Access: Supports for Living

NYAPRS Executive Seminar

Innovation in Behavioral Health Integration

Middletown Primary Care Integration in Behavioral Health Clinic

Middletown Clinic Integration
Middletown, NY

Partnership between HRHCare
&
Access: Supports for Living

HRHCare Article 28 Neighborhood Clinic
Co-located in
Access Article 31 Behavioral Health Clinic

Innovation in Behavioral Health Integration

- Learning through doing
- Initiated through DOH MAX Series
- Rapid Cycle Change – Continues

Middletown Clinic Integration

- Active collaboration and rapid cycle change process began as a MAX pilot project in January 2016
- Integrated care began in June 2016 when DOH approval of the Article 28 satellite site was approved
- Access obtained NYS OMH approval to provide substance u disorder services in addition to mental health services as a integrated behavioral health site in June 2016

Department of Health

Medicaid Redesign Team

DSRIP Annual Learning Symposium

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

Materials from the September 22, 2016
session on integrated primary and behavioral health care

Department of Health | Medicaid Redesign Team

Access Supports for Living/HRHCare
Montefiore Hudson Valley Collaborative PPS

Amy Anderson-Winchell
President and CEO, Access: Supports for Living

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

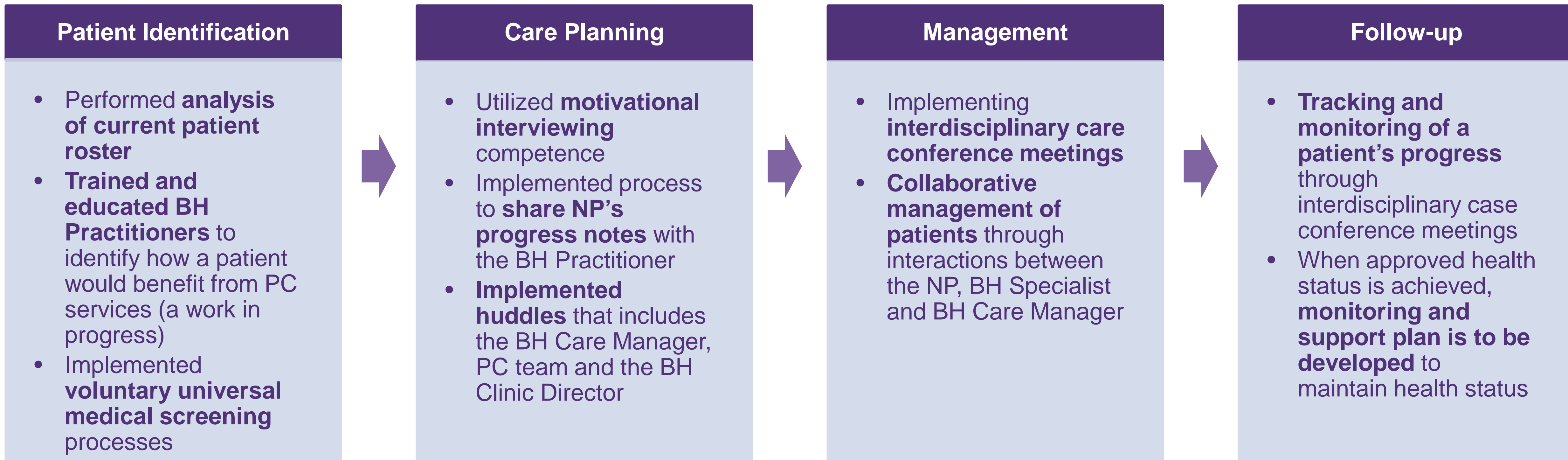
1. **Data** acts as a spotlight that shines light into places for change
2. **Bringing primary care and behavioral health together is a culture change**
3. **Champions of this change** are critical for successful integration
4. **Education** for all staff is key…
5. Integration requires **knowledge,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

Our Journey

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

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

Process Improvements:



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%

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

Integrated Care Outcomes

Metrics	Target	Baseline	Jan-17	Feb-17	Mar-17	Apr-17
ED utilization rate	0.035	0.03	0.014	0.022		
7 day follow up appointment	70.0%	45.5%	71.4%	50.0%		
Smoking cessation	21.0%	5%				
Diabetic A1C Control (>9)	16%	30%	18.2%	14%		
HYPERTENSION						
Hypertensive BP Control	75.0%	44.0%	65%	68%		
Undiagnosed Hypertension	5.0%	6.0%	6.7%	13%		
PRODUCTIVITY REPORTING						
Number Enrolled	600		211	231		
Average Productiviy (ALL)	N/A		6.80	6.86		
Appt. Utilization Rate	N/A		60.6%	55.7%		
Appt. No Show Rate	N/A		21.7%	17.9%		
Appt. Canc/Rescheduled Rate	N/A		32.2%	35.9%		

Progress

- Blood pressure within range (less than 140/90) has increased from 44% to 68% (for persons with hypertension dx)
- Rate of uncontrolled diabetes has dropped from 30% to 14%
- 231 persons enrolled in care as of April 2017

People Experience Improved Health and Health Care Experiences

- AJ is a middle-aged woman living with a diagnosis of schizophrenia. She has been getting behavioral healthcare at this clinic and trusts her nurse, psychiatrist and therapist. Because of paranoia she had no regular healthcare for several years. She had untreated hypertension and
other serious medical issues. A warm handoff to the onsite medical provider allowed her to engage in care and address her chronic medical conditions.

Lessons Learned

- Financial sustainability is harder to achieve than expected
- Culture change can be difficult
- Shared Care Plans are essential
- Champions make a difference
- Integration is creation of a whole new program, not an add-on service
- Having a clear vision about why integration fits your missio will help you keep at it when the barriers arise

Rapid Cycle Change

- Celebrate successes
- Reflect on results to date
- Brainstorm new ideas
- Continue the momentum and commitment to improvement in care for patients
- Continue to transform into a team that is doing things bett every day AND be able to prove it

New Strategies

- New presentation of integrated care as better care
  - Train/Coach Staff experientially to include medical care and integrate during intake and treatment planning
  - Develop Publicity plan for waiting area and high traffic areas
- Expectation that everyone have integrated care . . . with us if they choose
  - Develop regular meeting attendance and huddle participation pattern
  - Shared Care Plan
- Embracing HEDIS measures as indicators of quality
- Re-energized focus on people on antipsychotics to reduce risk of diabetes and cardio vascular disease
- Additional renovation to develop private space for lab draws

Integration of Behavioral Health in Primary Care

Bouakham Rosetti - Project Manager

April 27th, 2017

All Hands on Deck Executive Seminar

CARE COMPASS NETWORK

CARE COMPASS NETWORK

Provider Feedbacks:

- "I'm way too busy to offer much dialogue but when I have a patient that needs SW, I go get them, give them a little history and then pass it off to SW and they always get the patient what they need. ***It's a beautiful process***!"
- "**I only wish they were here all the time!** I have needed them a few times and they were both away at trainings."

CARE COMPASS NETWORK

Prior to Integration…

Walk in visit: Allergic reaction – 26F, Single, Employed, No Children, Recently moved in with father

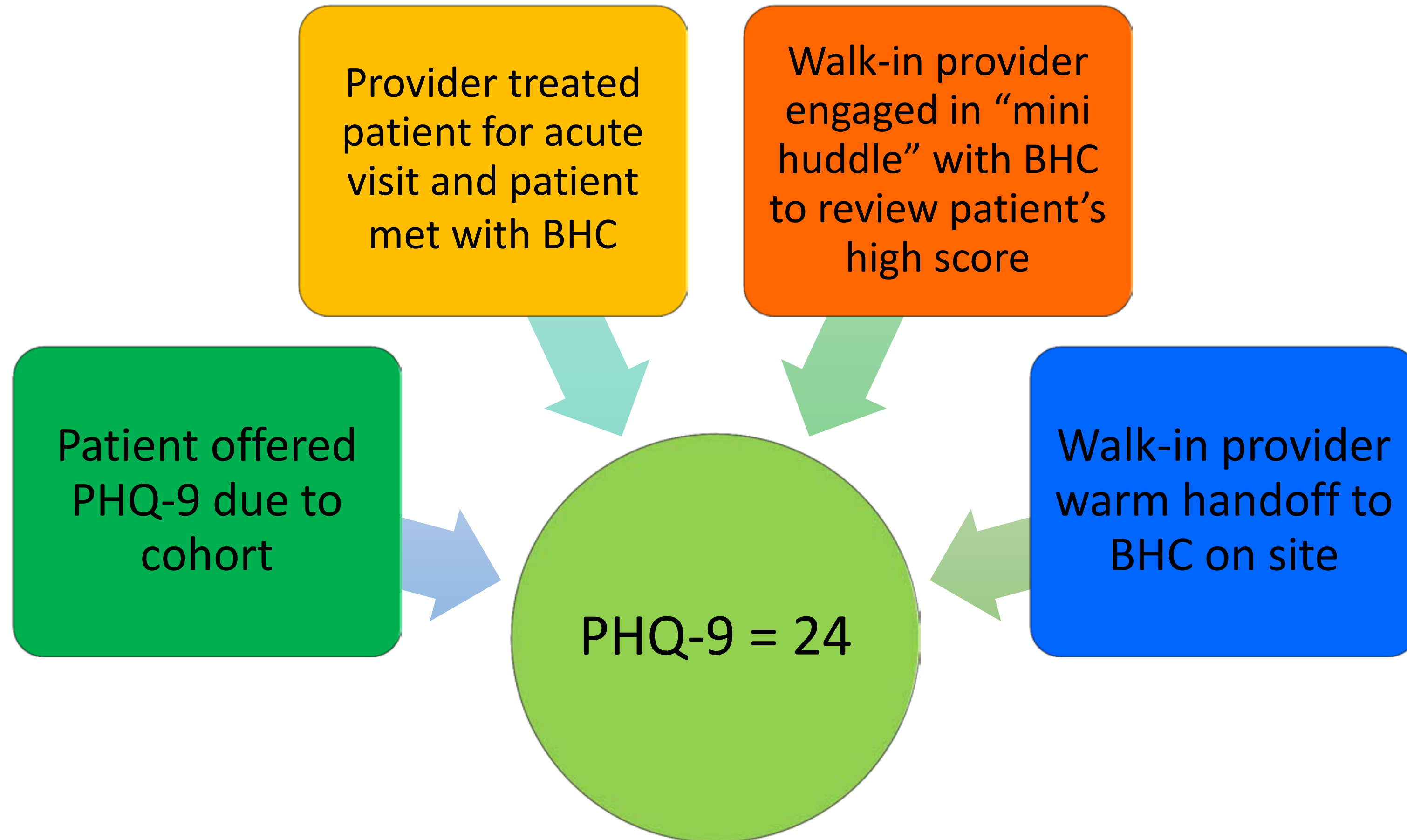
Patient treated for the allergic reaction

Discharged with appropriate medical treatment and/or prescription

Follow up appointment as needed with primary care provider

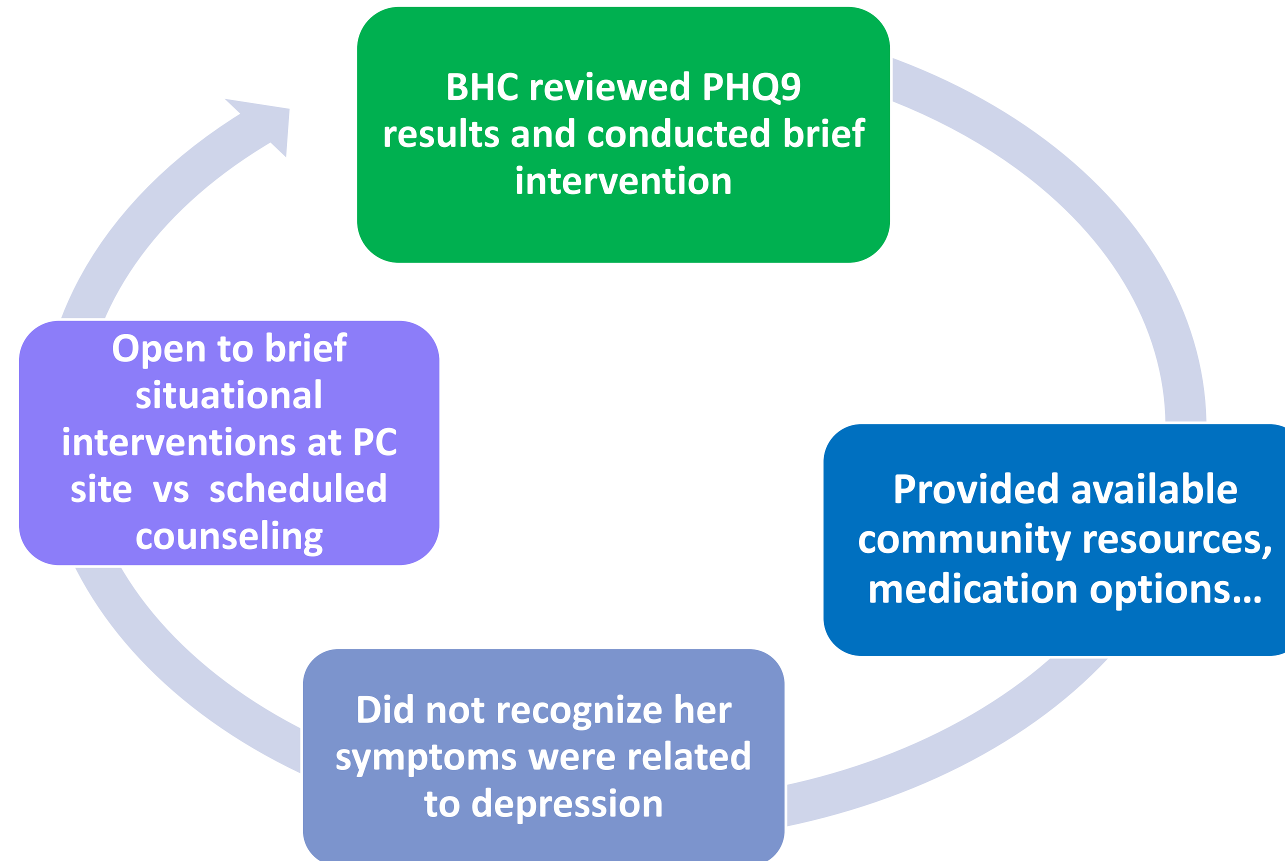
CARE COMPASS NETWORK

After Integration …



CARE COMPASS NETWORK

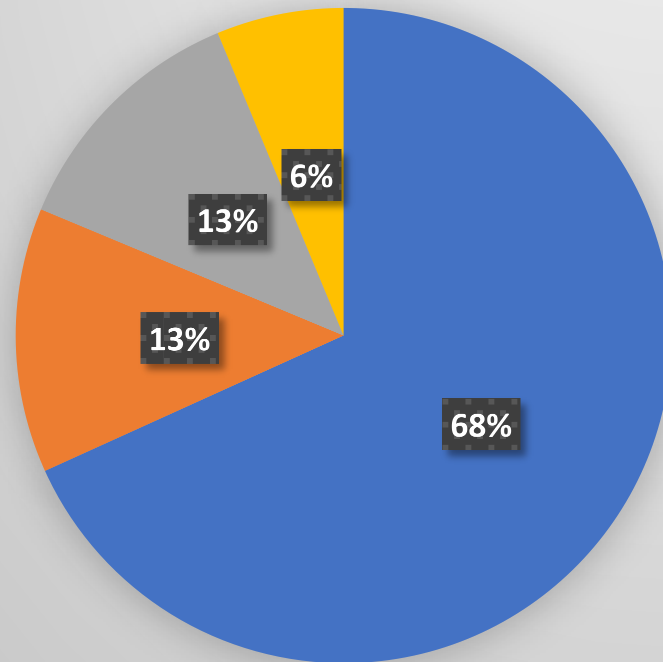
Same Day Visit Continues…



CARE COMPASS NETWORK

Lourdes Primary Care – MAX pilot 8 month Data Results

2,058 PHQ-9 screenings were offered to Patients



- PHQ9 - 0-9 - Minimal to no follow needed - assess for situational depression and re-screen at next appointment or 6 weeks depending on patient's circumstances
- PHQ9 - 10-14 - Moderate - Engages PCP or BHC counseling/intervention, treatment plan and/or medication options
- PHQ9 - 15-27 - Moderately severe to Severe - Engages BHC for immediate intervention, conduct further risk assessments
- Patients who refused screening

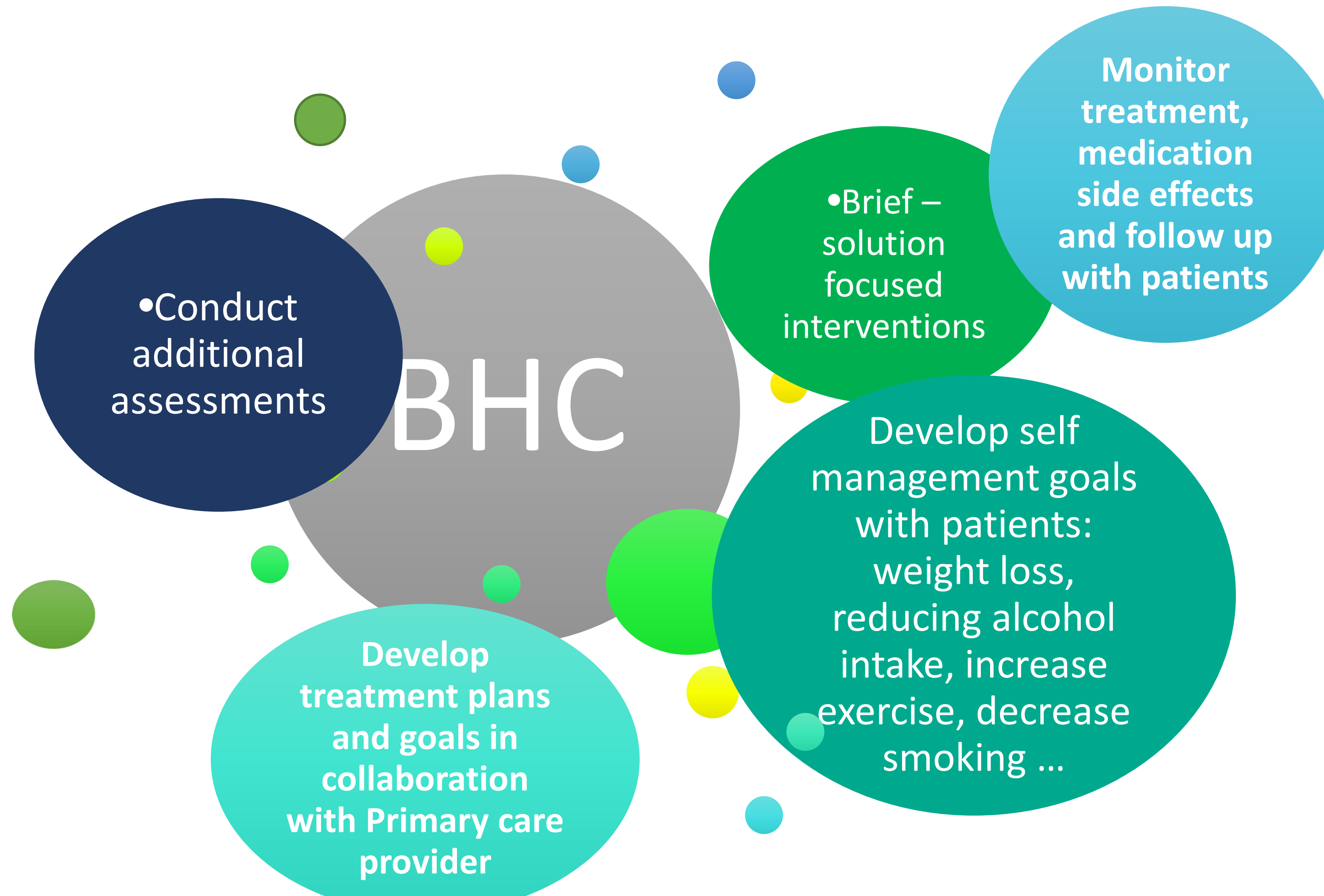
CARE COMPASS NETWORK

Benefits of Integration – Delivering care when it's needed most

- BHC – serve as the "bridge" between PCP, Patients and families
- Patient Engagement – receptive to BHC
- Remove stigma = patients receiving care when they need it most
- Patients does not have time and/or resources for long term traditional therapy in PC
- "Real Time" brief targeted situational interventions
- Initial PHQ2/9 – good baseline for PCP – early identification = early interventions
- "Troops mobilize quicker" to address patient needs

CARE COMPASS NETWORK

Impact of BHC at Primary Care
Meeting the needs of patients



CARE COMPASS
NETWORK

Practice Transformations

- Mini-huddles – collaborative care planning
- Mini Scripts – for staff and patients
- Shadow Opportunities between BHC and PCP
- Health Home Referral Enrollment Process
- ED/PCP follow up process with ED Social Work
- EMR BHC Referral Process
- Embedded social determinant questions in EMR
- Collaborative Agreement/Referral Agreement with Behavioral Health provider or agency
- Integrated treatment plan between BHC and PCP
- 3ai Model 1 Implementation Toolkit

CARE COMPASS NETWORK

Lessons Learned – Integration is hard work

- Identify your physician "**champion**"
- Identify your core team – Nursing, PCP, BHC, Operations, IT/DATA, Billing
- PCP education: Evidence based guidelines/protocols for common BH diagnosis and treatments
- Education for all staff is key – establishes purpose and cohesiveness
- Consistency is key - especially with workflow for staffs and clinicians
- Start Small! Define your target cohort. Set specific attainable goals.
- Meet Regularly and consistently – review data, support process improvement plans
- Data Management: Track and Monitor patients for improvements and responsiveness to treatment
- **Share successes! Changing culture takes time! Positive reinforcement always helps!**

CARE COMPASS NETWORK

Challenging Times…..Next Steps…

- Collaborative incentives to build and expand network of partners across continuum of care
- Workforce Development, Recruitment and Trainings
- Incorporate HEDIS Quality Metrics to measure outcome
- Start up Funding up to $50,000 for 3ai each practice sites
- Primary Care and Behavioral Health Resource Events
- Behavioral Health Screening IT Platforms
- Telehealth platforms to maximize behavioral health resources
- Peer Support Services in primary care

CCN PPS initiatives…

- Health Coaches in ED
- Telemonitoring for patients with depression in the home
- Opioid Pilot Project
- Transportation Vouchers initiative
- Eric Coleman Model – Care Transitions Health Coach Expansion to include discharged Medicaid Behavioral Health Patients from Inpatient Psychiatric Unit (Cayuga Medical Center and UHS)
- DBT Level 3 Training Pilot

Department of Health | Medicaid Redesign Team

Brightpoint Health

The New York-Presbyterian Queens PPS

Stephen Williams

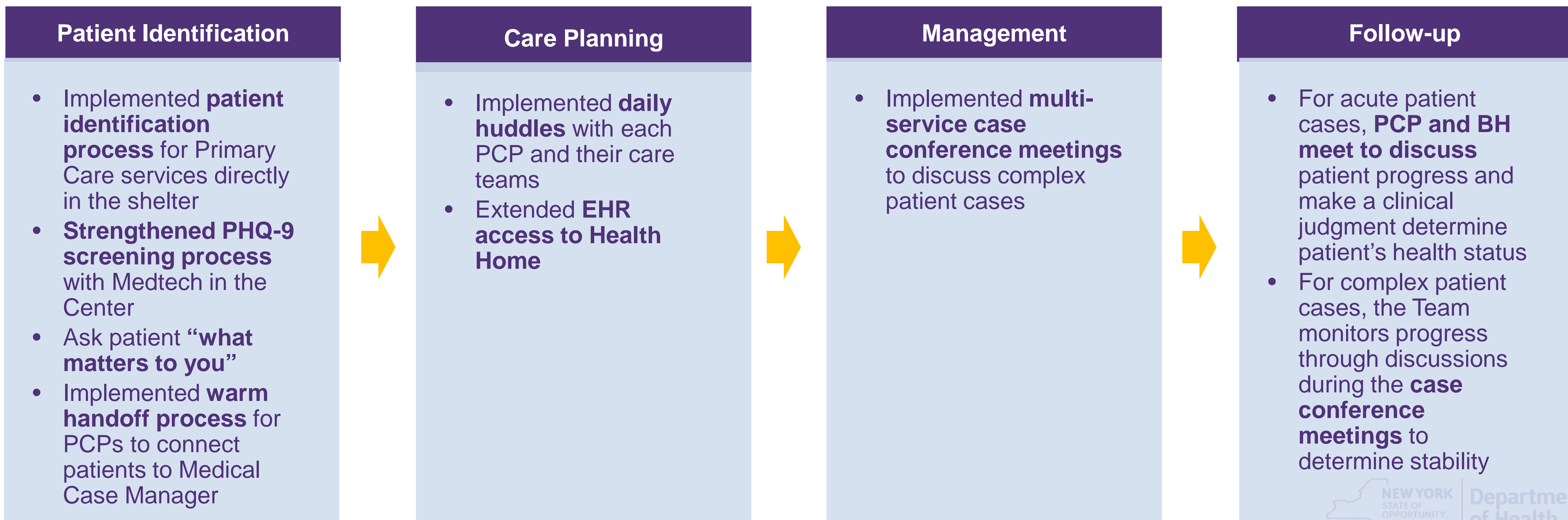
DSRIP Manager, Brightpoint Health

Our Journey

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

Integration Model: Integrating behavioral health into primary care

Process Improvements:



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

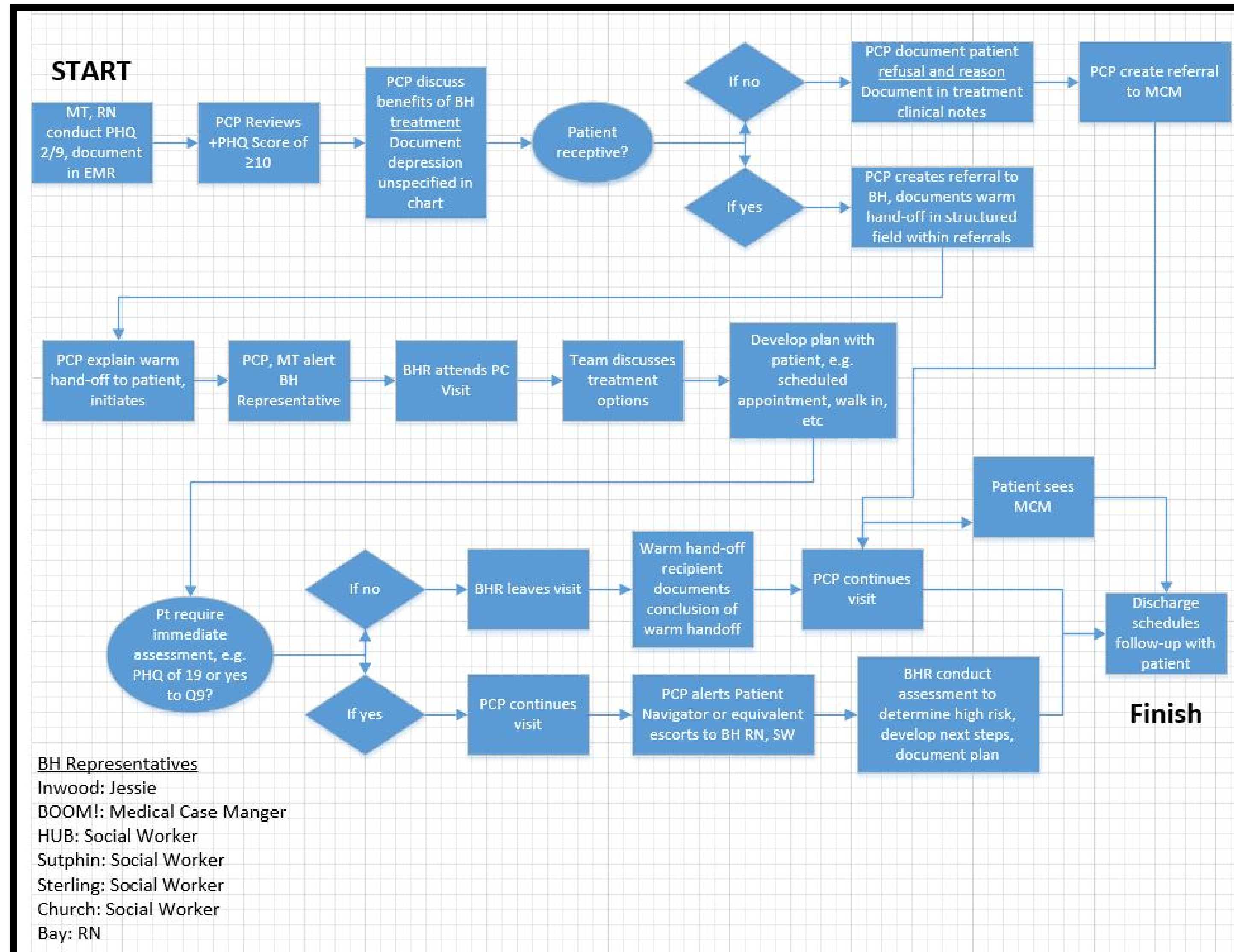
	Pre-MAX Baseline February 2016	Post-MAX August 2016	As of March 2017	
Data Element	Rate (/month)	Rate (/month)	Rate (/month)	%Δ from Baseline
PHQ Screening Compliance	71.3%	67.7%	83.9%	+17.7%
Attended first BH Visit	50%	29.6%	47.01%	-6.%
Wait Time for Patients in Cohort	Up to 5 hours	Maximum of 2 hours	60%	60%
Future State: Stable BH Patients Returning to PC	Baseline information not available	Interested in top 15% of patients returning to PC	Increased BH Capacity of 15%	Increased BH Capacity of 15%

Increasing Probability of BH Follow-up

Warm Hand-offs

- Breakdown stigma
- Increase trust with a new provider
- Seamlessly coordinate with BH provider
- Close the loop

Warm Hand-Off Workflow



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Increasing Probability of BH Follow-up

Self-Management Goals

- Patient, provider, case management created
- Small (but not insignificant) wins
- Build confidence in ability to affect change
- Follow-up with patient between visit
- Review at subsequent visits, adjust

Structured Self-Management Plan

Preventive Medicine
- Primary Care/Healt
- Counseling
- Dental
- Self Management
- Substance Abuse 8
- Pediatrics
- SBIRT Brief Interve
- Diabetes
- Hypertension
- HIV Disease
- Pain Management
- Hepatitis C
- MH Tx/Meds/Recom
- Goals

Self Management

Symptom	Presence	Notes
S Asthma		
S CVD		
S Depression		

Notes Browse ... Clear Select Default... Clear All...

Assessments Custom Treatment

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Structured Self-Management Plan

Preventive Notes

Free-form | Structured

Depression

Default for All | Clear All

Name	Value	Notes
Smart Goal:	Physical Activity	
Intervention/Plan:	Walk	Where:, Outside, When:, 4-7
Outcome/Progress:	Goal in progress	
Care Plan Completed:	02/27/2017	
Care Plan Review date:	02/27/2017	
Completed By:	Medical Provider	
Copy given to patient:	Yes	

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
- Standardize workflows for warm hand-offs
- Continue to **build on change** by looking at how self-management goals are created
- **Spread successes** to additional clinics