Open Door Community Health Centers

IBHP3 Project Start-up
March 23, 2010
BE/PCMH dimensions addressed:

- Prevention, early intervention and recovery for people with SMI and in our buprenorphine program.
- Practice as a team and coordinate care: CM will take responsibility for crucial patient issues which do not require a clinician.
- Provide information to patients and access to resources.
- Training influences: Effect of Masters level CM involvement
Measurements

Survey of perceptions of Providers regarding workload, especially non-medical or non-behavioral issues.

SF-12 Health Survey. Randomized - administered to all patients during a 2 week period in April and re-administered during the last 6 months of the project.

Patient demographics, diagnoses and some specific health information: HgA1c test results, blood pressure, weight and tobacco use, where appropriate.
Care Management Model

Recovery/Strengths: Interventions are driven by the patient, focus on strengths, goals are the patient’s own, promote patient’s autonomy.

Four CM Domains from Performance Measurement for Case Management: Principles and Objectives for Developing Standard Measures by Rufus Howe, RN-C, and Liza Greenberg, RN, MPH.

- **Assessment** (assess pt status, id needs, reassess)
- **Planning** (educate, act as coach, be creative)
- **Facilitation** (problem-solve, maintain continuity of care)
- **Advocacy** (negotiate on behalf of pt, id potential cultural dilemmas)
On your mark, ready, set & go...

- CM started 2/1/10.
  - Orientation to EMR
  - Introduced to Providers

- Creation of workflow integrated into EMR

- Referral system: paper, phone or EMR.

- ~50 patients seen in person, 4 by phone only (medical & BH)

- Variety of reasons for referral and interventions.

- Weekly meeting of CM with Project lead

- Working on timeline for other tasks
Coming Attractions

**Medication adherence:** CM to be part of making f/u calls to people with diabetes and HTN

**Behavioral change:** smoking cessation clinic w/BHC

**Support of SMI:** meet w/Psychiatry team to explore integration tactics

**Crisis Systems of care:** outreach to HCMH / explore models

**Frequent Flyer Prevention / Coordination:** outreach to St. Joseph Hospital (ER usage for our frequent flyers)
Challenges thus far...

- Establishing workflow for CM in EMR due to EMR idiosyncrasies
- Getting data *from* the EMR
- Familiarizing new Providers with CM role
- Decline in resources due to the recession
- Several Providers, at first, unsure of CM recommendations.
- Questioning whether the SF12 captures the effect of CM intervention vs. QOL measure