

Community Memorial Hospital - Hamilton

Leather Stocking Collaborative Health Partners

Our Cohort

(Data reflects Mar. '16 to Sept.'16)

Adult Behavioral health members with a PHQ 10+

≡ 80 

Our Actions

Patient Story

61 year-old female with a history of medication non-adherence and missing appointments required a heart procedure. PCP invited BH to participate in the patient's care and after 2 sessions with BH, the patient is able manage anxiety levels to obtain the heart procedure.

Process Improvements

Patient Identification

- PHQ-2/9 is administered and inputted in EHR
- PC determines if patient requires BH and performs warm handoff
- BH provides consults for both patient and provider following warm handoff

Care Planning

- BH huddles with each provider separately
- BH develops treatment plan in consultation with PC and shares progress notes in EHR

Management

- BH and PC consult on patient treatment plans and monitor and track patient progress

Follow-Up

- BH services remain part of the PC treatment until consultation concern is resolved or requires a higher level of care

Level of Integrated Practice



Lessons Learned

- Developing plans are important but need to be tested through trial and error to find what works
- Persistent communication and provider engagement contribute to overall success
- Be flexible to allow providers and clinicians the space to learn how to work together as a team

Our Impact

Baseline (Sept. '15 – Feb. '16) MAX Program (Mar. '16 – Sept. '16)

Patient Engagement

415 patients with positive PHQ screen

154 warm handoffs conducted

9 patients had follow-up in August with BH



PHQ Screening Rate

59%

78%

19%



Warm Handoff Count

-

154

-



Patients Connected to BH for follow up

-

9

-

*Calculations are based on self-reported data from Action Team

** All data reflects BH services co-located from Jul. - Aug.'16