Integrated Behavioral Health Project

Shelia McCann

Iliana Rodriguez

Health Choice Network of Florida

Bristol-Myers Squibb Foundation

Together ON Diabetes

Communities Uniting to Meet America's Diabetes Challenge

Project Goals and Summary

- A Community Patient Navigator led re-engagement of 250 adult patients with HbA1c > 9 who have not completed a primary care visit in past 12 months and have a PHQ-9 score ≥ 10.
- Create a seamless integrated primary – behavioral care workflow
- Address patient barriers with accessing care

Patient Story/Experience

Community Patient Navigator (CPN) reached male patient, morbidly obese, by phone. With encouragement, Patient made a primary care appointment. Centralized Care Team and CPN completed motivational reminder calls to complete previsit planning. Patient expressed concern with visit process. CPN greeted Patient who arrived with his wife. PHQ-9 indicated need for follow-up and Patient was referred for due to concerns with weight. CPN shepherded patient through stages of the appointment. At the end of the visit, Patient tearfully thanked CPN for encouragement. He didn't think anyone really cared about him. Concern demonstrated by CPN and motivational calls were critical to completion of appointment. Follow-up appointments have been scheduled.

Patient Story/Experience

- My success story is about a 45 year old male. At first contact, he did not want to speak to the CPN; he was too depressed and did not have time to discuss his personal information with a stranger. He asked the CPN to call him at a later time. 2 days later, he was more open and stated he knew he needs help. He stated that he was very depressed, was hearing voices, and did not have insulin. He accepted "next day" family medicine appointment. Upon arrival, the CPN referred the Patient to our patient financial services department and DCF to apply for Medicaid. He was referred to the Medication Assistance Program for help obtaining medications. Patient saw the doctor and spoke with our crisis unit for a behavior health appointment. Patient is so happy about the services rendered at CHI and stated he was very thankful because the CPN did not give up on him.

Project Results to Date

- Increased primary/behavioral health integration
- 477 Patients Identified
  - 100 Patients contacted
  - 16 Primary care appointments completed
  - 5 Behavioral health care appointments completed
- Learning To-Date
  - Barriers: 46% Illness; 25% Financial; 16% Insurance
  - Referrals: 49% Primary Care; 18% Behavioral Health; 10% Transportation

DDS-2

1. Overwhelmed by demands of living with DM
   - 7% No Problem
   - 40% Moderate Problem
   - **53% Serious Problem**
2. Often failing with my diabetes regimen
   - 7% No Problem
   - 43% Moderate Problem
   - **50% Serious Problem**