Virtual Health Management System

An ER Diversion Telemedicine Program for High-Utilization Patients
Today’s Presenters

• **Melissa Fox**, Senior Managing Director of Health Services, Public Health Management Corporation

• **Stephanie Puccia**, Director of Case Management and Social Services, Hahnemann University Hospital

• **Stewart Levy**, Founder and President of Health Promotion Solutions
After today’s session you will:

• Gain key learnings from the development of an innovative tele-health option.

• Learn the primary challenges which should be incorporated into the planning process.

• Be able to identify funding and develop the key partnerships needed to launch your own program.
Why are we here?
Who is PHMC?

- Nonprofit public health institute
- Improve community health through direct service, partnership, innovation, policy, research, technical assistance and a prepared workforce.
- Serving the greater Philadelphia region since 1972
- One of the largest and most comprehensive public health organizations in the nation.
PHMC is an FQHC.

- Five main sites
- Health Education
- Behavioral Health
- Chronic Disease Programs
- Financial Counseling
- Medical/Legal Services
- Insurance Enrollment
We identified a need.

- The uninsured and underinsured tend to have difficulty in accessing care.
- Limited access tends to result in overutilization of ED resources.
- Our hospital partners needed an efficient method to redirect appropriate patients to ongoing care management.
An Innovative Funding Partner

• PHMC sought startup funds to support the project.
• IBX Foundation saw and supported the vision.
• Aligned in terms of mission and expectations
• Partnered on the planning process
The Hospital Partner
Hahnemann University Hospital

• 496-bed academic, tertiary care hospital located in Center City Philadelphia
• Partnered with Drexel University School of Medicine
• Our Emergency Department cares for approximately 155 patients per day, 60,000 patients per year
• Top payors are Managed Medicaid, Medicare and Managed Medicare
• Admissions
Why Did We Partner with PHMC?

We identified:

- Poor health literacy impacting follow up
- Potential need for multiple resources at one location
- Trust issues between patient and healthcare provider
- Opportunity for real-time communication between care providers regarding fragile patients
- Need to better manage ED utilization
- Need to better manage avoidable readmissions
- Desire to better serve our community
Key Stakeholders

- ED physicians and nurses
- ED leadership
- ED social workers
- Transition managers
- Hospital Administrators
Assessment Criteria

- High/Frequent utilization of emergency departments for management on non-urgent conditions
- No PCP or no/limited contact with PCP
- Uninsured
- Social barriers to successful health management (i.e. Homeless, substance abuse, mental health issues, poor community support)
Referral Process

• Patient identified by ED staff
• Assessment completed by social worker to determine appropriateness for program
• Discuss program with patient and obtain consent for referral if patient agreeable
• Notify Care Clinic via phone of referral
• Complete Tele-Triage interview
• Provide patient with contact info to clinic and transportation assistance if needed
• Provide clinic with clinical documentation as needed for continued care
Telehealth trends
Key Points

• Telemedicine Growth and Trends
• Evolution Telehealth, Telemedicine, Telepresence
• Regulatory Challenges
• Technology Platforms
• Care Management Models
• Demonstration with a live clinic
• Case Studies
The Future is NOW!
Telemedicine Trends

✓ Exponential growth: 18 – 27 billion in next 3 years
✓ State and Federal Regs are in favor of expansion
✓ Consumers accept technology and find empowering
✓ Telemedicine has proven results
✓ Reimbursement being mandated by Government (Medicare) and 32 states for private pay insurance
✓ New reimbursement codes for remote care
✓ EHR integration from multiple sources
✓ New, flexible types of telemedicine models
Challenges of Wide-scale Telemedicine Adoption

- State Regulatory Laws
- Scalability
- Bandwidth Data Platforms
- Security
- Provider training and certification
- EHR Interfacing with other EHR applications
Clinical Uses of Telehealth vs. Telemedicine Technologies

1) Prevention of disease and health promotion (Health coaching)
2) Health advice by telephone (Referred to as tele-triage) (Telehealth Services)

3) *Transmission of medical images for diagnosis (Store and forward)
4) *Individuals exchanging health services or education live via videoconference (Teleservice or Video / Phone telehealth)
5) *Transmission of medical data for diagnosis or disease management (Referred to as Telehome or home monitoring)
Telemedicine Domains

- Home Health Monitoring
- Palliative Care
- Hospitals/Emergency Departments
- Critical Access Hospital
- Urgent Care Centers
- Clinics/Medical Homes/MD Offices
- Federally Qualified Health Centers
- Long-term Care Facilities
- School Systems/Community Health Centers
- Wound Care/Diabetes
- Pharmacy & Care Navigation-Med Management
- Self Insured Employers
- Correctional Institutions
Telemedicine State Coverage

- States have the option/flexibility to determine whether (or not) to cover telemedicine
- Types of telemedicine to cover;
- Where in the state it can be covered;
- How it is provided/covered – (First Patient Visit)
- Types of telemedicine practitioners/providers that may be covered /reimbursed
- How much to reimburse for telemedicine services
Four Major Telemedicine Care Platforms

- Primary Care & Specialty Care
- Neurology and Tele-Stroke Support
- Psych and Behavioral Health
- Remote Patient Monitoring
Telemedicine Technology Platforms

- Video
- Clinics
- Kiosks / Cart
- Telephone
- Mobile App
- Home Monitoring
“Teladoc” Phone - Acute Care

- Colds & Flu
- Eye Conditions
- Skin Conditions
- Sinus Infections
- Earaches
- Sore Throats
- Depression/Anxiety
- Bronchitis
- URI
## Telephonic Model Teladoc (No video)

### Results

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
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<tbody>
<tr>
<td>Member Satisfaction</td>
<td>97%</td>
</tr>
<tr>
<td>Physician Satisfaction</td>
<td>97%</td>
</tr>
<tr>
<td>Avg. Consult Duration</td>
<td>10 min</td>
</tr>
<tr>
<td>Malpractice Claims</td>
<td>0</td>
</tr>
<tr>
<td>Avg. Response Time</td>
<td>22 min</td>
</tr>
<tr>
<td>Patient Issues Resolved</td>
<td>91%</td>
</tr>
</tbody>
</table>

*Based on Teladoc reporting and member surveys*
Video to Video Telemedicine
Benefits of Telemedicine
Video plus Instruments (Clinic Model)

- View digital image of medical instrument
- Personalized by following eye contact of provider
- Acute Care, Chronic Disease, Wellness, Occ. Health
- Specialty Care and Trans-disciplinary Providers
- Results integrated into EHR
- Reimbursement from carriers (designated states)
- Sustainable business model
- Location retail, schools, nursing home, YMCA
On-Site Telemedicine / Telepresence Clinic
(Virtual Clinic)

Origination Site

Clinic Telemedicine Consult Room:

- Wall-Mount Set-Up
- High touch: on-site staff
- High res – 3D image option
- Pan tilt zoom camera
- Computer
- All-in-one exam camera
- Bluetooth instruments
- EHR Software integration
- Scheduling software
- Minimal Space Requirements
Clinic Telemedicine Clinic Options

Destination Site for clinic provider

Provider:

- Ability to see patients for intervention
- Specialty providers to see clinic patients via telemedicine

Set-up:

- Webcam
- Computer
- Software
- Capable of video, scheduler, and EHR
Telemedicine Clinic Kiosk

- Can be located in retail settings
- HIPAA compliant
- Patient convenience
- Build as origination and destination for R.Ph. or RD
On-Site Cart Model

Origination and Destination Site

- Ideal for nursing home
- High touch: on-site staff
- Portable option
- Pan tilt zoom camera
- Computer
- All-in-one exam camera
- Bluetooth instruments
- EHR Software integration
- Minimal Space Requirements
- Lower cost
Portable Telemedicine Units

Telemedicine Mobile Kit
Includes:

- All-in-one exam camera
- HIPAA Compliant video platform
- Bluetooth stethoscope
- Computer with telemedicine software suite
- Hard case for use of transportation of equipment
Home Telemedicine Monitoring

- Video consult capability for discharged patients – CHF, COPD, Diabetes, CV
- Create health teams for family members to track progress and utilization
- Tablet with software easy to use
- Patient education
Current Home Monitoring Telemedicine Devices

- Blood Pressure
- EKG
- Pulse
- Weight
- Glucose
- Prothrombin time
- Blood Oxygen
- Peak Flow Spirometry
- New - Ejection Fraction
- New - Ophthalmoscope
E Mobile App

- Branded mobile app
- Schedule or initiate a call
- Review provider bio, certifications & ratings
- Video call HIPAA compliant
- Dual encryption audio/video
- Text and photo capability
- Customized payment options/
Biometric Data Integrity Controls

- Collect real-time biometrics at events
- Dedicated, Stand-Alone Server
- Fully Managed Firewall with Strict Access Controls
Telemedicine Vendor Service Evaluation

- Consulting
- Telemedicine Platform
  - Equipment procurement
  - Installation
  - Training
  - Program support
- 24/7 IT Support
- Staff Scheduling
- Billing Options
- Account Management Support
- Quality Assurance, Quality Control & Consistency of Care
- Marketing & Communications
Telemedicine Demo
Case Studies - Georgia TeleHealth Partnership

800+ Telehealth endpoints and growing

200,000+ encounters per year

65+ years combined telemedicine experience

250+ deployments

8 Countries with International Presence

100 years combined healthcare expertise
Medical Institution Partners:
- Memorial Health University Medical Center
- Georgia Regents Medical University
- Medical College of Central Georgia
- Tifton Regional Hospital
- South Georgia Medical
Care Coordination in Telemedicine-VA System

• 445 veterans with Diabetes over one year
• Statistically significant reduction in
  – Patients who were hospitalized (50% reduction)
  – Emergency room use (11% reduction)
  – Reduction in the average number of bed days of care (decreased an average of 3.0 days)
  – Improvement in the Health Related Quality of Life (HRQL) for role-physical functioning, bodily pain, and social functioning.
Care Coordination in Telemedicine
Home Care with Hospital at Home

- Albuquerque, New Mexico–based Presbyterian Healthcare Services adapted the Hospital at Home® model developed by the Johns Hopkins University Schools of Medicine and Public Health
- Acute hospital–level care within patients’ homes.
- **Patients show comparable or better clinical outcomes** compared with similar inpatients, and they show **higher satisfaction** levels.
- Medicare Advantage and Medicaid patients with common acute care diagnoses, **achieved savings of 19 percent over costs for similar inpatients**.
- Savings were from **lower average length-of-stay and use of fewer lab and diagnostic tests**
- Hospital at Home advances the Triple Aim of clinical quality, affordability, and exceptional patient experience.

Lesley Cryer, Scott B. Shannon, Melanie Van Amsterdam, and Bruce Leff
Care Coordination in Telemedicine: Tele triage for Emergency Rooms

• Reduction in transfers between emergency departments.
• 2.2 million patients transported each year between emergency departments at a cost of $1.39 billion in transportation costs, telemedicine technologies would avoid 850,000 transports with a cost savings of $537 million a year.
Care Coordination in Telemedicine: Nursing Homes

- Costs of implementing telemedicine in nursing homes could be covered by
  - Savings from a reduction in transferring residents to ER and physician offices,
  - Savings by avoiding the costs of the emergency department visit
- 2.7 million transports made annually from nursing home facilities to emergency departments at a cost of $3.62 billion in transportation and emergency department visits
- Telemedicine could avoid 387,000 transports with a cost savings of $327 million.
- 10.1 million physician office visits made annually from nursing facilities at a cost of $1.29 billion for in-person physician office visits and transportation,
- Telemedicine could avoid 6.87 million transports with a cost savings of $479 million.
Care Coordination for Chronic Disease in Medicare Patients

- Telemedicine Care coordination approach called the Health Buddy Program,
- Integrates care management transdisciplinary team for chronically ill Medicare beneficiaries.
- Evaluated impact on spending for patients of two clinics in the US Northwest
- Significant savings among patients associated with spending reductions of 7.7–13.3 % ($312–$542) per person per quarter.

Care Coordination in Telemedicine: Correctional Facilities

- Correctional facilities could benefit from Telemedicine
  - Reduction in transporting patients to emergency departments and from physician offices
- 94,180 transports made annually from correctional facilities to emergency departments at a cost of $158 million in transportation and visit costs,
- Telemedicine could avoid almost 40,000 transports with a cost savings of $60.3 million a year.
- Telemedicine could avoid 543,000 inmate transports to physician offices with a cost savings of $210 million.
Care Coordination – Patient Centered Medical Home

• University of Pittsburgh Medical Center (PCMH)
• Telemedicine support primary care practices converted to patient-centered medical homes.
• From 2008 through 2010, sites participating in the UPMC pilot achieved
  – Lower medical and pharmacy costs;
  – More efficient service delivery, such as lower hospital admissions and readmissions
  – Less use of hospital emergency departments
  – 160 % return on investment when compared with nonparticipating sites.

Cynthia Napier Rosenberg, Pamela Peele, Donna Keyser, Sandra McAnallen, and Diane Holder
Care Coordination in Telemedicine – Indian Health Service

- The Indian Health Service (IHS), cares for 2 million of the country’s 5.2 million American Indian and Alaska Native people.
- Reduction in the life-expectancy gap between American Indian and Alaska Native people and whites (from eight years to five years)
- Improved measures of diabetes control (including 20 percent and 10 percent reductions in the levels of low-density lipoprotein cholesterol and hemoglobin A1c, respectively).
Care Coordination in Telemedicine for Schools

Children's Medical Center of Dallas - to two Pre-Schools

– Expanded to (27) campuses in 2015 including both public and private schools throughout North Dallas.
– Visits are 100% reimbursable with primary care
– No need for additional grant or Medicaid funding.
– Program has now spread to (57) campuses in urban and rural school districts in North Texas, in Dallas, Collin, Grayson and Tarrant counties.
Definition of the PHMC/Hahnemann Model
Process Flow

• Clinical and operational teams met to determine the outcomes and best patient flow.

1. HUH Social Worker meets with potential candidate in ER to discuss tele-triage and provide CC welcome packet.

2. If patient is appropriate for tele-triage and approves a remote session with CC, it will occur after discharge plan is discussed with patient.

3. HUH Social Worker will notify CC of the tele-triage session at least 1.5 minutes in advance.

4. Patient's demographic info, registration, and discharge paperwork are sent to CC prior to the tele-triage session.

5. CC RN reviews documentation and preps for the remote session.

6. During the session, the CC RN will provide a brief intro to the clinic, answer any questions, and schedule an initial appt. according to the ER's recommendations.

7. For patients with higher risk of no-show, same day CC RN visit may occur. Patient will be transported via taxi from HUH to CC. All patients will receive a token to attend their initial appt. at CC.

8. The CC RN will call patient prior to initial visit to remind patient of appt., confirm attendance, or resolve potential barriers.

9. CC RN will provide ongoing support for the patient following initial visit (Method of contact, frequency of contact, and duration TBD).
Key Challenges

- Learning curve with internal teams and patients
- Firewall and IT issues
- Internal Resources to support initiative
- Identification of best times for staff and patients
Results and Feedback
Hahnemann Results/Feedback

• 16 referrals to PHMC from Hahnemann with 0 readmissions, however only 2 referrals were made through Tele-Triage system
• Solid referral system identified and being utilized
• Clearly defined opportunities for process improvement identified
Questions
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The UAB Model of Care for Interprofessional Practice and Education in Chronic Disease Management: A Tale of Two Clinics

Cynthia S. Selleck, PhD, RN, FAAN
Shannon DeLuca, MSN, CRNP, CCTC, CHFN
University of Alabama at Birmingham School of Nursing
The UAB NEPQR Story

NEPQR #1
PATH Clinic
Starting teams

NEPQR #2
HF Clinic
Making teams work

NEPQR #3
BHI
Integrating behavioral health
Disclosure

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- Grant # UD7HP25047 (Interprofessional Collaborative Practice at the PATH Clinic), September 2012 to June 2015 ($1.4 million).
- Grant # UD7HP26908 (Interprofessional Collaborative Practice Enhancing Transitional Care Coordination in Heart Failure Patients), July 2014 to June 2017 ($1.5 million).
- Grant # UD7HP29873 (Bridging the Gap in Behavioral Health for Uninsured Populations in Birmingham), July 2016 to June 2018 ($1 million).

This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by, HRSA, HHS, or the U.S. Government.
Background

- UAB is an academic health science center
- UAB Nursing Partnership is our formal academic-practice partnership
- Effective academic-practice partnerships bridge the gap between academia and practice
- Full partnership is imperative to advance integrated systems of health care

UAB Nursing Partnership

Priority 1: Leverage resources to provide outstanding patient care

*Support creation and implementation of new models of care delivery*

Priority 2: Invest in teaching and training for interprofessional collaboration

*Provide team and interprofessional-based teaching and training*

Priority 3: Partner in research and scholarship

Priority 4: Implement sustainable partnership governance
UAB School of Nursing: Academic Partner

- Shapes patient-centered health care by preparing recognized nurse leaders who excel as clinicians, researchers, and educators in Alabama, nationally and internationally

- Offers baccalaureate, master's, and doctoral nursing education
UAB Hospital: Practice Partner

- Large academic medical center located in the medical district of downtown Birmingham
- 1300 beds at 2 campuses
- 3rd largest public hospital in the U.S.
- Employs approximately 2,500 registered nurses: 2245 staff nurses and 154 leadership roles
- 4 times Magnet designated
NEPQR #1: The PATH Clinic
(Providing Access to Healthcare)
Driving Forces for the PATH Clinic

Alabama Health Statistics

- In 2015, Alabama ranked 46th overall; 49th in health outcomes
- 12.9% of Alabama adults have diabetes, placing the state 47th
- 33.5% of Alabama adults are obese, placing the state 46th
- 27.6% of Alabama adults are physically inactive, placing the state 43rd

United Health Foundation, America’s Health Rankings 2015
The PATH Clinic

- The PATH Clinic is the first nurse-led IPCP clinic at UAB. It was previously funded by a NEPQR IPCP award (2012-2015)
- Now funded through ongoing partnership between UAB School of Nursing and UAB Hospital and Health System (annual budget = $383,000)
- Provides nurse-led, team-based care to uninsured patients with diabetes who are discharged from UAB Hospital with no source for ongoing care
- The PATH Clinic operates 16 hours per week in the UAB Medical Towers Building (primary care HPSA score = 8; mental health HPSA score = 17; dental health HPSA score = 12)
The PATH Clinic

• Interprofessional team of providers at the PATH Clinic includes:
  • Nursing (ACNP, FNP, ANP, PMHNP, RN Care Manager)
  • Social Work (PAP Manager)
  • Nutrition
  • Optometry
  • Medicine (General Internal Medicine)
  • Physical therapy

• Students/residents from each discipline are also incorporated into the team-based IPCP model at the clinic
PATH Clinic IPCP Structure

**Tuesday Team**
- 2 Nurse Practitioners (NP)
- RN Care Manager
- Psych-Mental Health NP
- Dietitian
- PAP Coordinator (Social Worker)
- Physical Therapist (wound care)
- Students

**Thursday Team**
- 2 Nurse Practitioners (NPs)
- 1 PMHNP
- RN Care Manager
- General Internist
- Optometrist
- Dietitian
- PAP Coordinator (Social Worker)
- Students + Residents
PATH Clinic Process

Resource Use
- Number of ED visits
- Number of Hospitalizations
- Total charges (costs)

Process Measures
- % clinic visits kept
- # clinic visits provided
- # services provided

Clinical Outcomes
- A1C, BP, BMI
- PHQ-9 Depression scale
- Mortality rate, amputation rate
- New/progressive retinopathy

Health & Social Outcomes
- Successful enrollment in other care sites
- Obtaining health insurance
- Successful enrollment in PAP
PATH Clinic Outcomes

Clinical Outcome Data

<table>
<thead>
<tr>
<th>% A1C</th>
<th>A1C at First PATH Clinic Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 8.0 (Target Range)</td>
<td>29.6%</td>
</tr>
<tr>
<td>8.0 – 8.9</td>
<td>13.2%</td>
</tr>
<tr>
<td>&gt; 9.0 (Uncontrolled)</td>
<td>57.2%</td>
</tr>
</tbody>
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*Based on 152 patients at the PATH Clinic at Medical Towers between August 2015 – August 2016; mean A1C = 9.79

### A1C on Referral vs Most Recent A1C

<table>
<thead>
<tr>
<th>A1C on Referral</th>
<th>Most Recent A1C</th>
<th>Mean Difference</th>
<th>Significance</th>
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<tbody>
<tr>
<td>11.61</td>
<td>8.14</td>
<td>3.47</td>
<td>p = .000</td>
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</table>

*Based on 55 patients who came to PATH Clinic between August 2015 – August 2016 with an A1C done at UAB Hospital

### A1C at Clinic vs Most Recent A1C

<table>
<thead>
<tr>
<th>First A1C at PATH Clinic</th>
<th>Most Recent A1C</th>
<th>Mean Difference</th>
<th>Significance</th>
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</thead>
<tbody>
<tr>
<td>9.79</td>
<td>8.41</td>
<td>1.37</td>
<td>p = .000</td>
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</table>

*Based on 88 patients for whom we have 2 or more A1C values from the PATH Clinic between August 2015 – August 2016
# PATH Clinic Cost Outcomes

<table>
<thead>
<tr>
<th></th>
<th>One Year Pre</th>
<th>One Year Post</th>
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</thead>
<tbody>
<tr>
<td>Inpatient rate per patient year</td>
<td>1.04</td>
<td>0.45 (p &lt; 0.001)</td>
</tr>
<tr>
<td>ED rate per patient year</td>
<td>0.77</td>
<td>0.93 (p = 0.04)</td>
</tr>
<tr>
<td>Median total cost per encounter (inpatient)</td>
<td>$5,650</td>
<td>$4,824</td>
</tr>
<tr>
<td>Median total cost per encounter (ED)</td>
<td>$448</td>
<td>$369</td>
</tr>
<tr>
<td>Total Cost (N = 218)</td>
<td>$2,507,820</td>
<td>$1,003,661</td>
</tr>
</tbody>
</table>
NEPQR #2: The Heart Failure Clinic
Driving Forces for Heart Failure Clinic

• HF leading cause of hospitalization among adults >65 years in U.S.

• Annually >1 million patients hospitalized with primary HF diagnosis

• HF accounts for total Medicare expenditure exceeding $17 billion

• Admission rates following HF hospitalization remain high and ≥50% patients readmitted within 6 months of discharge

HRSA Heart Failure Clinic

- HF Clinic is the second nurse-led clinic at UAB. It is currently in the 3rd year of NEPQR IPCP funding and builds on the PATH Clinic’s model with modifications to address the care complexity requirements of HF patients.

- Provides nurse-led, team-based care to uninsured patients with HF who are discharged from UAB Hospital with no source for ongoing care.

- HF Clinic operates in the second floor of the Russell Ambulatory Center on the UAB Hospital campus (primary care HPSA score = 8; mental health HPSA score = 17; dental health HPSA score = 12).
The interprofessional team of providers at the HF Clinic includes:

- Nursing (CNL, ANP, ACNP)
- Medicine (Cardiologist)
- Social work
- Health services administration
- Health information technology

As with the PATH Clinic, students from these disciplines are also incorporated into the team-based IPCP model at the clinic.
HRSA Heart Failure Clinic Triple Aim Outcomes

Cost Data (ED, Bedded-ED, Inpatient, Outpatient)

<table>
<thead>
<tr>
<th># Before Encounters</th>
<th># After Encounters</th>
<th>Reduction in Encounters</th>
<th>Before Cost Encounters</th>
<th>After Cost Encounters</th>
<th>Cost Saved</th>
<th>Reduction in Cost</th>
</tr>
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<tbody>
<tr>
<td>117</td>
<td>101</td>
<td>14%</td>
<td>$925,221</td>
<td>$575,889</td>
<td>$349,332</td>
<td>38%</td>
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</table>

*Based on 85 engaged patients seen at the HF Clinic from 12/1/2014 – 7/31/2016

Patient Experience

<table>
<thead>
<tr>
<th># Very Satisfied</th>
<th>% Very Satisfied</th>
<th># Satisfied</th>
<th>% Satisfied</th>
<th># No Answer</th>
<th>% No Answer</th>
<th>% Overall Satisfaction Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>327</td>
<td>79%</td>
<td>67</td>
<td>16%</td>
<td>22</td>
<td>5%</td>
<td>95%</td>
</tr>
</tbody>
</table>

*Based on 416 patients satisfaction surveys at the HF Clinic from 12/1/2014 – 9/30/2016
Patient Health Outcomes

SF-15 (*Adapted from the SF-36)

Mean Score

Clinic Visit

Mental Health

Physical Health
NEPQR #3: The Behavioral Health Integration

Behavioral Health Services
Wrap Around Process

PATH Clinic + Heart Failure Clinic
Driving Forces for Behavioral Integration

• Significant numbers of patients at both clinics have co-occurring mental and behavioral health conditions, the diagnosis and management of which could be markedly improved through the effective integration of behavioral health into the current IPCP models of care.

• Collaboration with community partners who have agreed to serve as referral sites for our patients needing substance abuse treatment.

• The ability for primary care providers and students to learn behavioral health integration.

• Ultimately, improved health for our patients and reduced costs to the health system.
Goals of the BHI- NEPQR #3

1. Implement an effective model in which behavioral health is fully integrated into primary care and chronic disease management.

2. Incorporate nursing and other health professions students into the expanded IPCP behavioral health model in order to expose future providers to integrated, team-based care and the healthcare needs of vulnerable populations.

3. Develop and implement a plan for long-term sustainability of the expanded IPCP model at both the PATH Clinic and HF Clinic.
Transitional Care Coordination IPCP Model
Across the Hospital, Clinic, Home, and Community

Leveraging Resources of Academic-Practice Partnership
Faculty/Staff Expertise, Clinical Integration, and Rapid Cycle Improvement

Behavioral Health Services
Wrap Around Process

Heart Failure and Diabetes
Underserved Population
Patient/Family Centered Care and Engagement

Population Health

Outcomes

Patient Experience

Cost per Capita

Knowledge that will change your world
Current Status of NEPQR #3

• Educated current clinicians (July – Sept 2016):
  • Met with staff at both clinics, including Launch meeting on Sept 29th
  • Completed F2F training on Motivational Interviewing, SBIRT and Tobacco Cessation
  • Clinicians completing 4 online modules on IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) and 8 IHI (Institute for Healthcare Improvement) modules on quality improvement (July – Dec)
Current Status of NEPQR #3

• Developed process for administering depression, tobacco and substance abuse screening at each visit
• Hired new clinicians
• Launched BHI on October 1, 2016
• And now we’re trying to figure it out!

Our ultimate goal:
To fully integrate mental and behavioral health into chronic care management in order to further improve the health and health care and decrease costs for the vulnerable populations seen at both clinics.
What have we learned through our NEPQR journey?

• The road to true team-based care is steep and long
• Experienced clinicians lack understanding of the roles/responsibilities of professions other than their own
• It takes time to learn to function as a team (Tuckman’s stages of team formation: forming, storming, norming, performing)
• Unexpected feeling of “leaderlessness” (education is needed to understand shifting leadership)
More lessons learned

• Interagency cooperation is vital
• Care management – crucial for our population
• PAP Coordinator - essential for navigating pharmaceutical company charity programs
• Reduction in hospital costs – difficult to assess
• Sustainability – need to start early
Clinician quotes about IPCP

• “I have worked in healthcare for 30 years and believe that this is the way it should be.”

• “I didn’t realize the richness that having multiple perspectives could bring to patient care. I now think this is a good way to practice rather than a difficult way to practice.”

• “IPCP helps to eliminate confusion by being able to talk directly to other clinicians instead of sending notes back and forth.”
Clinicin quotes about IPCP

• “Overall I think the collegial relationship between the providers has improved some patient outcomes.”
• “I think that the different professional perspectives positively reinforce discussions with patients... I think the patients hearing things more than once helps and patients hearing things in different terminologies helps.”
Clinician quotes about IPCP

• “The main thing, which is very joyful actually, is the time we spend together processing how the patients are doing and coordinating the different specialties. You know, processing time. We just don’t have that in private practice.”

• “I guess the most important lesson would be that if I had my choice for my next (practice) site it would definitely be an interprofessional practice.”