Keynote Speaker: Amy Boutwell, MD
Transformation

How cross-continuum partnerships fundamentally change care

Amy E. Boutwell, MD, MPP
Finger Lakes PPS Partnership Symposium
Fundamentally change....
Why....should we?
Why... don’t we?
How....could we?
Future....
What’s the Goal of Delivery System Transformation?
How Do We Demonstrate Value?
Cost

- Acute Care
- Expensive meds, tests
- Waste

Quality

Experience
Frederick and Carroll Counties, MD

- Transformed care: for patients with behavioral health needs
- Cross-Continuum Partnership: optimize what exists in service of mutual goals
2 Counties: Identify & Optimize Existing Resources

Carroll County

- 25-member cross continuum team
  - SNF, HH, Aging Services, Transportation, Pharmacy
  - Meets monthly
  - Track and trend readmissions
  - Review and discuss readmissions
  - Weekly “co-management” virtual rounds

- Ask: Who is your Behavioral Health partner?
  - Didn’t have one! Didn’t even know who to call!
  - Googled BH multi-service agency in the county
  - Cold called the Executive Director – “of course!”
  - Point of contact: BH ED & Hospital VP
  - Identify - Warm handoffs – Case Conferencing

Frederick County

- Hospital’s goal to reduce avoidable utilization
- County with behavioral health peer navigators
  - Outreach efforts in community were not working
- Hospital and County had aligned interests
  - Hospital – how to decrease ED use for BH patients
  - County – deploy BH peer navigators to show impact
- Hospital and County partnered
  - Formal agreement: goals, measures
  - Co-located BH peer navigators in ED for case finding
  - Navigators connected with and followed patients
• 46 man with substance use disorder and marginal housing
  • Engaged in-person in the ED
  • Recovery Coach
  • Detox, residential rehab
  • Local career center, employment assistance
  • Food benefits
  • Housing assistance
  • Transportation
  • Primary care and behavioral health providers
  • Interdisciplinary, cross-setting case conferencing to iteratively address needs as time passes

• ~50 ED visits in year before engagement to 1-2 ED visits in the year after
North Central Region, MA

- Transformed care: for children with behavioral health needs
- Cross-Continuum Partnership: State Agency, ED, School District, Behavioral Health Services, Social Service Agencies, Children and Family Services
High rates of substance use in region

High rates of poverty, joblessness

High rates of abuse, neglect

Increasing frequency of behavioral health issues occurring at school

School is not prepared to manage these issues – send child to the ED

ED without psychiatrist, assessment is focused on whether needs inpatient care

Extremely long wait times (sometimes days) in ED awaiting psych bed

Child goes through the cycle, to be discharged back to setting, nothing changes

Cycle continues....
Goal: Goal to reduce BH ED visits and ED boarding times

Data: Identified pediatric BH subgroup

Root Cause: Asked “why” pediatric BH patients come to the ED → school sending in

Value: Decrease BH ED use and ED boarding if increase BH services to kids

How to Deliver: Serve kids in school, because that is where they are and where issues arise

Partnership: Hospital ED, Hospital Community Benefits, School District

Services 1.0: BH coordinator on-site in schools

- Work with school staff, meet with families, provide education, support
- Champion the development of or update of BH plans for students in need
- Navigate families to local resources: benefits, services, supports, stress

Results: 35% reduction in ED BH revisits at the hospital*

*for all ED BH patients
“The coordinator is the glue that brings school – families – hospital together”

“It was always disjointed and difficult .... it was “their plan” versus “our plan” and now all the people connected with the student are at the table coordinating on the plan and it’s the student’s plan"

“The whole relationship of the families with the school and the hospital has changed in a community...all because of 2 people!”
Gloucester, MA

- Transformed care: for people with substance use disorder
- Cross-Continuum Partnership: City Government, Police, EMS, Hospital, ED, Behavioral Health Services, SUD Treatment Providers, Advocates, Public Health
“In the spring of 2015, the exasperated police chief in the fishing town of Gloucester, Mass., announced that anyone who showed up at the police station and asked for help overcoming an opiate addiction would get it, without fear of arrest, no matter where they lived or whether they had insurance. Police, he said, would get them into treatment.”

Source: Politico 2018
• 376 people in the first year took him up on the offer
  • 95% of them were successfully directly linked to treatment
  • …far surpassing the 63% rate of Boston Medical Center’s linkage program

• 3 years later, a national partnership of 390 police departments has helped 12,000 people get into treatment

Source: Politico 2018
“Who would have thought that the access to treatment for somebody in opiate addiction would be through the lobby of a police station? That really highlights a failure of the health care system....”

Frederick Ryan
Police Chief, Arlington MA
Co-Chair PAARI

Source: Politico 2018
Creating & Demonstrating Value

From High Tech, Sub-Specialized to High-Touch and Trusted
Creating Value in Delivery System Transformation

• Navigating
• Hand-holding
• Arranging for....
• Providing with....
• Harm reduction
• Meet “where they are”
• Patient priorities first
• Relationship-based

“Our navigators are flexible, proactive, and persistent; they address all needs. Each of them has incredible interpersonal skills.”
Creating Value = Ask, Listen, Observe

- Establishing connection
- Gathering information
- Understanding person in context
- Eliciting beliefs, priorities, concerns
- Identify care seeking patterns
- Assessing problem solving, self-efficacy
- Observing family/relationship dynamics
- Forming a trusting, helpful relationship
Creating Value = Whole-Person Approach

• “We look at the whole person, the big picture”
• “We address goals and ask what the patient wants”
• “We meet the patient where they are”
• “First and foremost it’s about a trusting relationship”
• “We do whatever it takes”
Execution

Only Execution Drives Results

Close the Gap

Patients “Served” vs. Total Target Population

Drive Up Completion

Attempts Don’t Count!

Increase Contacts

Drive Up Patient-Facing Contacts with Same FTEs
Engagement: Change “how” we do “what” we do → Close Gaps

Key lessons:
- Reliably identify target pop
- Face to face in-hospital
- Opt-out approach
- Continuation of your care
- Avoid “special program”
Service Delivery: Change “how” we do “what” we do - Attempts Don’t Count

Key lessons:
• “It’s my job to check on you once you go home”
• Use texting
• Any relevant contact
• Call their cell prior to discharge to confirm #
Service Delivery: Change “how” we do “what” we do → Service

Key lessons:

- Brief in-hospital visit
- Prioritize community visits
- Batch SNF visits
- Batch home visits
- Batch documentation
Cross-Continuum, Whole-Person Care Creates Value

- Suburban Hospital: "Return" Reduction 27%
- Small Rural Hospital: Readmission Reduction 58%
- Mid-Sized Community Hospital: "Return" Reduction 29%
- Urban Emergency Department: ED HU Visit Reduction 24%
- Rural Emergency Department: ED HU Revisit Reduction 27%
- Regional Emergency Department: ED BH Revisit Reduction 34%
Thank you for your commitment to transforming care

Amy E. Boutwell, MD, MPP
President, Collaborative Healthcare Strategies
Questions