

Blueprint

IN THIS ISSUE

A WORD WITH JIM TALLON

What we mean when we say “patient engagement”—and what myths we can lay to rest. PAGE 3

GRANT SPOTLIGHT

Promoting stronger partnerships with family caregivers at 21 hospitals across New York City. PAGE 4

CLINICAL QUALITY FELLOWS

Successful and practical projects by Quality Fellows are spreading to other departments of their home hospitals. PAGE 5

FAMILY CAREGIVING

Helping realize the CARE Act’s potential, with guidance for patients, providers, and families. PAGE 5

TRUSTEES HONORED

UHF’s annual tribute honors 28 hospital trustees for their dedication and leadership. PAGE 6



INSURANCE UPDATE

Sustaining New York’s efforts to keep individual insurance affordable. PAGE 7

HOME CARE

Helping reduce central line infections in the home care setting. PAGE 7

ON THE CALENDAR

OFF THE PRESS
ON THE WEB
PAGE 8

Managing Mental Health: A New Essential for Primary Care

It’s a double-whammy familiar to many—depression, anxiety, and other common behavioral health issues have a profound effect on patients’ physical health and quality of life, especially in people with chronic illness. Yet these conditions are vastly underdiagnosed and undertreated. A growing body of evidence, however, shows that successful identification and treatment can be provided or facilitated as part of primary care.

Integrating physical and behavioral health care is now acknowledged as an essential capability of what are known as patient-centered medical homes and advanced primary care. It is, in fact, a major goal of New York State’s health care reform efforts and the only objective included among the projects selected by every one of New York’s 25 Performing Provider Systems—the collaborative groups carrying out the State’s Delivery System Reform Incentive Payment (DSRIP) Medicaid transformation effort.

For the past four years United Hospital Fund has been working on several fronts to help bring behavioral health care into primary care practices across New York City, not only among the large practices and organized systems where it has begun to take root but also in the small and medium-size practices that treat many New Yorkers.

“About 20 percent of New Yorkers have symptoms of a behavioral health disorder, often depression or anxiety, but fewer than a quarter of them receive treatment from a mental health specialist,” says Andrea Cohen, UHF senior vice president for program. “We know that even when their primary care providers identify their conditions and refer them to specialty care, many patients



don’t follow through, whether they feel there’s still a stigma to seeking mental health care, it’s inconvenient or they have cost concerns, or they’d prefer treatment from someone with whom they already have a relationship. The toll of untreated depression and anxiety is high, though: increased risk of serious illness and worse outcomes, decreased quality of life, and higher health care costs. Those add up to a clear case for increasing the ability of primary care practices to systematically diagnose and treat or assertively manage the care of behavioral conditions.”

SCALING DOWN TO SCALE UP

That’s not easy, particularly for smaller practices. In New York City, 40 percent of primary care providers are in sites with five or fewer clinicians; many of those practices are unlikely to have sufficient funds or space to bring a behavioral health specialist on board. With UHF grant support, a practical new guide, featuring a “framework” for moving through the integration process, has been created to help. “The framework is flexible enough to work with a range of practices, and powerful enough that any practice can follow it and make thoughtful

continued on page 2

Managing Mental Health *(continued from page 1)*

progress,” says Henry Chung, MD, vice president of the Montefiore Care Management Organization, medical director of Montefiore’s Accountable Care Organization, and professor of clinical psychiatry at Albert Einstein College of Medicine. Dr. Chung and Harold Alan Pincus, MD, of Columbia University and NewYork-Presbyterian Hospital’s Department of Psychiatry, led the project.

The new guide—*Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework*, available at www.uhfnyc.org—delineates the specific steps to integrating behavioral health into primary care, identifying preliminary, intermediate, and advanced stages of eight different components of practice integration, such as case finding and screening, ongoing management of evidence-based care, and proactive follow-up and engagement of patients.

The steps range from the most basic, such as identifying symptomatic patients one at a time, to the most advanced—population-wide outreach, screening, engagement, and follow-up, for example. Practices can move through the steps of the various domains at different rates rather than aiming for one standard of achievement across all domains.

That makes for an important difference between this approach and “collaborative care,” the evidence-based model that is the standard for integrating behavioral and primary care. Collaborative care is best suited to organizations—large hospital-based practices, for example—with the scale, size, and infrastructure that facilitate the addition of new staff and technology. “That’s too high a bar for many practices,” says Gregory C. Burke, director of innovation strategies at UHF. “This framework breaks the process into manageable pieces, using ongoing performance improvement. Recognizing that complete integration won’t be a realistic goal for *all* practices, it allows for intermediate steps that will still make a positive difference in patients’ lives.”

CHALLENGES REMAIN

Still, integrating behavioral and medical care is not without challenges. “This kind of transformation

requires a fundamental change in practice culture,” notes Dr. Chung. Limited resources—technological, human, and financial—and regulatory issues pose significant barriers as well. The investment required for improved health information systems or additional staff may well be a make-or-break factor for many practices.

“If you’re using fee-for-service payments, taking on more responsibilities and spending more time on non-revenue-producing activities are going to hurt the economics of the practice,” says Mr. Burke. “Value-based payment makes up for that once integration is well established and a practice is demonstrating improved depression scores or reduced utilization costs, but that generally takes one or two, even three years. Our payment system somehow needs to recognize and ameliorate that.”

A PART OF BROADER REFORM

The framework—which will be widely distributed, and fine-tuned as users gain experience with it—has roots in a 2013 roundtable co-sponsored by UHF at the request of the State’s commissioners of Health and Mental Health. Bringing together a broad range of stakeholders, the roundtable explored ways to make behavioral health an integral part of advanced primary care.

UHF work is also informing the City’s broad new THRIVE mental health initiative, as it prepares to train a corps of recent social work graduates to provide behavioral health services within primary care practices, and as it launches a major effort to diagnose and treat the post-partum depression common among low-income women.

“This heightened attention to the role of mental health in overall health and well-being—and to making behavioral health care more accessible and acceptable—is critical to the success of the integrated, team-based approach that is the linchpin of a more effective health care system,” says Jim Tallon, president of UHF. “We’re gratified that we’re helping develop and spread practical, effective tools like the framework that will, ultimately, improve the lives of millions of New Yorkers.”

Blueprint

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United Hospital Fund is an independent, nonprofit organization working to build a more effective health care system for every New Yorker.

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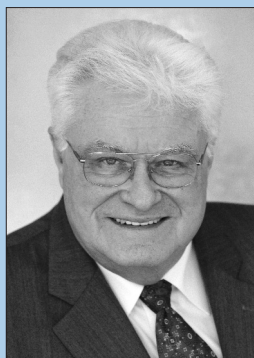
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A Word...

WITH JIM TALLON

Keeping Patient Engagement Relevant



There's general agreement in health policy circles that over the next five years the growing emphasis on patients understanding our health care system

and taking an active role in it will continue to gain in importance. Yet our ability to detail the responsibilities that "patient engagement" implies remains elusive.

In part that's a reflection of the quality of debate on the future of health care—whether it, and we, are mature enough to overcome ideological differences and grapple with pressing challenges. And in part it's a reluctance to let go of some of the givens of an earlier health care age, like the need for "skin in the game."

Those underlying assumptions still hold power, but the changing structure of health care is making them less meaningful, even as we call for patients to be active, informed consumers. If we are to truly embrace patient engagement as a worthy goal, we need to understand how entwined the concept is with four of the major challenges of health care today.

NEW STRUCTURES, NEW DEMANDS

The first challenge is maintaining the momentum we've gained—some 20 million people's worth—toward health insurance coverage for all. This means continuing to strengthen the public programs, Medicaid particularly, that in many states have created almost universal coverage for the economically disadvantaged. It also means continuing support for employer-based health insurance, through tax incentives and

regulatory standards. Equally important, we must maintain large health insurance pools in which risk is not segmented, recognizing that most people's health status and health care costs vary over time. All three of these elements are at the core of the Affordable Care Act, and critical to the effective operation of health care. Simultaneously, we must weigh and balance patients' cost-sharing and their ability to utilize covered services, to ensure that an economic stake in the system doesn't lead to self-rationing of needed care or unsustainable debt.

A second essential is virtually unlimited information flow. We've tended, traditionally, to prioritize privacy, and surely

Integral to value-based payment is provider understanding of what patients find most meaningful—the "measures that matter."

any of our modern information transfer systems needs to ensure adequate security. But enabling the highest-quality care requires that information be effectively communicated: electronic health records are a vital tool but the actual sharing of the information they contain is the essential, and trickier, element—one to which both patients and providers must be committed.

Third, expanded primary care is a basic building block of a successfully operating health care system. The traditional doctor's visit, 15 minutes of one-on-one time, is giving way to a relationship with a team-based practice supported by electronic records and open communication. Instead of relying on patients to make an appointment, these practices are taking responsibility for reaching out to patients

who will benefit from a checkup or test or intervention; additionally, the historical chasm between physical and mental health care is being bridged, as behavioral health diagnosis and interventions are being offered in the primary care setting.

Fourth, primary care practices are increasingly being linked with other organizations in integrated networks buoyed not by fee-for-service payments based on type and volume of care provided but by value-based payments grounded in the quality of care and outcomes achieved. Integral to this evolution is patients' understanding of how quality is judged, and that individual performance—"the best doctor"—is subsidiary to how complex parts of an organization work together. Providers, for their part, need to understand what is most meaningful to patients. For both of those goals, reducing the huge volume of current quality assessments and focusing on "measures that matter" is urgent.

RETHINKING OLD MYTHS

It wasn't long ago that "patient engagement" was often little more than "consumer-directed health care," essentially the idea that increased out-of-pocket costs yielded better consumers. Today, we are more likely to see that as last-generation mythology, less relevant as new policies and practices reshape health care. The four issues above are among the most serious we face, yet with the exception of insurance coverage they are not, largely, within the scope of serious public debate. It is vital that we make certain they are, to propel a vision of individuals interacting with the health care system in working relationships based on open communication and informed judgment.

GRANT SPOTLIGHT

Embracing Patients' Families as Partners, Not Visitors

A family member at a hospital patient's bedside can do much more than lift spirits and lessen anxiety. A growing body of evidence shows that the presence of a family caregiver or other support person can have a significant impact on quality and safety, by helping the patient monitor care, understand instructions, and ask vital questions about treatments, medications, and discharge plans.

Embracing families as partners and not merely visitors is the driving force behind a new project, supported with an \$80,000 United Hospital Fund grant, in which 21 hospitals across New York City are considering broader visiting or family presence policies and promoting stronger partnerships with caregivers.

"We are thrilled that so many hospitals are participating in this pilot project aimed at changing the perception of families from visitors to partners," says Beverley Johnson, president and CEO of the Bethesda, Maryland-based Institute for Patient- and Family-Centered Care (IPFCC), who is co-leading the project with Chris Meyer, board officer and project advisor for New Yorkers for Patient and Family Empowerment.

POLICY CHANGE AS POSITIVE FORCE

"Multidisciplinary teams from each participating hospital—administrators, nursing leaders, social workers, and other staff—are coming together," Ms. Johnson says, "to explore changes in policy and practice that will promote families as integral members of the care team."

The project is encouraging hospitals to consider that less restrictive visiting

policies need not be at odds with priorities like hospital security, infection control, and manageable staff workloads—and that closer collaboration with families has great potential to improve patient safety, and patient, family, and staff satisfaction.

The project kicked off in March with an all-day learning collaborative focused on strategies for evaluating current policies and practices, making specific changes that better promote family presence and

"We hear it all the time: 'She's not a visitor, she's my wife!'" says project co-leader Chris Meyer. "For patients, family caregivers are extensions of themselves."

participation, and acknowledging and addressing staff concerns. Speakers included an administrator from a Maryland hospital that provides 24/7 access and engages families as valuable assets in care.

After completing self-assessments of their current policies and practices, participants will devise tailored action plans that will include identifying specific policy and practice changes aimed at enhancing partnerships with families.

All participants have access to IPFCC's extensive toolkit of resources, including videos on how different hospitals implemented changes to policies and practices, presentations for hospital staff, sample policies and guidelines, and more.



Reconsidering visiting policies to promote stronger partnerships with family caregivers is the goal of a new UHF-funded project.

Project leaders will conduct five bimonthly coaching calls, ending in February of 2017, in which hospital teams can discuss their experience and progress, receive guidance on dealing with challenges, and share successful approaches.

ASSESSING CHANGE

Progress will be measured through several strategies. Hospitals will compare their pre-project self-assessment with a post-project assessment to chart their progress toward meaningful, sustainable change. New Yorkers for Patient and Family Empowerment will produce an updated version of a survey that will allow comparisons of, among other things, changes in the publicly posted visiting policies of participating hospitals over the course of the project—and among those that did *not* participate. IPFCC will also post new guidance on its website to help other hospitals duplicate the process.

"This project syncs well with UHF's long-standing emphasis on supporting and involving family caregivers, and building a more patient- and family-centered health system," says UHF President Jim Tallon. "It's challenging and sensitive work, but the ultimate goal is a worthy, essential one."

Quality Fellows Use New Skills to Improve Patient Care

Helping children with sickle cell disease in the ED get needed pain medication quickly. Decreasing the time it takes for admitted patients to move from the emergency department to a patient floor. Creating real-time alerts to address urgent inpatient needs. Reducing physician errors in the electronic entry of patient medication orders.

These are just some of the improvements successfully established by recent graduates of the United Hospital Fund and Greater New York Hospital Association Clinical Quality Fellowship Program, who completed an intensive 15-month program to learn proven techniques to advance quality and patient safety programs in their hospitals. The fellows and their Capstone projects were celebrated and featured at a culminating meeting and dinner at United Hospital

Fund on April 14. The program's seventh class—sixteen physicians and four nurses—were joined by the program's volunteer faculty, program alumni, members of the 2016–2017 class, and other leaders from the graduates' hospitals.

"This program provides uniquely practical training in quality improvement, which is challenging to find elsewhere," noted Rohit Bhalla, MD, MPH, vice president and chief quality officer at Stamford Health and the fellowship program's chair. Since it began, he said, "more than 125 projects have been generated by the program's 125 graduates—125 bursts of positive energy and creative thinking to address real-world health care challenges." Dr. Bhalla also acknowledged the commitment of program



At right, Amrite Gupte, MD, MPH, with her diploma from the program, with Hillary Jalon of UHF, Lorraine Ryan of Greater New York Hospital Association, and Rohit Bhalla, MD, MPH, of Stamford Health.

faculty, who have generously given their time and energy to shape the program.

"This class's capstone projects tackled important issues of today, ranging from handoffs in care transitions to innovation using information technology to improving the patient experience," said Hillary Jalon, director of quality improvement at United Hospital Fund. "Many have been so successful, they've already spread to other parts of the hospital."

UHF Finds Opportunity in New York's CARE Act

When United Hospital Fund launched its Families and Health Care Project in 1996, family caregivers were largely invisible. Times have changed, and one indication is New York State's Caregiver Advise, Record, Enable Act—more commonly called the CARE Act—which went into effect on April 23.

The CARE Act, a version of which has been enacted in 25 states, is intended to ensure that family caregivers receive the training they need to provide post-discharge care to patients. It requires hospitals to ask patients on or shortly after admission if they wish to designate a caregiver with whom information and

training about the patient's care plan can be shared. If a caregiver is named by the patient, the caregiver's name is entered in the medical record. The patient is also asked to sign a consent form to allow hospital staff to work with the caregiver.

While the CARE Act is designed to address gaps in transitions from hospital to home, many specific questions will arise in implementing its requirements. For example, what should a hospital do when a patient refuses to name a caregiver but clearly will need help at home?

Taking the lead on responding to the anticipated challenges, UHF is developing materials to help patients, family

caregivers, and hospital staff understand the law and ensure that it is implemented effectively. With information from interviews of hospital staff, community-based organization representatives, and patients and family caregivers, new guides for patients and family caregivers will be available on UHF's Next Step in Care website later this year. The website will also offer a separate toolkit for health care providers.

"The CARE Act is a response to the report UHF published with AARP Public Policy Institute, *Home Alone: Family Caregivers Providing Complex Chronic Care*," said Carol Levine, director of the Families and Health Care Project. "We see this as another opportunity to support more constructive relationships between family caregivers and health care providers."

Honoring Hospital Trustees' Service and Leadership

Saluting their vital contributions to their hospitals and communities, UHF honored 28 exemplary volunteer leaders at its annual Tribute to Hospital Trustees on May 9. The event brought together more than 600 health care, community, and business leaders, colleagues, family members, and friends, to celebrate the extraordinary service of the honorees, nominated by hospitals throughout New York City, Nassau and Suffolk counties, the Hudson Valley, and nearby Connecticut and New Jersey.

“As health care trustees you play a key role not only in the governance of your institutions,” UHF President Jim Tallon noted, “but also in how your institutions participate in the system-wide trends transforming health care.” The chances for real progress are good, he continued, “in part because

of the dedication of leaders like you.”

Supporting UHF’s work to advance just such positive change, the TD Charitable Foundation provided underwriting support for the event for the 12th consecutive year. Greg Braca, head of U.S. corporate and specialty banking, and Peter Meyer, president, New York City market, led a group of executives from the Foundation and bank.

Co-chairing the luncheon were Steven Hochberg, senior vice chairman of Mount Sinai Health System, and Howard Milstein, longtime Weill Cornell Medicine trustee and a member of the UHF board. Greater New York Hospital Association President Ken Raske was event vice chairman, and GNYHA Ventures President Lee Perlman chaired the journal.



Top: UHF Board Chairman J. Barclay Collins II and President Jim Tallon, with Luncheon Co-Chairman Steven Hochberg. Bottom: Journal Chairman Lee Perlman, TD Bank’s Greg Braca, and UHF Senior Vice President Sally Rogers.

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Recent UHF Grant

LEGAL ACTION CENTER (LAC) \$60,000

People involved in the criminal justice system— in prison, awaiting trial, or on probation—are seven times more likely than the general population to experience mental illness, substance abuse disorders, and other chronic conditions. Without Medicaid or other insurance once back in the community, they are at high risk. LAC has been working to create new models for enrolling this population into Medicaid and facilitating immediate access to health care upon re-entry; it will now develop and disseminate two guides examining progress and challenges to effective reforms related to providing insurance and creating linkages to health care services, for use by State and local health and criminal justice agencies, policymakers, and practitioners.

For additional information: www.uhfnyc.org/grants

Keeping Insurance Coverage Within Individuals' Reach

Before the rollout of the Affordable Care Act in 2013, a New Yorker trying to purchase health insurance on the individual market faced monthly premiums that were generally more than \$1,000—unaffordable for most. By 2014, however, a range of new programs and substantially increased enrollment resulted in an average individual New York monthly premium of \$430, along with drops in health plans' medical expenses on a per-member-per-month basis.

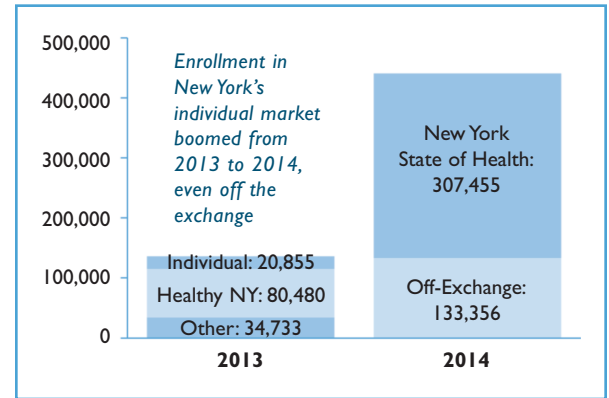
How did New York resuscitate its individual market? In a new UHF “snapshot” report, *Affordable Care Act Brings New Life—and Covered Lives—to New York's Individual Market*, Peter Newell, director of UHF's Health Insurance Project, and Nikhita Thaper, a

research assistant at UHF, explore what it took.

A major factor was the big jump in enrollment, from 136,000 in 2013 to over 440,000 in 2014. Most of that growth was new enrollment in Qualified Health Plans through the state's health insurance exchange. But even in the off-exchange individual market, where no premium or cost-sharing subsidies were available, enrollment boomed.

And that counteracted the vicious cycle that had hurt the individual market for years: the small number of enrollees tended to be the sickest, which drove premium prices up, in turn making coverage difficult to afford and concentrated among an ever-smaller group with more expensive health care needs.

New York addressed this persistent problem with a wide range of policy tools, subsidies, and tax credits made possible by the ACA.



The report notes that while New York's individual health insurance market is much improved, it is not out of the woods yet: sustaining that improvement requires continued action by the State and by health plans to keep the market's risk pool stable, to expand coverage to those still uninsured, and—especially—to keep premiums affordable. Among possible ways to do that: controlling costs through value-based payment arrangements, figuring out ways to keep prescription drug costs down, and, potentially, strategic use of new federal waiver authorities.

A Toolkit that Helps Make Home Care Safer

Advances in medicine now allow patients to be discharged from hospital to home while they are still receiving care through a “central line”—an intravascular catheter that is used for administration of intravenous medications, fluids, blood products, and nutrition, among other treatments including chemotherapy. While most patients are happy to be home, there's nevertheless a major safety concern.

Central lines are a frequent source of infections that can be life-threatening.

Such infections have long been a challenge in hospitals, but efforts in hospitals—including those led by United Hospital Fund and Greater New York Hospital Association—have helped reduce the incidence of such infections by nearly half nationwide. Yet home care providers have not generally participated in the quality improvement efforts, leaving home care patients at greater risk.

To address the problem, a new toolkit has been produced, offering practical approaches and tools for home care professionals and hospital acute care providers to systematically assess risks and reduce the incidence of central line-associated bloodstream infections. The result of collaborative work between United Hospital Fund and two UHF grant

recipients, Montefiore Health System and Northwell Health, the toolkit fills a void for home care providers.

“We wanted to provide a basic framework that can be customized to meet the needs of home care agencies regardless of size, patient population, or staffing model,” said Hillary Jalon, director of quality improvement at UHF. “We are hopeful that our toolkit will receive positive feedback because of its practical strategies and recommendations, as well as the concrete tools and resources included in it. And every infection prevented is a potential life saved.”

Preventing Central Line-Associated Bloodstream Infection (CLABSI) in the Home Care Setting is available from UHF's website.



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ON THE CALENDAR

JULY 14

UHF's annual Medicaid conference, with keynote by Jason Helgerson, New York State Medicaid director and Office of Health Insurance programs deputy commissioner. New York Academy of Medicine

SEPTEMBER 26

United Hospital Fund Gala, presenting the Health Care Leadership and Distinguished Community Service Awards, and a special tribute. The Waldorf-Astoria

NOVEMBER 15

The 27th annual Symposium on Health Care Services in New York: Research and Practice, addressing critical health care delivery issues and current research, practice, and policy advances. New York City location TBA

OFF THE PRESS

You Get What You Pay for: Measuring Quality in Value-Based Payment for Children's Health Care examines the quality measures and outcomes that could be used in value-based payment arrangements for children's health care in New York—a key component of the State's health care payment reform efforts.

Preventing Central Line-Associated Bloodstream Infection (CLABSI) in the Home Care Setting is a toolkit that offers practical approaches and tools for home care professionals and hospital acute care providers to assess risks and reduce the incidence of infections in patients receiving home health care services.

Affordable Care Act Brings New Life—and Covered Lives—to New York's Individual Market looks closely at the successful steps New York took to improve its individual health insurance market, and considers how to sustain that improvement.

These and other UHF reports are available at www.uhfnyc.org.

ON THE WEB

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