

Care  
Transitions  
Network

for People with  
Serious Mental Illness

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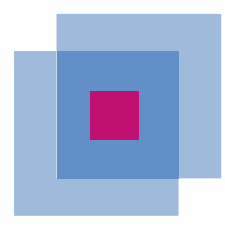
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# ACACIA/WESTCHESTER CENTER OF EXCELLENCE



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## IMPACT

AGENCY: Acacia/Westchester Center for Excellence

LOCATION: New York

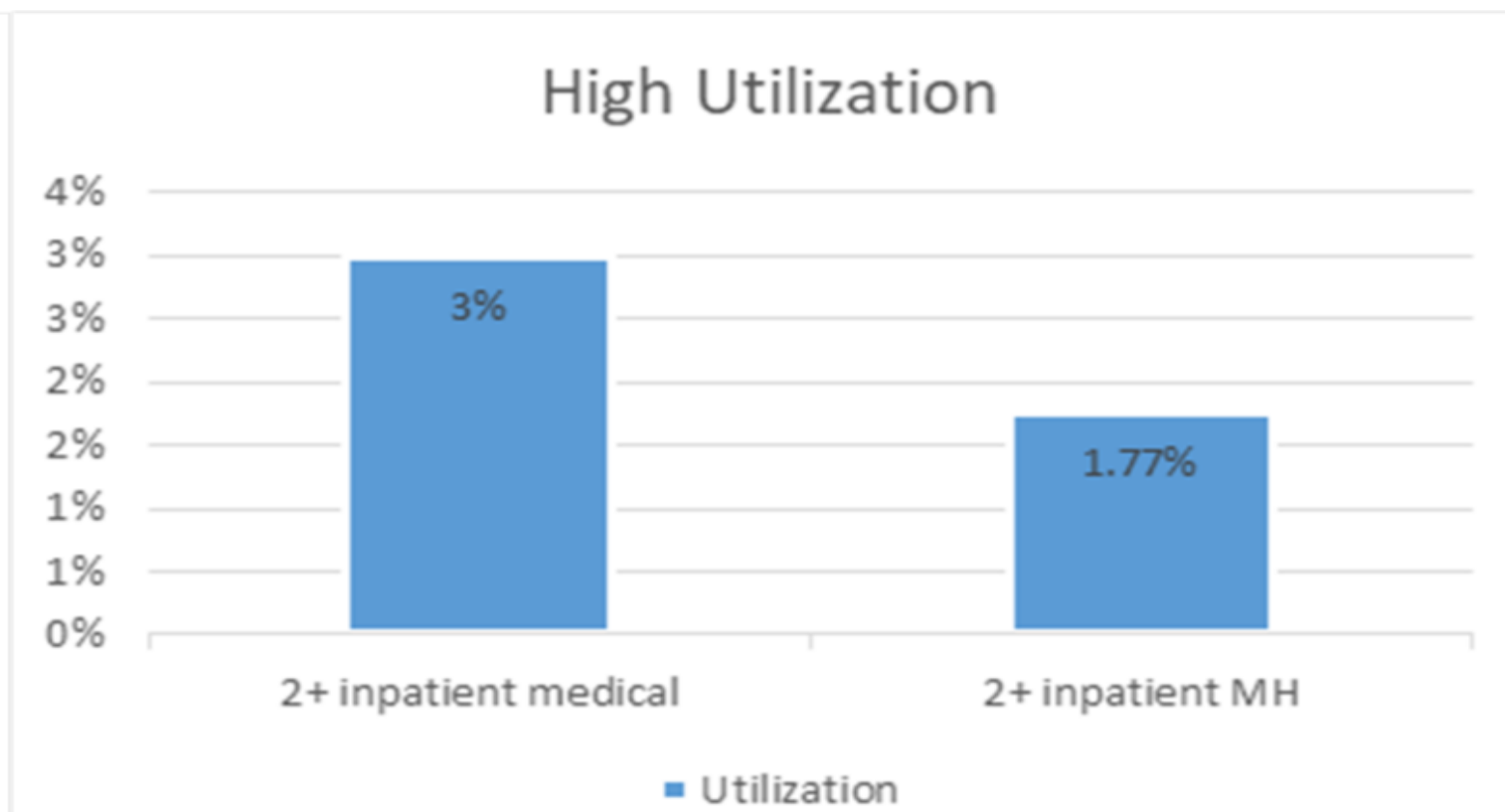
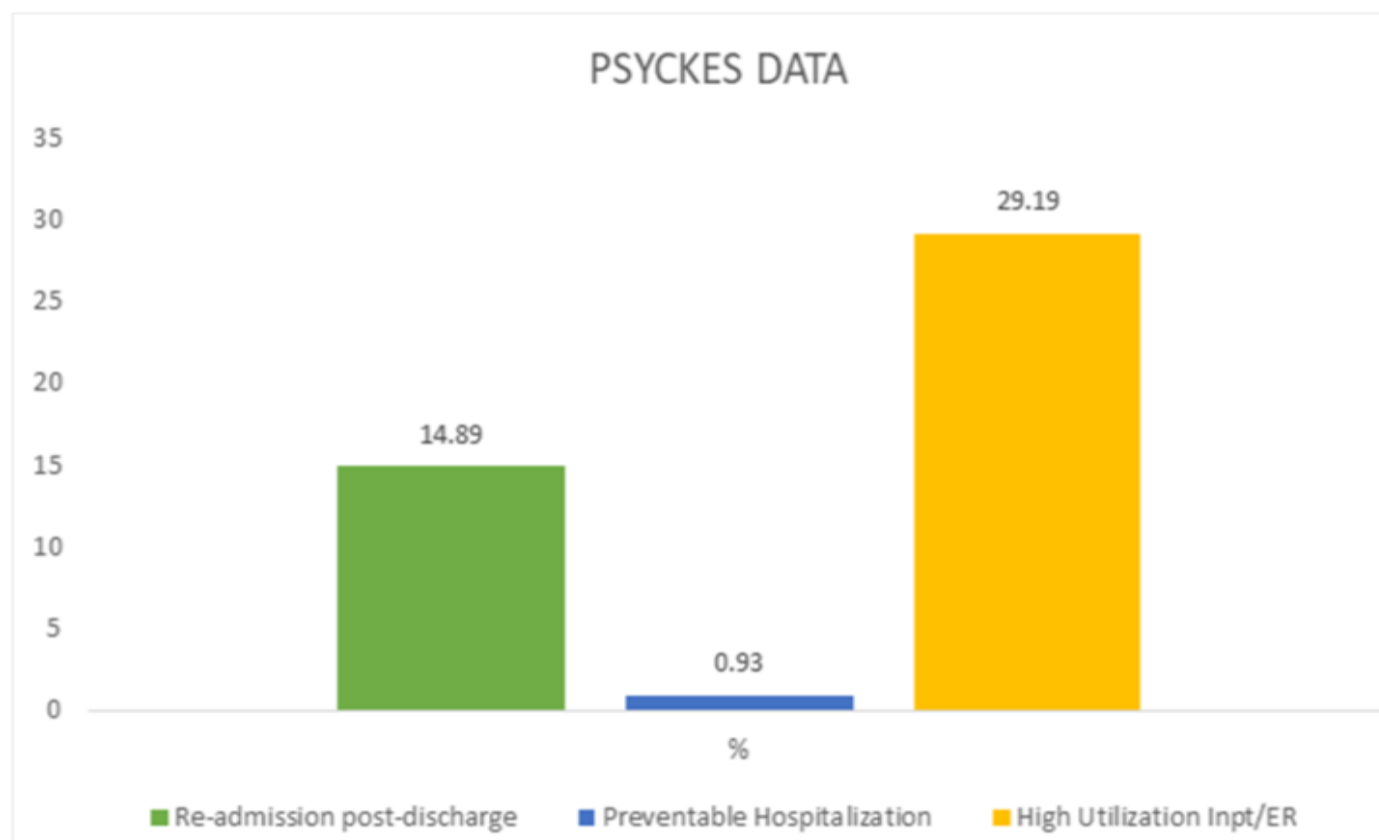
PRACTICE SITES: 1 Clinic (MH and SUD)

NUMBER OF CLINICIANS: 10SW and 1 intake specialist

NUMBER OF PATIENTS: 1632

### Implementation of Recovery Support Team

- Core metric set improvement including:
  - 15% of clients were re-hospitalized within 30 days of discharge. A 12% improvement over baseline
  - Preventable hospitalizations: 93%



## INTERVENTION

- At intake, the Clinical Supervisor uses a new workflow to identify people with high utilization for hospital use or clinical needs.
- Individuals meeting criteria have an integrated meeting – Psychiatrist, Nurse, SW, and a Peer with the client to see how collectively the needs of the person can be met. Recovery Supervisor tracks and ensures momentum following the meeting.
- Approach is improving engagement through holistic connection with the person on their whole health.
- Clients on medical pathway are seen by the nurse for monitoring. Co-located with a primary care on the same floor.
- Repeated at 3-month interval with determination on future schedule for meetings.
- New team approach with Peers, Psychiatric Rehabilitation Staff, CASAC. Contract with a PROS program to come on-site to offer skill services (CCBHC).
- Offer social and health education groups which create connection and boost health promoting behaviors.

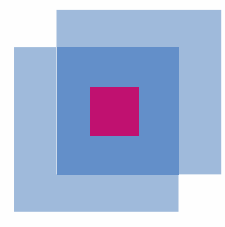
## KEY DISCOVERIES

- It took time to create a safe container for people to disclose their substance use. Creating trust that this disclosure would not be used against them.
- Shared space and changes in the clients using space raised some concerns initially. For example, people with SUD in what had traditionally been a mental health clinic. The change in integrated care impacts clients and clinicians' expectations and norms.
- Improvement in engagement with the larger care team being on-site, in one place and are talking with each other. A response system for their whole health.
- Care coordination is short term with a transfer to Health Home if needed.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN.

- Staff training is critical. Acacia used CTI.
- Thinking in creative ways about engagement and events that connect with the person outside of their identity as a person with a mental health issue.
- Assess and reassess workflows.
- Professional coder to maximize billing strategy for work completed.

# ACHIEVE BEHAVIORAL HEALTH – BIKUR CHOLIM



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## IMPACT

AGENCY: Achieve Behavioral Health – Bikur Cholim

LOCATION: Rockland and Orange County, New York

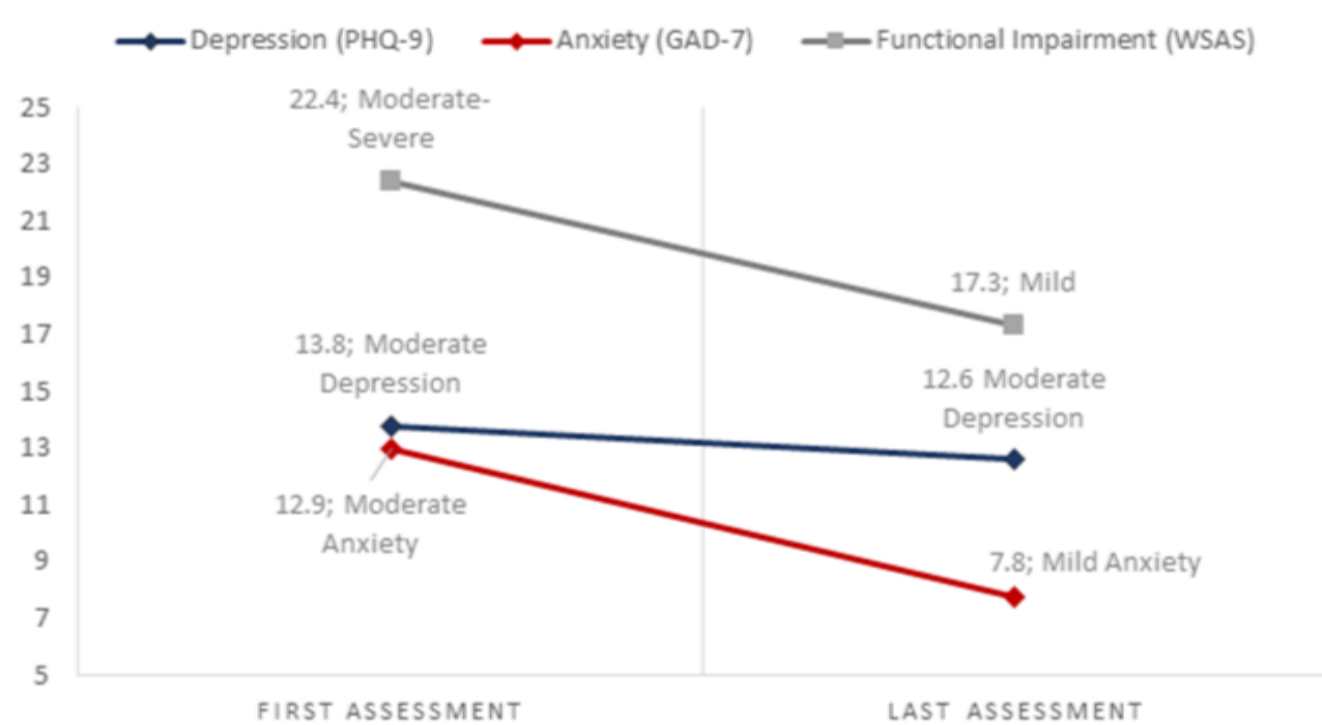
PRACTICE SITES: 4 locations + multiple locations

NUMBER OF CLINICIANS: 125

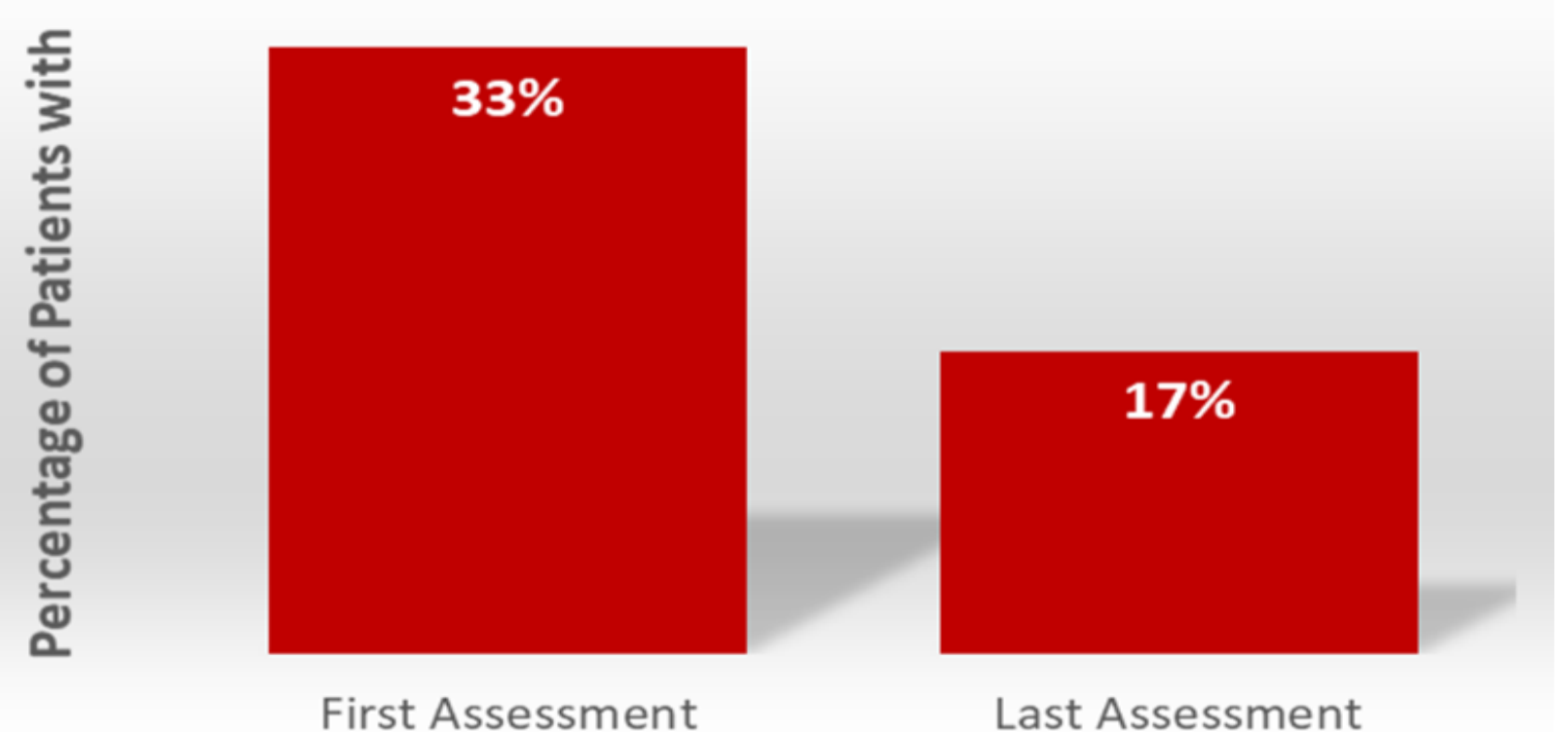
NUMBER OF PATIENTS: 2300

- Improvement in health outcomes high risk cohort in IOP.
- 66% reduction in hospitalization in 1 year.
- 30-day readmission rates fell 100% from 1 year prior to IOP to enrollment and post-IOP.
- Average number of days in the hospital for those patients who were hospitalized fell 32% from 1 year prior to IOP to enrollment and post IOP.
- Clients with jobs almost quadrupled from pre IOP to IOP and post IOP.

## IOP CLINICAL METRICS AND FUNCTIONING



## Positive Screen for Suicidality



## INTERVENTION

The high-impact processes and evidence-based interventions being used to drive clinical outcomes:

- DBT Treatment: Groups available daily in addition to regular psychotherapy treatment.
- Regular screening using standardized assessments
- Weekly screening for suicidality
- Case management as a standard component of care
- High availability of psychiatric care
- High availability of nursing services for health monitoring
- Bi-weekly case conference
- Team e-mails: all providers see all communications about clients for timely communication about needs
- Building a new infrastructure, iterative process
- Dedicated groups of champions to support this process of change for the organization.

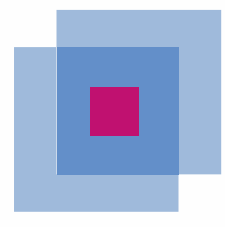
## KEY DISCOVERIES

- Communication across the team was essential. This was rooted in operating in a more traditional individual model and this project created an entirely new approach, within which team communication was foundational.
- DBT coaching essential feature.
- Building metrics into the fabric of the program. This included defining data, building metrics into the workflows and creating capacity to measure and report.
- The organization focused on measuring functioning, as evidenced by the focus on work. Moving beyond a depression score to improving functionality.
- Continuous quality (PDCA) improvement throughout the organization.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Focus on staff champions and supporting the change process for the organization.
- Focus on function, not just clinical symptoms. Value improvement in functional scales, even if the clinical markers do not improve.
- Build an infrastructure to build skills and response prior to the crisis to impact hospitalization rates.
- Focus on a new blend of psychiatric rehabilitation skills with clinical skills.
- CCBHC instrumental in creating and sustaining this work.

# BRIDGING ACCESS TO CARE



Care Transitions Network

for People with Serious Mental Illness

## IMPACT

AGENCY: Bridging Access to Care

LOCATION: Brooklyn, NY

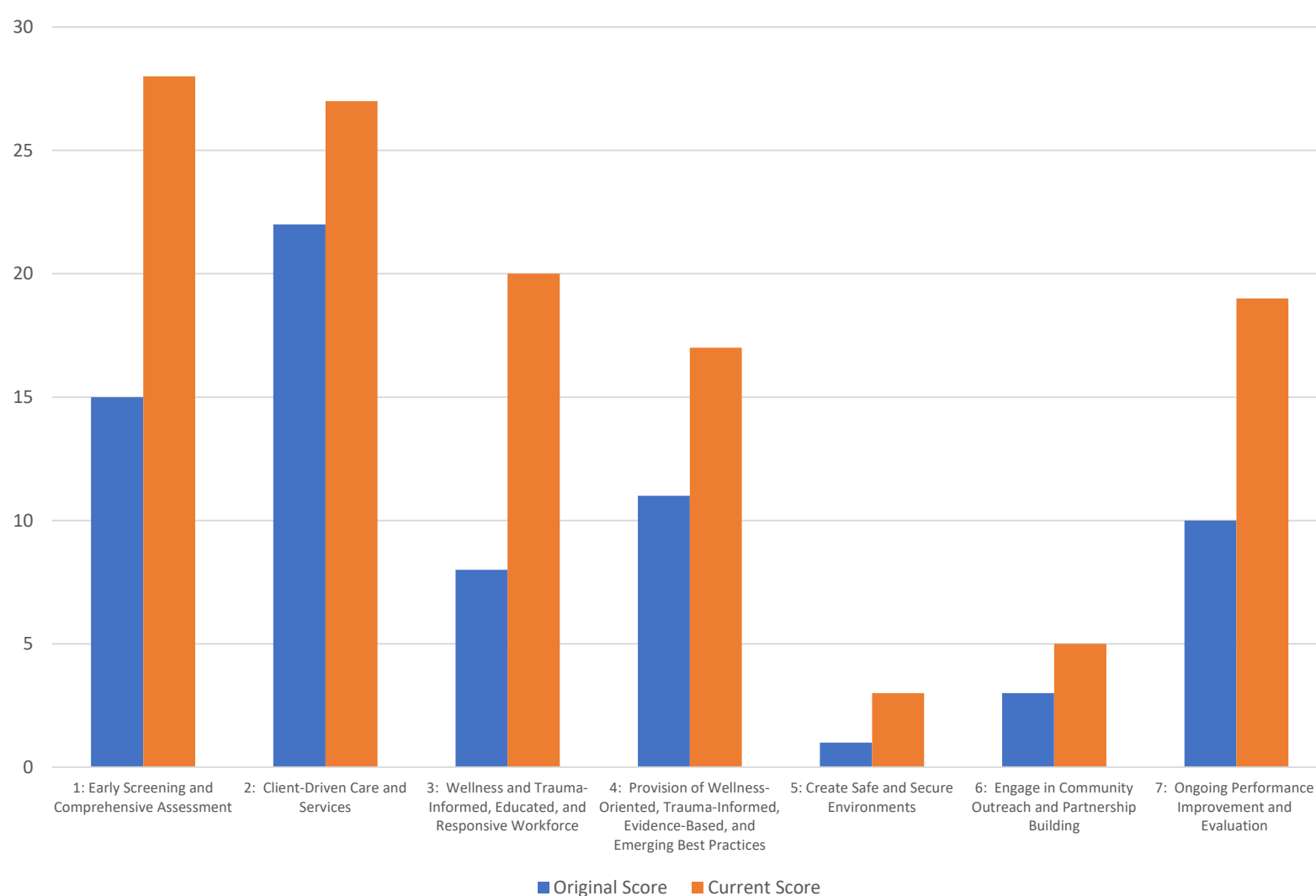
PRACTICE SITES: 1 Clinic/Implemented Agency-wide

NUMBER OF CLINICIANS: 16

NUMBER OF PATIENTS: 520 clinic and 4000 agency-wide

- Population health clinical and operating construct scaled across the agency. (Every aspect changed – think rebuilding your home.)
- Established standard population healthcare pathways, prompts and feedback loops in EMR.
- Wellness-Oriented Trauma-Informed Care (WOTIC) Domain Score gains across the board.
- Pioneer in starting meaningful conversations on “Return on Investment.”

WOTIC Domain Score Progress



Period 1	
<b>Level of Functioning and Diagnosis</b>	
<b>Primary DSM-V of:</b> F33.1 Major Depressive Disorder, recurrent, Moderate F14.21 Cocaine Dependence, in remission B20 Human Immunodeficiency Disease	
<b>Total Cost</b> <b>\$6,699.17</b>	
<b>Average DLA20 Score</b> <b>4.6</b>	
Mild impairment or problems in functioning	
<b>Number of contacts during this period:</b> <b>49</b>	<b>Frequency of contact</b> Average of contact Hours per week for period – 3.13 Hrs.
Period 2	
<b>Level of Functioning and Diagnosis</b>	
<b>Primary DSM-V of:</b> F33.1 Major Depressive Disorder, recurrent, Moderate F14.21 Cocaine Dependence, in remission B20 Human Immunodeficiency Disease	
<b>Total Cost</b> <b>\$3,467.00</b>	
<b>Average DLA20 Score</b> <b>5.0</b>	
Mild impairment or problems in functioning	
<b>Number of contacts during this period:</b> <b>32</b>	<b>Frequency of contact</b> Average of contact Hours per week for period – 2.60 Hrs.

## INTERVENTION

- Starting with Culture – trauma-informed care and resilience. Steering Committee and seven subcommittees to focus on domains.
- Organizational Performance Improvement Wellness: Oriented Trauma-Informed Care (WOTIC) tool.
- Created a population health pathway through technology and operational workflows. “Treatment Wizard” to scale standard care pathways.
- Automated monitors, ticklers and alerts.
- Monitor trends in symptoms, functioning and outcomes.
- Every quarter agency closes (skeletal crew) for a “Retreat Day” where mandated training and team building occurs. Responsibility for training development rotates among departments.
- Initiated peer review.

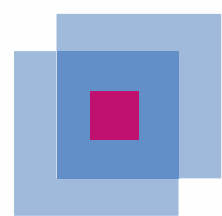
## KEY DISCOVERIES

- Going through this process brought to light massive operational differences in our departments. Procedures, data, clinical emphasis, basically everything! There was an inability to do population health because of these processes and data definition difference. It was poignant when we could not respond to a survey on who we served. This is easy to report on now.
- Committee structure led to integration across departments in extraordinary ways.
- Culture change success included changes in Executive Leadership position descriptions everyone took the same trainings. For example, all watched Trauma 101.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Must have complete buy-in from Executive Leadership. Leadership must be present on the implementation committee.
- Emphasis on “why” change was needed.
- Communication: starting a newsletter to support continued implementation and staying on track.

# CAPE: SAMUEL FIELD Y



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## IMPACT

AGENCY: CAPE: Samuel Field Y

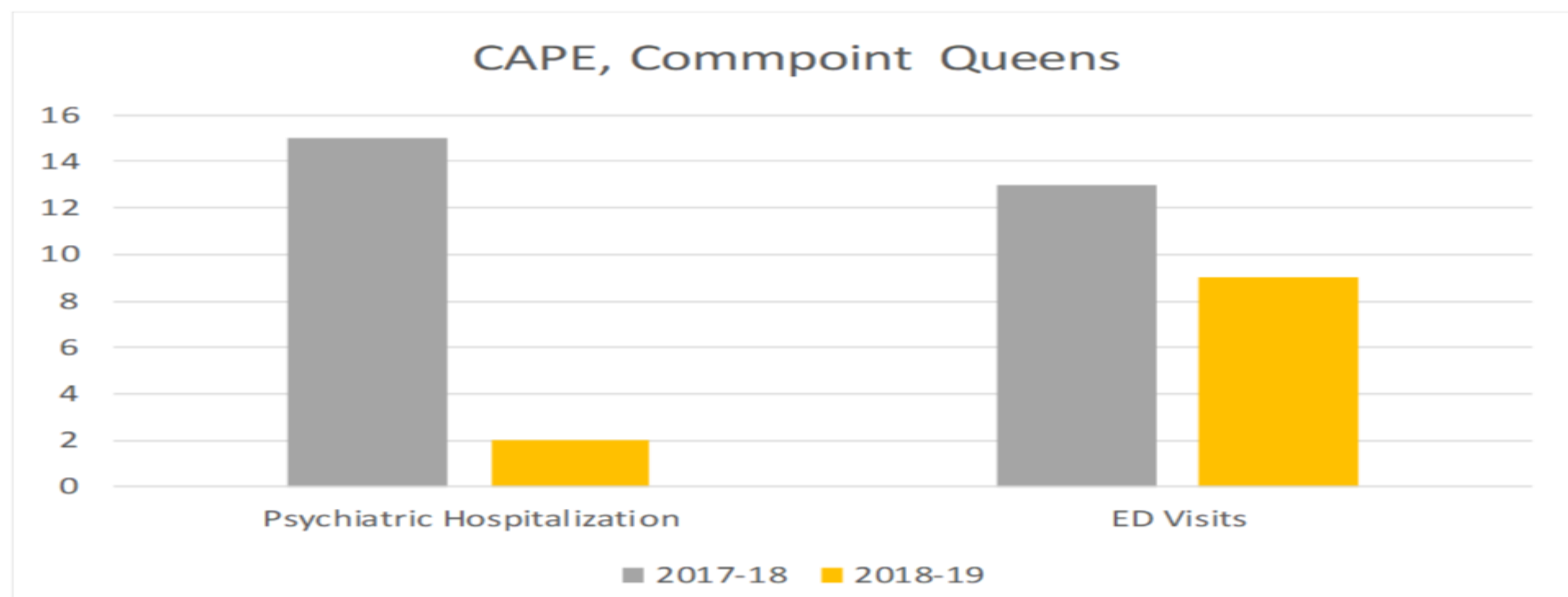
LOCATION: Queens, NY

PRACTICE SITES: 1 Clinic 6 Sites

NUMBER OF CLINICIANS: 15

NUMBER OF PATIENTS: 955

- Reduction in psychiatric hospitalizations and emergency department visits for seniors with mental illness.
- Improved patient activation (engagement) and adherence (compliance).



## INTERVENTION

- Combination of site-based clinic, satellites in senior centers and visits to homebound clients.
- After-hours call system where clients can connect with a clinician 24/7.
- Medication adherence track via RHIO coupled with collaboration with all prescribers and pharmacies.
- Transportation to the clinic is provided.
- Reminder phone calls for patients with cognitive issues or poor attendance records.
- Geriatrician on-site offers complimentary cognitive assessments. If cognitive issues are identified, ideal modalities are identified. These may be medical or psychiatric.
- Developed communication pathways through the EMR for improved care delivery and coordination.

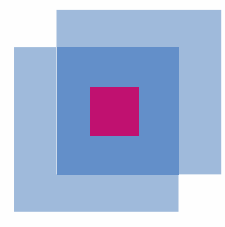
## KEY DISCOVERIES

- Process identified significant mis-diagnosis of seniors' mental health issues. There are cultural aspects that have been misinterpreted.
- Access for seniors with various insurance is limited.
- Unnecessary hospitalization rate for seniors were notably high. UTI's were significant drivers of hospitalizations.
- A cohort of individuals with significant mental illness who were cared for by aging parents. In particular, people over the age of 50 years.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Critical to differentiate cognitive impairment from mental illness and then identifying the optimal modality. Personalized medicine.
- A strong team approach and culture has been a success factor for wrap-around elements (on call, transportation, creating personalized solutions for people served.)

# CATHOLIC CHARITIES NEIGHBORHOOD SERVICES



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## IMPACT

AGENCY: CATHOLIC CHARITIES NEIGHBORHOOD SERVICES

LOCATION: BROOKLYN & QUEENS, NY

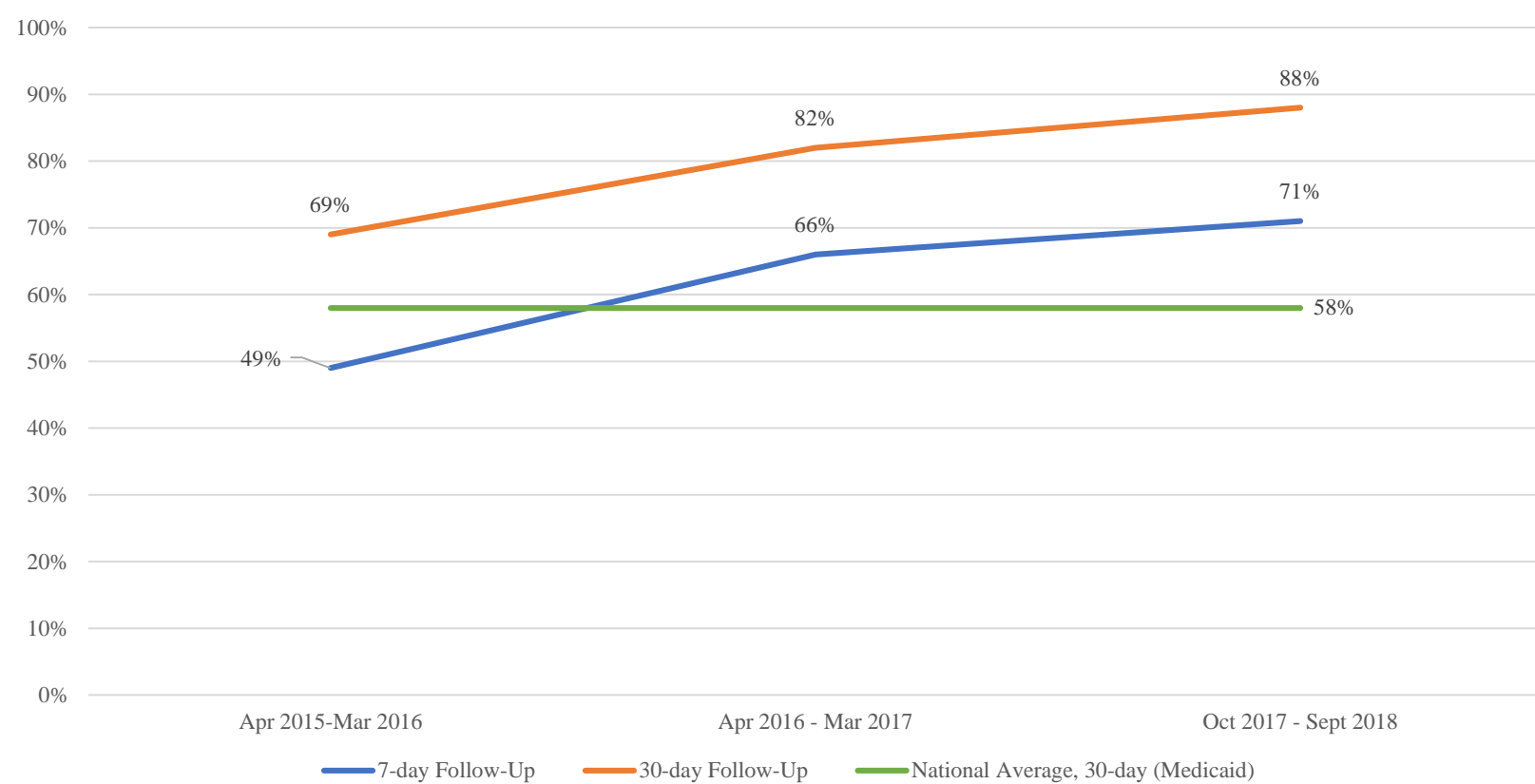
PRACTICE SITES: 5 CLINICS WITH 2 SCHOOL SATELLITES

NUMBER OF CLINICIANS: 60

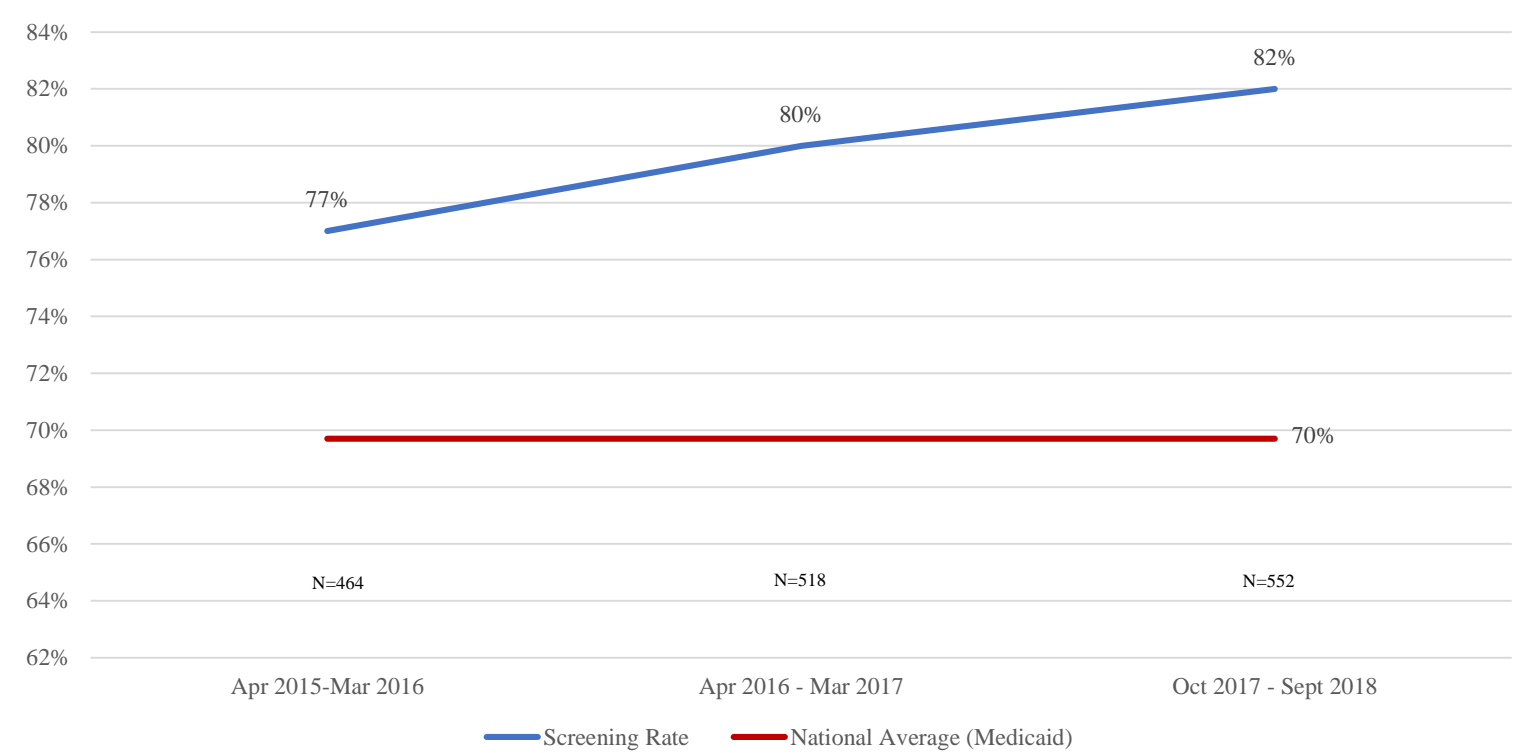
NUMBER OF PATIENTS: 7000

- Improved access (7-day) and engagement (30-day) for people with an identified mental illness in outpatient treatment and support.
- 22% increase over 2 years in access to MH outpatient treatment (7-day).
- 19% increase in engagement in treatment (30-day) over a 2-year period.
- Diabetes screening of 82%.

Follow-Up After Hospitalization for Mental Illness



Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications



## INTERVENTION

- Core values, culture and capacity flowed into our selection as a CCBHC.
- CCBHC encapsulates our standard of comprehensive and integrated care to deliver health outcomes.
- Culture and practice pathways for validated screening, patient activation/engagement and evidence-based treatment.
- Every clinician reviews, acts and reports on a client's emergency department presentation or hospitalization.
- Telepsychiatry has enhanced prescriber access across numerous sites. Support immediate response to walk-in clients. Hub and spoke model.
- Nurses on staff to monitor diabetes and those identified as medically high risk meet with the nurse weekly.

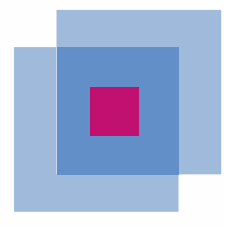
## KEY DISCOVERIES

- Telepsychiatry has been well received by consumers. It was somewhat surprising that telepsychiatry has been successful, easy and relatively inexpensive.
- Open Access key to achieving engagement.
- Actively screen new staff for alignment with culture and practice approach.
- Billing team that is well versed with individual plan practices.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Built strong connection with hospitals for flow of referrals.
- Open access requires close monitoring and communication to ensure staff and outside referral entities use it well.
- Communication of data back to primary care provider, staff and patient supports.
- Engagement is supported with peers who are employees.
- Working on sustainability in the event CCBHC is not extended.

# CN GUIDANCE AND COUNSELING SERVICES



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## IMPACT

AGENCY: CN Guidance and Counseling Services

LOCATION: Long Island, New York

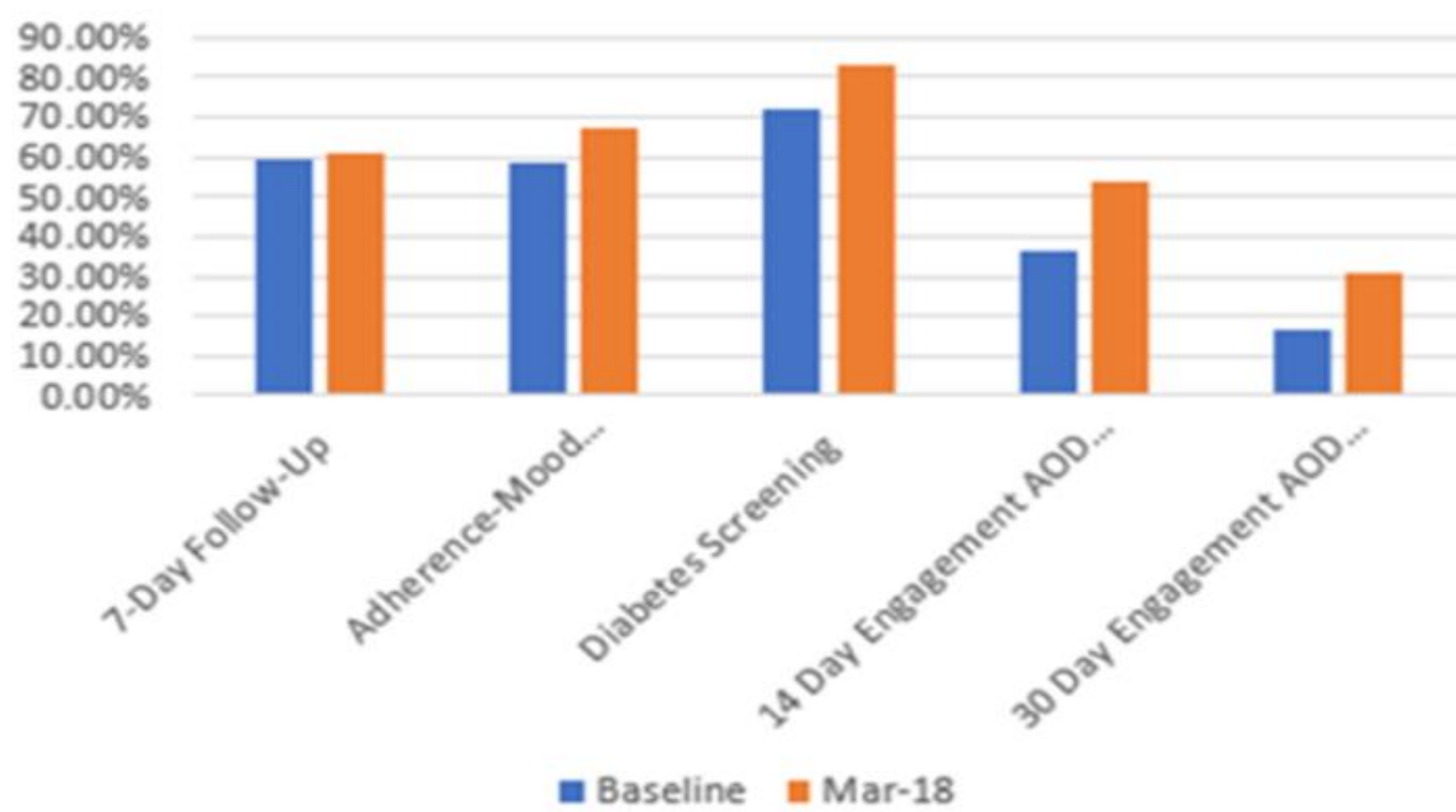
PRACTICE SITES: All Services

NUMBER OF CLINICIANS: 350

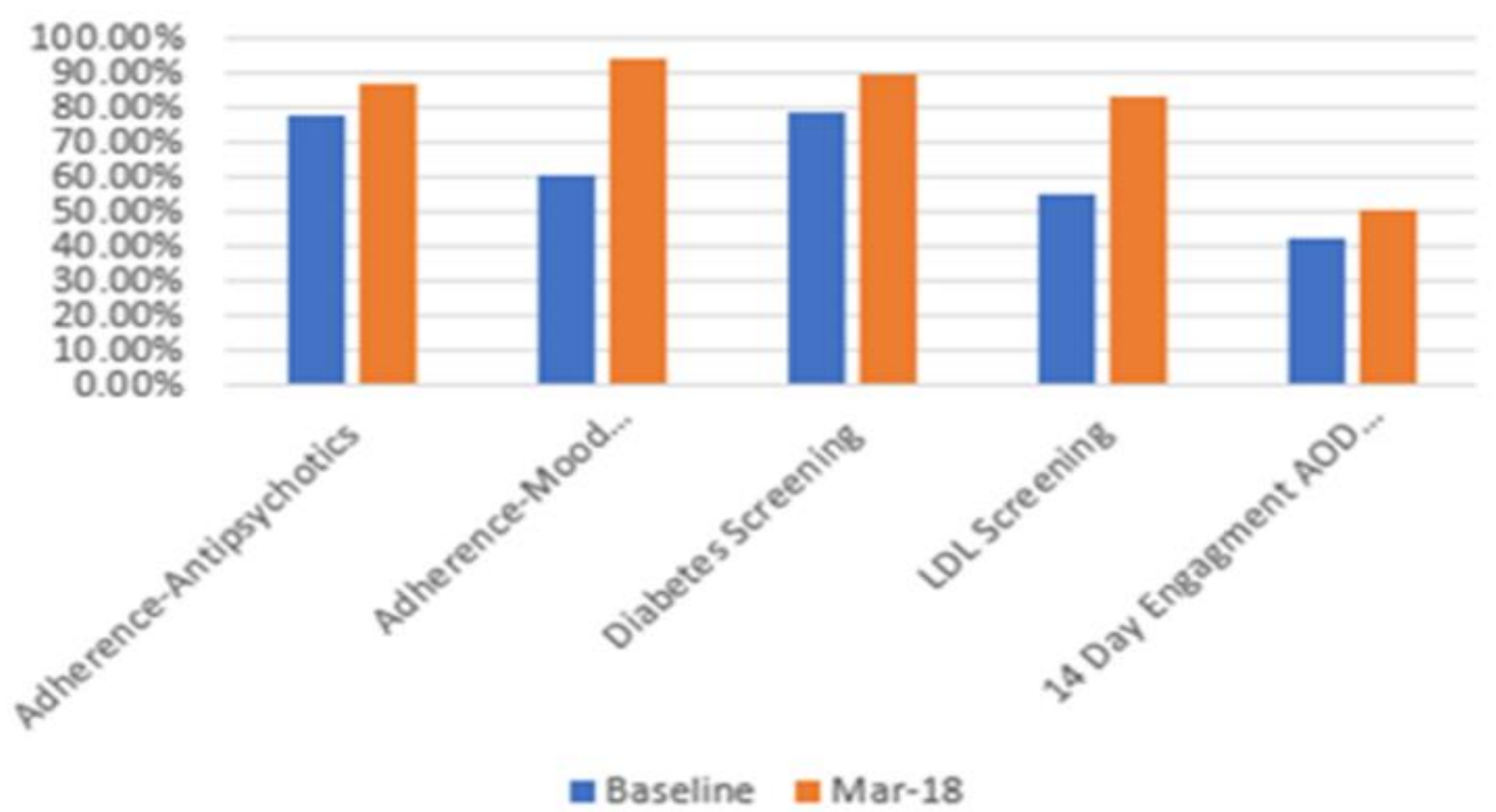
NUMBER OF PATIENTS: 7000

- Major culture shift to whole person-model of care.
- Data-driven.
- Achieved over 10% increase in performance on 6 of 13 HEDIS measures.
- 50% improvement in PHQ-9 scores.

### Mental Health Clinics



### PROS



## INTERVENTION

- Population management via workflows with real time data.
- Open access scheduling for clients to increase access and engagement.
- Routine feedback to staff by sharing data and providing an opportunity for staff to develop strategies to enhance performance. This creates a culture of transparency and accountability.
- Culture of quality, streamlined and documented workflows, and trained staff on evidence-based practices.
- Engage with our community providers to enhance service offerings and facilitate strong transitions of care.
- Developed connections with clinical measures (such as PHQ-9) and HEDIS measures (payer view). Connecting meaningful data feedback to clinicians while driving performance on HEDIS.

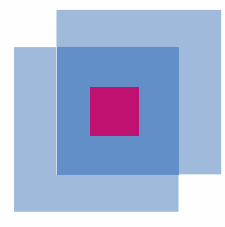
## KEY DISCOVERIES

- Assumptions about the way we deliver care and the way our organization worked were proven or disproven in significant ways. Data was the meaningful driver of change. Changed the game, “not throwing darts at the dartboard any longer.”
- Defining care pathways where commonly occurring themes are created to ensure knowledge transfer.
- Whatever you think culture shift will take, double that estimate. Sense of resistance was not actually resistance, but fear of losing high quality care. Carefully scripted messages.
- Data can be very powerful part of the script to deliver intended population health messages.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Use change management strategies. Start change management with management team.
- As CCBHC needed integrated license. Cross trained everyone. Respectful, but basic training in either MH or SUD. Building competence and comfort in delivering the full scope of clinical care. Managers nurtured a new community of clinicians with an integrated focus.

# FAMILY SERVICES, INC.



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## IMPACT

AGENCY: Family Services, Inc.

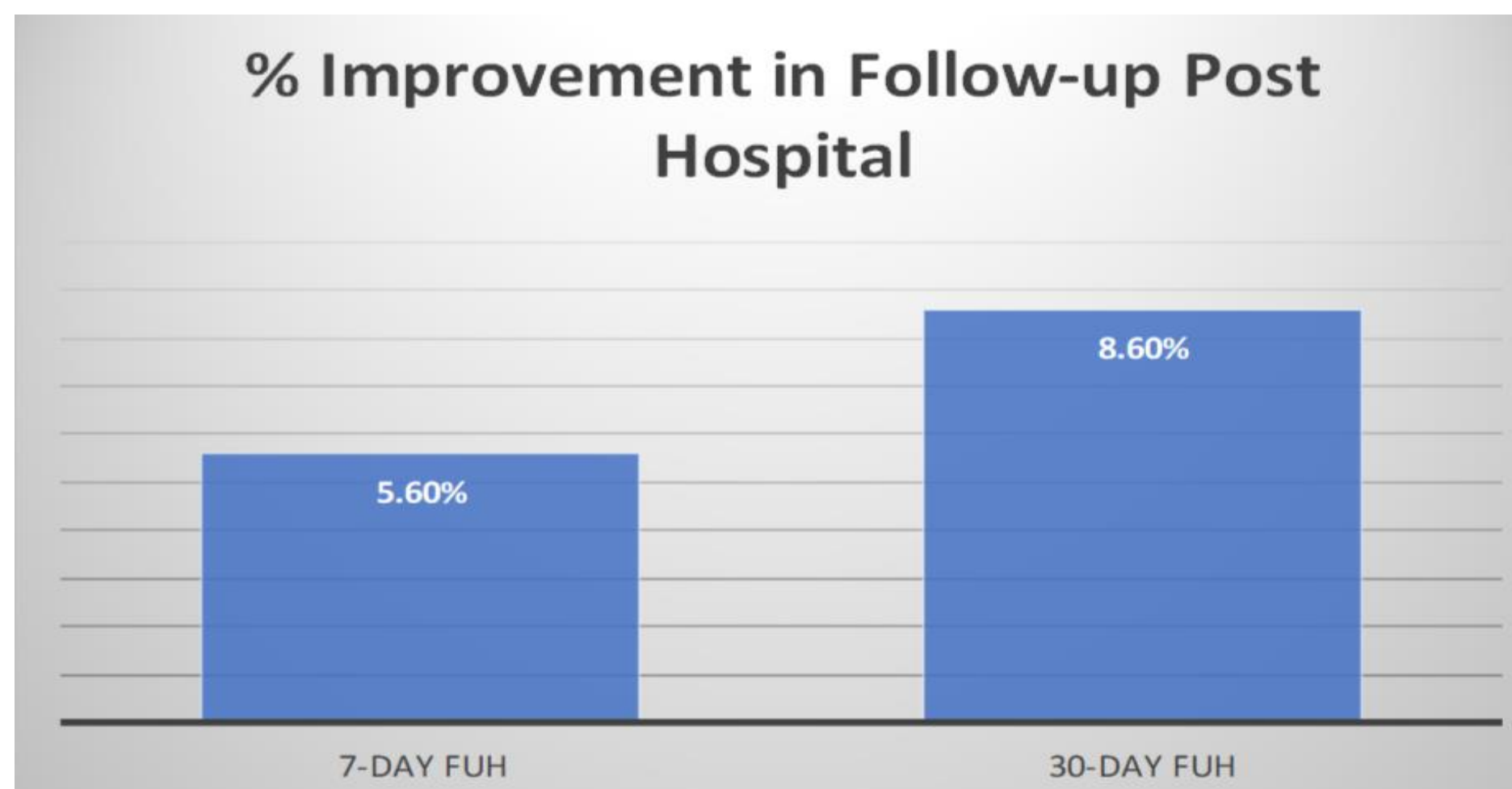
LOCATION: Dutchess County, New York

PRACTICE SITES: 8 Centers

NUMBER OF CLINICIANS: 65

NUMBER OF PATIENTS: 5000

Improvement of Follow-Up After Psychiatric Hospitalization  
7-day and 30-day



## INTERVENTION

- Collaboration is a foundation to improving transitions of care. Examples include RESTART, which is an innovation program that provides treatment and re-entry services to male and female inmates housed in the Dutchess County Jail.
- Family Services is also a member of Coordinated Behavioral Health Services (CBHS) since 2016.
- HEDIS measures are tracked using the New York State Office of Mental Health PSYCKES platform and their access to Medicaid Claims data through the CTN data dashboard to track and monitor measures related to readmissions and follow up visits.
- Plan-Do-Check-Act cycles.

## KEY DISCOVERIES

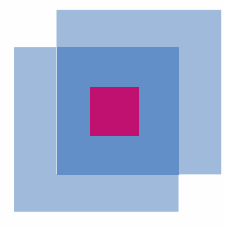
- Using change management tools was important for success: the ADKAR model (Awareness, Desire, Knowledge, Ability, and Reinforcement).
- This model is a change management tool to help identify why change is difficult and why some changes succeed while others are not as successful. It builds off five building blocks that help organizations bring about successful change.
- This model is powerful and can help address employee resistance to change.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Family Services attributes their transformation and implementation of continuous quality improvement to their engagement in the PTN. By using the practice assessment tool, coaching calls, and technical assistance, Family Services has been able to identify their areas of need and developed practical solutions to address these challenges.



# INSTITUTE FOR FAMILY HEALTH



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## IMPACT

AGENCY: Institute for Family Health (IFH)  
LOCATION: Hudson Valley and New York City  
PRACTICE SITES: 23 FQHCs  
NUMBER OF CLINICIANS: 1300  
NUMBER OF PATIENTS: 117000

- Advance care coordination to improve patient experience and transitions of care with a focus on patients using hospital instead of primary care.
- 100% achievement of 7-day post hospital patient visit.

Description of Metric	Metric Baseline	12 months post-implementation
1. Percent of patients who visit partner ER with outreach completed	70%	95%
2. Percent of patients who visit partner ER with a future appointment scheduled (within 14 days of discharge)	50%	60%
3. Attendance at scheduled appointment	20%	100%

## INTERVENTION

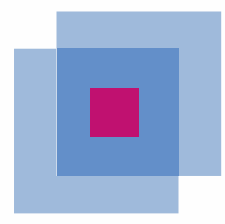
- Transitions of Care report – built within the EMR. Anyone on the care team with access to the patient can see the care coordination process.
- Notification when the patient is in the hospital and their care coordination contact status. Training teams on the technology to advance the organization’s mission. Part of ongoing supervision, to look at success rate for TOC contacts and how many eventually come in for the primary care appointment. Nurse Care Coordinators monitor and support the TOC process.
- Partnerships with Mt. Sinai (DSRIP) / St. Luke’s supported with relationships, phone numbers and workflows.
- Established a communication protocol. Hospital flags patient, contacts IFH as soon as discharge is known.
- All patients were involved or enrolled in care management with an established relationship. Foundation to deliver valuable patient education and motivation for creating health care changes.

## KEY DISCOVERIES

- Training workforce is critical.
- Staff dedicated to this project were essential. Both in terms of time dedicated and the type of people who are doing the work at IFH.
- Partnership to be able to actually do the work. Make sure you have a common goal and are talking with the right people.
- Created workgroups with the hospitals to set the stage for building the workflows. In the workgroups shared vision was established and the kinks could be worked through.
- CareEverywhere – consented access to facilities, which included Mt Sinai. Both hospital and Care Manager can look simultaneously at the record.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Culture and Workflow – initiative pervades everything that is done. Context/philosophy within which the work happens.
- Leveraging the EHR to optimize the workflows and performance tracking so that the focus is on patient care and transitions of care.
- Establishing effective partnerships and collaborations with external providers.



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# INTERBOROUGH DEVELOPMENTAL AND CONSULTATION CENTER

## IMPACT

AGENCY: INTERBOROUGH DEVELOPMENTAL AND CONSULTING CENTER

LOCATION: Brooklyn, NY

PRACTICE SITES: 1 SITE

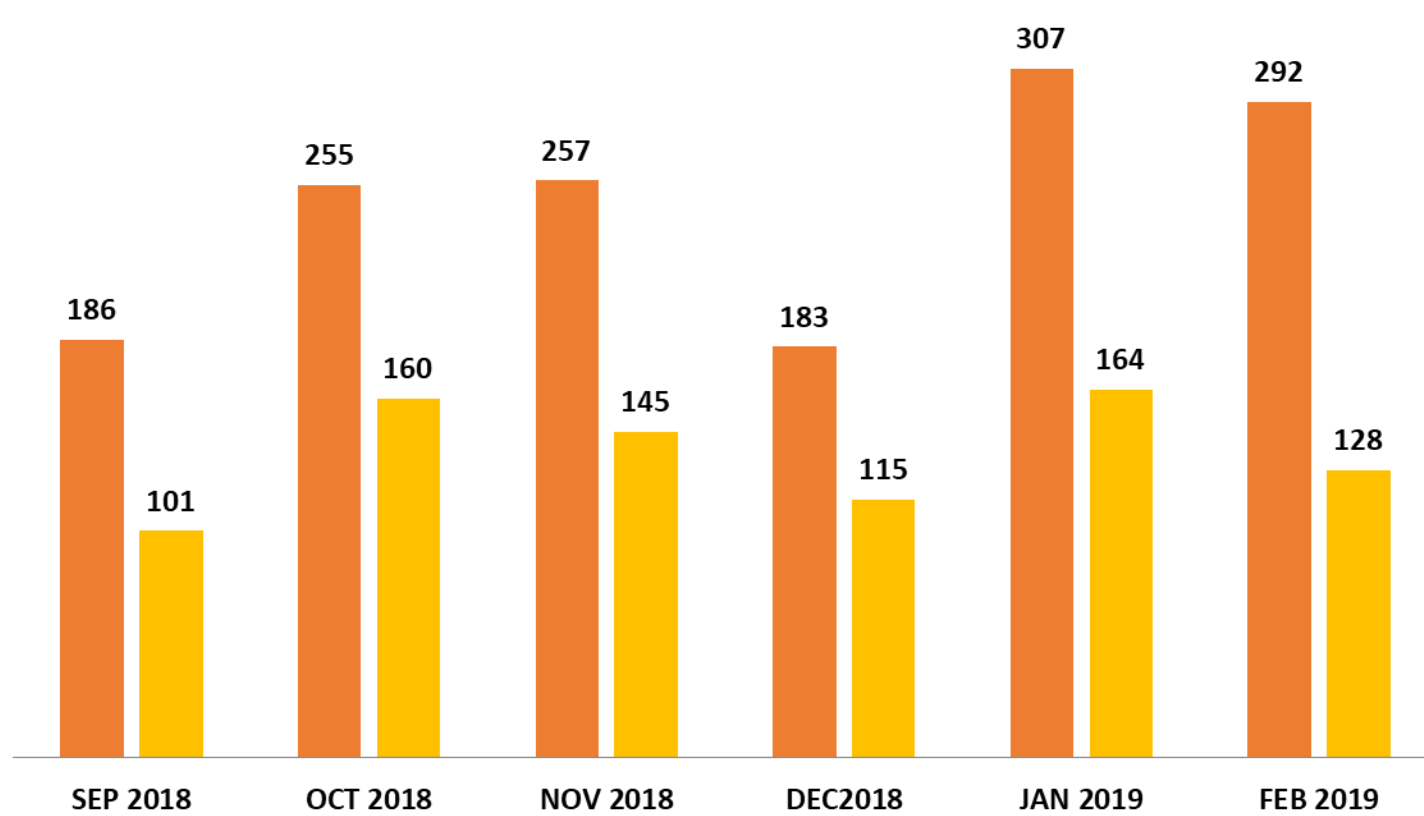
NUMBER OF CLINICIANS: 98

NUMBER OF PATIENTS: 6200

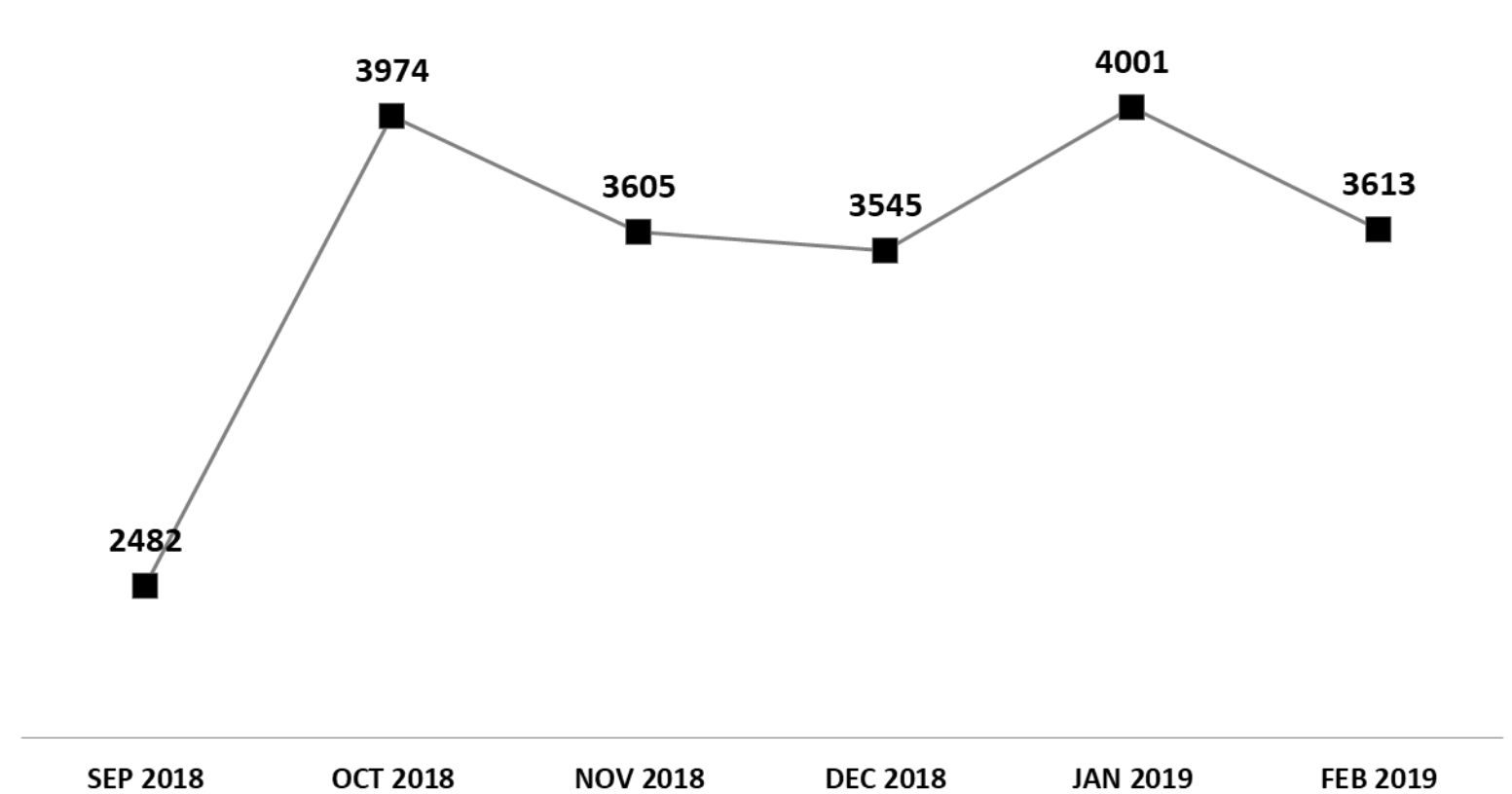
- 25% increase in kept 1<sup>st</sup> appointments.
- Building a culture of performance improvement and ability to scale across agency.

### Crown Heights

■ CALLS ■ INTAKES



### Crown Heights Sessions



## INTERVENTION

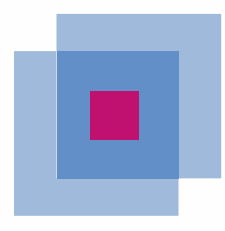
- Introducing continuous quality improvement (PDCA) as a strategy to improve patient outcomes through improved clinical practice.
- Goal to schedule the appointment on the first call whenever possible.
- Supervision involvement to actually listen in to intake calls was powerful in creating the energy for change.
- Training to ensure the person taking the calls “smiles through phone”
- Expert in customer service delivered coaching session to front line staff.

## KEY DISCOVERIES

- The person taking the calls is key to bringing the people into care.
- Supervision, training of person taking the call leads to improved performance.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Staff availability for high demand hours and locations is a challenge.
- Looking at script to support implementation long-term.



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## IMPACT

AGENCY: Jamaica Hospital

LOCATION: Queens, New York

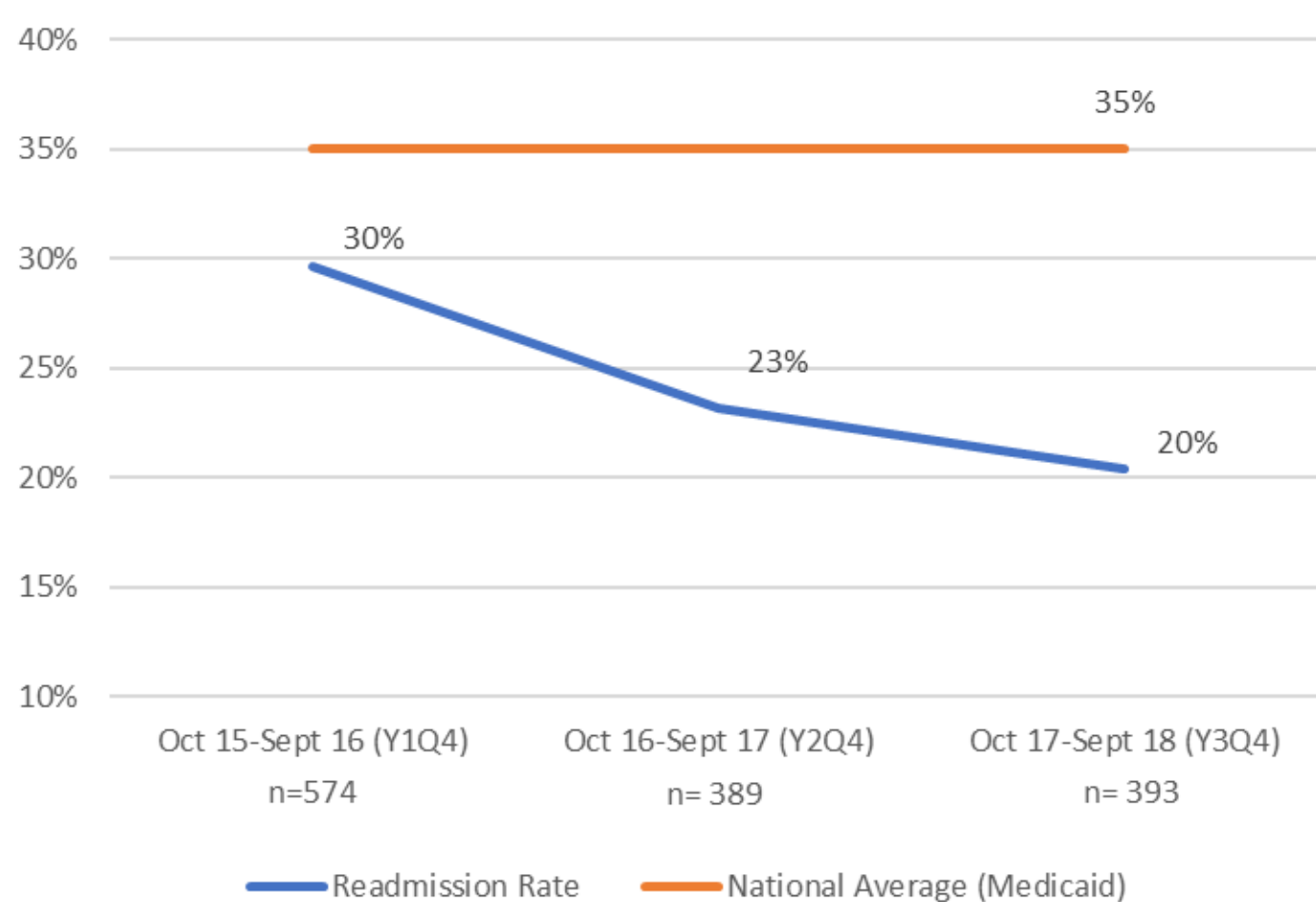
PRACTICE SITES: 14

NUMBER OF CLINICIANS: 550

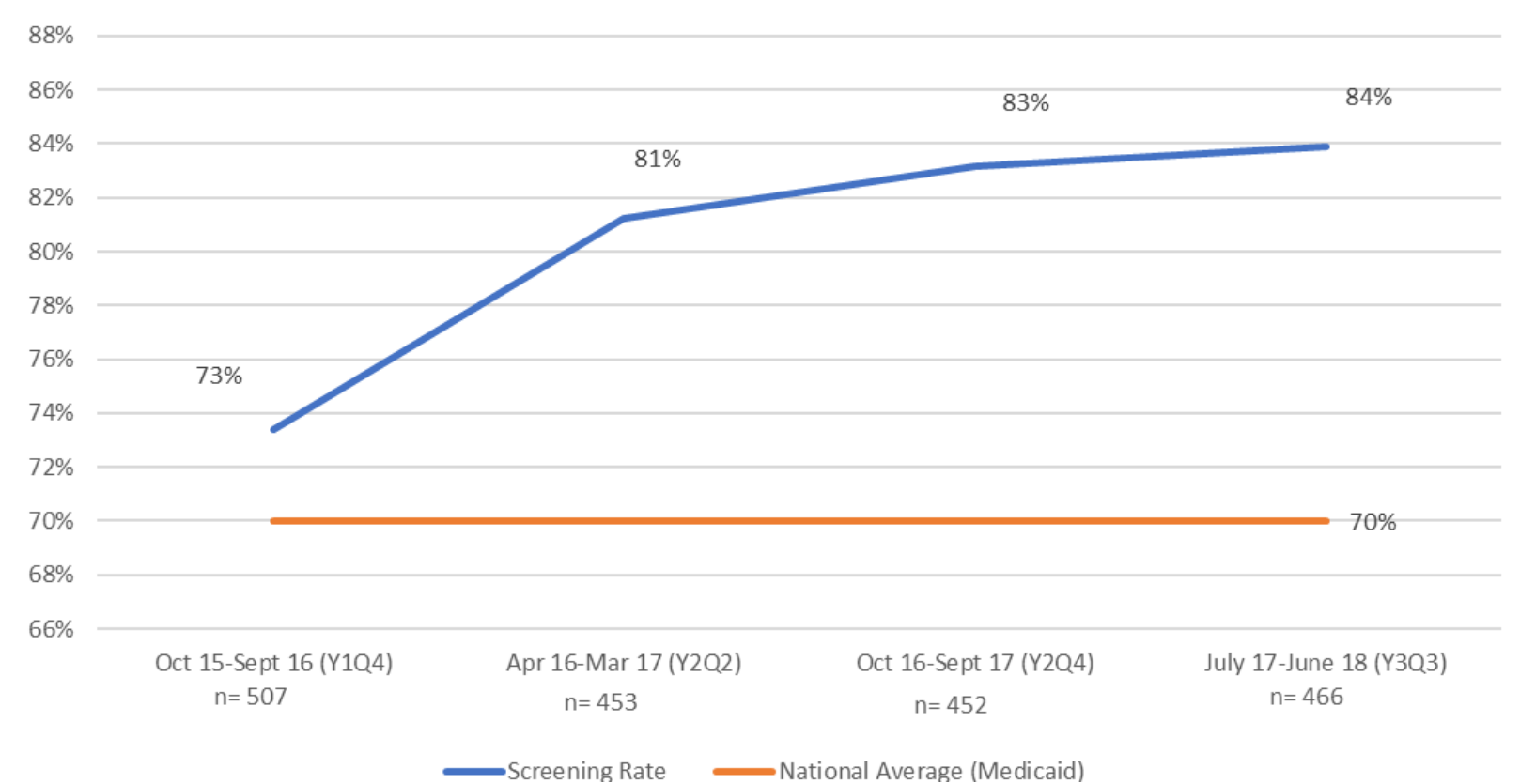
NUMBER OF PATIENTS: 439,000

- Reduced both all cause and mental health readmission rates by 25%.
- Realized substantial cost savings with the decrease in recidivism. Our \$1,453 Total PMPM cost is within 2% of the \$1,479 benchmark.
- Continued to ensure and achieve high patient satisfaction ratings as evidenced by our most recent survey results scoring an average rating of 4.6 out of 5.

30-day MH re-admission



Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications



## INTERVENTION

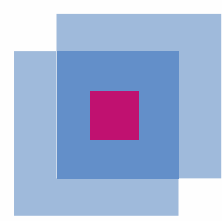
- Incorporated validated evidence-based screening tools into our initial and on-going assessments.
- Regular inpatient/outpatient meetings to review clinical status of identified high risk patients.
- Formulate safety plans with at risk inpatients and outpatients encouraging family involvement.
- CPEP Mobile Crisis team and MAX program to follow at risk discharged inpatients/outpatient.
- Primary care physician on site at the MH Clinic to provide initial and yearly physical exams, consultations, health monitoring services, referrals to sub-specialties, and care coordination.
- Receive immediate feedback from patients via text message satisfaction surveys after every contact.
- Offer long-acting injectable medications.

## KEY DISCOVERIES

- Provided patient activation and engagement training for clinical staff.
- Established an on-site pharmacy on the premises the Mental Health Clinic.
- Participate in and provide free screenings at Community Health Fairs and school functions to promote mental health awareness.
- Expanded our telepsychiatry service to off-campus Medisys Ambulatory Care sites.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Being a part of a large medical system offering a full range of inpatient and outpatient services provides our patients a “one stop shopping” system of care, which ties directly to our mission statement: “To serve our patients and the community in a way that is second to none.” What makes us unique is our strong organizational focus on being client centered, a community partner, a high reliability organization, and outcomes driven.



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## IMPACT

AGENCY: Jawonio, Inc.

LOCATION: Rockland County, New York

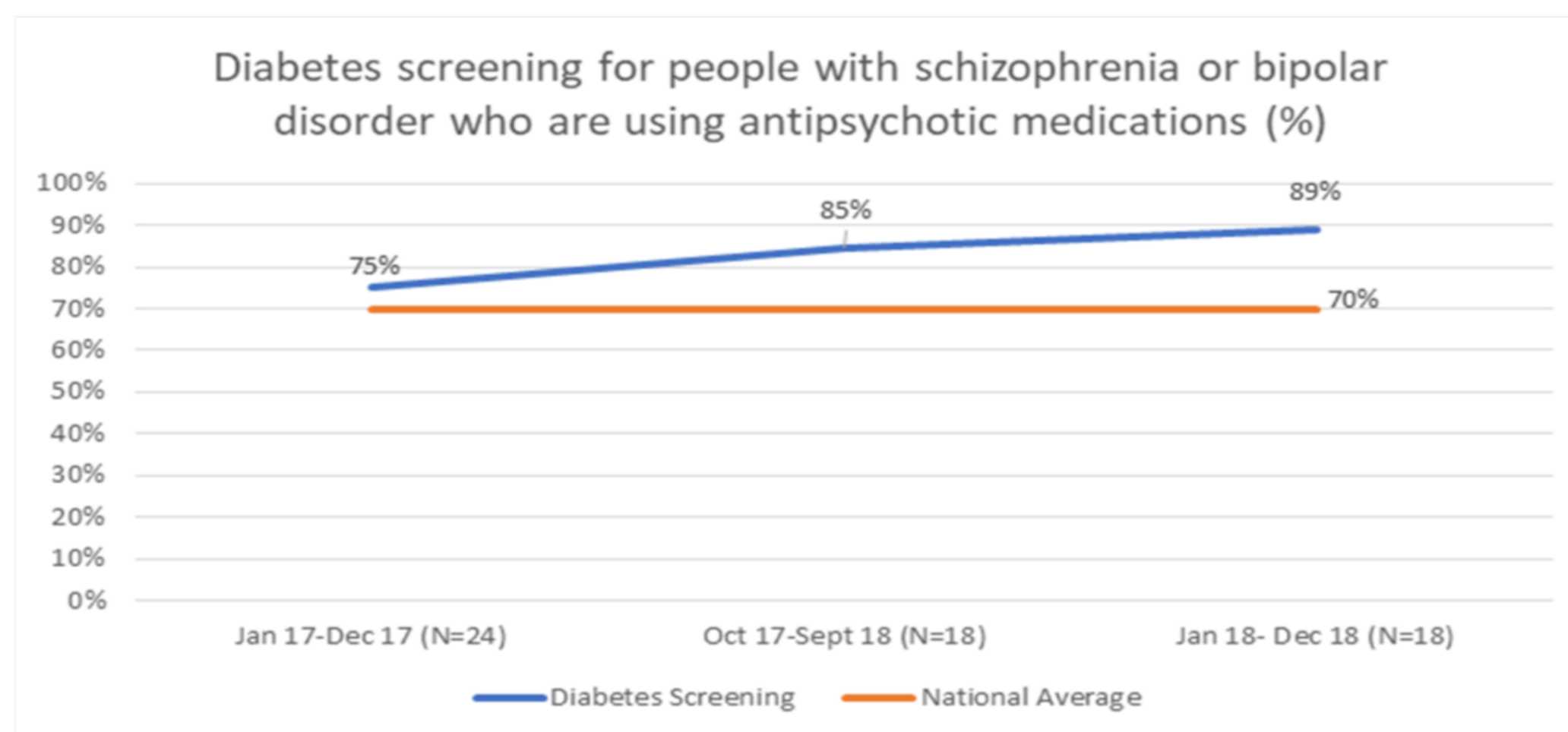
PRACTICE SITES: 1 Health Home Care Management

NUMBER OF CLINICIANS: 10 (Care Managers)

NUMBER OF PATIENTS: 250

### Health Home Care Management Key Performance Metric Improvement

- Diabetes screening rate of 89%, a 14% improvement from the baseline over 2 years.
- Significant improvement in Consumer Acceptance of HARP and HCBS participation.
- 57% of individuals eligible for HCBS are assessed by Jawonio.
- 78% of those assessed as eligible accept referral for HCBS.



## INTERVENTION

- A new position was added to complete the process “HARP/HCBS Assessor.” As a clinician, this person is very attuned to the sensitivity of the trauma dimensions of the assessment process.
- Establish Care Coordination Pathways to drive performance on key metrics.
- Create “team” between Care Managers and HARP/HCBS Providers to improve presentation of services to consumers and referral services.
- Continuous quality improvement strategies and deployment of data to inform practices.
- Diabetes screening improvement driven by strengthened connection with primary prescribers to schedule regular screenings; using RHIO and PSYCKES to identify flags for those due for screening and CMS’ work with members to ensure that they schedule and comply with treatment protocols, etc.

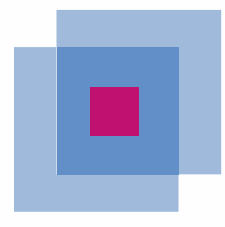
## KEY DISCOVERIES

- The work that Care Managers have to do to engage consumers in the HCBS process is extraordinary.
- Leadership worked with Care Managers to understand the front-line complexities of completing paperwork, scheduling and assessments. The process was viewed negatively and was overwhelming. A new, team structure was added.
- Data received for HARP/HCBS does not provide consistent information. The HARP/HCBS Assessor verifies status by phone with the Medicaid Managed Care Plan. This can improve compliance and time for the care managers.
- Prescribers did not routinely address the metabolic impacts for members without prompting.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- PROSCI (Change Management) training can provide tools to support these changes.
- Create space through retreat/meetings for staff to contribute to understanding the organizational goal, implementation roadblocks, knowledge gaps and operational paths for success.
- The “HARP/HCBS Assessor” is instrumental. Sustainability path through impact on Care Managers ability to increase their billable capacity.

# THE JEWISH BOARD OF FAMILY AND CHILDREN'S SERVICES



Care  
Transitions  
Network

for People with  
Serious Mental Illness

## IMPACT

AGENCY: The Jewish Board of Family and Children's Services

LOCATION: Manhattan, New York

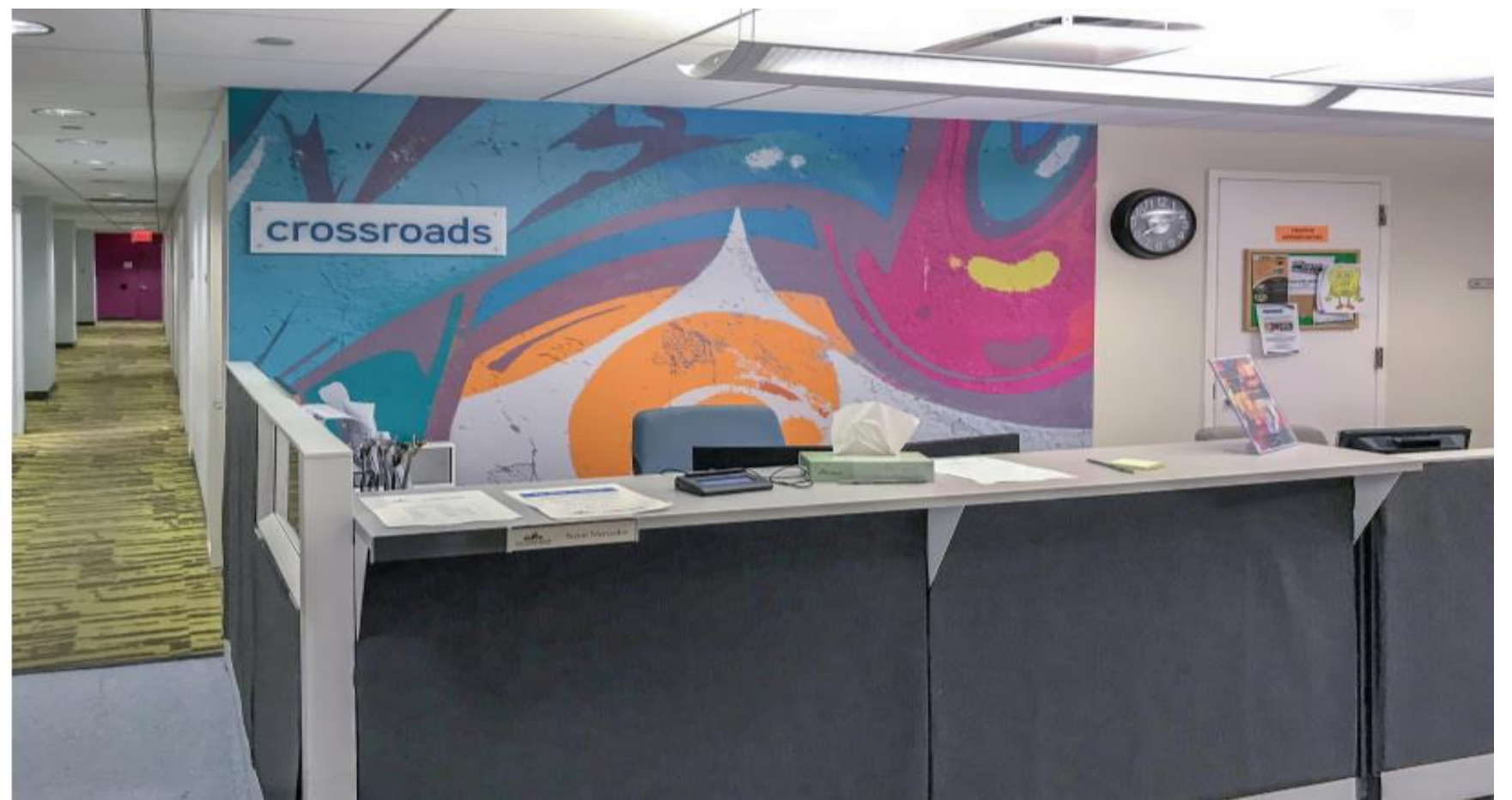
PRACTICE SITES: All Services

NUMBER OF CLINICIANS: 16

NUMBER OF PATIENTS: 262

### Engagement for Transition Aged-Youth (TAY)

- 14% increase in census.
- 17% increase in the average number of monthly services provided.
- 70% show rate for services, which is nearly 10% higher than show rates for TAY receiving services in a nearby Jewish Board clinic that serves all ages.
- Established youth co-design and ownership.



## INTERVENTION

- Inclusion of peer specialist and outreach/engagement social worker on clinical team
- Development of Youth Council to inform programming and services.
- Formed via open process, including information in waiting room. Invited some with strong investment. Partnered with Bridging the Gap. Supported through initial phases. Established mission, advisory role.
- Staff bring issues, groups questions to the Youth Council.
- Peer-developed marketing materials in development.
- Coaching and support in developing broader advocacy skills and opportunities.
- Inclusion of engagement activities such as drop in events. Open space for the clients with youth-driven topics. Ex: youth writing drop-in and art drop-in.

## KEY DISCOVERIES

- Keeping the process simple was important. Youth given a \$20 gift card and youth select food to have at meetings.
- Retention linked to the relationships youth form with each other. Young Adult Peers provide connection for Youth Council and bridge the work with the other staff.
- Drop-ins offer an opportunity to connect with the Jewish Board outside of the clinical experience. Create belonging and community as well as access.
- Young people are leading the way in increasing the Jewish Board's presence on social media.
- Increasing "show-rates" is good for the bottom-line.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Young Adult Peer involvement is integral.
- Working with staff to be open minded about youth involvement. Creating buy-in. Coaching the team on the benefits, working through questions and concerns, teaching how to engage youth in new and different ways.
- Identify training needed for youth and for staff.
- Need to balance unbillable time with additional resources from grants. Can package drop-ins for donors.

# LIBERTY RESOURCES INTEGRATED HEALTH CARE



for People with  
Serious Mental Illness

## IMPACT

AGENCY: Liberty Resources Integrated Health Care

LOCATION: Central New York

PRACTICE SITES: Syracuse Based Center with 3 satellites  
and 40 school-based clinics

NUMBER OF CLINICIANS: 75

NUMBER OF PATIENTS: 2700 (PC: 1080 / BH: 1700)

- Fundamentally changed the way care is delivered through the establishment of comprehensive integrated care.
- On-site health, behavioral health, pharmacy, patient registry, integrated care reviews weekly, embed of care management, treatment with evidence-based interventions and dual licensure with OMH and OASAS.
- Unique view of integration leads to expansion of optometry and other specialties.

PATIENT	*****	*****	*****	*****	*****	*****
PROVIDER	Sarmast	Tooley	Tooley	Sarmast	Sarmast	Sarmast
DATE	5/30/2017	3/26/2018	7/16/2018	1/8/2018	10/13/2017	9/29/2017
A1c	12.4	10	10.7	12.1	12.9	10.1
DATE	4/30/2018	11/28/2018	10/17/2018	5/14/2018	3/13/2018	5/4/2018
A1c	8.9	12.5	9.7	13.5	8.1	8.8
DATE	8/2/2018	2/27/2019	2/8/2019	2/5/2019	7/10/2018	8/31/2018
A1c	9.7	13	8.7	14	11.1	8.8
DATE	10/30/2018		4/17/2019		10/12/2018	4/30/2019
A1c	8.6		9		8.8	8.1
DATE			5/2/2019			
A1c			8			

75% Patient Improvement  
50% Improved from Poor Control to Control

Patient Name		PC Provider Sarmast, Farzad, M.D.			
Progress on Key Health Indicators					
	Baseline	Reassessment(s)			
	01/31/2017	08/08/2017	01/08/2018	08/16/2018	
Breath CO (0-6)	19 (ppm)	38 (ppm)	8 (ppm)	40 (ppm)	
BMI (< 24.9)	32.95	29.76	30.45	32.87	
Weight	205.03 (lb)	189.60 (lb)	194.01 (lb)	209.44 (lb)	
Waist Cir. (M < 40, F < 35)	55.12 (in)	43.31 (in)	41.73 (in)	44.09 (in)	
Systolic BP (< 120)	109	123	134	104	
Diastolic BP (< 80)	75	83	82	70	
Fasting Glucose (< 99)	87 (mg)		98 (mg)		
Hemoglobin (< 5.7)					
Total Cholesterol (125-200)	166 (mg/DL)		201 (mg/DL)		
LDL Cholesterol (20-129)	70 (mg/DL)		125 (mg/DL)		
HDL Cholesterol (40+)	29 (mg/DL)		36 (mg/DL)		
Triglycerides (30-149)	334 (mg/DL)		198 (mg/DL)		
# of Nights: Homeless	0	0	0	0	
# of Nights: Hospital	0	0	0	0	
# of Nights: Detox	0	0	0	0	
# of Nights: Jail	0	0	0	0	
# of Visits: ER	0	0	0	0	
Patient Readiness to Change Score (CIRCLE):					
	1 or 2	3 or 4	5 or 6	7 or 8	9 or 10
	Not Ready	Contemplation	Make Plans	Start Plan	In Progress
Client Medical Treatment Goal(s):			Mental Health Treatment Goal(s):		
Barriers Identified:			Self-Management Tools:		
Client Signature: _____		Staff Signature: _____		Date: _____	

## INTERVENTION

- Patient-Centered Medical Home tenets to start with as an intentional culture shift. Collaborative, integrative and a shared philosophy. Clear message this is not a phase, but our culture and way of doing business.
- Focus on the holistic wellness of the people we are working with. Shifting vision and then creating access and capacity as a change agent to connect people with what they need. Trauma-focus foundational.
- Staff dedicated to being integrated. Resourced in this manner within the organization.
- Attention to physical plant in terms of quality and functionality and message it sends about integration. For example, creating one waiting room.
- Shared governance model which yields continuous quality improvement, acceptance of failure in well intentioned efforts use as opportunity to learn and grow.
- Approach to ease of use and wellness self-management through an "Individualized Wellness Report" which is reviewed 2x per year with the patient.

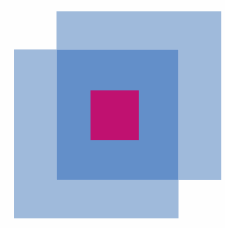
## KEY DISCOVERIES

- Foundational expectations on integration within recruitment, job descriptions, roles, supervision.
- Clarity in the culture both energized the workforce and was a trigger for others moving on based not seeing connection to the culture.
- Scale in primary care is important for sustainability-going from 2 to 10 primary care exam rooms.
- Finding of people tailored primary care experience with trauma-informed lens, single site for services and pharmacy. Quality and volume connected to impact.
- Meaningful celebration of impact with the team. Recognizes small wins with value to the team member.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Clinical pathway and EBPs are looked at by the Key Stakeholders Group with a decision on which fits best with Liberty Resources.
- Optometry, mammography and dental services were identified as needs for future iterations.
- New technologies with telepsychiatry and telehealth.
- Financial projections capacity is essential on the primary care and behavioral health business lines.
- Community partnerships are cultivated to share data and to continue to have opportunities to innovate.

# LIGHTHOUSE GUILD



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Network

for People with  
Serious Mental Illness

## IMPACT

AGENCY: Lighthouse Guild

LOCATION: New York City

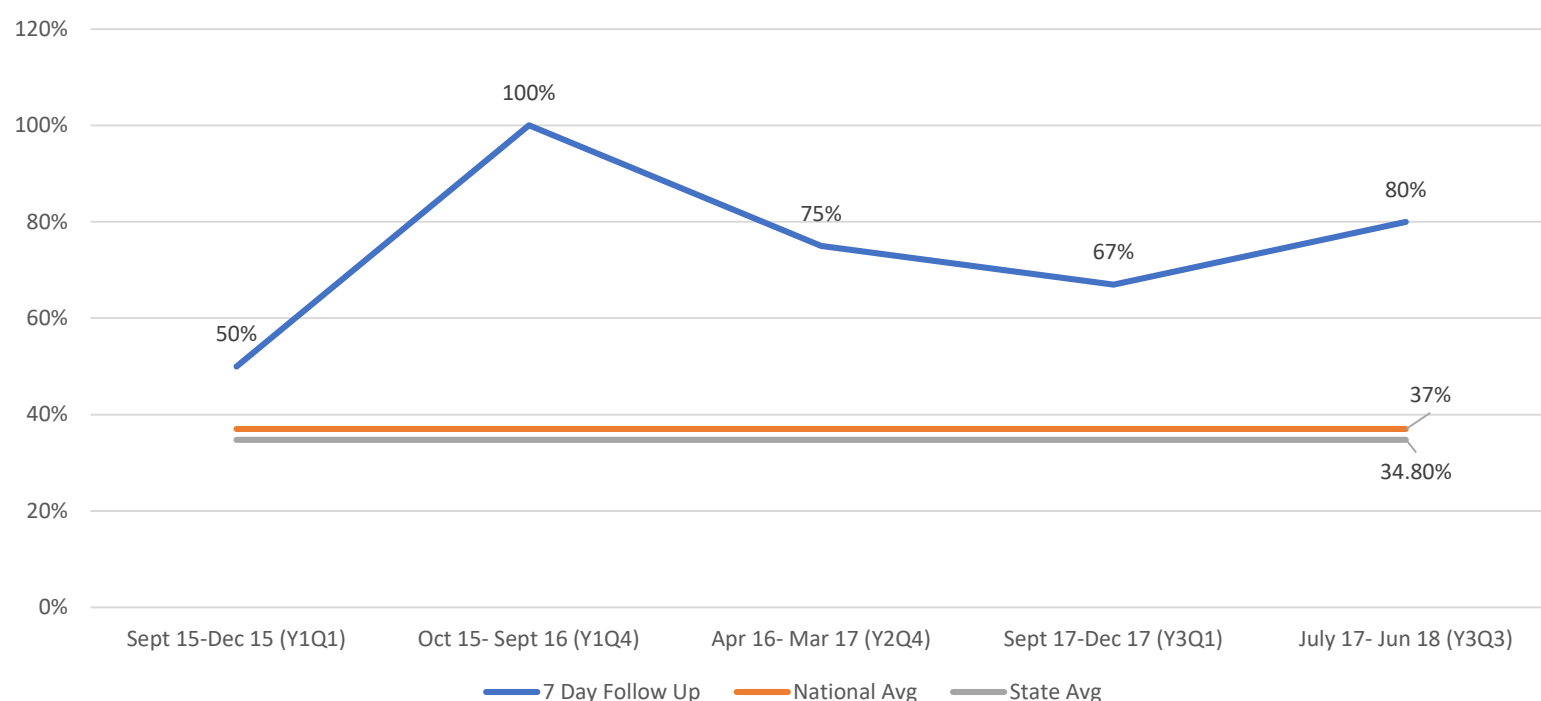
PRACTICE SITES: 1

NUMBER OF CLINICIANS: 20

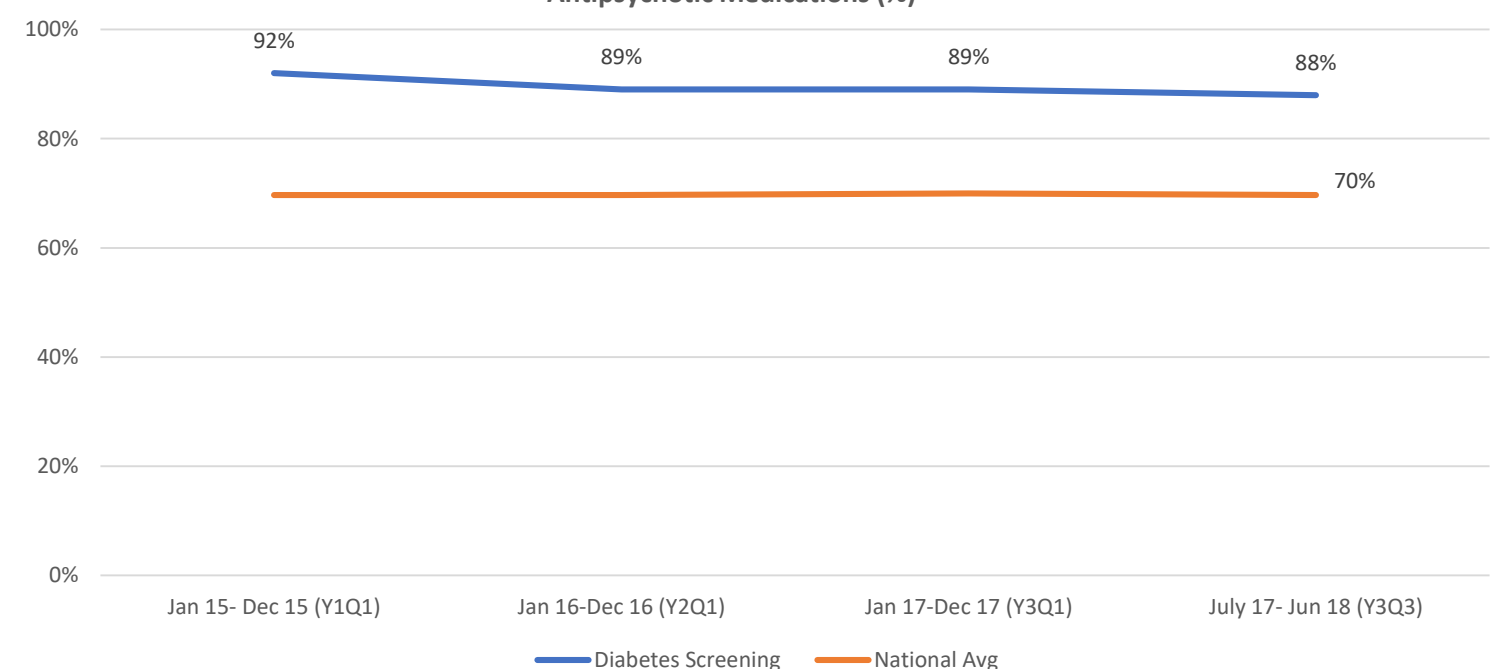
NUMBER OF PATIENTS: 800 (in behavioral health)

- Works with a unique population: Serves those who are blind or have vision loss and require behavioral health and medical care support.
- Added a part-time registered nurse to our staffing mix at our Article 31 clinic.
- Nurse provided health monitoring services to our Article 31 population such as tracking metabolic indicators, wellness and smoking cessation education.
- Maintained and sustained our high performance for diabetes screenings.
- Improved our 7-day follow-up rates by 30%.

Follow Up Appointment Post Hospitalization - 7 Days



Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (%)



## INTERVENTION

- Hired a registered nurse to work in Article 31 clinic
- Consultation services with MTM Services:
  - Trained staff in Collaborative Documentation; therefore, involving clients in a person-centered approach, resulting in improved client engagement, reduced no/show cancellations, improved medication adherence and enhanced quality of clinician work life.
  - Adopted an Open Access intake methodology.
- Developed workflows for referrals and testing between programs within the organization.
- Created a workflow built around RHIO alerts from hospitals and emergency departments for transition of care planning prior to discharge.
- Developed a partnership with a Health Home to come and complete referrals on site for eligible clients.

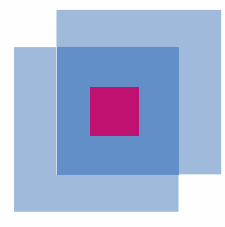
## KEY DISCOVERIES

- Having a nurse embedded to the behavioral health clinic helps treat the whole person.
- Open Access scheduling helps get clients into care more efficiently and quickly.
- Utilization health information technology helps support strong transitions of care and client engagement.
- Development of clear and consistent workflows supported goals around screenings, referrals, and collaboration across the agency.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Identify silos with organization and identify ways to improve collaboration across the organization. Leadership buy in.
- Continue to support nursing hours within the behavioral health clinic
- Continue to utilize PSYCKES and other data sources to track performance and identify where workflows may need to be adapted or changed

# MENTAL HEALTH ASSOCIATION OF WESTCHESTER



Care Transitions Network

for People with Serious Mental Illness

## IMPACT

AGENCY: Mental Health Association of Westchester

LOCATION: Tarrytown, New York

PRACTICE SITES: 7

NUMBER OF CLINICIANS: 35

NUMBER OF PATIENTS: 10,000

- Implementation of population health culture and tools drives personalized treatment and care management.
- Clinical pathways built incorporating patient engagement and activation with evidence-based practices.
- Improvement in 7-day follow-up after hospitalization by 13% and 30-day follow-up by 9%.

Ask us about our person centered Integrated Care initiatives!



## INTERVENTION

- Transitions of Care Services: Collaboration between hospital discharge and our staff. We meet with client in Hospital and often transport them home post discharge.
- Whole Health Risk Tool a.k.a OMH High Risk log enhancement: Developed from CTN project and after many iterations merged with OMH mandated Clinic High Logs.
- We utilize the RHIO Hospital alerts and Microsoft Flow to implement a measurable process to track 7/30 day follow-up post-hospitalization and ED visits.

## KEY DISCOVERIES

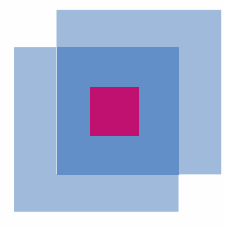
- DSRIP and CTN lead us to sustainable change!
- Ideas can come from any staff at any level given the opportunity. We had a “Shark Tank” competition that resulted in a patient wallet card.
- If you build it they will come! We embedded Care Managers and Employment Specialists in our clinic sites. It has been so successful we are looking to expand our physical office space!

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Technology. Use it to help automate processes and have a tech-friendly person on every team.
- Be fluid. Get feedback. Nothing works the way you think it will. Change and adapt.
- Buy-in is infectious. Find your staff champions. Celebrate successes publicly.



# MONTEFIORE BEHAVIORAL HEALTH CLINIC



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Network

for People with  
Serious Mental Illness

AGENCY: Montefiore BHC

LOCATION: Bronx, New York

PRACTICE SITES: 1 site

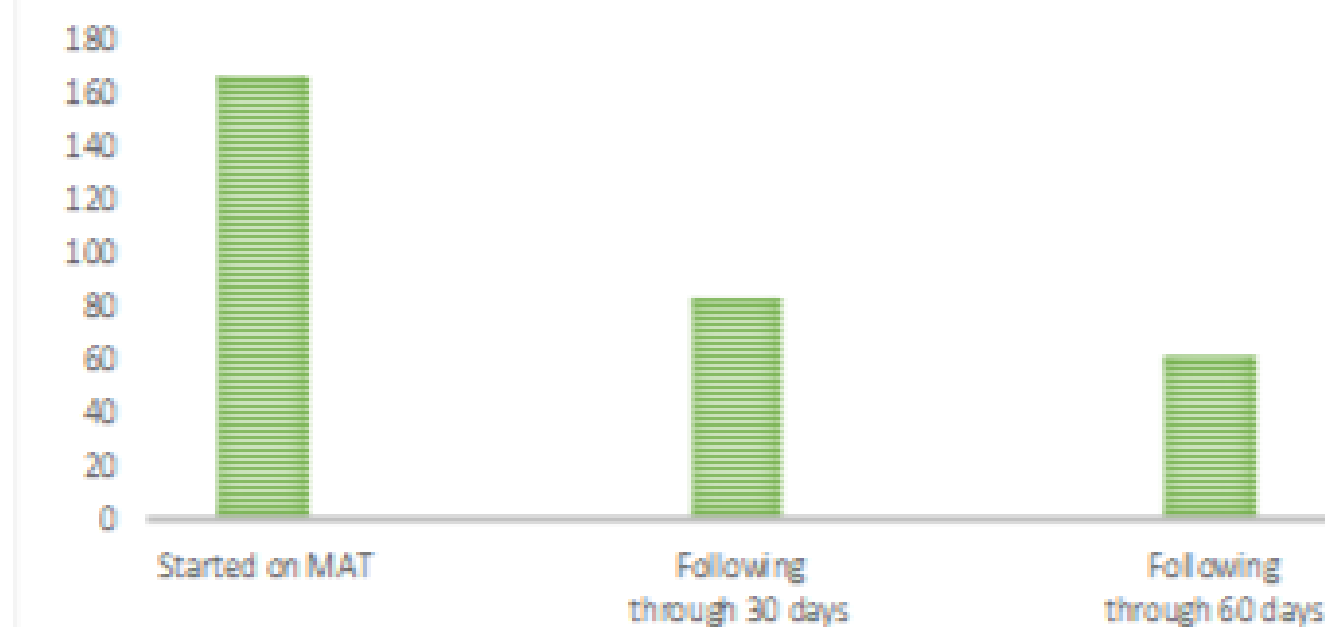
NUMBER OF CLINICIANS: 39

NUMBER OF PATIENTS: 4100

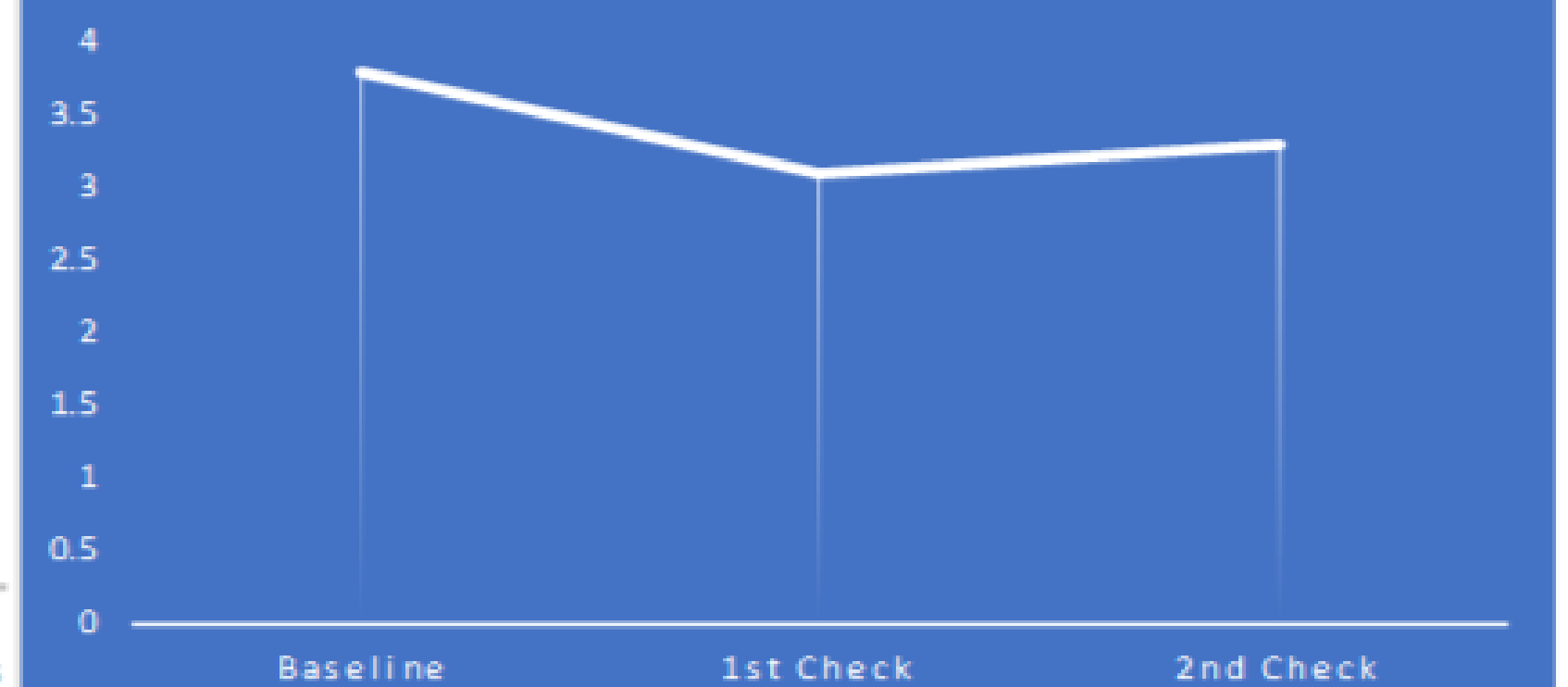
## IMPACT

- Design and implementation of a highly effective and relatively low-cost approach to engagement of patients for smoking cessation.
- As of June 2019, 166 patients who smoke on some form of MAT, 106 agreed to MI in combination of MAT. At baseline, patients were smoking an average of 3.8 packs per week. This reduced to 3.1 packs per week at first follow-up. At second follow up, use was 3.3 packs per week. As a result of the uptick, revamped the follow-up to include incentive.

## SMOKING INTERVENTION IMPACT



## PACKS SMOKED/WEEK



## INTERVENTION

- In partnership with CMO enrolled patients in smoking and alcohol reduction/cessation project.
- Unique approach based on history of past attempts to impact substance use by the organization.
- Developed strategy for prescribing parameters and length of treatment needed for success. Bi-directional clinical process.
- Assess for smoking and identify treatment.
- Screening all for patients for smoking at check-in. Provider sees the results at the visit. Provider engages in MI and smoking reduction interventions.
- Harm reduction approach. Medication assisted treatment a foundational element (smoking and alcohol).

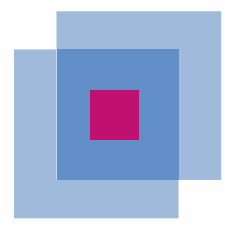
## KEY DISCOVERIES

- Health educator was not needed for success in screening in 200 patients into the program. Approach of screening at check-in and using provider for engagement was highly effective for identification and for enrollment.
- Using PDSA, follow-up was built into the process. The EMR is used to track patients who are enrolled, identify next scheduled appointment with reminder to provider to address and check-in on smoking reduction. Key process. With small numbers this was manageable. Nearly doubled the workload for support staff.
- Missed appointments are contacted by clerical staff with a supportive script to check in and engage in rescheduling coupled with an incentive (\$5 CVS gift card).

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Design Structure
- Tracking system and capacity (FTEs)
- Figure out your process with an eye towards replication
- Relatively low-cost intervention with a high return on investment

# MOSAIC MENTAL HEALTH



Care Transitions Network

for People with Serious Mental Illness

## IMPACT

AGENCY: Mosaic Mental Health

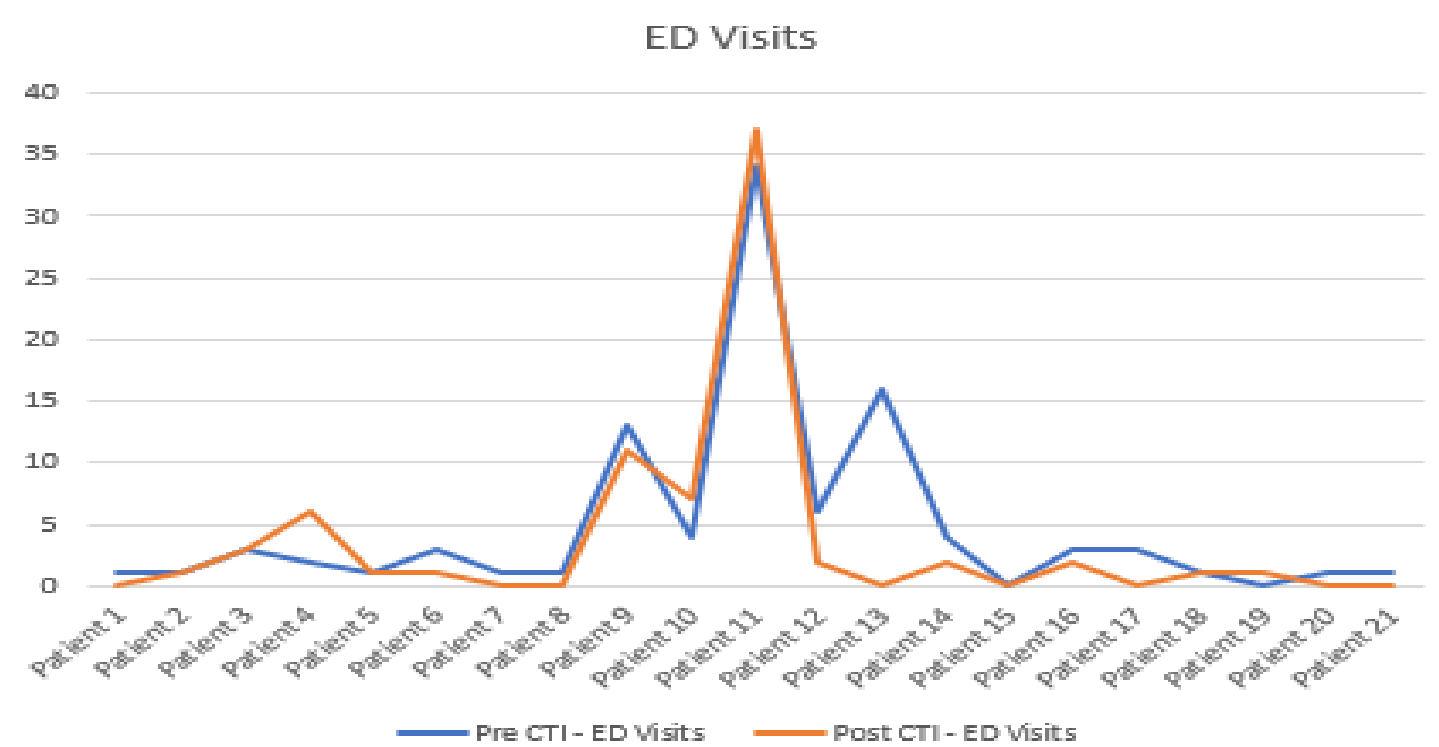
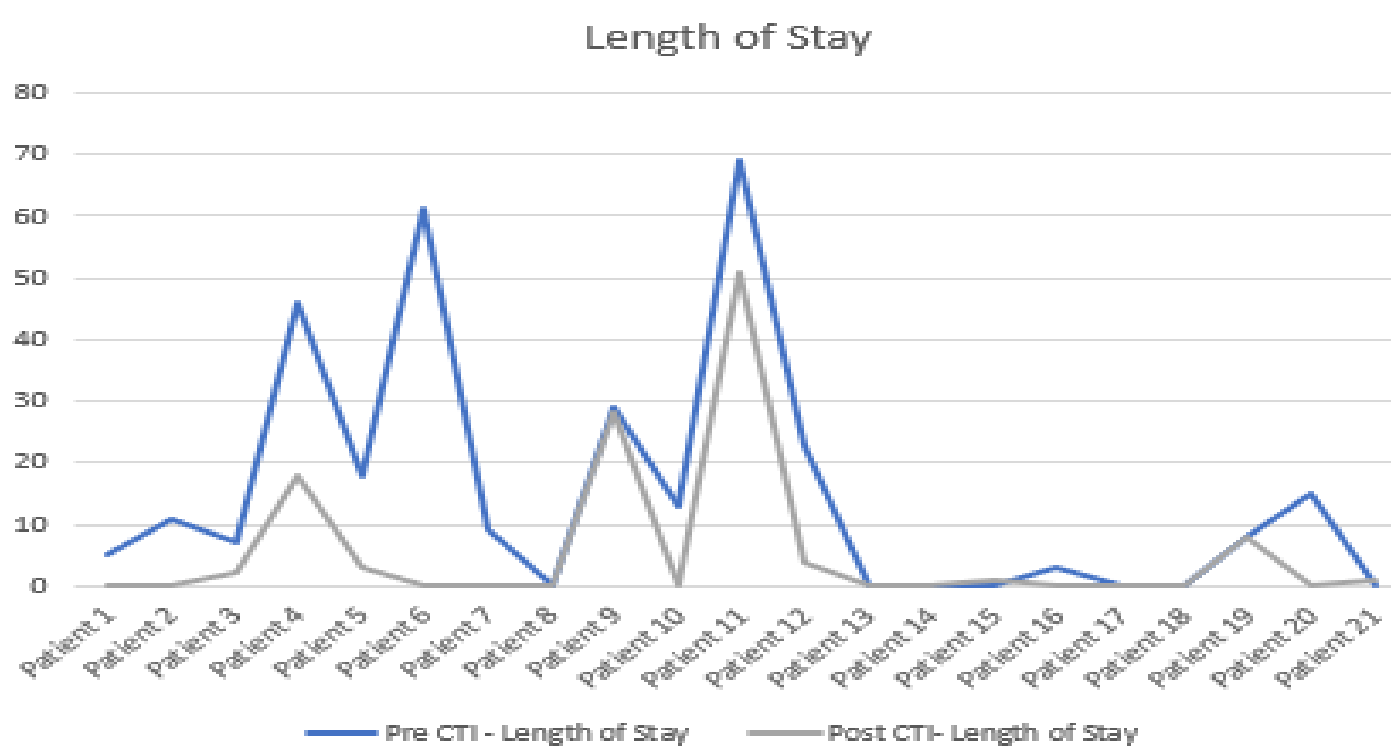
LOCATION: Bronx, New York

PRACTICE SITES: 1 site + short term care respite

NUMBER OF CLINICIANS: 6

NUMBER OF PATIENTS: 85 (people with high utilization)

- Reduced overall utilization (hospital admissions and ED visits) by 54%.
- Saved hospitals \$550,000 in 6 months – methodology for tracking for SBH system. Medicaid utilization in prior year vs. intervention.
- Success in connecting people with permanent housing.
- Creation of effective team with hospital as demonstrated by the obtaining badges for entry and a seat at ground rounds.



## INTERVENTION

- High level buy-in on CTI (Critical Time Intervention)
- Developed the model to include care management with specialized training and on-going supervision.
- Provided education to clinical staff on engagement strategies to support clients and ensure successful transitions of care.
- Implemented QI process where the organization obtained feedback from the Care Managers to make the initiative successful (petty cash, high level intervening).
- Small caseloads – to afford intensity necessary for success.
- Flexibility in how and how often you can work with a person

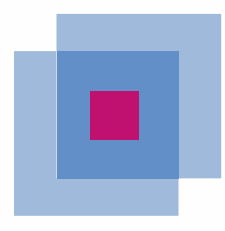
## KEY DISCOVERIES

- Housing is difficult to secure, but the team was exceptionally successful. Using the crisis respite component was of high impact in situations where a bridge was needed.
- With the approach used, the organization accepted every referral and was successful with very complex and challenging situations.
- To meet the needs of people with high utilization a multi-pronged approach is needed to identify people. For example, PSYCKES data, “organic” partnering with hospitals where shared motivations come through.
- Intervention must be started when the person is in the hospital.
- There are specialized populations who need “booster CTI.” This includes IDD, sexual offending behaviors. This is not readily available in the community now.
- CTI is dramatically different from traditional non-face-to-face methods.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- No barrier was too big. Culture, knowledge and pathway to develop personalized solutions need to infuse the entire effort.
- The practice needs to pervade the organization, not just operations. For example, finance needs to be able to expedite petty cash.
- Currently supported by PPS Innovation funds. At present, BPHC PPS and have two proposals pending with NYP PPS and One City PPS. Connection to Health Homes helps to maintain gains.
- Conversations with managed care plans are in process.

# OUTREACH DEVELOPMENT CORPORATION



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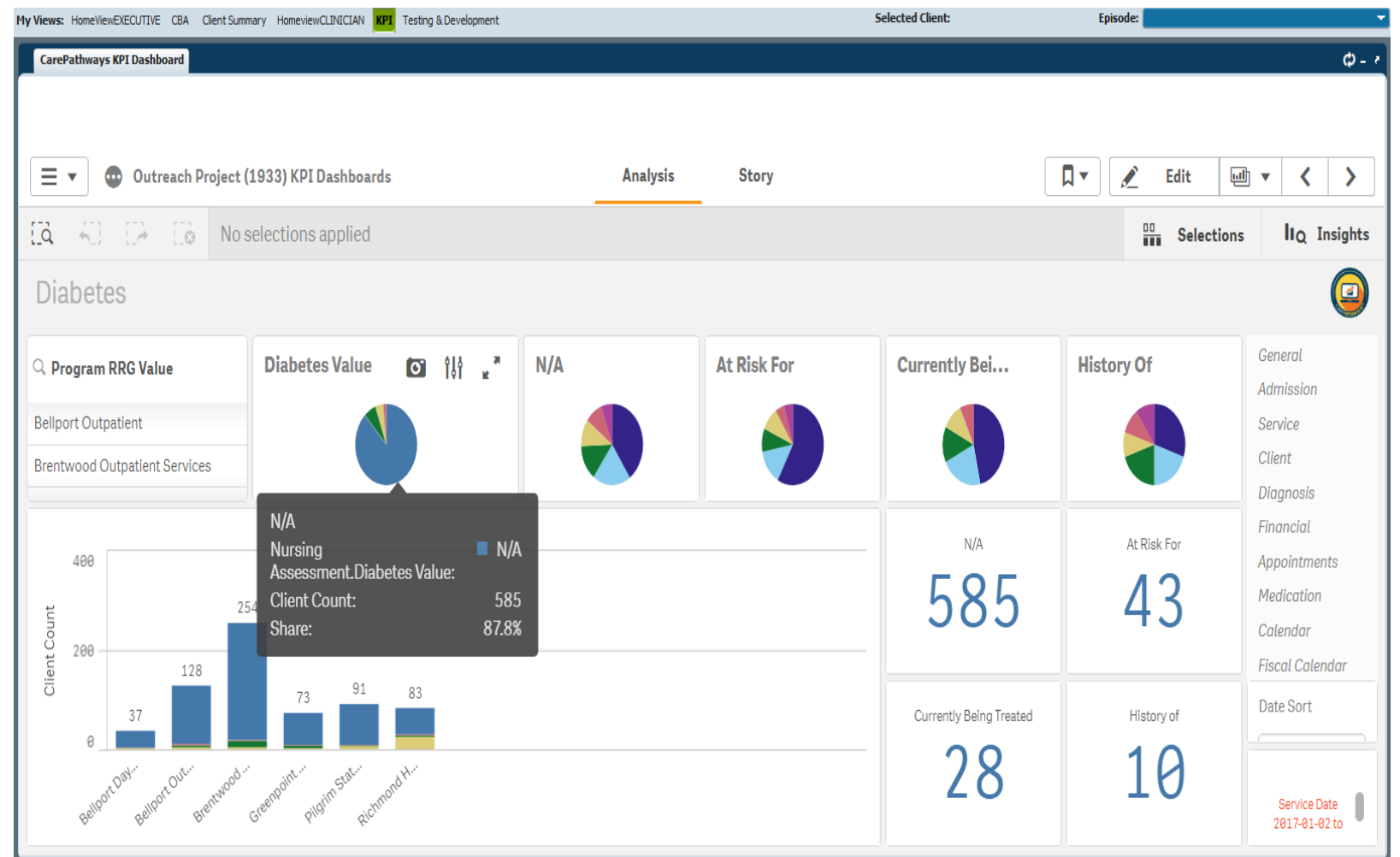
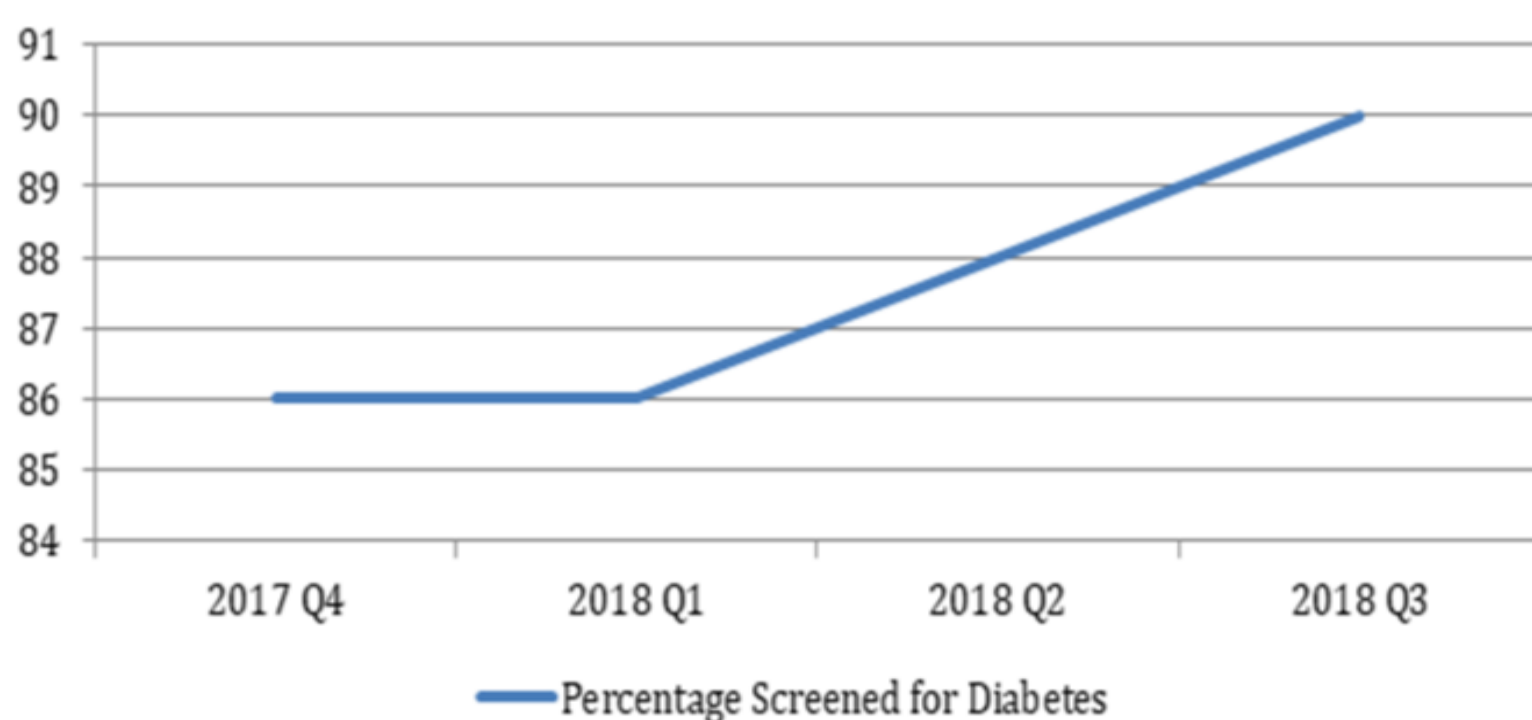
for People with  
Serious Mental Illness

## IMPACT

AGENCY: Outreach Development Corporation  
LOCATION: Long Island, Queens, and Brooklyn, New York  
PRACTICE SITES: 9 clinics with 5 satellites  
NUMBER OF CLINICIANS: 145  
NUMBER OF PATIENTS: 2800

- Integrated care at the point of behavioral health treatment for people with MH, SUD and other medical condition.
- On-site physical healthcare via partnerships with 2 FQHCs.
- Diabetes screening at 10% greater rate than state average.

## % Clients with co-occurring mental health diagnosis Screened for Diabetes



## INTERVENTION

- Early in the assessment process, built-in screening for chronic diseases using validated tools to guide treatment pathway. Assessment for all.
- Systems in place to ease and guide process for clinician from screen to treat to outcomes.
- Clinical dashboard and reporting through electronic health record at the client and organization levels.
- Emphasis on patient engagement, activation and locus on behavioral health program as the provider of choice.
- Access to broad populations including adolescents, women, and people speaking various languages. Bilingual staff optimal.
- Trauma-informed, person-centered approach.
- Motivational interviewing, CBT and perception of care surveys contribute to success.

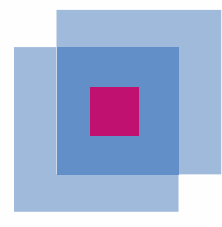
## KEY DISCOVERIES

- This approach contributes to employee "joy in work." Outreach was voted on the Best Companies in New York State for the 9<sup>th</sup> year in a row.
- Survey across agency demonstrated a high number of clients with diabetes, which was a surprise. We were well versed in communicable diseases, but diabetes lands people in the hospital more frequently.
- Without access to insurance, having diabetes leads people to using the hospital as the provider of choice. With this project, we were able to use the FQHC as a more optimal primary care provider.
- People can stay healthy when connected with primary care.
- People have been able to work through their shame in the physical health arena and have become very honest and engaged in their health.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Continuous quality improvement is critical. We welcomed mistakes and iteration. Culture of self-correction.
- Start with manageable, sustainable and trackable goals, starting with multiple chronic conditions was too big.
- This is culture change for staff. Physical health impacts the specialized work behavioral health does. Important to include this in operational and clinical workflows which operationalizes the culture change.
- Successes are shared among the entire team of organization.
- This work will be sustained and is envisioned to grow.

# SPECTRUM HEALTH AND HUMAN SERVICES



Care Transitions Network

for People with Serious Mental Illness

## IMPACT

AGENCY: Spectrum Health and Human Services

LOCATION: Western New York

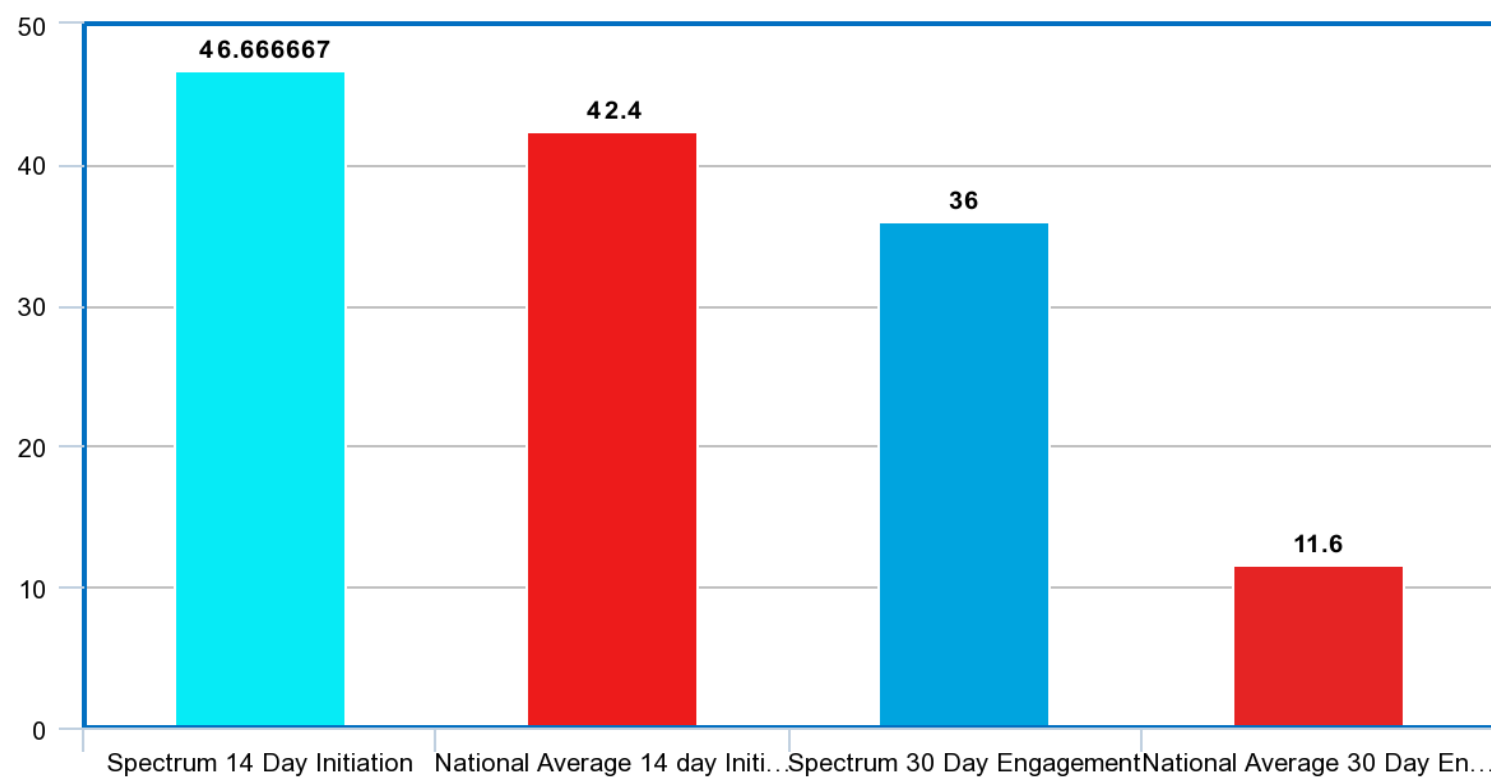
PRACTICE SITES: 11 Sites – Continuum of CARE

NUMBER OF DIRECT SERVICE STAFF: 153

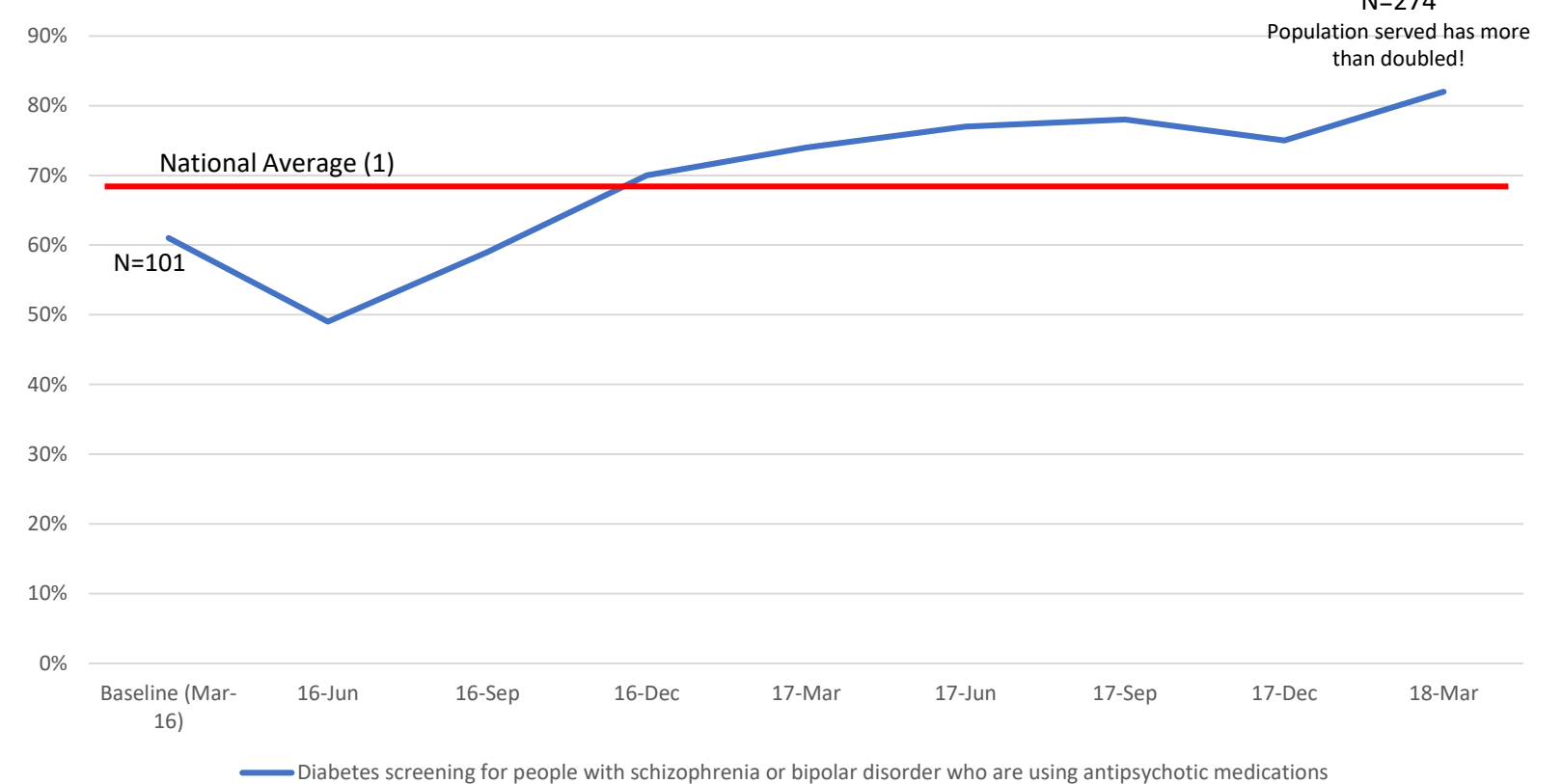
NUMBER OF PATIENTS: 2017: 6608. 2018: 7910

- Improving access as demonstrated by 14-day engagement SUD outpatient treatment by 7% from baseline.
- Improving engagement as demonstrated by 30-day engagement SUD outpatient treatment by 10% from baseline.
- 22% (n=173) increase in people screened for diabetes.

Performance on SUD Initiation and Engagement 2018 and 2019 Qs 1 & 2



Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications



## INTERVENTION

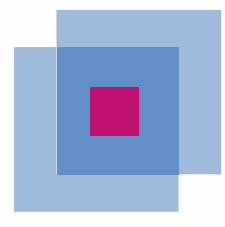
- CCBHC in Western New York creates new structure to deliver integrated care with emphasis on metabolic monitoring and substance use outcomes.
- CCBHC opened new doors for diversification of staff and improvements in clinical tools, care pathways and operational workflows. Example: nurses for diabetes screening and management.
- Created and continue strengthening connections with primary care providers. Hired two clinical assistants with behavioral health knowledge to coordinate with the PCP.
- Incorporate all voices into definition of what is effective and what will work (avoids clinic as usual).

## KEY DISCOVERIES

- Technology is something people want and there is much we can do in this area of behavioral health.
- We cannot underscore the need to review workflow changes to ensure they are working as you planned. A strong CQI service.
- Staff training is very different in today's world. All staff in a variety of roles need to understand the "why" for the patient from various perspectives. For example, why is the AC13 important.
- The "family" litmus test is a true gauge: Would you have your family member treated here?

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Clinical leadership meeting weekly with data, physical health integration and finance to truly understand where the impact and success is and any modifications needed.
- Willingness to completely rethink our work. "We Got You." I will get you what you need.
- Even if you are not a CCBHC there are things you can do if you get creative. Grants and other sources are there. We have obtained \$1M in grants in the past 12 months.



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Serious Mental Illness

# STRONG MEMORIAL- STRONG TIES

## IMPACT

AGENCY: Strong Memorial – Strong Ties

LOCATION: Rochester, New York

PRACTICE SITES: 1 Center

NUMBER OF CLINICIANS: 54

NUMBER OF PATIENTS: 1900

CCBHC provides the culture, clinical and connection to improve consumer outcomes on key health measures including a 27% improvement in tobacco screening.

### CCBHC Measures Demonstration Year 1 - July 1, 2017 to June 30, 2018

Measures	Strong Memorial Hospital Reported Measures	CCBHC State Reported Measures
Adherence to Antipsychotic Meds for individuals with Schizophrenia	68.8%	52.4%
Follow-Up after Emergency Dept. Visit, 30 days	91.2%	89.3%
Plan All Cause Readmissions Rate	18.7%	24.2%
Adult MDD Suicide Risk Assessment	90.1%	85.6%
Initial Evaluation within 10 days	83.5%	79.9%
Alcohol Use Screening	76.5%	69.2%
Tobacco Use Screening	95.4%	68.9%
BMI Screening	77.9%	56.9%
Suicide Attempts	0.18%	0.55%

## INTERVENTION

- Evidence-based screening tools to identify MH/SUD and risk for suicide and depression. Screening tools include Audit, C-SSRS and PHQ9.
- Updated EMR templates including initial assessment documentation to include SUD.
- Weekly triage meeting to identify patients at high risk for SUD or MH amongst both programs with one integrated treatment plan.
- Crisis therapy services, psychiatric rehabilitation (individually and in group), peer support services, Targeted case management and embedded chemical dependency counselor.
- Crisis team receives a weekly acute services utilization report. To identify patients that use an acute service in the last 7 days, in addition to daily collaboration of any Strong Ties patients.

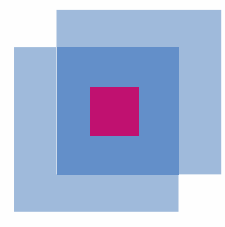
## KEY DISCOVERIES

- Creation of a Risk Stratification Tool that allows us to identify patients with co-occurring disorders, recent suicide attempts, and recent acute care contacts for each individual clinician so that services can be individualized. This tool also provides an acuity indicator that allows us to consider overall clinical needs, for example, for group or other services that can be offered in response.
- Participation in the OMH CQI: Suicide evidence-based screening, tools, and interventions to identify and manage patients at highest risk for suicide. This initiative has supported much of the work we have done to support our highest risk patients.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- The CCBHC includes Strong Ties, The Strong Recovery (an OASAS licensed chemical dependency treatment program that offers medication assisted treatment), and a clinic of the Child and Adolescent Psychiatry Program. This journey to prepare for and become a CCBHC was occurring at the same time we began our Care Transitions Network (CTN) initiative. The transition allowed us to further develop and support integrated treatment across all the programs that were associated with the CCBHC at our institution.

# SULLIVAN COUNTY DCS BEHAVIORAL HEALTH CLINIC



Care  
Transitions  
Network

for People with  
Serious Mental Illness

## IMPACT

AGENCY: Sullivan County DCS BH Clinic

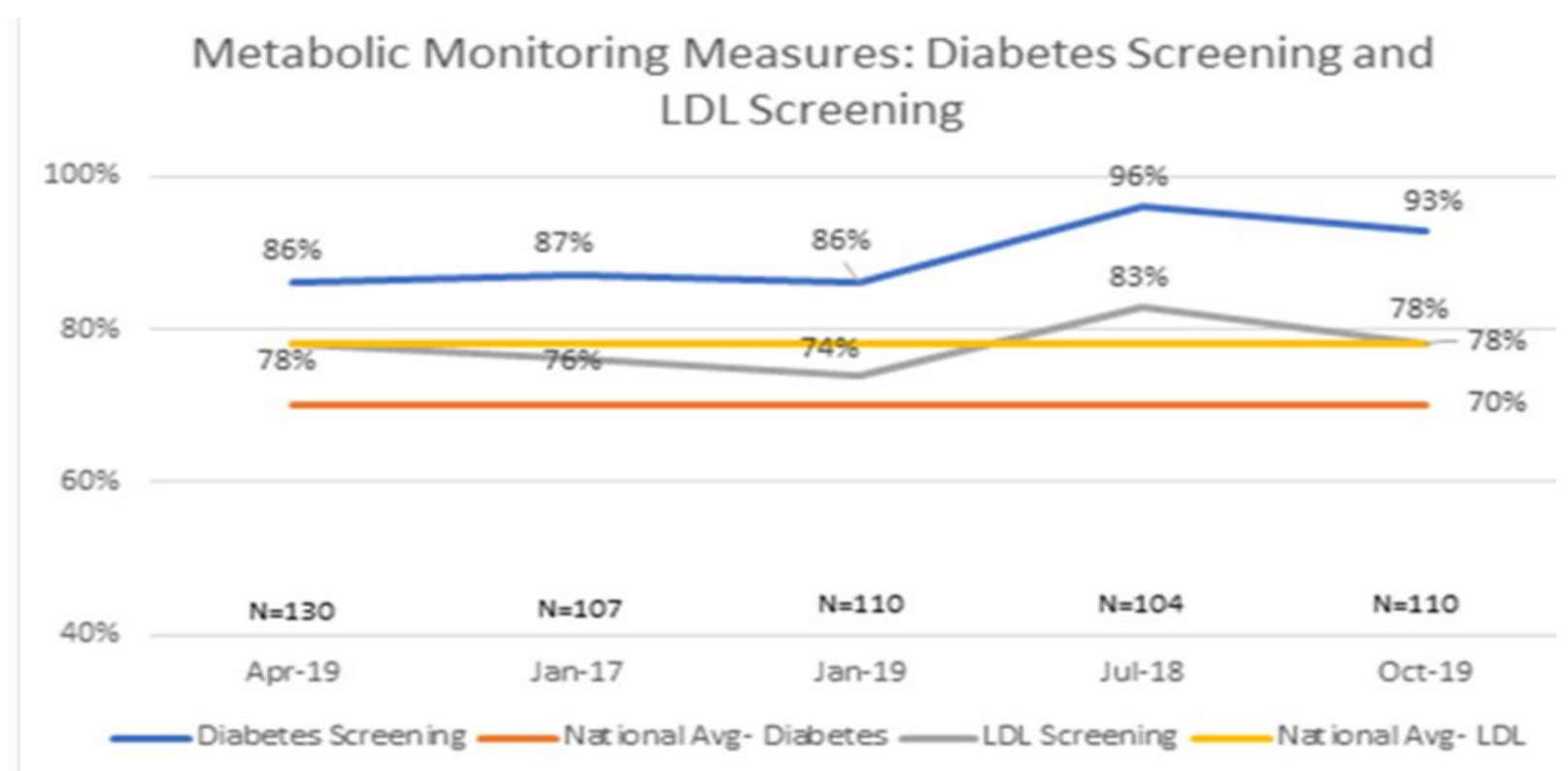
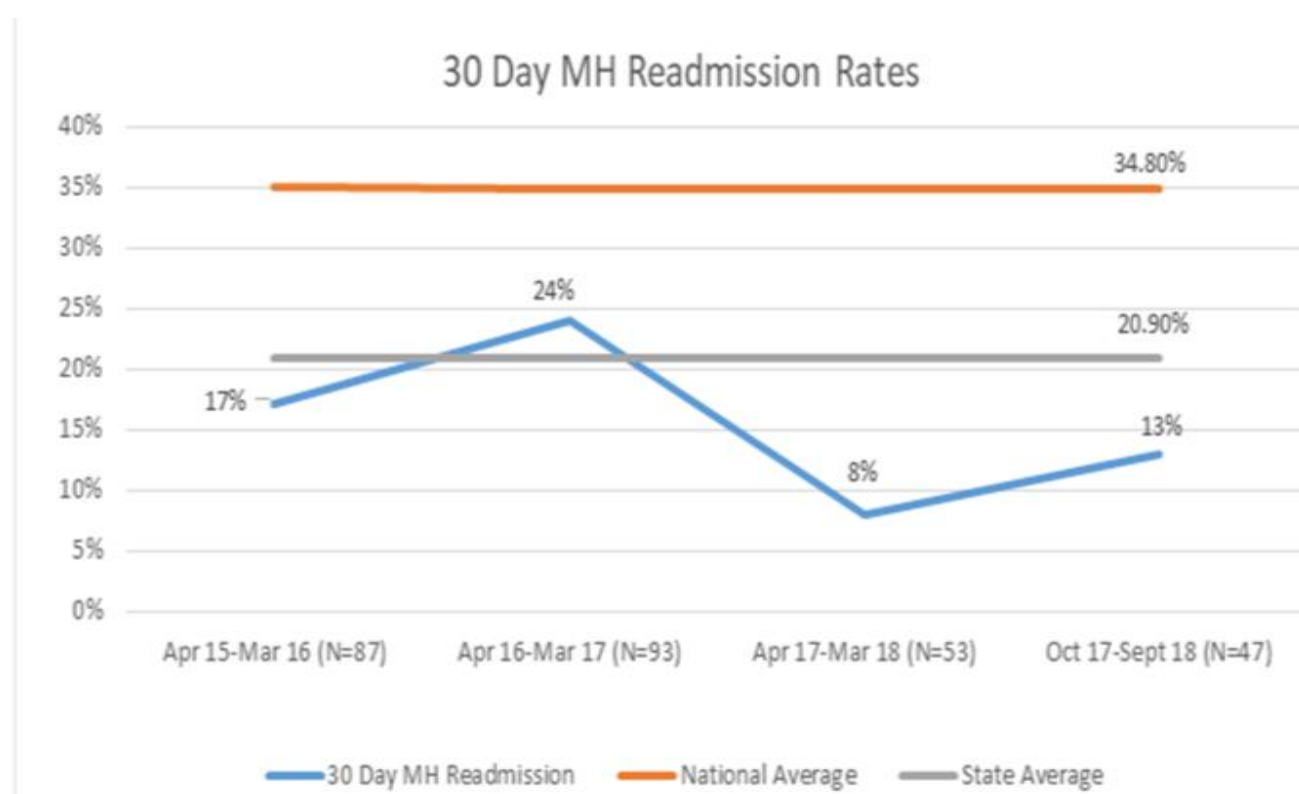
LOCATION: Liberty, New York

PRACTICE SITES: 1 Clinic with 15 School Satellites

NUMBER OF CLINICIANS: 23

NUMBER OF PATIENTS: 13,184 (8861/MH;  
1,697/SUD; 2,626/CM)

- Polypharmacy Prescribing Practices (This has been a premier issue as Sullivan has the highest rates of polypharmacy in their region due to a takeover of another clinic)
- Reducing hospital admissions
- Reducing Emergency Department Presentations
- Improving Transitions of Care
- Managing Co-Morbidities



## INTERVENTION

- Met with prescribers to present the polypharmacy issue. Once willing to address the needed a tool to drive change through the EMR. Hyperpharmacotherapy Assessment Tool (HAT).
- Presented impact on consumers which helped with momentum for change.
- Developed community partnerships with shared accountability for patient outcomes.
- Deployment of validated screening tools and tracking key performance indicators.
- Streamlined triage process
- Moved to a blended clinic (behavioral health).
- COMPASS-EZ measures and organization's ability to work with people with complex needs with a welcoming format: "no wrong door." This tool is being repeated to measure gains post-intervention.
- Renaming campaign.

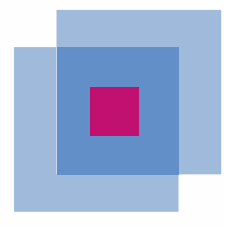
## KEY DISCOVERIES

- A local hospital welcomed Sullivan's approach to addressing polypharmacy.
- A consumer's quietness/lethargy as a side effect of polypharmacy was not equally perceived as a problem.
- Cross training was important to ensure shared understanding within the clinic team and in the community for our role as a blended clinic.
- Staff blended clinical approaches, values and treatment exceptionally well. Each area (MH/SUD) saw the complementary value of the other area.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Approach performance improvement with an educational, involved approach. (Change management techniques)
- Stay the course once you start. Wavering on implementation when times are tough may set you back.
- Approach has provided an improved quality of care.
- Sullivan County is working on the financial impact analysis.

# WESTCHESTER JEWISH COMMUNITY SERVICES



Care  
Transitions  
Network

for People with  
Serious Mental Illness

## IMPACT

AGENCY: Westchester Jewish Community Services (WJCS)

LOCATION: Westchester County, New York

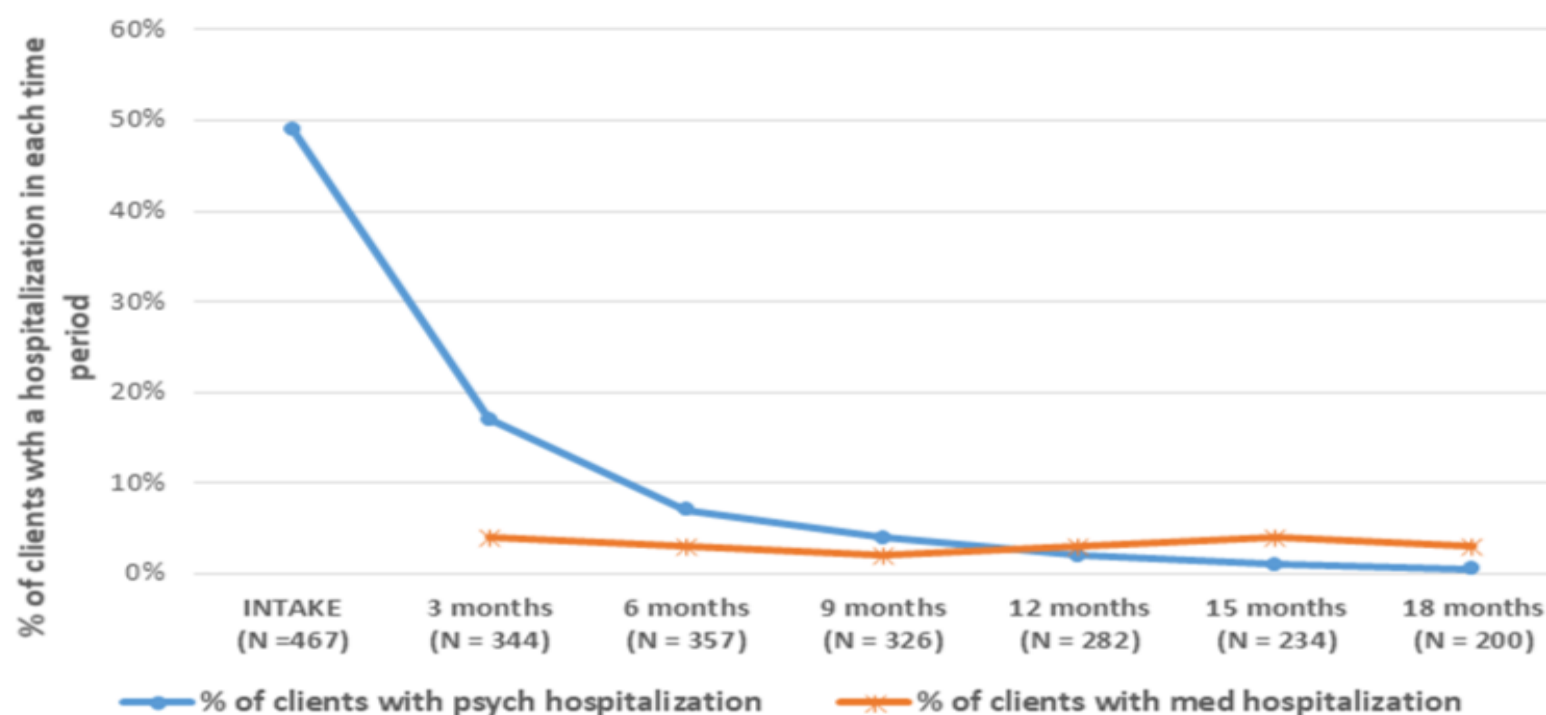
PRACTICE SITES: 4 clinics with 9 satellites

NUMBER OF CLINICIANS: 100

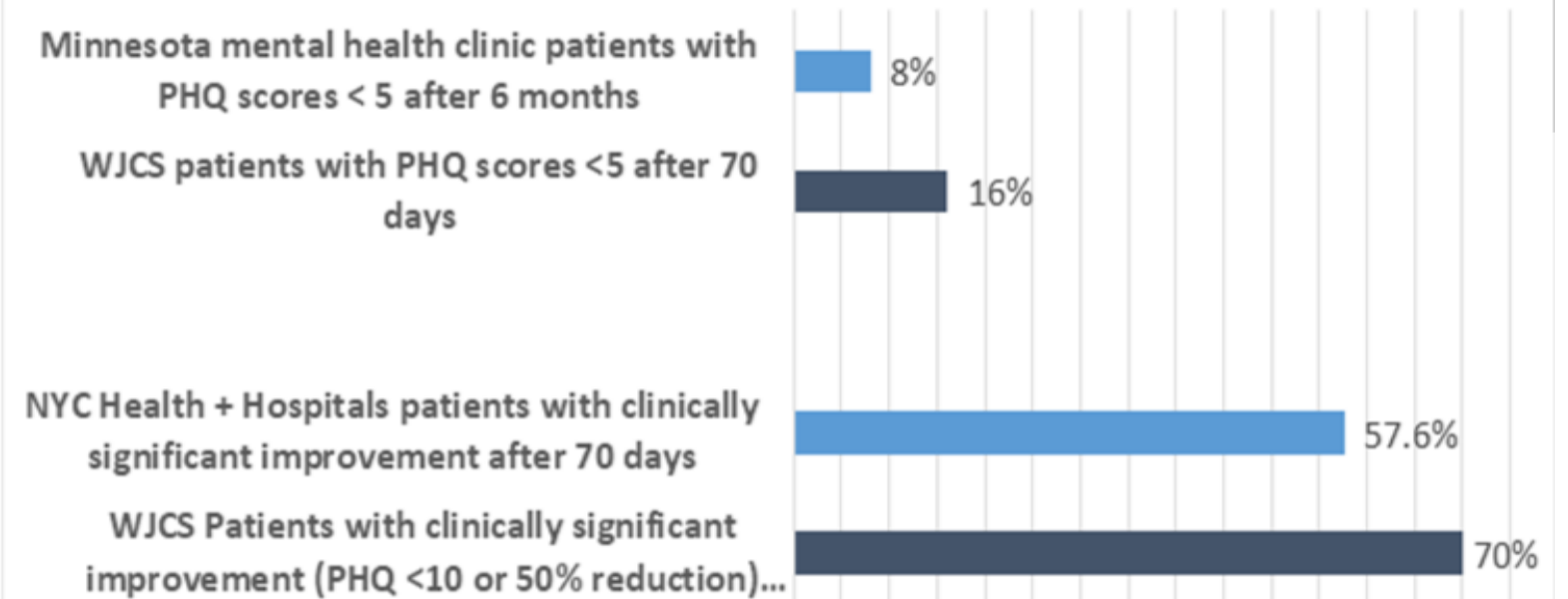
NUMBER OF PATIENTS: 4000

- Reduce depression symptoms for people with significant depression within 70 days (n=70%).
- Offer timely feedback to clinicians on efficacy of depression treatment. Encourage focus on client impact. Continue treatment or try something new.
- Engage people with history of self-harm behaviors in DBT with the intent of reducing suicidality and self-harm and reducing ED or inpatient use.

Decline in Hospitalizations



PHQ-9 Outcomes



## INTERVENTION

- DBT offered as first line treatment for individuals with high-risk behaviors associated with hospitalization.
- DBT included individual therapy, group skills training, and offered skills coaching calls. Medication treatment was offered as well.
- Individual sessions focused on proximal causes of target behaviors leading to hospitalization.
- Group skills training focused on learning the skills (mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance) that help clients reduce target behaviors (suicidal ideation, self-injury, and/or significant emotional distress). Coaching calls aimed to help clients rehearse skills in context and reinforce skills utilization.
- DBT therapists participated in weekly 1 ½ hour DBT Consultation Team Meetings that aid clinicians in serving high-risk/high-need clients and manage burnout.
- Development of research protocol that assisted with capturing and tracking treatment changes.

## KEY DISCOVERIES

- Female client was hospitalized 25 times prior to intake. Over the course of 40 months of treatment she had no new hospitalizations.
- Clients benefit greatly from DBT:
  - DBT is helpful in that it targets and reduces the behaviors that result in hospitalization
  - DBT clients report multiple benefits of treatment including improved quality of life and a healthier lifestyle
  - Hospitalization often unhelpful to clients
- Cost savings to insurers is significant:
  - 71% (92 out of 129) of clients with a history of psychiatric hospitalizations who remained in DBT treatment for 1 year were not re-hospitalized in that year.
  - Average charges for a psychiatric hospitalization for depression are estimated at \$6990 for 8.4 days and \$3,616 for 4.4 days.
- Clinicians benefit from DBT:
  - Clinicians value the opportunity to be trained in DBT.
  - DBT helps clinicians with burnout and improves self-care.

## REPLICATION ADVICE AND SUSTAINABILITY PLAN

- Agency commitment in time, revenue impact and future planning was important. Learned that it was effective to ask clinicians to sign a 2-year work commitment when advancing them for DBT training.
- Will sustain and expand in a substance use Intensive Outpatient Treatment (IOT).
- Agency Research Director position important to the success of this project.