HEALTHY LIVES: Community-Based Care Coordination for Complex Patients

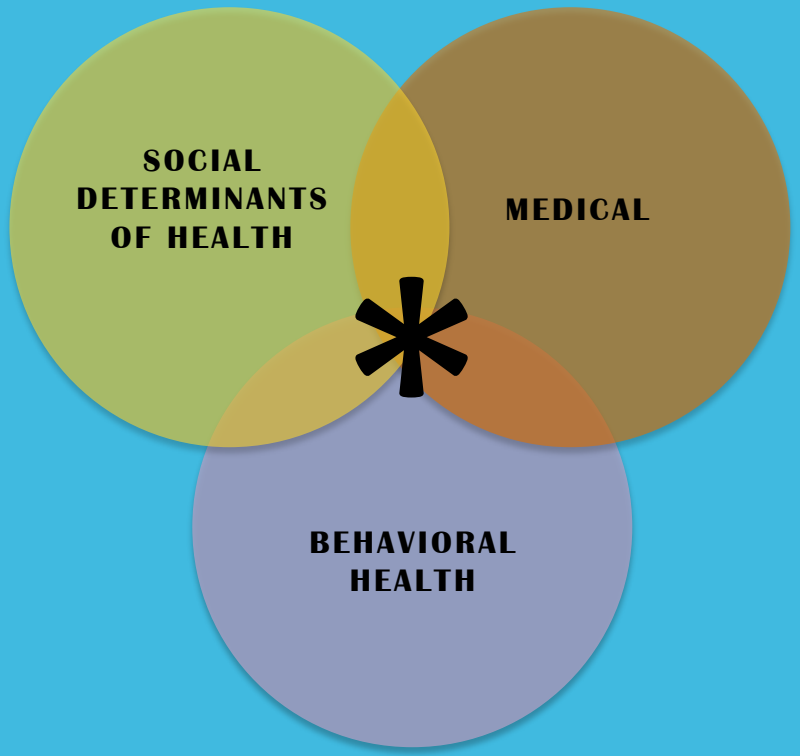
BROOKLINE COMMUNITY MENTAL HEALTH CENTER

Henry White, MD

Hannah Scott, PMHNP-BC

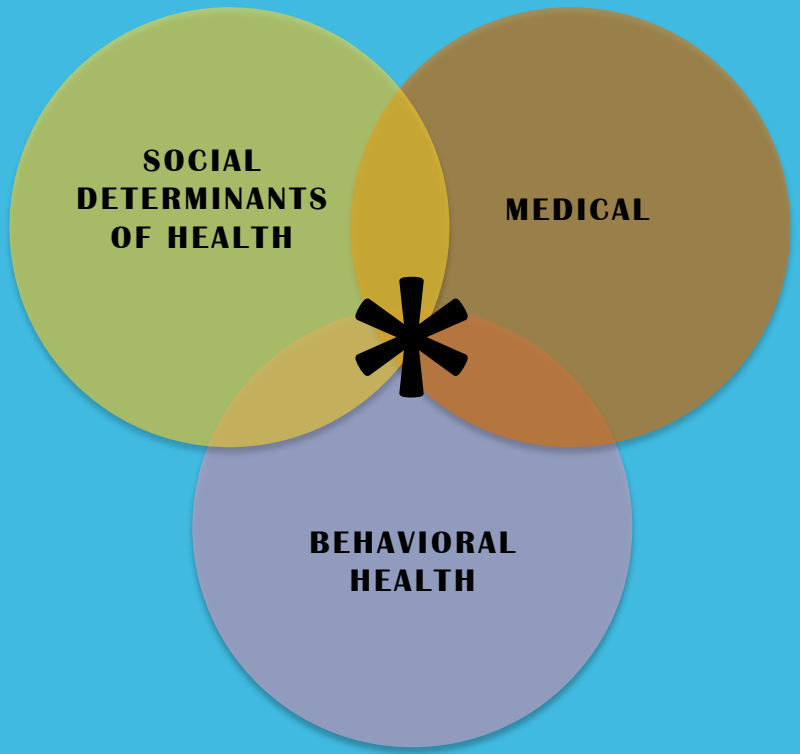
The CHALLENGE

The patient population lies at the intersection of those with high medical needs, complicated behavioral health needs, and multiple needs related to the social determinants of health.



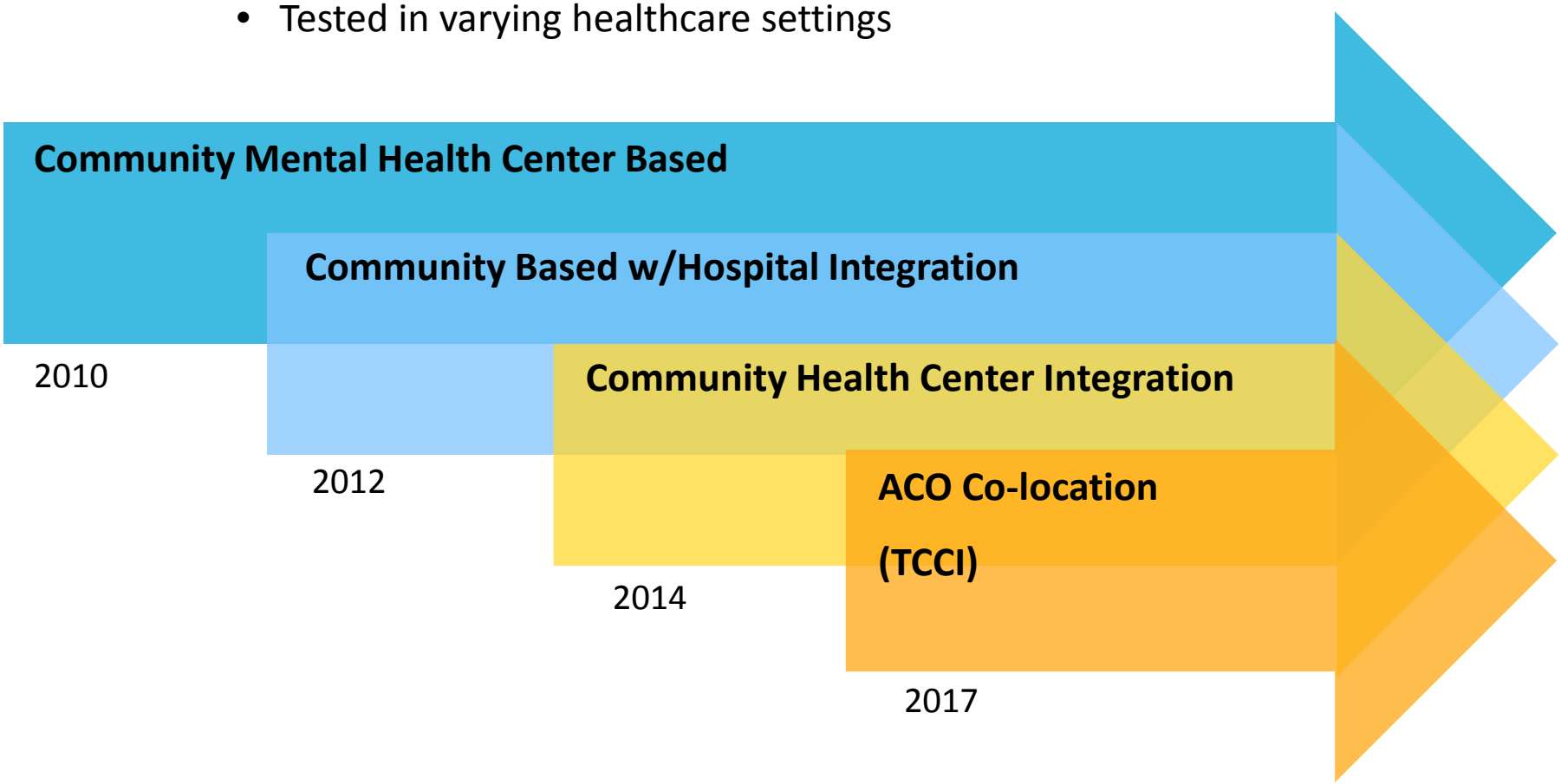
The SYSTEM

Most care for complex patients is delivered in segregated systems. Providers in each system work in isolated settings without inter-disciplinary communication or integrated care planning.



Healthy Lives

- Started in response to patient needs
- Provides integrated, community based care
- Tested in varying healthcare settings

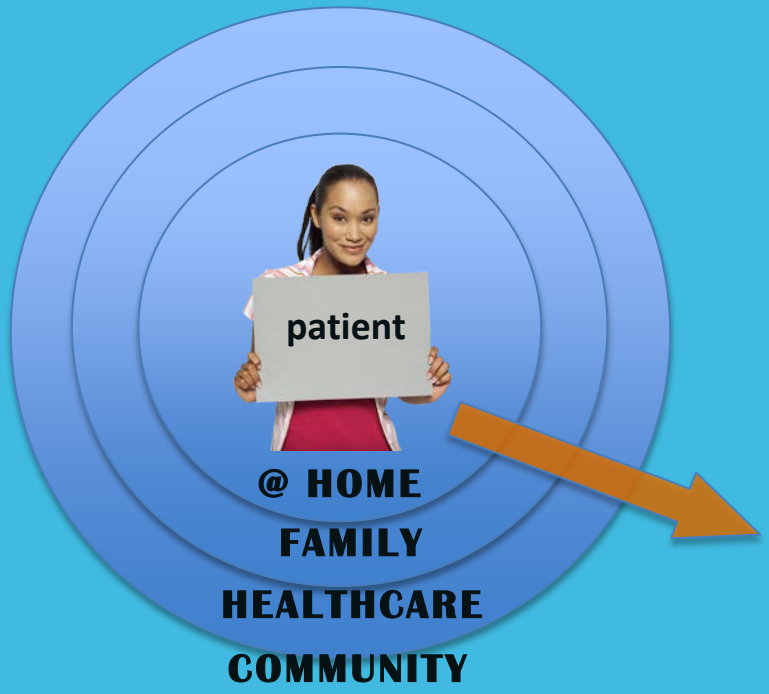


The TEAM

- Managed by a Nurse Care Manager or LICSW
- Consists of Bachelor's Level Community Health Workers
- Share proficiency in medical, mental health, and social service expertise

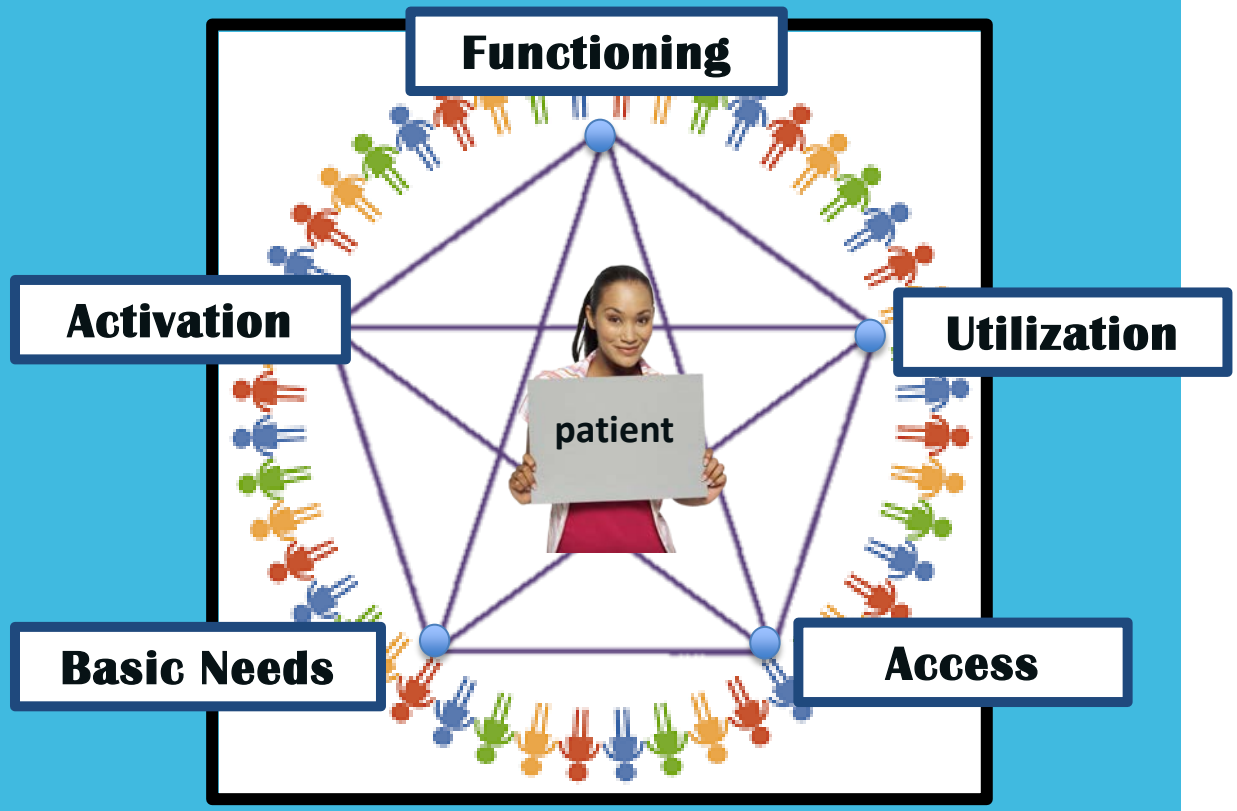
The APPROACH

- Begin with patients in their home environments
- Goal: build a comprehensive understanding of the patient's environment including family, friends, agencies, and providers



The INTERVENTION

- Form a team around the patient for long-term support
- Address all domains of health
- Connect providers and supports
- Create an integrated, shared understanding of the patient for all team members



The EXPERIENCE

"SUSAN"

SOCIAL DETERMINANTS OF HEALTH

- Low fixed income
- In danger of eviction
- Isolated/No social supports

MEDICAL

- Diabetes
- Obesity
- Congestive Heart Failure
- Heavy Smoker

BEHAVIORAL HEALTH

- Bipolar 1 Disorder
- Distrustful
- Poor executive functioning

The EXPERIENCE

INTERVENTIONS

SOCIAL DETERMINANTS OF HEALTH

- Consolidate debts
- Collaborate with housing
- Connect to service providers

MEDICAL

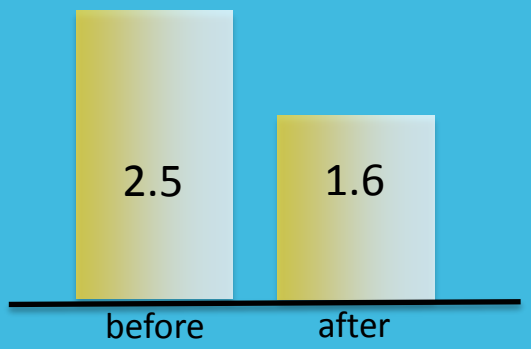
- Meal Planning & Delivery
- Daily Weights
- Appointment Attendance
- Smoking Cessation

BEHAVIORAL HEALTH

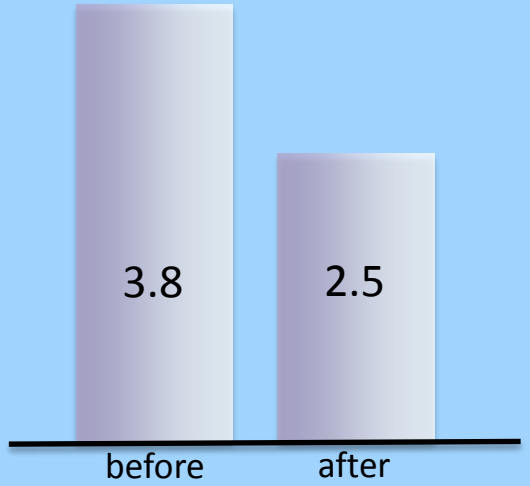
- Integration of Care Team
- Focus on Relationship Building
- Concrete Assistance w/Tasks

9 Month Interim Outcomes

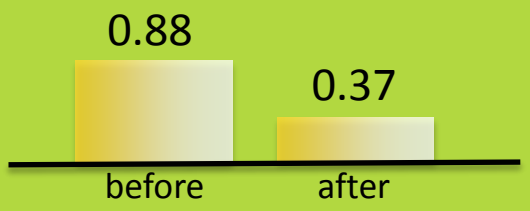
Inpatient Utilization
(per patient/year)



ED Utilization
(per patient/year)



30-Day Readmissions
(per patient/year)



Health Outcomes

68% of patients showed improvement in relevant outcome selected at enrollment

e.g A1c, BP, BMI, pain

Homelessness

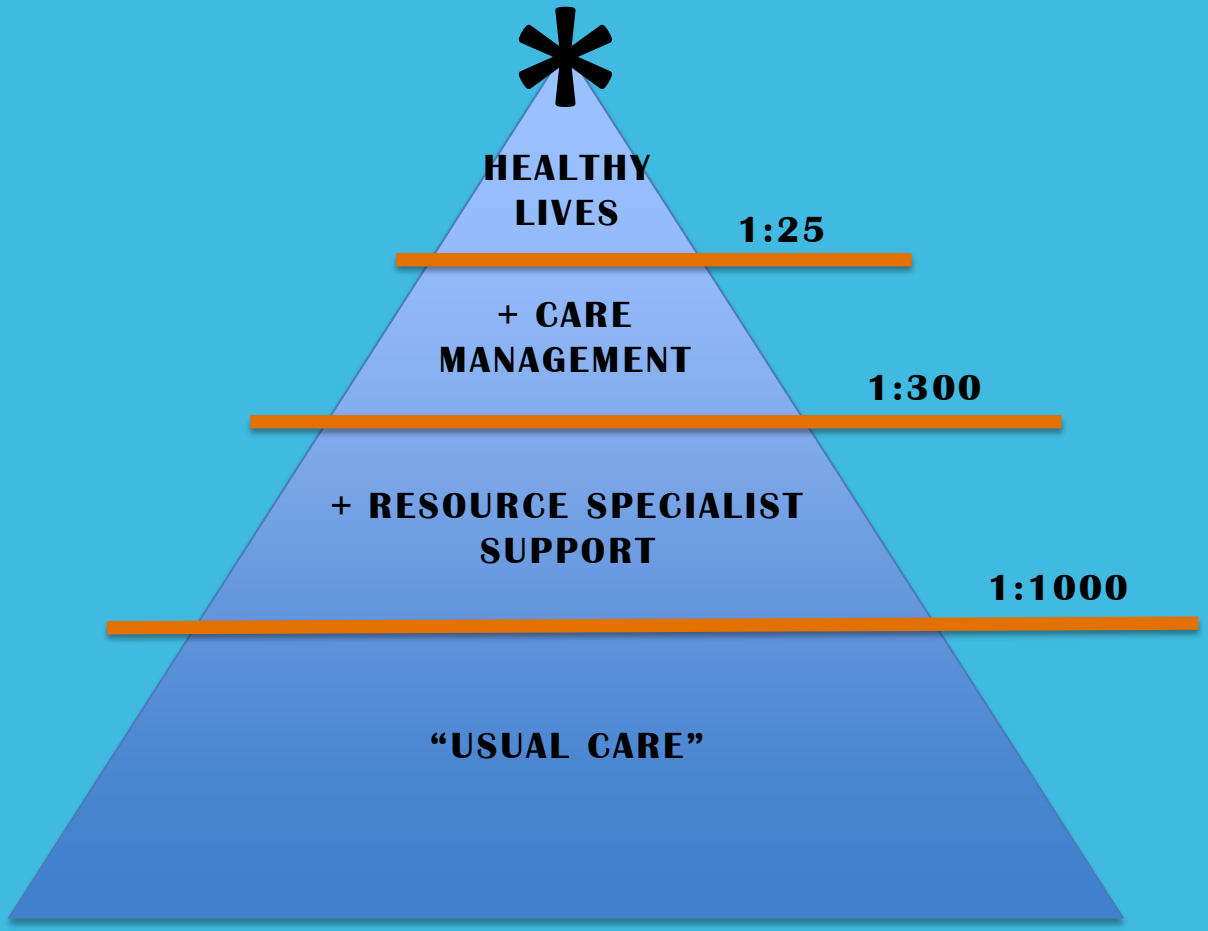
18% of patients reported homelessness or housing instability at engagement

2% reported after 9 months of enrollment

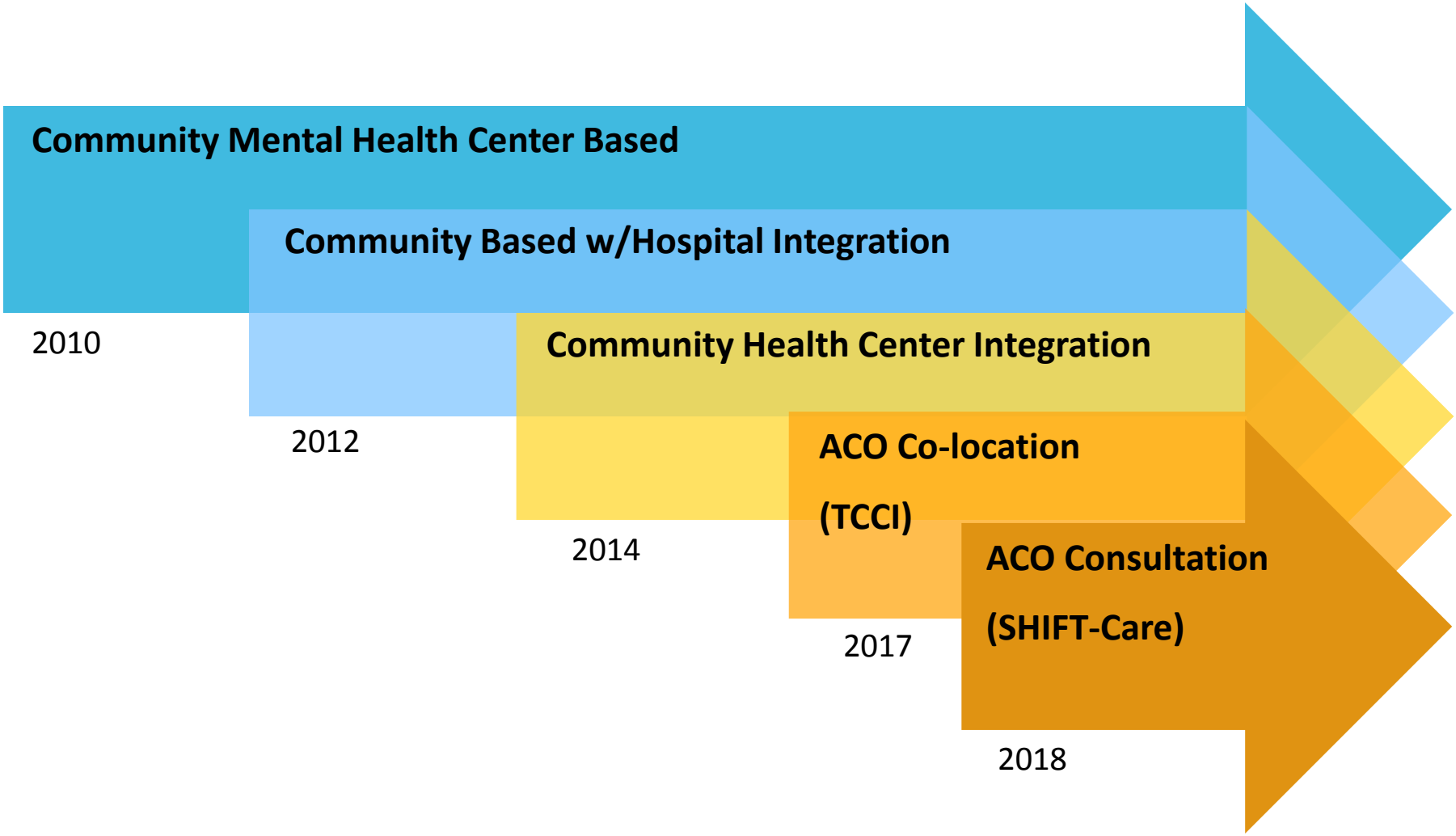
*Data annualized and based on 12 months pre-enrollment and annualization of 9 months post-enrollment for all measures; n=41

The CONTEXT

A hierarchy of care coordination/care management services has been developed by healthcare systems.

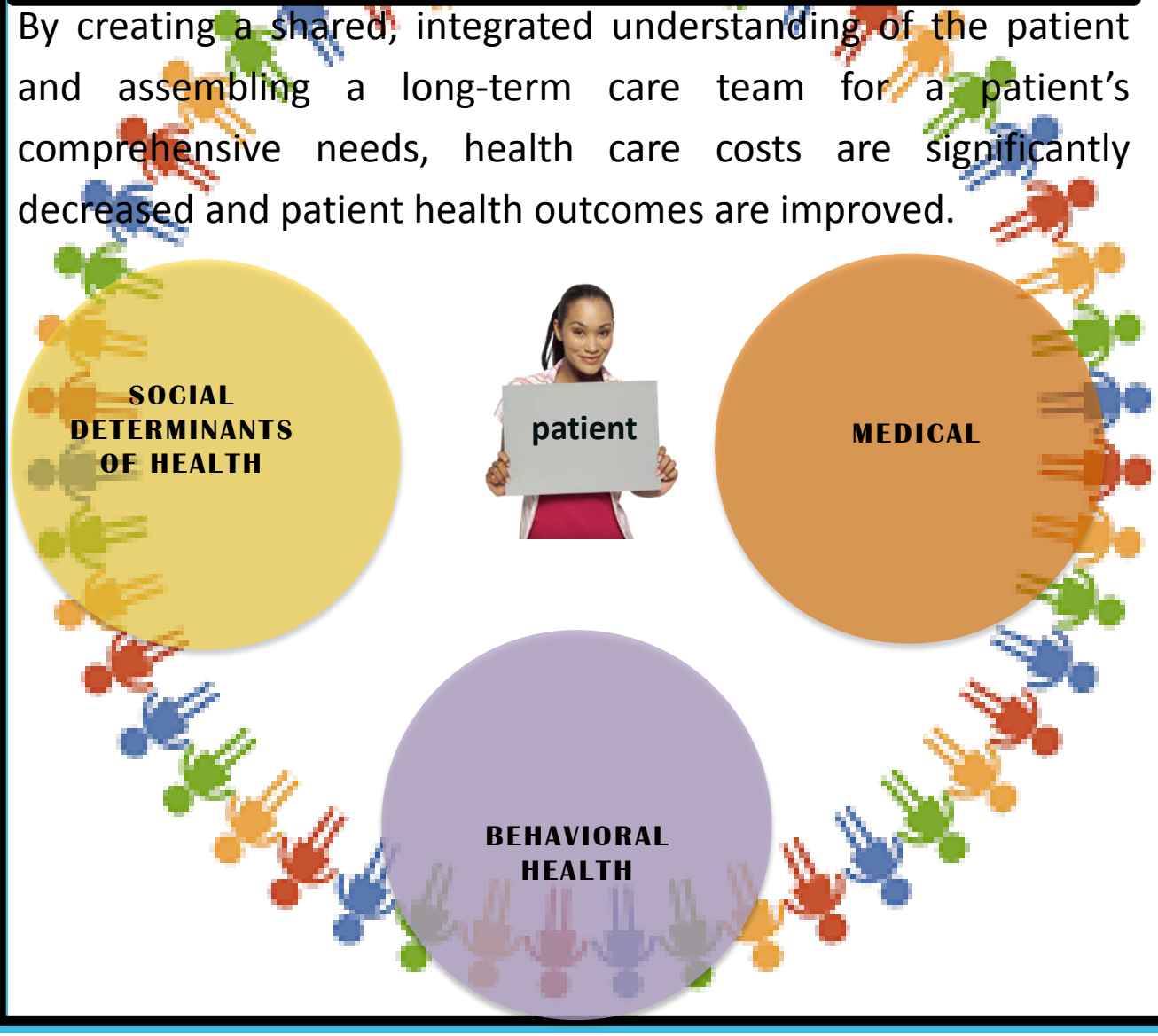


NEXT STEPS


Community Mental Health Center Based
Community Based w/Hospital Integration
2010
Community Health Center Integration
2012
ACO Co-location
(TCCI)
2014
ACO Consultation
(SHIFT-Care)
2017
2018

In CONCLUSION

By creating a shared, integrated understanding of the patient and assembling a long-term care team for a patient's comprehensive needs, health care costs are significantly decreased and patient health outcomes are improved.



POLICY IMPLICATIONS

- Recognition of the impact of complex, multidimensional systems on health
- Targeting high-cost, high-need patients with flexible, intensive, community-based interventions
- Provide integrated training opportunities for healthcare professionals
- Necessity of integrated electronic health records and information exchange between providers

BROOKLINE COMMUNITY
MENTAL HEALTH CENTER

contact us

Henry White, MD

Clinical Director

henrywhite@brooklinecenter.org

Hannah Scott, PMHNP-BC

Director of Care Strategy & New Business Development

hannahscott@brooklinecenter.org