Mental Health & Addiction CONNECTION

1-866-603-0016

Your 24/7 resource for scheduling, questions and concerns

Allina Health™

PROVIDER

Allina Health Mental Health & Addiction Services

FOR MORE INFORMATION, CONTACT:

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CHALLENGE

As a large, geographically dispersed health system, limited and disjointed access to Mental Health & Addiction (MH&A) services was detrimental to the health of our patients. The disparate MH&A services did not have a communication roadmap. Patients struggled to navigate and access programs and received inconsistent information. The system lacked cross-clinic scheduling and handoffs were confusing.

INNOVATION

We partnered with a sophisticated health care contact center to create a dedicated MH&A Connection line for patients, providers, and community to facilitate access. It aggregates all disparate service sites into a centralized resource, providing 24/7 access for patients and clinical teams. The contact center team acts as a navigator service, provides general information, schedules appointments, and makes connections with clinical resources for patients with all levels of MH&A acuity and in all stages of condition management.

IMPROVING HEALTH

- Enables resource identification, care coordination, and information dissemination through a single integrated point of contact for MH&A services.
- Provides 24/7/365 real-time access to align assistance at time of need.
- Supports clinician-to-clinician patient assessment.
- Enhances care navigation at ED discharge.

ENHANCING PATIENT EXPERIENCE

- Phones are answered and coordinated information is available for optimal single-call resolution.
- Entire system collaborated on patient service standards and process workflows that set the stage for a consistent patient experience across all of the organization's MH&A services.
- 90 percent of calls answered within 45 seconds.

TAKING AIM AT AFFORDABILITY

- Decreased use of ED beds entirely due to proper resource triaging and management of MH&A patients.
- Increased productivity of service line leaders as centralization limits the escalation issues created by lack of information.
- A single access point allows for more robust analytics. This results in greater service design and implementation.

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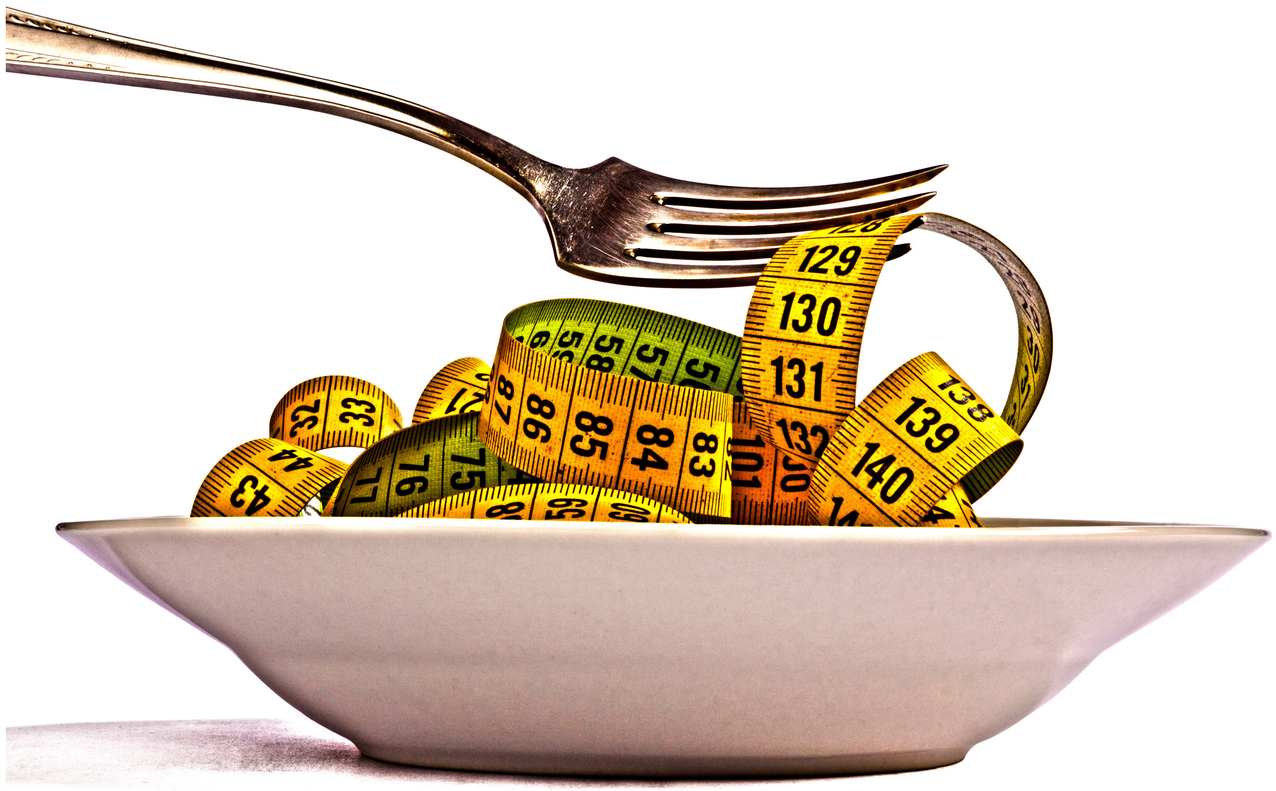

Accelerated Refeeding

· INNOVATION ·

PARTNERS IN EXCELLENCE

Melrose Center

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Park Nicollet Melrose Center

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CHALLENGE

Melrose Center had the same patient refeeding process for more than 10 years, with no formal protocol. The process focused on weight restoration of 2 to 3 pounds per week while in Intensive Residential (IRes) and Residential (Res), and approximately 2 pounds per week in the Partial Hospitalization Program (PHP). No guidelines had been established in literature to identify a recommended rate of weight restoration for adult patients with Anorexia Nervosa and OSFED diagnoses.

A 2015 study* looking at refeeding and weight restoration outcomes in anorexia nervosa found that a patient's weight can be restored at a rate of 4.3 pounds per week in an inpatient unit and 2.99 pounds per week in PHP on average. The study found that an increased rate of weight restoration decreased length of stay and increased patient satisfaction. The study found no medical contraindications to the increased rate of refeeding.

INNOVATION

We created and implemented an accelerated refeeding protocol for patients admitted to IRes and Res programs at Melrose Center. Through this protocol project we:

- Standardized caloric meal plan increases and micronutrient composition.
- Developed a lab protocol and Epic SmartSets to ensure patient safety during refeeding.
- Created a Best Practice Alert (BPA) to alert all staff when a patient is on the protocol.
- Incorporated existing outcome measures into the protocol to track depression, anxiety and eating disorder symptoms.
- Developed additional family education and meal opportunities.

IMPROVING HEALTH

- Rate of inpatient weight restoration predicts better outcomes.
- Depression/anxiety and cognitive impairments improve with restored weight.

ENHANCING PATIENT EXPERIENCE

- Accelerated refeeding results in fewer re-admissions.
- Reduced trepidation for patients over increases in meal plan.
- Enhanced family education and training.

TAKING AIM AT AFFORDABILITY

- Reduced admissions to IRes leading to reduction in cost of care.

*Redgrave, G. W., Coughlin, J. W., Schreyer, C. C., Martin, L. M., Leonpacher, A. K., Seide, M., . . . Guarda, A. S. (2015). Refeeding and weight restoration outcomes in anorexia nervosa: Challenging current guidelines. International Journal of Eating Disorders.

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Improving the Value of Depression Care with Systematic Outreach

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Park Nicollet Health Services

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CHALLENGE

Depression is a serious condition, affecting 17 percent of all adults nationwide. If left untreated, it can lead to major depressive episodes leaving the individual feeling helpless and hopeless for months or even years. This high risk population requires a comprehensive approach to detect and effectively treat this major debilitating disease, which is associated with significantly higher health care utilization and costs. In Minnesota, the remission rate for depression as measured by Minnesota Community Measurement at six months is 8 percent.

INNOVATION

We developed and implemented tools and processes for patients with depression, starting with correctly identifying high-risk patients and their remission windows. We then provide personalized "high touch" care team outreach during the patient's individual remission windows. We added three-month and twelve-month outreach contacts to the standard six-month outreach, and we improved care team communication and care coordination by adding treatment plan updates to Epic.

IMPROVING HEALTH

- Increased standardized symptom assessment and monitoring.
- Patients have timely care and treatment.
- Patients have less time with depression symptoms.
- Increased likelihood for patients to reach full remission.

ENHANCING PATIENT EXPERIENCE

- Patient partners' first-hand knowledge used to enhance team empathy and understanding to better meet the needs and priorities of our patients.
- Meets patients where they are at by using their preferred mode of communication.
- Decreases stigma and fosters care of the whole person.
- Provides consistent care through care teams guiding ("quarterbacking") across medical and behavioral health needs.

TAKING AIM AT AFFORDABILITY

- Fourteen percent increase in our major depression remission rate, resulting in 18 percent remission at six months overall – twice that of the state average.
- Anticipate 9 to 16-percent savings achieved through effective integration of Behavioral Health and Primary Care.
- Increased outpatient contact and management to reduce emergency department visits and hospital admissions.

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Collaborating with Patients to Establish Care with a Primary Care Provider

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CHALLENGE

Research shows that patients with an established Primary Care provider have better overall health outcomes and are more likely to receive preventive services. In 2012, internal measures showed 24 percent of patients seen at Park Nicollet either had no one listed in the Primary Care Provider field of the electronic medical record or had a generic non-provider identifier within the Primary Care Provider field.

INNOVATION

Created in 2013, the Clinician Finder Team assists patients in finding a Primary Care provider. The Clinician Finder Team's main focus is to contact patients without an identified Primary Care Provider, share the importance of having a Primary Care Provider, and assist patients with scheduling a visit with the right provider for them. Park Nicollet also developed an identifier in the electronic medical record to help flag patients for outreach.

IMPROVING HEALTH

- Patients identified as needing a Primary Care provider are contacted to help them receive appropriate care.
- Building relationships with a Primary Care provider promotes management of chronic conditions, increased access to preventive services, coordination of care, and collaboration with other healthcare resources.

ENHANCING PATIENT EXPERIENCE

- Created pamphlet to increase patient awareness of the importance of having a primary care provider.
- Attributed over 72,000 patients to a Primary Care Provider in less than four years.
- Developed process with the Hospital Unit Coordinators to contact the Clinician Finder Department at the time of hospital discharge for patients without a Primary Care Provider.
- Created partnership with OB/GYN department to assist expecting mothers to establish care with a pediatrician.

TAKING AIM AT AFFORDABILITY

- Standardized process and consolidated resources to a specific group, removing work from others and enabling them to focus on their true tasks.
- Helped to close gaps in care and improve quality metrics.

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Transforming Care for Medically Complex Children

· INNOVATION ·

PARTNERS IN EXCELLENCE

MAYO CLINIC

PROVIDER

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CHALLENGE

Pediatric patients with feeding and swallowing disorders secondary to a wide variety of etiologies did not always experience an efficient, organized, or consistent system of care delivery. Children entered through different departments and, depending on whom they saw, received disparate evaluations and varied treatment recommendations. Care at times was disjointed and suboptimal. Multispecialty evaluations could take months to complete.

INNOVATION

Physicians launched a multispecialty project to completely redesign the practice model and improve the evaluation and treatment of children with feeding and swallowing disorders. Through the assistance of an internal health care systems engineering analyst, multiple workgroups formed to focus on specific aspects of the redesigned practice (e.g. intake and triage, scheduling, clinical algorithms, care coordination). The overarching goal was to create a seamless, coordinated, thorough, consistent and efficient multispecialty aerodigestive program using a pediatric and family centered approach.

IMPROVING HEALTH

- Established best practice guidelines.
- Improved communication with a weekly multi-disciplinary care conference.
- Reduced variation in care with multiple subspecialties involved.

ENHANCING PATIENT EXPERIENCE

- Reduced itinerary (three to five days) for comprehensive diagnostic evaluation.
- Access to the entire team of clinicians within two to three weeks versus three to six months prior to the start of the project.
- More than ninety percent of patient families surveyed believed treatment goals were met and would recommend this clinic.
- Satisfaction was due to communication with team, appointment access, RN Care Coordinator as a point of contact, and communication for transition with primary care provider and/or referring provider.

TAKING AIM AT AFFORDABILITY

- Practice standardization decreases unnecessary care variation and reduces costs.
- Developed clear and agreed-upon referral guidelines for all points of access.
- Reduced anesthetic exposures by 50 percent by coordinating OR procedures and testing.

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