NJ DSRIP Program

Integrated Health Home for the Seriously Mentally Ill (SMI)

Kimball Medical Center
Learning Collaborative Update
January 8, 2015

Integrated Health Home: Kimball Medical Center

- Affiliate of Barnabas Health System
- Serving Ocean County Residents for More than 100 Years.
- Fully Accredited Acute-Care Facility Offering a Full Range of Modern Diagnostic Services, Treatment Services, and Wellness Programs
- 60 Inpatient Psychiatric Beds Located at the Barnabas Health Behavioral Health Center

Integrated Health Home: Objective

- Fully Integrate Behavioral Health and Physical Health Services for Patients with a Serious Mental Illness by Developing and Co-Locating a Primary Care Service at the Barnabas Health Behavioral Health Center in Toms River, New Jersey, in Order to Provide Evidence-Based, Whole-Person Care.

Integrated Health Home: Goals

- Reduced Overall and Psychiatric Readmissions
- Reduced Emergency Department Visits
- Reduced Client 1st Appointment "No-Show" Rate
- Improved Client Adherence to their Treatment Regimen and Medication plan
- Improved Care Processes

Integrated Health Home: Pilot Program Logistics

- Pilot Program Began October 1, 2014
- Location Staff Include;
  - Program Supervisor (LCSW)
  - Family Practice APN
  - Psychiatric APN
  - Social Worker (LCSW)
  - Community Health Workers (LPN & MHA)
- Co-Located Treatment Facility at Barnabas Health Behavioral Health Center

Integrated Health Home: Pilot Program Components

- Early Assessment of Patients on Inpatient Unit
- Discharged to the Integrated Health Home with Intake Appointment to be seen within 72 Business Hours of Inpatient Discharge
- Integrated Treatment Team Intake including Psychiatrist, Medical APN, Social Worker and assignment of Community Health Worker at 1st Appointment
- Development of Single Integrated Treatment Plan to Follow the Patient

Integrated Health Home: Pilot Program Status

- # of Patients Screened: 37
- # of Patients Enrolled: 31
- # of Patients Active: 23
- % of Patients Attending First Appt: 87.1%
- % of Patients Seen within 72 Bus. Hrs.: 70.4%
- % of Patients with 30-Day Treatment Plan Evaluation: 100%
- % of Active Patients Readmitted within 30 Days: 13% (3/23)
- Top Co-Morbid Conditions Identified:
  - Diabetes
  - Hypertension
  - Obesity

Integrated Health Home: Learning Collaborative – 12/18/14

- Stage 1 Metrics100% Complete Including the Quality Plan
- Stage 2 Metrics Underway – 35% Complete
- Stage 3 and 4 Metrics Underway – 30% Complete
- Continued Engagement with Partners and Hospital Leadership Regarding Program Status
- Two Rapid-Cycle Improvements Underway:
  - SF-36 Patient Wellness Assessment Automated Scoring
    - Phase: Do – Build of Bi-Directional Interface for Real-Time Results Scoring
  - Program Referral Sources
    - Phase: Plan – Expansion of Additional Referral Sources to the IHH Program

Integrated Health Home: Triumphs, Challenges, Observations

- Triumphs:
  - The Pilot has Begun!
  - Low No-Show Rate for 1st Appt. Attendance (Below 20%)
- Challenges:
  - Lower than Expected Patient Volume
  - Manual Scoring of Patient Wellness Assessment
  - Delayed Receipt of Patient Attribution List
- Observations:
  - Patients with Managed Medicaid Enter IHH Program with Designated PCP

Integrated Health Home: Questions

QUESTIONS?

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