NJ DSRIP Program

Integrated Health Home for the Seriously Mentally Ill (SMI)

Monmouth Medical Center Southern Campus
Learning Collaborative Summary
July 9, 2015

IHH Patient Engagement: Where Does It Start?

- Early Assessment of Patients on Inpatient Unit for Potential IHH Referral.
- Discharged to the Integrated Health Home with Intake Appointment to be seen between 3 and 7 days from Referral
  - Key component:
    - Streamlined Transition of Care cannot be overstated
    - Collaborative Communication between IHH and referral source
      - Information sharing via EHR from Inpatient units and consented information sharing from other referral source partners.
- Integrated Treatment Team Intake including Psychiatrist, Medical APN, Social Worker and assignment of Community Health Worker
- Development of Single Integrated Treatment Plan to Follow the Patient
  - Patient agreement and participation

IHH Patient Engagement: How Does it Continue?

- Appointment Reminders and Wellness Calls
  - Barnabas Health Access Center Staff Performing 72, 48, 24 hour reminder phone calls bridging inpatient care or initial referral point to first IHH patient Intake appointment
  - Access staff conduct wellness calls to patients based on a tiered risk stratification model
- Community Health Worker (CHW) Outreach
  - CHWs work with patients in the community to ensure adherence to their treatment plan
    - Home Visits
      - Visits in-home or in the community (i.e. coffee shops, church, etc.)
  - Working with the interdisciplinary team, remove barriers to patient's access to care
    - IHH Offers Transport to appointments when other sources are unavailable

IHH Patient Engagement: How Does it Continue?

- Patient Wellness and Education
  - Providing Health Education and Wellness opportunities to support patients and their families
    - Understanding Medications
      - Education about medications
      - How to recognize and manage side effects
    - Respiratory Health
      - Respiratory health and smoking cessation
    - Diabetic Education
      - Understanding the disease, monitoring, know your numbers
    - Nutrition
      - Color Your Food, Create your Mood
        - Cooking demonstration using healthy ingredients
        - Provided tasting samples and take home ingredients to re-create the healthy meal in-home

IHH Patient Engagement: Expanding our Patient Population

- Pilot program took referrals only from Inpatient Behavioral Health units
- Post-Pilot expansion has included referrals from:
  - PESS
  - IOP program
  - Inpatient Medical Nursing Units
- Currently building marketing plan to seek referrals from:
  - Hospitals that service patients in the Ocean County Catchment area
  - Emergency Departments
  - Community Mental Health Clinics
  - State Hospitals.
- Working with Barnabas Health Decision Support Department to identify patients on our attribution list that fit our SMI population for outreach.
- Word of Mouth
  - Receiving referrals from programs that have heard about IHH from patients, families, hospital staff

IHH Patient Engagement

- Triumphs:
  - High Patient Satisfaction
    - High Survey Scores – 95.2% Overall
    - Verbal and written patient affirmations
  - Low 30-Day Readmissions of IHH Patients
    - 9.4%
  - Low No-Show Rate to First Appointment
    - 22.2%
- Challenges:
  - Managing Co-Morbid Medical Conditions
    - Strong in behavioral health management and social support linkages
    - Learning how best to manage and track progress of medical co-morbidities
- Observations:
  - Patient Health Literacy
    - Education empowers patients to better manage their medical conditions
    - Importance of educating patients in understanding their Medicaid/Medicaid Managed Care benefits and how to access them
    - Strong Community Support linkages are essential

Integrated Health Home: Questions

QUESTIONS?

Contacts

Stanley Evanowski, LCSW – Director Outpatient Behavioral Health Services
sevanowski@barnabashealth.org

Aubrey Hunt, LCSW, LCADC – Supervisor Integrated Health Home
auhunt@barnabashealth.org