Engaging Patients with Complex Needs Amid COVID-19: Lessons from Provider Organizations

August 31, 2020, 2:00 -3:30pm ET

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Agenda

- Welcome & Introduction
- OneCare Vermont: Using Data to Identify High-Risk Patients
- Montefiore Medical Group: Redesigning Screening During COVID-19 Crisis
- Maimonides Medical Center: Engaging Patients through Text Messaging
- Moderated Q&A
- Wrap-Up
Today’s Presenters

**Karla Silverman**, MS, RN, CNM, Associate Director, Center for Health Care Strategies

**Tyler Gauthier**, MHA, CPHQ, CSM, Director, Value-Based Care, OneCare Vermont

**Teresa Hsu-Walklet**, PhD, Attending Psychologist, Behavioral Health Integration Program, Montefiore Medical Group

**Magdalena Gordon**, LMSW, Director, Behavioral Health Care Management, Maimonides Medical Center

**Susan Mende**, BSN, MPH, Senior Program Officer, Robert Wood Johnson Foundation

**Miguelina Germán**, PhD, Director, Pediatric Behavioral Health Services, Montefiore Medical Group

**Danielle Cuyuch**, MUP, Senior Director, Population Health Program Integration, Maimonides Medical Center

**Brian Pisano**, MA, Manager, IT Implementation and Support, Maimonides Medical Center
About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans
Care designed to meet person’s priorities, goals, and needs.
Opportunities created by the COVID-19 pandemic

Population health management

» AHRQ defines practice-based population health as a way of, “helping providers focus on the preventive care needs of all of their patients, including those individuals who do not appear in the office for routine care.”

» Proactive management and coordination of care

» A best practice for people with complex health and social needs
OneCare Vermont

Using Data to Identify High-Risk Patients

Tyler Gauthier, MHA, CPHQ, CSM
Director, Value-Based Care, OneCare Vermont

OneCare Vermont
onecarevt.org
Agenda

Overview of OneCare Vermont

Innovation amid COVID-19

Challenges faced in launching new tool

Sustaining the innovation and the new way of identify at risk patients

Patient and provider response to initiative

Lessons learned and next steps
~250,000 Vermonters (630,000 population)
- Medicaid (Medicaid Next Generation)
- Medicare (VT Medicare ACO Initiative)
- Commercial (BCBSVT and MVP)

14 Hospitals
133 Primary Care Practices
276 Specialty Care Practices
9 FQHCs
27 Skilled Nursing Facilities
10 Home Health Agencies
11 Designated Agencies for Mental Health and Substance Use
5 Area Agencies on Aging

* Vermont Medicaid Next Generation only
‡ Vermont Medicaid Next Generation and BCBSVT only
COVID-19 Care Coordination Prioritization APPLICATION

A data tool to help identify patients with the greatest COVID-19 virus risk
COVID-19 Care Coordination Prioritization
Prioritizing Outreach for Care Coordination in the Midst of the Pandemic

Populations at highest risk from COVID-19
as indicated by the World Health Organization and Johns Hopkins

- Patients over the age of 60 who also have diabetes, heart disease (CAD and/or CHF), lung disease (COPD and/or asthma), hypertension, and/or cancer
- Patients who are considered frail
- Patients who have been identified as having high use of health care resources
- Patients who have seen at least 7 different providers in past year indicating potential coordination issue
- Patients with evidence of mental health or substance abuse comorbidity based upon the limited available data
- Patients with high social complexity risk and evidence of food access issues and/or social isolation

Number of patients in filtered list:

Click on Patient for Detail
COVID-19 Patient Prioritization
Application and Training Stats

COVID-19 Application *External* and *Internal* User Sessions, Cumulative Sessions

COVID-19 Applications Stats:

<table>
<thead>
<tr>
<th>Stats</th>
<th>External</th>
<th>Internal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique Users</td>
<td>64</td>
<td>19</td>
<td>83</td>
</tr>
<tr>
<td>Organizations</td>
<td>29</td>
<td>N/A</td>
<td>29</td>
</tr>
<tr>
<td>Total Time</td>
<td>79.1 hrs</td>
<td>143.1 hrs</td>
<td>222.2 hrs</td>
</tr>
<tr>
<td>Average Time per Session</td>
<td>25.9 mins</td>
<td>25.6 mins</td>
<td>25.7 mins</td>
</tr>
</tbody>
</table>

Key OneCare Data Corner Stats:

- 400+ hrs spent in COVID-19 module on OneCare Data Corner
- 15 external users have visited the COVID-19 Patient Prioritization module on 120+ different occasions

Time Spent in the OneCare Data Corner COVID-19 Patient Prioritization Module by *External* and *Internal* Users*

*Course instructors excluded*
I went on the new COVID App yesterday for my own patients and it really was successful at surfacing the riskiest people, some of whom I might not have thought of without the tool.

Dr. Norman Ward
Chief Medical Officer, OneCare Vermont
Highlights from Provider Outreach

Reinforce and provide new education for COVID-19 and chronic conditions.

Patients have taken opportunity to receive assistance with advanced directives.

Patients appreciative of proactive outreach and genuinely happy to talk to someone.

Reassured patients that there is always a way to connect with their provider, even if it is in new ways such as telephone or video visits.
Lessons Learned

Tool NOT time consuming for providers
The COVID-19 Patient Prioritization application was purposely designed to be a simple and quick tool.

Data literacy
Application was rolled out with a corresponding training video.

Clear communication of tool availability and context for updates
As data became available and more information was learned about COVID-19, OneCare made periodic updates to the tool.

Next Steps

1. Redesign key self-service tools to enhance end user experiences.
2. Develop uniform process to roll out future tools and updates, including training material, to ensure first interaction with tools are always positive.
Thank you

OneCare Vermont
onecarevt.org
Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.
Montefiore Medical Group: Redesigning Screening in the Midst of the Bronx COVID-19 Crisis

Miguelina Germán, Ph.D.
Director, Pediatric Behavioral Health Services, Montefiore Medical Group
Director, Staff Emotional Support
Associate Professor, Albert Einstein College of Medicine

Teresa Hsu-Walklet, Ph.D.
Director of Clinical Operations, Pediatric Behavioral Health Services, Montefiore Medical Group
Interim Director, Finance and Grants Management
Assistant Professor in Pediatrics, Albert Einstein College of Medicine
Objectives

1. Describe the Bronx COVID-19 surge and the demands that the pandemic placed on behavioral health.

2. Highlight how the Pediatric Behavioral Health Integration Program (BHIP) was redesigned during the COVID-19 surge while adhering to population health values.
Our Community in the Bronx

Economic Indicators
- 27.3% live at or below the poverty line (as of July 2019)
- 40.1% of children are at or below poverty (as of July 2019)
- 8.7% without health insurance (as of July 2019)
- 24.7% unemployment rate [as of June 2020]
  - 4.60% unemployment rate pre-COVID [as of Feb 2020]

Race/Ethnicity
- 56.4% Hispanic (Dominican Republic, Puerto Rico)
- 29.2% Black or African-American (Jamaica, West Indies)
- 15% Other (Caucasian, Middle Eastern, South Asian, West African, etc.)

Insurance
- Medicaid/Medicare 65%*
- Commercial 31%*
- Other 4%
The death rate per 100,000 people (both confirmed and probable COVID-19 deaths) in the Bronx exceeds all other NYC boroughs*.

*Data as of August 14, 2020
Montefiore COVID-19 Surge & BHIP Adaptation

- Stopped all face to face visits except vaccinations birth-4 years
- 1st group of BHIP clinicians deployed to inpatient work
- 1st of 5 trainings for BHIP team on redesign
- 2nd group of BHIP clinicians deployed to inpatient work
- All MMG sites open for face to face visits
- 8 total cases (MHS)
- Telehealth visits began
- All clinicians began administering COVID Short Screen
- BHIP developed and piloted COVID Short Screen
- Last BHIP clinician returned from deployment
Goal of Redesign: Achieving Stabilization in an Overwhelmed System

**Challenges**

- Managing behavioral health referrals with fewer clinicians.
- Keeping patients out of the Emergency Department and hospital.
- Majority of well-child visits suspended which vastly disrupted our behavioral health screening process.
Adapting our Population Behavioral Health Model

- Redesigned our Pediatric Behavioral Health Integration Program during the COVID-19 surge by:

1. Building a telehealth platform in a matter of weeks.

2. Creating a triage process that broke down silos between the Pediatric and Adult treatment programs.

3. Used waivers and telehealth to decentralize provision of treatment.

4. Advocating to be able to email patients with fewer encryption requirements in order to maximize clinicians’ ability to send resources to patients.
BHIP COVID Short Screen

Example of one section

- Assessed for:
  - Activities of daily living;
  - Health-related social needs;
  - Self harm;
  - Other stressors on the entire family (not just children).

1. PARENT/CAREGIVER -- Functioning Assessment

   In the last two weeks:
   - Are any problems with sleep making it difficult to take care of your children?
   - Are you able to shower? Are you able to make sure your child showers or takes a bath?
   - Are you able to feed yourself and your child everyday?
   - Do you have enough food in your home?
   - If your doctor prescribes medication for your child, do you have the medication at home? If your doctor prescribes medication for you, do you have the medication at home?
   - Are you able to remember important tasks like giving medication and feeding children?
   - Are you preventing any accidents in your home such as turning off the stove, watching children, locking doors, following COVID-19 safety recommendations?
   - In the past two weeks, has the electric, gas, oil or water company shut off your service or threatened to cut it off?
   - Is there anything happening at home that makes you feel that you or your child are in danger?
Engaging in a behavior that without regular BHIP contact strongly increases the likelihood patient will decompensate and have to go to the ED.

**ACUTE**
- Contact psychiatrists who would evaluate patient and arrange for psychiatric hospitalization that would be expedited to minimize impact on ER staff.

**HIGH**
- Patients assigned to receive weekly therapy sessions with BHIP clinicians.

**MODERATE**
- Patients assigned to receive biweekly therapy sessions with BHIP clinicians.
- Email patient resources.
- Patient given dedicated BHIP Phone Line to call if symptoms worsened.
- No therapy sessions scheduled.

**MILD**
Pilot Data & Script

### Pilot Data On BHIP COVID-19 Screen

<table>
<thead>
<tr>
<th># Of Screens Conducted:</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type Of Patient:</td>
<td>Pediatric, New Referral</td>
</tr>
<tr>
<td>Age Range:</td>
<td>20 months - 13 years</td>
</tr>
<tr>
<td>Time Range To Administer the Screen:</td>
<td>11-45 Minutes</td>
</tr>
<tr>
<td>• MILD CATEGORY = administration time ranged from 4-18 minutes (18 minute screen used translator service); intervention offered immediately and averaged 7 minutes</td>
<td></td>
</tr>
<tr>
<td>• MODERATE CATEGORY = administration time was 45 minutes (patient had suicidal ideation and risk assessment conducted)</td>
<td></td>
</tr>
</tbody>
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**Script for Calling a Deployed Clinician’s Patient**

Hello, my name is ***. I’m calling from Montefiore on behalf of your child’s behavioral health provider, Dr. ***. You are receiving this call because we understand that you and your child have starting working with Dr. *** to address (PRESENTING PROBLEM).

We recognize that it is a stressful time, and we want to make sure our patients and their families have their needs addressed and remain safe. Some members of our team are being asked to work in other units throughout Montefiore, so our appointment availability is more limited at this time.

So, I’m calling you today to ask you some screening questions about you and your family that help us determine what follow-up plan is best for you at this time/during the stay-at-home restrictions. Please keep in mind that some of these questions are sensitive but will help us with understanding how you and your family are doing.
NUMBER OF BHIP REFERRALS BY MONTH IN 2020

Total Referrals, April – August = 1,055

<table>
<thead>
<tr>
<th>MONTHS</th>
<th># OF REFERRALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>93</td>
</tr>
<tr>
<td>May</td>
<td>211</td>
</tr>
<tr>
<td>June</td>
<td>235</td>
</tr>
<tr>
<td>July</td>
<td>295</td>
</tr>
<tr>
<td>August</td>
<td>221</td>
</tr>
</tbody>
</table>
Thank You
Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.
Maimonides Medical Center: Engaging Patients through Text Messaging

Danielle Cuyuch, MUP; Senior Director, Population Health Program Integration
Magdalena Gordon, LMSW; Director, Behavioral Health Care Management
Brian Pisano, MA Econ ’22; Manager, IT Implementation and Support
Maimonides Medical Center

- A long history of leadership in population health
- Health Home/Care Management
- Information Technology & Analytics
- Community Engagement
- Workforce Development
The Brooklyn Health Home (BHH)

• Maimonides-managed entity that provides community-based care management services to Medicaid patients with multiple chronic medical and behavioral health conditions, serious mental illness (SMI), and/or HIV/AIDS, with functional impairments and social determinants of health

• Network comprised of twenty care management agencies, including hospitals, community-based organizations, and social service providers that identify/address full range of behavioral, medical, and social problems affecting chronically ill patients

• BHH currently provides services to over 8,000 individuals across Brooklyn, NY
COVID-19 Rapid Response Pilot

• New York City, the hardest hit region in the country

• NYC COVID-19 Rapid Response Coalition (cross-sector collaboration with leaders from social services, healthcare and technology) had just formed and offered to help

• Pro bono project management from Bain & Company, tech expertise & solutions from Amazon Web Services, and guidance from Manatt, Phelps & Phillips, LLP

• Brooklyn Health Home members are particularly vulnerable due to chronic medical and behavioral health conditions, social determinants of health, socioeconomic status

• Connected all members who responded to message to a care manager to address identified needs
COVID-19 Rapid Response Pilot

- AWS Professional Services team built-to-suit an **SMS-based chatbot platform** for proactive and light-touch member outreach leveraging:
  - **Amazon Pinpoint**, a highly scalable and globally distributed SMS service
  - **Amazon Lex**, a service for building conversational interfaces uses voice and text
  - **Amazon Connect**, an omnichannel cloud contact center that directly connected members to managed call centers and other resources
  - AWS, Maimonides, Manatt, Phelps & Phillips, LLP, and Bain & Company worked iteratively to **design, deploy, and refine** the solution over a three-week period
- Deployment steps and set-up guide (including **multi-language support**) available
- Designed as a “Wellness Check In” text, in English or Spanish
COVID-19 Rapid Response Pilot

Simplified outreach script requires only 3 responses before getting connected

Start: Does the patient have a need?

Yes → Language Screen

No → We hope you and your family stay well. Please try to stay at home and help prevent the spread of coronavirus. Text Hi at any point to restart.

Yes → Connect to care manager?

No → Transfer to Brooklyn Health Home Care Mgmt

Followed by

When transferred, patients connected to our 24-hour staffed answering service and provided a short survey to collect data on the population’s needs

Survey:
- Do you need help with food, unemployment assistance, or housing issues? (Y/N)
- Do you have a fever, cough, sore throat, or trouble breathing, or are you worried about COVID? (Y/N)
- Do you need extra emotional or mental health support? (Y/N)
- Are you having problems getting your prescription medications or refills? (Y/N)
- Are you having trouble reaching your doctor for other urgent health needs? (Y/N)
- Do you have any other issues that you need help with? If so, what are they?
## Findings & Insights

| Members texted | 5,605  
|                | Excludes members where text attempt failed |
| Members who responded | 599  
|                     | 11% of total |
| Members who didn’t need help | 139  
| (responded “No” to introduction) | 23% of members who responded |
| Members who needed help | 456  
| (responded “Yes” to introduction) | 77% of members who responded |
| Members who needed help and asked to be connected to a care manager | 184  
| 40% of responding members who needed help |
| Members who connected to a care manager | 159  
| 35% of responding members who needed help |

- 87% of respondents identified food, unemployment, or housing need
- 25% indicated need for emotional or mental health support
- 23% reported COVID symptoms or concerns
- 17% reported having trouble reaching their doctor for urgent health needs
- 13% indicated problems getting medication or refills
Findings & Insights

Text pilot served as a tool for re-engagement

Member enrolled with BHH CMA on 12/1/2019 with a qualifying serious mental illness

Member became disengaged immediately after enrollment
No contact between 12/13/2019 through 5/12/2020

Chat Bot Intervention: On 5/11/2020, member responded to text-based outreach to indicate need with unemployment assistance

Care Manager successfully reengaged member on 5/13/2020

Text pilot surfaced critical issues and allowed care manager and health home to mobilize supportive services

Member enrolled with BHH CMA prior to COVID

Chat Bot Intervention: On 5/16/2020, member responded to text-based outreach to indicate assistance needed food, domestic violence, stimulus

Case Conference held on 5/19 with health home and CMA. DV service identified

Patient connected to DV service on 5/21 and remains engaged
Looking Ahead

- **Designed as pilot** to be time-limited service – immediate response to COVID
  - AWS continuing to work with other hospital departments
- In partnership with NYC, will continue to utilize this intervention to improve COVID testing rates in Brooklyn’s most vulnerable communities
- Efficient way to communicate and assess needs of large group of members but posed challenged given not integrated with EHR
- Simplicity and accessibility of text messaging as a familiar form of communication for patients

- If provided an opportunity to implement this technology again—
  - Additional analysis underway to learn which of our patients are best served by this type of intervention
  - What adjustments can we make to maximize engagement?
  - How can we better connect to our EHR and improve response times?
  - Exploring how to use this intervention for members at safety risk (with history of IPV, suicide risk)
  - Possible application as a suicide prevention note intervention
Contact information

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Questions?

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Question & Answer
Wrap Up
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