CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

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Across New York, Organizations are Redefining Best Practices in Care Management

First challenge tackled: Dealing with mental health

All across the Empire State, healthcare payers, providers, and community-based organizations have spent several years participating in a grand, national experiment of improving medical care for the highest-risk Medicaid enrollees.

While other states are participating in the Affordable Care Act's Medicaid health home model, New York has integrated this model with existing case management providers to a greater extent than anyone else.

The New York State Health Home Program has no restrictions on which Medicaid providers can deliver services. Medicaid health home organizations enroll patients who have chronic illnesses and a behavioral health issue. They are assigned to care managers who help them take care of their immediate social and behavioral needs before they

CMA SERIES: NEW YORK CASE MANAGEMENT MODEL LEADS THE WAY

This special issue of *Case Management Advisor* focuses on the New York State Health Home Program. This is the first of a two-part series about how the health home model works and seeks to improve healthcare coordination and case management services for at-risk Medicaid patients. This issue features stories about health home best practices and how it works. The November issue will include articles about the model's reliance on helping people with social determinants of health and the program's enrollment obstacles.

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receive the medical help they also need.

The program is a resource-intensive method of handling the people who are most likely to ignore health problems until they're severe enough to require hospitalization or an ED visit.

But if it works, and all the case managers and others discussing their work with the program say they think it will succeed, it could be a model for the rest of the nation.

Triple Aim Goal

The program's results are still being collected and studied, but leaders of participating organizations express optimism. "Not only do I believe it will work, but we believe it's the right thing to do," says **Amanda Semidey**, LCSW, director of Coordinated Behavioral Care (CBC) Health Home in New York City.

"This integrated model definitely is the way of the future," says **Margaret Leonard**, MS, RN-BC, FNP, vice president for Medicaid government and community initiatives for MVP Healthcare, a managed care organization in Schenectady, NY. *(For more information on how the health home program works, see related article on page 112.)*

"In New York, we're revising the whole system, especially for Medicaid," Leonard says. "This is a fantastic opportunity for us to really get it right."

Under the health home model, each enrollee will have one care manager, Leonard says. "We'll have the challenge of identifying the member's needs and getting folks the services they need."

The lofty goal is the triple aim of improving healthcare: reducing unnecessary ED visits, driving down unnecessary costs, and improving population health, Semidey says.

"We're talking about system transformation, and transforming healthcare is a process," Semidey says. "It takes patience and planning and building alliances, especially in healthcare."

Semidey says she believes the state's grand experiment will work, but it still is too early to talk about outcomes. "It's taken a while to build up programs and market them appropriately."

Many Agencies Embracing Health Home

Both traditional case management organizations and agencies that, previously, did not offer care management services are transitioning over to the health home care management model, says **Molly Stuttler-James**, CASAC, coordinator of adult care management services at Onondaga Case Management Services, Inc. in Syracuse, NY. *(See sample list of quality measures collected for health home programs, page 113.)*

"We are one of the larger care management organizations, with 55 to 60 care managers," Stuttler-James says. "This program gives us an opportunity to be creative with what we're doing."

Onondaga can try something new under the health home model, and if it works, the strategy can be employed in other case management programs, she adds. "We're always trying to adapt and evolve to meet the client's needs."

Many of the organizations

involved with New York's program have adapted their programs to fit the broader health home initiative. For instance, Upstate Cerebral Palsy in Utica, NY, has evolved over the decades from one disease-specific focus to a broader wellness focus, including mental health, to its current activity with care management under the health home model, says **Tara Costello**, MSW, CASAC, vice president of behavioral health services at Upstate Cerebral Palsy.

"In the past 35 years, our behavioral health division has grown substantially to include providing housing for individuals with mental health issues, and our specialty is management," Costello says. "Not only do we provide health home services for the state, but we also provide homeless care management, mentoring services, drop-in centers for people with mental health and substance use issues, and we have an early recognition/prevention program for screening young children."

Care managers work closely with patients to prioritize what's needed to keep someone's health on track, Costello notes.

"Our goal is to engage and work with the individual to make sure their healthcare needs are being attended to," she adds. "The care manager is responsible for this."

Community Healthcare Network (CHN) in New York City also started years earlier as a nonprofit community-based organization with a different focus. CHN has 14 health centers across the city, plus two mobile units and a school-based health center, says **Karlo Francis**, LMSW, deputy director of care coordination for CHN's Health Homes Program.

"The care coordination services initially were geared toward persons with HIV under a New York state initiative that provided intensive case management services for persons with HIV/AIDS," Francis says.

The new health home model is similar, although the focus is on any Medicaid enrollee who has the two qualifying conditions. HIV infection counts as one of the qualifying conditions, Francis says.

CHN has trained outreach staff that identifies patients' immediate needs and shows them how the health home program could help them out.

> THE LOFTY GOAL IS THE TRIPLE AIM OF IMPROVING HEALTHCARE: REDUCING UNNECESSARY ED VISITS, DRIVING DOWN UNNECESSARY COSTS, AND IMPROVING POPULATION HEALTH.

"This could be a person who needs food and they're not sure where to get a warm meal," Francis says. "Or they might tell us they're being evicted from their apartment, and we have a list of legal agencies that could work with them on helping them stay in their apartment."

Outreach personnel then ask patients if they interested in enrolling in the health home, where they could receive that kind of help.

"Our guiding principal is we turn no one away, so if a person is in need of assistance, we collaborate and help that person get the assistance he needs," Francis says.

Sometimes, care managers hone their detective skills to even locate a particular at-risk patient. "We had a woman we needed to locate who had something like 21 ER visits over an 18-month period of time," Leonard says. "We finally collaborated with a health center that she visited once in a while, and they said they often saw her at a local laundromat, where she kept warm."

A peer specialist visited the woman at the laundromat and enrolled her in the health home program. The peer specialist learned that the patient had trouble living in her own federally subsidized home, despite being the most reliable caretaker of a granddaughter, who also lived in the home. The woman's daughter and her daughter's boyfriend were addicted to drugs, and she wouldn't stay in the home when they were both there.

"So we helped her get the daughter help," Leonard says. "Then she was able to get guardianship of the grandchild."

Case management also helped the woman straighten out some legal difficulties she had with the housing authority. Finally, after these issues were taken care of, they addressed the patient's uncontrolled diabetes and assisted her with returning to school, which had been her personal goal.

"Her A1c and blood sugars have been really great, and she is regularly seeing her primary care doctor, as well as a therapist, who is helping her handle the stress in her life," Leonard says. "It's those kinds of things that are multigenerational that can really affect how a lot of people live." ■

Here's How the Care Management and Care Coordination Work in NY

Contact patient within 48 hours of referral

Typically, referrals to New York's health home program are made by doctors, probation officers, or mental health clinics, although they could be made by any community organization or provider.

People are eligible for health home care management services with the following:

- active Medicaid,
- meet resident requirements,
- have two or more chronic conditions, or HIV/AIDS, or one or more serious mental illnesses, and
- significant behavioral, medical, or social risk factors that can be addressed through care management.

The six-page community referral application, used by one health home agency, lists close to 200 chronic conditions, covering everything alphabetically from acquired or congenital hemiplegia and diplegia to vesicoureteral reflux.

The health home care management organization has 48 hours after the referral in which to contact the patient and schedule a meeting, says **Tara Costello**, MSW, CASAC, vice president of behavioral health services at Upstate Cerebral Palsy.

Organizations assess whether patients are being contacted and given proper informed consent to enroll voluntarily in the health home program, says **Margaret Leonard**, MS, RN-BC, FNP, vice president for Medicaid government and community initiatives for MVP Healthcare, a managed care organization in Schenectady, NY.

"Are they being engaged? Do they have a primary care provider? Is the care plan done?" she says. "While we're waiting for that information to get to us, we're still managing them."

The health home program is being improved continuously as organizations figure out ways to perform certain tasks more efficiently and to communicate more effectively. For instance, one improvement might be to have weekly rounds with different care management agencies to go over a list of patients who should be enrolled, Leonard suggests.

> "A LOT OF TIMES, PATIENTS ARE NOT ABLE TO COMMUNICATE THEIR NEEDS EFFECTIVELY, AND THE CASE MANAGER ACTS AS AN ADVOCATE FOR THAT INDIVIDUAL."

Communication between doctors, hospitals, and others has been a challenge because healthcare providers have worked in silos for so long, Costello notes.

"This program is trying to undo those old behaviors and get people back to working together," she says. "We're trying to get hospitals to communicate better with community providers."

It is fun watching the process work as care managers collaborate, Leonard says. "People get excited about it."

Care management has to be signed off by a licensed professional, but some of the services can be delivered by peer specialists, Leonard says. "There's total flexibility of the care managers."

Once a patient agrees to receive the health home service under Medicaid, a case management agency assesses the person's needs and risk factors, including housing issues, unemployment, and difficulty navigating the health system, Costello says.

"The case management agency does a comprehensive assessment on the individual, looking at all life areas including social, mental, and all major components," Costello says. "Once it's complete, it's patient-driven: What does the patient want today?"

As a first step, the case manager might determine why the patient has missed appointments and help the person solve transportation problems. In some cases, the case manager may even go to the first doctor's appointment with the patient to ensure he or she keeps the appointment and knows how to discuss his or her problems with the physician.

"A lot of times, patients are not able to communicate their needs effectively, and the case manager acts as an advocate for that individual," Costello says. "Also, if the patient is not eating properly or not exercising, the care manager can address that with the doctor as part of care

coordination."

Depending on patients' needs, care managers will meet with them at a minimum of once a month, to several times a month. Some contacts will be by telephone, Costello says.

The meetings can last anywhere from 45 minutes to several hours, and the care management continues indefinitely. "They stay in our care until they no longer have any needs to be met," Costello says. "They could be with us forever."

The challenge for care managers is to keep patients engaged and on the caseload if their situations are high risk, such as patients who are homeless and mentally ill.

New York health home organizations also use technology to facilitate more efficient care coordination.

"Health homes have to have a dashboard where all care coordination services can be documented," says **Amanda Semidey**, LCSW, director of Coordinated Behavioral Care (CBC) Health Home in New York City.

"All levels of service providers can access the system, with the appropriate information technology requirements, to update care plans," she says. "It's a team approach, and it should be individualized to the member's unique needs and interdisciplinary team."

Case managers/care coordinators can communicate with individual health home members through Sense Health, a health information technology solution for patient engagement. The HIPAA-compliant program allows direct contact with members for engagement and health motivation purposes.

"It can be as simple as sending a text to remind a member of an appointment," Semidey says. "It's all done in a secure way, uploaded into a dashboard." ■

Sample List of Quality Measures Under Health Home Model

NY state's list is five pages

The New York State Health Home Program has a five-page list of goal-based quality measures collected to assess the program's success. Here is an abbreviated list of the goals and what is being collected and measured:

- **Goal 1:** Reduce utilization associated with avoidable (preventable) inpatient stays.
  - Clinical outcomes.
  - Experience of care.
  - Quality of care.
- **Goal 2:** Reduce utilization associated with avoidable (preventable) ED visits.
  - Clinical outcomes.
  - Experience of care.
  - Quality of care.
- **Goal 3:** Improve outcomes for persons with mental illness and/or substance use disorders.
  - Clinical outcomes, including mental health utilization and follow-up after hospitalization for mental illness.
  - Experience of care.
  - Quality of care, including antidepressant medication management and adherence to antipsychotics for individuals with schizophrenia.
- **Goal 4:** Improve disease-related care for chronic conditions.
  - Clinical outcomes.
  - Experience of care.
  - Quality of care, including medication management for people with asthma, and comprehensive diabetes care.
- **Goal 5:** Improve preventive care.
  - Clinical outcomes.
  - Experience of care.
  - Quality of care, including chlamydia screening in women, and colorectal cancer screening.

Source: http://on.ny.gov/2ck4QXa. ■

CMS is Accepting Applications for Five-year Primary Care Model

Providers could use technology for monitoring

CMS has begun enrolling applications for its new nationwide primary care model, Comprehensive Primary Care Plus (CPC+).

A five-year primary care medical home care model, CPC+ provides incentive payments through the proposed Quality Payment Program. CMS estimates the program could reach as many as 5,000 primary care practices, serving 3.5 million beneficiaries. CPC+ builds on the Comprehensive Primary Care initiative (CPC) that launched in 2012.

Through payment reform and practice transformation, primary care practices can build capabilities and care processes to deliver better care, which will result in a healthier patient population, according to CMS.

The new program is another strategy for working with patients and actively enrolling them, says **Ron Sterling**, CPA, MBA, of Sterling Solutions, a national independent consultant on electronic health records and medical billing solutions, in Silver Spring, MD.

Healthcare providers need care management to communicate with patients and monitor their care, but they also need technological tools to monitor high-risk patients more consistently, Sterling says.

Care coordination is all about increasing contact with patients and improving their care as efficiently as possible, Sterling says.

"At the end of the day, we only have so many providers," he says. "And we have an aging population with chronic issues."

Because of the way demonstration projects like CPC+ are designed to reimburse through incentives, providers have greater flexibility in how they improve patients' care. They could spend it primarily on care coordination and case management, or use a combination of case management and technological monitoring.

"With a demonstration project, there's funding," Sterling says.

> "THIS MODEL ALLOWS PRIMARY CARE PRACTICES TO FOCUS ON WHAT THEY CARE ABOUT MOST: SERVING THEIR PATIENTS' NEEDS WHEN AND HOW THEY CHOOSE."

Using technology to monitor patients' vital signs is less costly than having nurses make multiple visits to patients who are having health issues. And technology can make it possible for healthcare providers to monitor patients without actually seeing them each week or month.

For instance, technology exists to monitor continuously a patient's pain level, wound healing, or to send remotely to doctors the patient's weight, pulse, blood pressure, and glucose readings. This type of monitoring can be more accurate than having someone call the patient to ask what their weight or readings are, Sterling says.

Technological monitoring helps case managers prioritize which patients they need to call and check on, he adds. "They can focus their attention on the patient who is not doing well or who has not been in touch with the doctor."

By redesigning the payment model, CMS is giving primary care providers the chance to have greater cash flow and flexibility as they deliver the desired high-quality, whole-person, patient-centered care, CMS officials say.

According to CMS, the new program will benefit patients in the following ways:

- support patients with serious or chronic diseases and help them achieve their health goals,
- give patients 24-hour access to care and health information,
- deliver preventive care,
- engage patients and their families in their own care, and
- work with hospitals and other clinicians, including specialists, to provide better-coordinated care.

The project's goal is to lower use of unnecessary services that drive the total costs of care, and to build on the agency's previous efforts in aligning payment reform and providing motivational incentives and robust data sharing.

According to CMS, practices involved with CPC+ will use the following comprehensive primary care functions:

1. access and continuity,
2. care management,
3. comprehensiveness and

coordination,

4. patient and caregiver engagement, and

5. planned care and population health.

Also, the program's participants will focus on caring for patients with complex medical, behavioral, and psychosocial needs.

Part of the CPC+ work will involve developing strategies to achieve comprehensiveness, such as using analytics to identify population-level needs and to prioritize strategies for meeting those needs, CMS officials say.

Primary care providers will be expected to build capacity within their practices to meet patient needs, and they'll need to develop strong and coordinated referral networks within their medical neighborhoods.

Comprehensiveness adds breadth and depth to the delivery of primary care services, builds on the element of relationship that is at the heart of effective primary care, and is associated with lower overall utilization and costs, less fragmented care, and better health outcomes, according to CMS.

"We see CPC+ as the future of primary care in the U.S. and are pleased to partner with payers across the country that are aligned in this mission to transform our healthcare system," said **Patrick Conway**, MD, MSc, CMS deputy administrator and chief medical officer, in an Aug. 1, 2016, news statement.

"This model allows primary care practices to focus on what they care about most: serving their patients' needs when and how they choose," Conway said.

CPC+ will begin in January 2017 for 14 regions, including Arkansas, Colorado, Hawaii, Kansas and Missouri's Greater Kansas City region, Michigan, Montana, New Jersey, New York, Ohio (including northern Kentucky), Oklahoma, Oregon, Pennsylvania, Rhode Island, and Tennessee.

Primary care practices can choose to participate in the program's Track 1, in which CMS pays practices a monthly fee in addition to regular Medicare fee-for-service payments, or in Track 2, in which practices receive the monthly fee, as well as a combination of reduced Medicare fee-for-service payments and up-front comprehensive primary care payments that will allow greater flexibility in how practices deliver care.

Using Track 2, primary care practices can provide more comprehensive services for patients with complex medical and behavioral health needs, including addressing their psychosocial issues, according to CMS.

The demonstration project is part of the Affordable Care Act's Center for Medicare and Medicaid Innovation, which has the ultimate goal of improving healthcare by paying providers for what works, and improving quality.

For more information about the model, visit the CMS website at: http://bit.ly/2c7fqx7, or email CPCplus@cms.hhs.gov. ■

New Initiative Slashes Opioid Prescriptions, Boosts Community Response

The Monterey County Prescribe Safe Initiative (MCPSI) is a multi-agency collaborative conceived in February 2014 as a way to address the problem of prescription opioid misuse in Monterey County, CA. The idea for the initiative originated at Community Hospital of Monterey Peninsula (CHOMP), but the effort has now grown to include 17 organizations, including all four hospitals in the region, urgent care centers, primary care and mental health providers, advocacy groups, and law enforcement.

While the name of the initiative implies a focus on prescribing, the initiative actually includes multiple interventions that address different aspects of the opioid crisis, and emergency providers have taken a leading role in driving these interventions.

"It was just a matter of trying to figure out how to get patients the care they need in a safe way," explains **Reb Close**, MD, an emergency physician at CHOMP and one of the physician leaders of MCPSI. "At the time the initiative began, the epidemic was becoming much more understood and more appreciated, and so **Anthony Chavis** [MD, MMM, FCCP, the vice president and chief medical officer at Montage Health, CHOMP's parent company] and I started brainstorming about it and coming up with how to address it. And it has just spider-webbed in so many different directions because so many different people are affected by this."

The results of MCPSI thus far are impressive. They include a 59% reduction in ED visits and a 47% reduction in variable cost avoidance

in a population of recurrent visitors that are under biopsychosocial care management. Additionally, the initiative has more than halved the number of narcotic pills prescribed at primary care clinics in the region. Perhaps most notable is the reality that providers are beginning to think about both addiction and their role in treating patients who present with addiction problems in a new way.

For instance, physician leaders at CHOMP are not fans of the term "drug-seeking" to describe patients who recurrently present to the ED to fill prescriptions for narcotics.

"That is a particularly loaded and challenging term," says **Casey Grover**, MD, an emergency physician at CHOMP who also has taken a leading role in MCPSI. "These patients may be looking to get a medication, but there is another reason that is bringing them to the ED."

Such a patient may experience uncontrolled pain, suffer from an uncontrolled mental health condition, or may have an addiction, Grover notes. "It is not so much that the patients are doing something bad or wrong if they have an untreated illness ... and repeatedly going to the ED isn't fixing it," he says. "So [under CHOMP's recurrent visitors program] these patients are given a plan of care, and usually what that is designed to address is the underlying issue. Is it that they need a real pain specialist? Is it that they need to see our recovery center [the hospital's associated outpatient addiction clinic]? Is it that they need to see a psychiatrist? Those are all meant to address the underlying illness that is making them show up to the ED requesting or seeking various medications."

Grover allows that the idea of addressing addiction in the emergency setting initially raised some eyebrows in some quarters, primarily because this just adds to emergency providers' long to-do list.

"There has been research that we should do HIV screening in the ED and we should do domestic violence screening and depression screening," he says. "It was one more thing that people are expecting us to do, but then as we have gone through the data, people realize that if you treat [patients] with the right medications for what is a disease, namely addiction, people have fewer ED visits and they are likely to get better faster."

Emergency providers all went into medicine to help people get better, Grover adds.

"You present the data and people kind of put the barriers down and think that maybe they can provide better care for patients this way," he says.

While the motivation to address addiction is there, the way emergency providers at CHOMP treat patients who present with an opioid addiction is in flux, Close notes.

"Previously, we had reasonable access in our county to the recovery center for all patients," she explains. "If someone presented with an opioid addiction and was interested in recovery, we would start them on a single shot of buprenorphine in the ED, and then we would refer them to our recovery center where they would be seen basically the next day and [continued] on medication-assisted treatment [MAT]."

The approach seemed successful, Close observes. However, funding difficulties forced the ED to alter its approach.

"The availability for patients to see a MAT-prescribing physician in rapid fashion was non-existent, so we couldn't use buprenorphine anymore in the ED."

To get around this problem, emergency providers have had to adjust their addiction pathway to accommodate a longer wait time for access to MAT.

"So we give patients a prescription for a five-day course of medication with tapers [including clonidine, gabapentin, tramadol, and ondansetron], and then refer them to an addiction clinic for ongoing care. The addiction clinic can't get them medications for treatment rapidly, but it can give them addiction services rapidly," Close explains. "That is the model we are using right now."

However, Close stresses that ED administrators hope to restart their earlier approach soon, involving the administration of buprenorphine while patients are still in the ED along with the referral to an appropriate outpatient setting in which patients will receive immediate chemical and dependency support services. Other hospitals in California are considering implementing a similar protocol, Close says.

"We are using expertise throughout the state to formalize how we can do these plans for patients," she says.

Close acknowledges there still is plenty of resistance in the emergency medicine community to the idea of providing buprenorphine to patients with addictions while they are in the ED.

"We treat these patients every single day, so [it's a matter of] reminding providers that these patients are already in their EDs and that they have a tool that can help them more safely and more effectively than any other tool they have," she explains. "These patients are agitated, sweaty, uncomfortable, angry, and frustrated. And you give them a shot of buprenorphine and then come back in 20 minutes, and they are calm and pleasant. They thank you, and they feel so much better."

A centerpiece of MCPSI is

countywide implementation of pain management protocols for the ED, but Grover acknowledges that crafting guidelines does not guarantee adherence. Nonetheless, he notes that CHOMP has been able to achieve effective compliance with these guidelines by initiating broad educational initiatives to both providers and the public.

"We had a CME [continuing medical education] event for our providers — a big lecture on safe pain care. We also educated them about use of California's prescription drug monitoring program [the Controlled Substance Utilization Review and Evaluation System, or CURES]," Grover explains. "Then we also educated the public that this is what the county believes is safe, and it is in all of our county EDs. In our particular hospital, every patient, no matter what they come in for, gets a copy of these guidelines at discharge, so the public knows what to expect and what we think is safe."

There has been a general misconception that if a physician prescribes narcotics, such drugs must be safe, Grover adds.

"Between the medical side and the community side, there is a big movement to educate the whole group that these medicines can be really dangerous, so be careful, and let's monitor them closely," he says.

As part of this education process, providers receive advice on how to teach patients most effectively about opioids, the potential hazards associated with them, and how to minimize any negative effects, Close adds. Providers also learn about more effective responses when patients report that they need something for pain.

"The reflex is not to write a prescription for [a narcotic]; it is to talk to them about what this means," she explains. "There are all these different treatment options, and teaching the physicians and the patients that there is not just one answer has really changed all of our practices."

It is still up to the treating provider ultimately to make decisions about what to prescribe, but now when a decision is made that is counter to the pain management guidelines, a provider generally will approach ED physician leaders to explain why an exception was needed in this particular case. Close notes that there are valid reasons to deviate from the guidelines. For instance, the physician may report that the patient experienced a surgical emergency and he or she thought it was in the patient's best interest to prescribe an opiate.

Close notes that the issue of opioid prescribing comes up regularly during emergency group monthly meetings, and plans are in the works to study the effect of the opioid guidelines on prescribing and provider decision-making.

Development of the guidelines for the ED at CHOMP was actually a good starting point for more communitywide participation in the overall initiative, Close says.

"Those guidelines were very well thought out and put together, and we gave them to our physicians, and then we said, 'Hey, the clinics need them,' and so we took the ED framework and shared it with the clinics, and then we shared [the guidelines] with the community," she explains. "There was not one person I contacted out of the blue that questioned why we were doing this, so getting people involved ... and getting those ED guidelines, I think, for us, was a big hurdle that really made a difference."

The original networking that took place to disseminate the guidelines created many other avenues to pursue to tackle the opioid crisis, Grover explains.

"Our contacts with the sheriff's office turned into us being able to work with them to sponsor drug take-back events," he explains. Such events provide an opportunity for the public to safely dispose of unused narcotics, ensuring these dangerous medications don't fall into the hands of people who should not use them.

Similarly, contacts with the district attorney's (DA's) office have enabled emergency providers to take a firm stand on prescription forgery and prescription drug diversion, which already has paid dividends, Grover explains.

"The license and DEA number belonging to one of our providers were taken by a patient, and medications were fraudulently called in," he says. "The DA investigator for healthcare fraud in Monterey County had been through the process with us, so we knew how to advise this provider, and it just all of a sudden made things so much easier to move forward."

The physician leaders of the MCPSI discovered that much of the work they wanted to pursue was already underway in some fashion in the county — they just needed to knit all these efforts together, Grover explains.

"Doing all this work in the name of safety has been very important. It is not telling a patient that [he or she] is addicted. It is offering to treat a medical disease, and make decisions to choose medicines that are the safest," he says. "That really inspires people that this is a good program for the community."

Grover adds that the approach also reduces conflict when a patient presents to the ED with an addiction problem, and the provider conveys that he or she will not refill a

prescription for narcotics because the provider is concerned about the patient's safety.

"The family member will look at you and you look them in the eye and say that you are really concerned for their safety. They know you mean it and they know it is for the right reasons," he explains.

Whereas prescribing used to be a point of considerable disagreement between patients and providers, "we have now all unified ourselves under the greater goal of safety," Grover adds.

While MCPSI has slashed prescriptions for narcotics and strengthened the community's response to the opioid crisis, charting the initiative's effect on drug overdoses has been difficult. Part of the problem is that the electronic medical record (EMR) system at CHOMP does not facilitate such tracking, Grover explains.

"I am currently keeping a list of all the overdoses because we are planning, as one of the next steps in this project, to start alerting providers that are prescribing scheduled substances when one of their patients overdoses," he says. "Anecdotally, I have not seen a fatal drug overdose in quite a while, and I can tell you that in 2013 we had around 50 fatal overdoses in Monterey County related to scheduled medications. So, anecdotally, we are seeing fewer overdoses."

Grover stresses that he is only able to chart the overdoses that people tell him about or those of which he is personally aware, so it is hardly a perfect system. MCPSI leaders hope to devise a better way of tracking such events in the future.

Editor's note: For more information about the MCPSI, including access to the prescribing guidelines for the ED and other resources, please visit: http://bit.ly/2ccanMw. ■

Warm Handoffs Connect Substance Abuse Patients to Vital Services

Although there are varying perspectives on whether emergency providers should place substance abuse patients on medication-assisted treatment (MAT) while such patients are still in the emergency setting, there is wide agreement that linking all such patients to treatment is important. This mechanism, often referred to as a "warm handoff," ensures patients can turn to a resource for help in dealing with their substance abuse problem immediately.

Of course, the specifics involved in this transition are critical. That's why emergency providers at Reading Hospital in West Reading, PA, work closely with the Council on Chemical Abuse (COCA), a non-profit organization that focuses on issues involving substance abuse in Berks County, PA, to develop an effective warm handoff approach.

"We developed the program based on feedback that we received from multiple sources, including COCA and our mental health services, as well as emergency providers and the staff here," explains **Kristen Sandel**, MD, associate director of emergency medicine at Reading Hospital.

The resulting warm handoff program includes several components, all designed to ensure patients with addiction problems are connected to a treatment plan as soon as their medical emergency has been addressed.

At first, the program was targeted specifically toward patients who had overdosed on heroin because there was an epidemic of heroin overdoses in Berks County and surrounding areas, Sandel says.

"As the program evolved, we recognized that there are many more patients who could benefit from these services, so we approached COCA to see if we could offer the same program to patients who wanted assistance with their addictions involving other opioids," she explains. "We have not been able to extend it to other substances beyond opioids at this point, but our successes with the program thus far have made it clear that this may be a program we can expand in the future."

The new program, which has been up and running since February, has gained steam.

"Initially it was a little bit slow and we had a few glitches, but as the program has become more robust and more mature, our providers have been very active in offering these services," Sandel says. "We are averaging one patient [taking part in the warm handoff program] every two days ... and it is a resource that didn't used to be available."

What happens when a patient with an addiction problem presents to the ED?

"The initial focus is stabilization of the patient and treatment of their acute, life-threatening medical condition," Sandel notes. "At that point, we have a frank discussion with the patient about the reason he or she is in the ED if it was a heroin

overdose, or we ask the patient about his or her substance use history and social history, and if we see that this person has an issue with a controlled substance, including opioids or heroin, then we offer the program."

Sandel emphasizes that emergency providers are instructed to treat these patients like they would treat any patient with any other medical condition, whether it is a heart attack or appendicitis.

"Addiction is a disease, and part of the treatment is offering recovery, just like we would offer a cardiac catheterization to a patient having a heart attack or medication for a patient who is having a stroke," she says.

The warm handoff program is voluntary, so patients certainly can decline, but if they do accept the warm handoff the provider will contact a mental health liaison and a hospital social services representative.

"At that point, the mental health liaison will call the consultant/recovery expert from COCA," Sandel explains. "In most cases, they will come to the ED within 30 minutes to an hour to meet with the patient before they are discharged home, or [the patient] will be offered an inpatient treatment program if that is the best option."

To make sure emergency providers were aware of the warm handoff program, administrators inserted a prompt into the electronic referral process.

"When someone consults our mental health services regarding a patient, the first question that is asked is whether this is a warm handoff," Sandel says. "The provider has to answer that question, so it is always in the forefront of their mind: Do I need to offer this patient warm handoff services for an opiate or heroin addiction?"

If the provider says, "yes," that triggers the mental health worker to recognize not only the mental health issues that the patient may have, but also the substance abuse issue, Sandel explains.

"The reason we put the hard stop in [the electronic process] was to ensure that our providers are thinking about [substance abuse] and asking patients about it," she says.

Additionally, administrators held an information session with emergency providers to explain the warm handoff process and to review the types of conversations in which providers might engage with substance abuse patients. Sandel stresses communication with patients is key.

"This isn't just an option that patients can take or not. It is something that could change their lives," she says. "It is telling a patient that he almost died today or that he lost his heartbeat and wasn't breathing, and that you had to provide lifesaving treatment to ensure that you could be having this discussion."

At the same time, it is important to convey that you are there to help and that addiction is a disease, Sandel adds.

"We are not pointing fingers or blaming patients for this. We want to help them, and many times the best option is getting them into a recovery program, whether that is in an inpatient setting or an outpatient setting with the help of recovery specialists," she explains. "That communication piece, where we actually have the discussion with the patient or the patient and their family, is critical."

For the warm handoff process to work, there must be treatment providers in the region ready to accept patients. That was not always the case in Berks County, Sandel notes.

"In the past, when patients wanted to go into recovery, if we didn't have a bed or we couldn't find a bed somewhere in one of the surrounding areas, we would discharge a patient with a phone number or an address," she explains. "It really was a disjointed effort, and one of the reasons was because there were limited resources."

Pennsylvania authorities have been improving access to recovery programs, including both outpatient and inpatient approaches.

"The state is also looking at both mental health and substance use because they are so intertwined and making sure we have the resources to meet both the mental health needs and substance use issues," Sandel notes.

While it's important to build relationships with treatment providers, you also have to finesse how the ED will communicate and interact with these services, Sandel advises.

"We had some growing pains [in this area] in the beginning, but once we worked those out, it has been a very smooth process," she says.

Another critical element of success is making sure that everyone is on board with the process, from the physicians and nursing staff to mental health services, social services, and allied staff throughout the ED.

"This is a process where everyone has a piece," Sandel says. ■

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CE QUESTIONS

1. The goal and triple aim of the New York State Health Home Program is which of the following?

A. Eliminating homelessness, reducing mental health relapses by 50%, and finding substance use treatment for 100% of those who need it.
B. Reducing unnecessary ED visits, driving down unnecessary costs, and improving population health.
C. Cut Medicaid expenses by 5% by 2020, reduce hospitalization rates among chronically ill by 20%, and eradicate HIV/AIDS by 2025.
D. All of the above.

2. In New York State Health Home Program, care coordination focuses on which of the following?

A. Keeping patients engaged and on the caseload if their situations are high risk, such as patients who are homeless and mentally ill.
B. Directly observed therapy.
C. Marital and family counseling.
D. None of the above.

3. Listed in the New York State Health Home Program's goal-based quality measures is which of the following for the goal of improving preventive care?

A. Provide beta-blocker treatment after heart attack.
B. Chlamydia screening in women.
C. Follow-up care for children prescribed with ADHD medication.
D. Adherence to mood stabilizers for people with bipolar disorder.

4. CMS is taking applications for its new nationwide primary care model, Comprehensive Primary Care Plus (CPC+), which CMS says will provide which of the following benefits to patients?

A. Support patients with serious or chronic diseases and help them achieve their health goals.
B. Give patients 24-hour access to care and health information.
C. Deliver preventive care.
D. All of the above.