQ-9** | |

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# Action Team: **Care Compass Network – Lourdes Primary Care**

## Our Lessons Learned and Success Factors

### 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

### Success Factors

- A **supportive and engaged Team**
- **Sharing of success stories** with Action Team, providers and senior management team

### Next Steps

- Continuously improve the integrated care planning processes
- Continuously foster a culture of collaborative care. **All of us *care* about all of you!**
- Continue to focus on ED and Health Home follow-up processes

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Brightpoint Health

*The New York-Presbyterian Queens PPS*

**Stephen Williams**

*DSRIP Manager, Brightpoint Health*

# Action Team: **New York Presbyterian Queens - Brightpoint Health**

## Our Journey

Patient Population: **Homeless population transported to Brightpoint from 2 'premium account' shelters**

Integration Model: Integrating behavioral health into primary care

Process Improvements:

### Patient Identification

- Implemented **patient identification process** for Primary Care services directly in the shelter
- **Strengthened PHQ-9 screening process** with Medtech in the Center
- Ask patient **"what matters to you"**
- Implemented **warm handoff process** for PCPs to connect patients to Medical Case Manager

### Care Planning

- Implemented **daily huddles** with each PCP and their care teams
- Extended **EHR access to Health Home**

### Management

- Implemented **multi-service case conference meetings** to discuss complex patient cases

### Follow-up

- For acute patient cases, **PCP and BH meet to discuss** patient progress and make a clinical judgment determine patient's health status
- For complex patient cases, the Team monitors progress through discussions during the **case conference meetings** to determine stability

# Action Team: **New York Presbyterian Queens - Brightpoint Health**

## Our Impact and Results

### Patient Success 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.

### Quantitative Results

| | Baseline (Timeframe: Sept. '15 – Feb. '16) | | Post-MAX Launch (Timeframe: Mar. '16 – Aug. '16) | | |
|---|---|---|---|---|---|
| **Data Element** | **Total Baseline** | **Rate (/month)** | **Total Post-MAX** | **Rate (/month)** | **%Δ** |
| **PHQ Screening Compliance** | 530 | 71.3% | 457 | 67.7% | -3.7% |
| **Attended first BH Visit** | 56 | 50% | 54 | 29.6% | -20.4% |
| **Wait Time for Patients in Cohort** | Up to 5 hours | | Maximum of 2 hours | | 60% |
| **Future State: Stable BH Patients Returning to PC** | Baseline information not available | | Targeting top 15% of stable patients returning to PC | | Increased BH capacity of 15% |

# Action Team: **New York Presbyterian Queens - Brightpoint Health**

## Our Lessons Learned and Success Factors

### Lessons Learned

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

### Success Factors

- If you do not succeed on the first attempt, **keep testing new changes** until you find what works

### Next Steps

- **Continue to use data** to help inform existing and new improvement ideas and to track and monitor performance
- Develop a strategy on how to **better engage with patients** who do not attend appointments
- Continue to **build on change** by looking at how patient assessments are performed
- Attain LEAN and Six Sigma certification to **sustain efforts**
- **Spread successes** to additional Clinics

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# Access Supports for Living/HRHCare

*Montefiore Hudson Valley Collaborative  PPS*

**Amy Anderson-Winchell**

*President and CEO, Access: Supports for Living*

# Action Team: Montefiore PPS – Access Supports for Living and HRHCare

## Our Journey

Patient Population: **67 adult Behavioral Health members diagnosed with diabetes**

Integration Model: **Integrating Primary Care into Behavioral Health**

Process Improvements:

### Patient Identification

- Performed **analysis of current patient roster**
- **Trained and educated BH Practitioners** to identify how a patient would benefit from PC services (a work in progress)
- Implemented **voluntary universal medical screening** processes

### Care Planning

- Utilized **motivational interviewing** competence
- Implemented process to **share NP's progress notes** with the BH Practitioner
- **Implemented huddles** that includes the BH Care Manager, PC team and the BH Clinic Director

### Management

- Implementing **interdisciplinary care conference meetings**
- **Collaborative management of patients** through interactions between the NP, BH Specialist and BH Care Manager

### Follow-up

- **Tracking and monitoring of a patient's progress** through interdisciplinary case conference meetings
- When approved health status is achieved, **monitoring and support plan is to be developed** to maintain health status

## Our Impact and Results

### Patient Success Story

A man with very high blood pressure who is **engaged for behavioral health care** has developed **trust in the NP** through multiple brief visits and now is **compliant with medication to control** his blood pressure.

### Quantitative Results *[for time period: May (when Primary Care license was issued) – August 2016]*

| | Baseline (Timeframe: Sept. '15 – Feb. '16) | Post-MAX Launch (Timeframe: Mar. '16 – Aug. '16) | |
|---|---|---|---|
| **Data Element** | **Baseline** | **Total Post-MAX** | **%Δ** |
| **ED Utilization** (Average # ED Visits per patient per month) | .07 | .08 | 14.29% |
| **Primary Care visits within 6 months** (% of Cohorts seen by PCP within the last 6 months) | 49.3% | 64.4% | 30.63% |
| **Number of Patients Connected to Integrated Primary Care** (500 needed for sustainability) | - | 66 | - |
| **7 Day Follow-Up Appointment** (% of Cohorts seen 7 days after hospitalization) | 43,5% | 50% | 14.9% |
| **Smoking Cessation** (% of Cohorts that smoke and engage in cessation counseling) | - | 6% | - |
| **Blood Pressure within Range** (% of cohorts with blood pressure less than 140/90) | 31.3% | 57.7% | 84.35% |

# Action Team: Montefiore PPS – Access Supports for Living and HRHCare

## Our Lessons Learned and Success Factors

Lessons Learned

- **Engagement with PPS** has leveraged PPS's clinical depth and best practice knowledge to support integration
- Well **established partnership and working relationship** with HRHCare practitioners at the front line to work on the integration together
- Good will and expertise from both sides **did not instantly result in work flows for integration**
- Communication to practitioners needs to **go beyond the importance of integration**
- Barriers, often surprising, need **continuous attention and optimism**

Success Factors

- Behavioral Health Nurse or Practitioner to champion the efforts
- Partnership between organizations with the will, belief this is positive for patients, and dedication to make it work

Next Steps

- Build volume of patients in integrated Behavioral Health and Primary Care
- Demonstrate and message improved care through integration lead by BH practitioner champions

## Lessons Learned

1. Integration of care is about creating a whole new way of delivering care…not just adding another service
2. Having a clear vision about why integration fits your mission will help you keep at it when the barriers arise
3. Recognize that **culture drives practice**
4. Data is the magnifying glass to identify whether what you are doing is working…for the patient and for your processes (i.e. how does integration support keeping people out of crisis)
5. **Practice champions are key and developing the overall functioning of the team cannot be overlooked.**
6. There is opportunity in understanding the **effectiveness of leveraging staff outside of physicians and providers**
7. Persistence is required and tackling obstacles with small tests of change will keep you moving forward.
8. Integration is a **continuous journey, not a destination.**

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# Questions and Answers

# Closing Remarks