Transitions in Care: Community Health Network

GLS Grantee Meeting
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Executive Director, Integrated Behavioral Health
Community Health Network
Community Health Network

✓ Large health care system – 5 hospitals; over 600 physicians

✓ 123 bed acute care psychiatric hospital

✓ Full continuum of behavioral health and substance abuse treatment programs – over 900 employees

✓ Including two community mental health centers
Transitions of Care – Current State

- Focus has been on BH product line
- 9854 patients seen in crisis department in 2015
- 4422 discharges from IP in 2015
- Saw urgent need for better transitional care planning
Transitions of Care – Current State

Keys to practice change

✓ Hired three Intensive Care Coordinators
✓ Training on CALM
✓ Developed a clinical pathway for patients with high risk suicide
✓ Developed an improved collaborative safety plan
✓ Roll out of the CSSR-S
✓ Clarified data reporting expectations
✓ Developed reports to help with accountability tracking
EMR build – Banner for Clinical Pathway
Data data data data …………..

Key data reporting
- Deaths by suicide
- Suicide attempts
- ED frequent guests
- Readmissions within 30 days
- Scheduled 7 day appts from IP
- Kept 7 day appts from IP
- Intensive Care Coordinator dashboard
Our Internal tracking system - MIDAS

**Suicides** of persons in our care
- Seen within past 90 days OR have a future appointment

**Suicide attempts** of persons in our care
- A non-fatal self-directed potentially injurious bx with any intent to die as a result of that bx. May or may not result in injury.
So let’s talk Intensive Care Coordinators

✓ Our initial focus has been persons seen in our crisis department AND persons admitted to our acute care inpatient hospital

✓ CSSRS is completed in crisis and/or on the IP unit – based on the score and clinician judgement a decision is made to place an individual on the high risk clinical pathway

✓ ICC then receive EMR notification when patient is placed on the pathway
Intensive Care Coordination

- ICC makes immediate caring contact via phone, email or text
- ICC provides care coordination to ensure following the collaborative safety plan, assess need for personalized lethal means restriction, support person getting to first and follow up appt, and have adequate supports in place
- Treatment team (with ICC input) determines when it is time to come off pathway
# ICC Dashboard

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<th>Total # Active</th>
<th>Avg # days</th>
<th>Average Age</th>
<th>Case ID</th>
<th>Age</th>
<th># on pathway</th>
<th>Current status</th>
<th>Reason inactive</th>
<th>MIDAS</th>
<th>Referral</th>
<th>Prior ICC</th>
<th># past attempts</th>
<th>County</th>
<th>Race</th>
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Lessons Learned

✓ It is so NOT like pushing the EASY button!

✓ Starts with leadership support and endorsement

✓ Takes longer than you think it will
  ✓ Especially EMR build
  ✓ Culture change

✓ Have an action plan with owners, timelines and metrics

✓ Work teams get it done!
Lessons Learned

- It is all about the data
- Accountability through reports
- Watch for the Culture of optionality
- Tell the stories
  - Celebrate Successes
  - Learn from Opportunities – near misses
- Don’t give up – the journey is long but so worth it!
Thank you!

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