Solution Title: Population Health: A Paradigm Shift in how we care for Behavioral Health Patients

Overview of Project

A drive to Population Health and changes in reimbursement have prompted the need to develop new strategies to keep Behavioral Health and medical patients with co-occurring behavioral health disorders well, decrease their use of the emergency room, reduce inpatient admissions and prevent readmissions. A paradigm shift has occurred. It is not just about reducing inpatient admission numbers, but rather about reducing readmissions through quality initiatives and engaging with community providers.

The role of nursing and social work has changed to include going beyond the traditional discharge planning to increasing communication with outpatient providers and primary care physicians. There is a focus to be patient-centered by increasing patient and family involvement in recovery/discharge planning, and following up with the patient post-discharge. Early identification of barriers and finding creative ways to eliminate those barriers is key to a patient’s success and reduces readmissions.

As hospitals and health systems work to develop population health strategies to better serve their communities and rein in the overall cost of care, Behavioral Health patients—who have higher-than-average rates of emergency department visits, hospitalizations, and readmissions—cannot be ignored. Behavioral Health is pervasive and impacts many conditions including patients with diabetes, cancer, stroke, post-partum depression, heart disease, COPD, and congestive heart failure. The increase in Emergency Department use and admissions can be as high as 60% for patients with co-occurring depression and medical illness. Implementing strategies to reduce readmissions benefits the patient, family and emphasizes quality comprehensive care.

In 2012 we had a 12% readmission rate on Behavioral Health. Strategies to reduce readmissions, increase quality care, increase patient-centeredness, and identification of depression through a screening process for medical-surgical patients were identified as goals and rolled out over a three year period.

By fall of 2015 the readmission rate decreased from 12% in 2012 to 6.7% in 2015. This 5.3% decrease resulted in $168,000 savings to the organization and increased patient satisfaction from 4.47/5.0 to 4.67/5.0 on Behavioral Health. Depression screenings were done on two project units with congestive heart failure patients in the fall of 2014 for four months and 27% of patients were newly identified as having a co-occurring depression. After a presentation of the data to the medical executive committee, the Patient Health Questionnaire-9 (PHQ-9) was
approved as a screening tool for all patients. The screening will now be completed on all admitted patients by nursing in their admission assessment.

**Process**

The Theory of Planned Behavior (TPB) is the theoretical framework for the CHF screening project. Despite the high rate of depression, it is often under-recognized and under treated (Kee & Overstreet, 2007). The Theory of Planned Behavior was proposed by Icek Ajzen in 1985 through his article “From intentions to actions: A theory of planned behavior” (Ajzen, 1991). Ajzen’s theory is often used to understand/predict health behavior. TPB has been used successfully to explore determinants of screening with regard to nurses’ use of clinical guidelines and assessments (Armitage & Connor, 2001). It offers a conceptual framework for understanding screening behavior (Hart & Morris, 2008). TPB has predicted the uptake of new techniques by health providers. The practice gap has prompted the need for educational communication strategies that modify intentions, confidence, and attitudes towards behaviors (Grimshaw, Shirran, & Thomas, 2001).

The framework of John Kotter to implement the strategies to reduce readmissions.

**John Kotter’s Change Model**

1. **Creating a sense of urgency:** The goals of the CHF screening project were explained through educational sessions provided to over 150 staff and physician groups plus nursing leaders. Face to face power point presentations were given to the nursing teams and the physicians groups at their staff meetings. In addition, information about the project was sent to those physicians not present at the meetings. The rationale for the project was explained using evidence-based research.

2. **Form a guiding coalition:** Nursing champions and the managers guided the implementation of strategies to reduce readmissions. They identified the CHF patients on their floor each day and administered the PHQ-9 depression screening tool. They scored it and notified the physician of the score if it was positive for depression. Physicians then determined the need for a psychiatric consultation based on the score and assessing their patients.

3. **Create a Vision:** It was important to generate enthusiasm about the project to get buy-in. The teams were made aware that they were the pilot units for an evidence-based project. Ongoing enthusiasm was generated by going back to the participating groups throughout the initial project weekly and giving them positive feedback, reviewing the results, and encouraging them to continue the great job they were doing. Nursing expressed excitement to be selected to be a part of the project units. Physicians expressed that they were glad to have a tool to identify depression and looked forward
to the partnership with behavioral health to care for their patients. Nursing leadership was on board and also assisted with generating enthusiasm.

4. **Communicate the change**: Clear objectives of project reviewed with nursing teams and physician teams. Notebooks were prepared with a log to input patient participation. CHF education folders with patient materials were distributed for use with the screening. Clear directions on how to administer the PHQ-9 were given and scoring guides reviewed. Stickers were given to put on the front of the chart with the PHQ-9 score to remind the physician.

5. **Empower broad-based action/remove obstacles**: Occasionally a new nursing team member had to be trained on the screening process. Also, weekly follow-up was necessary to assure that all CHF patients were screened. The project was also extended to four months rather than three months due to low census for CHF patients. A total of 130 patients participated.

5. **Create short-term wins**: Communicating the results of the implemented strategies to reduce readmission to the team members involved was important to give feedback and value to what they are doing. Finding patients with depression who were not previously in treatment and getting them a psychiatric evaluation was encouraging for the team. Nursing expressed hope that the patient’s quality of life would be improved if their depression was treated and that they might be more compliant with their medical regime for CHF if they were not suffering from depression.

7. **Build on the Change**: The outcomes of the project for the CHF screening showed that 26% of the 130 patients were positive for depression. This was presented to the medical staff and nursing team. Approval was obtained to implement the screening throughout the two hospital system to all admitted patients.

8. **Embed the change in the culture**: Sharing the results with Nursing Leadership, Nursing Practice Council, and physicians was important to gain support for sustaining the new approaches to reduce readmissions. Electronic documentation will now include the screening as part of the admission assessment. This will allow for the physician to easily see the scores for their patients. Integration of behavioral health into the inpatient areas is important for identifying patients and providing follow-up consultation. Medicine and nursing journals both emphasize the relationship between depression and quality of life, compliance with medicine regime, readmission rates, and mortality.
There were multiple strategies implemented to reduce readmissions. One strategy implemented was providing patient medications in hand at time of discharge for those patients who had financial or transportation issues that created a barrier to compliance. Work was done with a local pharmacy to have medications delivered to behavioral health prior to a patient’s discharge.

Call backs to patients were also implemented with RN calls to patients discharged the previous day to determine if they had any questions or concerns about the discharge instructions. If barriers were identified the RN worked with the case manager to resolve the issues to assure the best possible outcome.

Appointments for outpatient were made prior to discharge and reminder calls made. No shows were called to identify any barriers to making another appointment. If transportation was an issue, a taxi voucher was sent to them.

A new position was developed: High Risk Case Manager. The Case Manager will follow those patients identified by behavioral health team as high risk for readmission. They will follow up with them after discharge and assist them if needed out in the community.

The top 120 readmissions to Behavioral Health over one year period were identified and High Risk Treatment Plans were developed. These plans are on a Share Points platform and can be viewed by Emergency Room physicians or the Behavioral Health evaluator. When patients revisit the ED, staff can view the history and previous plans of care and discuss with the patient. Increased communication was accomplished by use of CRISP. CRISP assisted with identification of high utilizers of the ED and prompted use of High Risk Treatment Plan.

Behavioral Health consultants in the ED went from an on call model to full-time on site in our two EDs at Upper Chesapeake Health. This increased continuity of care, decreased wait times in the ED, increased communication among providers, and increased customer service. Peer Recovery support for patients with substance abuse was implemented through collaboration with the health department.

Wellness Recovery Action Plan (WRAP) was started as a group on inpatient Behavioral Health to provide for more patient involvement in their own recovery and discharge planning. Patients were encouraged to use the WRAP information to identify the steps to recovery.

Bedside shift report was implemented by nursing teams. Taped report was replaced by nursing going together to introduce the oncoming nurse and give a brief report with the patient involvement. If the patient has any questions or concerns they can be addressed promptly.

An injection clinic in outpatient was implemented. Meds were obtained for the patient prior to their scheduled visit thus eliminating the obstacle of patient remembering to retrieve and bring the needed medication.

Screenings for depression with the CHF project was successful in identifying depression in 27% of the patients screened. As a result, screenings started on a routine basis on all CHF patients on two telemetry units. As a result of our success with CHF patients, screening for depression will be done starting Spring 2016 on all inpatients throughout the hospital on admission through electronic documentation including automatic psychiatric consults for scores in the moderate depression to severe depression range.
A Family Support Group was developed to support families with loved ones who have a mental illness. Families have returned after their loved one has been discharged for the support and education provided by the group run by nursing.

Behavioral Health met with community agencies and primary care physicians in our county to establish rapport and discuss the services to promote collaboration and a better understanding of resources available.

**Measurable Outcomes**

**Reduce readmissions by 3% or greater over three years. Results:** Behavioral Health readmissions were reduced from 12% in 2012 to 6.7% in 2015. The initial goal was met and exceeded.

**Identify and implement changes in the roles of nursing & social work in population health environment that will increase patient-centered care. Results:** Patients are more involved through bedside shift report and each nurse now is administering their own meds to their patients as opposed to an assigned medication nurse providing for more one on one teaching. A change was made so each nurse reports in rounds and receives feedback as opposed to only charge nurse allowing for more multidisciplinary communication. The new High Risk Case Manager works with high risk patients while inpatient and follows the patient after discharge. Education and training was completed on Person-Centered Treatment planning and the patient will now be a part of the daily multidisciplinary rounds to allow them to understand their treatment plan and contribute to their plan. Visiting hours were expanded to include longer
visitation and afternoon visiting through the week. Patients also state on patient satisfaction
that they are highly satisfied with their preparation for discharge (4.8/5.0).

**Explore a process to identify co-occurring depression in medical-surgical patients by fall, 2015. Results:** CHF depression screening utilizing the PHQ-9 was successful in identification of depression in 27% of patients with CHF during the project. Screening was approved to roll out PHQ-9 to all medical admissions. It has been built in our computerized documentation (Meditech) and education to begin end of 2nd quarter fiscal year 2015-2016 with rollout in January, 2016.

**Demonstrate how implementing strategies improves patient satisfaction and financial performance. Results:** A 5.3% reduction in readmissions was accomplished over 3 years resulting in a savings of $168,000 to our organization. Patient Satisfaction scores on behavioral health increased to 4.67 out of 5.0. Value Options has identified our organization as one of the top performers for low readmissions.

**Sustainability**

Behavioral Health strategies to reduce readmissions are ongoing within our organization. Behavioral Health is growing and integration into the medical realm is welcomed by providers. The Cancer Center, Women’s and Children’s services and a pulmonary physician have reached out to us and asked us to provide behavioral health support for their practice.

Research shows that people who get treatment for co-occurring depression often experience an improvement in their overall medical condition, better compliance with general medical care and a better quality of life. The screening tool will assist with identification and early intervention.

More than 80 percent of people with depression can be treated successfully with medication, psychotherapy or a combination of both. Our team is collaborating with primary care practices to provide smooth transitions of our patients from inpatient or outpatient back to their practices while providing consultative services when needed.

Early diagnosis and treatment of mental health disorders can reduce patient discomfort and morbidity, and can also reduce the costs associated with misdiagnosis, and the risks and costs associated with suicide. Plans are underway to integrate into primary care practices by embedding a behavioral health licensed clinician into two medical offices, the cancer center, and women’s and children’s service lines. This will provide quick access to care and relieve the primary care physician of the task of finding a referring provider for their patient.

Depression often goes unrecognized and untreated in the clinical practice. Implementation of a screening tool for depression in the medical-surgical population would increase the ability
to recognize patients with depression and hopefully increase access to mental health professionals. Knowledge regarding the role of recurrent depression as a specific risk factor for patients will be useful in promptly identifying high-risk patients. The maintenance of a close cooperation between medical physicians and psychiatric consultation may prove supportive in cases where immediate referrals might be necessary.

CHF is the number one readmission diagnosis at our community hospital. Because of unique psychological backgrounds, physical stresses, and the impact of these factors on coping resources, CHF patients may have unique characteristics that require special treatment. From a clinical perspective, there should be heightened awareness of the role of depression in HF and screening tools in place for assessment.

As a result of the successful screening for HF patients, the screening tool will now be implemented for all inpatient medical patients. It is recognized that as high as 60% of the medical patients may have a co-occurring behavioral health diagnosis.

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**Role of Collaboration and Leadership**

Implementing change or any new strategy within an organization requires a feeling of urgency on the part of the entire organization. It was the job of management to create that urgency by explaining to the staff why the implementation was necessary. Leadership helped the team understand how the organization and patient benefits from the new implementation, but it also needed to get the organization to see the setbacks of not making a change. It was the responsibility of leadership to put a monitoring system in place, analyze the data that was being generated during the implementation and make any necessary changes to make the implementation more efficient.

Given that effective implementation of changes requires a highly inclusive approach, leadership effectiveness is critical for this approach to thrive. Executive teams developed strategic plans that included the goals and objectives that directed change initiatives. They realistically assessed organizational readiness for change and provided for its sustainability. Senior leaders clarified who had the authority for making change happen, reinforcing that authority as needed.

**Leadership roles** within a change process included communicating within and outside the organization. Leaders “build the public will” by providing a clear and concrete definition of what practice model is being advanced, what strengths are in place, what problems need to be solved, what improvements and innovations are desired, what is tangibly being done, and what is being learned along the way. They were persuasive champions of the change effort, instilling a sense of excitement about the possibilities and pragmatic resolve to actually make good things happen.

Leaders also created constructive relationships with dissenters, establishing a balance between safety and accountability with them. They listened to staff and stakeholders and
adapted change efforts as appropriate, modelling inclusiveness and learning, while at the same time reinforcing their resolve to core practice model principles and outcomes for the patients.

Collaboration between Behavioural Health and the medical physicians has increased and medicine has recognized the importance of addressing behavioural health issues to provide optimal health to their patients. They have welcomed the new strategies of Behavioural Health and the increased access to consultation services.

Innovation

Health matters. Regaining physical and mental health in recovery is an important part of living a fulfilling, enriching life. Innovations in Behavioral Healthcare is about the exploring best methods of treating patients and helping them attain physical and mental health for the long-term—but it’s also about fostering the health of your organization and community. Theories of innovation applied to healthcare settings have focused on a ‘whole systems’ approach to mapping the potential for the successful implementation of innovative practices and the ability of organizations to create, innovate, and deploy new systems of practice.

By screening all patients for depression, we are focusing on the person-centered holistic approach to health. Integrating care is vital to addressing all the healthcare needs of individuals with mental health and substance use problems. Many integrated care models illustrate the successful integration of primary care into behavioral healthcare, and can guide behavioral healthcare organizations in integrating medical care.

Maryland’s new CMS waiver focuses on reducing readmissions. The shift is now towards population health and total patient revenue. There is a renewed focus on keeping costs down through reduction of 30 day readmissions and connecting patients with community providers and resources. Our strategies listed above were focused not just on keeping costs down but also improving the patient overall experience by identifying barriers to success after discharge and implementing a plan to try and eliminate or reduce the barriers. The high risk case manager now works with high risk patients for readmission for 30 days or longer following their discharge and assists the patient with finding community based providers, and apply for eligible entitlements. Physicians and nurses throughout the organization have received education about the role mental health may play in whole person wellness.
Screening for Depression in CHF Patients in Fall, 2014 showing scores on PHQ-9
N = 130