Dennis O’Connor, MD
Family Medicine

Sue Sutherland, RN
Care Manager

Keuka Family Practice Associates
Accountable Health Partners
7573 State Route 54, Bath, NY

Practice Baseline

Practice Description	Physician Group
Number of Annual Patients	7,000
Number of PCP and BH Providers	3.0 FTE, Family Practice PCP 2.0 FTE, Nurse Practitioners 1.0 FTE, Physician Assistant 1.0 FTE, Care Manager 0.25 FTE, Social Worker
Payer Mix	40% Medicaid Managed Care 15% Commercial Health Insurance 10% each: Medicare FFS, Medicaid FFS, Medicaid Advantage, and Self-Paying or Uninsured 5% Other Governmental Programs
Ethnicity	90% White 5% Black or African American 5% Asian or Pacific Islander *5% Latino/Hispanic, of total population*

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Project Motivations

1. Patients with BH needs will have better care.

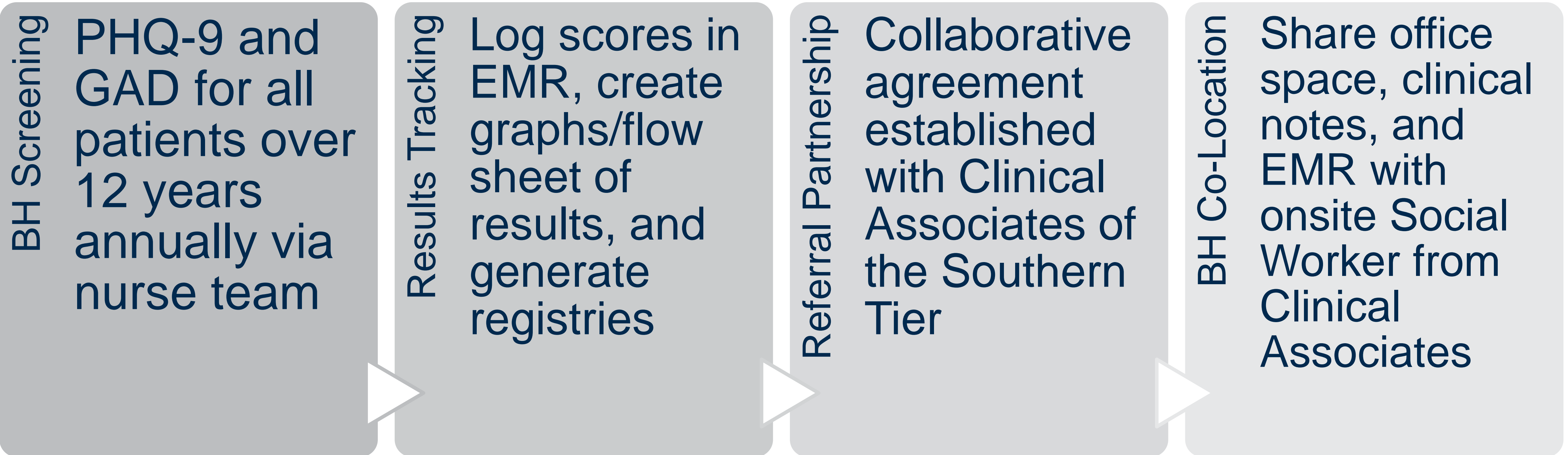
2. Clinic staff will achieve excellence in BH service delivery.

3. The practice will become more efficient and effective in delivering primary care.

Target Domains Progress

Domains Targeted in Continuum Framework			
#	**Domain**	**State at start of project**	**Six-Month Goal State: April - September '17**
1	Case finding, Screening, and Referral to Care		
1.1	Screening, initial assessment, and follow up	Intermediate	Intermediate
1.2	Referral facilitation and tracking	Intermediate	Advanced
2	Multi-Disciplinary Team (including patients) Used to Provide Care	Intermediate	Intermediate II
3	Ongoing Care Management	Intermediate	Intermediate II
7	Information Tracking and Exchange among Providers	Intermediate	Advanced

Workflow and Referral Partnerships



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Value of Onsite Care Manager: Sue Sutherland, RN

- Essential Team Member
- Manages patients with chronic illness and/or BH issues
- Maintains close follow up
- Provides patient education
- Accesses community services

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Case Study: *41 year old female with multiple co-morbidities*

Patient History

- Recurrent major depression episodes, PTSD, bipolar, anxiety, mood disorder, morbid obesity, type 2 diabetes
- Patient homeless & her HHA's quit
- Burned bridges with previous supports
- A lot of people were working with her, but no coordination or information sharing

Care Management Plan

- Coordinated care & enrolled in a MLTCP
- Regular follow-ups with care team
- Enrolled in medical adult day care program
- Provide self-management educational support
- Assisted with finding appropriate housing

Identified Challenges

- Some screening and BH care is lost when things get really busy
  - Hired new NP and LPN, so this should ease the problem over time

- Compensating providers, nurses, and really all staff for value; not just per visit.

- Still difficult to provide BH care for children
  - Clinical Social Worker doesn't see kids in her practice

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