



Pledge to Connect

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ISSUE

Individuals with behavioral health issues often seek care from the emergency department (ED) due to challenges finding and maintaining outpatient mental health services. In addition, once they have been discharged from the ED, they can face multiple barriers accessing follow-up care (Walker et al., 2021).

PROJECT GOAL

Improve access to outpatient behavioral health services for individuals who are seeking care from an ED, with the longer-term goal of ensuring access is available before an emergency visit occurs.

Background

In the fall of 2020, Oaks Integrated Care (Oaks) launched a new Certified Community Behavioral Health Clinic (CCBHC) in Camden County and began conversations with local EDs about how to work together to support individuals who were overutilizing acute behavioral and physical healthcare resources. Simultaneously, the Camden Coalition was meeting with hospital and community-based partners to understand how lessons learned from

its [7-Day Pledge initiative](#) — which connected Medicaid patients recently discharged from the hospital to a follow-up appointment with a primary care physician within seven days — could be applied to the behavioral health space. Together, Oaks and the Camden Coalition recognized their shared goals and worked together to form a collaborative partnership with Cooper University Health Care and Virtua Health System to attempt to address these critical needs of the community.



This new collaboration came in the wake of the establishment of New Jersey's Quality Improvement Program - New Jersey (QIP-NJ; New Jersey Department of Health: Public Consulting Group, 2022). QIP-NJ is a Medicaid-funded initiative to improve performance in maternal care and behavioral health processes and services by making all acute care hospitals in the state eligible for QIP-NJ performance payments through the achievement of performance targets on certain state-selected quality measures such as improvements to connections to behavioral health services, and reductions in potentially preventable utilization for the behavior health population.

Project design

In spring of 2021, the joint Pledge to Connect team, composed of staff from the Camden Coalition, Oaks, and Cooper, designed and launched two new service pathways (“high acuity” and “low acuity”) to connect patients who have behavioral health needs and seek help at Cooper’s ED — but do not

meet criteria for inpatient admission — to outpatient follow-up care. “High acuity” patients have more severe and persistent mental illness, and present to the ED for an acute mental health crisis. They also have complex social barriers. “Low acuity” patients have less social complexity and/or mental health concerns of mild to moderate severity.

The two different pathways provide a higher-touch model for “high acuity” patients who are in more immediate need of services. For “low acuity” patients, the focus is on connecting them to follow-up services after they leave the ED. This bifurcated process allows for more effective utilization of resources, with patients being routed to the appropriate level and types of services more quickly.

The “high acuity pathway” employs a face-to-face model, in which members of Oaks’ CCBHC case management staff are embedded in the Cooper ED to support discharge-planning and next steps for patients with more acute behavioral health needs and social barriers. Once individuals are identified by ED psychiatry or medical staff, Oaks



team members provide bedside intervention in the ED, and then continue to provide ongoing community-based supports, such as linking individuals to the Board of Social Services, emergency housing, ongoing behavioral health treatment and support, substance use treatment, and/or food resources. In addition to connecting individuals to outpatient services within their institution, the Oaks' CCBHC case management team also helps re-connect individuals to other behavioral health agencies if they have a pre-existing relationship.

“Low-acuity” patients are automatically referred to the Camden Coalition for telephonic follow-up post ED discharge. During telephonic outreach, the Camden Coalition’s behavioral health community health workers check on how the individual is doing and offer to help them connect to appropriate discharge appointments such as behavioral health, primary care, and/or referrals to social service resources. In addition, during these calls, the Camden Coalition behavioral health navigators collect patient feedback

about their experience within the ED to report back to Cooper.

The referral process is facilitated by the [Camden Coalition Health Information Exchange](#) (HIE), which receives real-time admission, discharge and transfer data (ADT) from area hospitals. With patient consent, the Camden Coalition HIE provides a two-way flow of patient care information between the community providers, which is also available to ED staff. As referrals are sent and received, community partners can view and update outreach attempts, outpatient discharge plans, and follow-up appointments. It also allows for all partners to access pertinent medical, behavioral health, and social information to assist with decision-making.

This design, combined with the relationship-building focus within the high-acuity workflows, is built to form therapeutic alliances which have shown to increase participant activation and engagement (Allen et al, 2017).

Another crucial aspect of the program’s development is community involvement. Beyond the individuals being



connected in the ED or over the phone, the Pledge to Connect team engages other community members with lived experience as members of the team, who play an integral role in building out programs. Two peer liaisons, both of whom have gone through the behavioral health system and experienced its various challenges, attend monthly meetings with the Pledge to Connect team to provide valuable insight on their experiences in the ED, on how care can shift to be more trauma-informed and person-centered, and how the information on our pathways to access behavioral health resources can be shared with the community at large.

Progress to date

So far, much of the program's early success is based on frequent communication and collaboration between partners. Monthly meetings between Pledge to Connect team members from Oaks, Cooper University, and the Camden Coalition provide regular opportunities to work through referral challenges and find ways to improve services. In addition, there is

real-time communication between partners to ensure the steady flow of referrals, appropriate triage, and address any issues with the ED that individuals share during calls with Oaks or the Camden Coalition staff. All organizations have committed staff champions, data resources, and project management support to ensure that the workflows and initiatives are not contingent on one individual, but instead supported by a deep bench of interdisciplinary team members.

As the pilot and relationships have developed, project partners have been able to move from not only capturing patient-reported system barriers as well as successes experienced within the ED, but also quantifying these data points to drive health system quality improvement and reinforce positive practices.

In addition, after launching and piloting the initial workflows, the team was joined by the Cooper NJ-QIP team to identify and facilitate PDSA cycles to integrate these pathways permanently into the Cooper Emergency Department. As a part of this process in spring 2022, Cooper began screening



Progress to date (cont.)

all patients visiting the ED for depression and suicidal ideation. Depending on the screening results, patients are now systematically referred along the two different pathways, with the ability for providers to also refer patients who have behavioral health or social stresses but do not screen positive.

As of the beginning of August 2022, all patients who were interested in receiving follow-up behavioral health services have been offered appointments. While there can be challenges with rescheduling if appointments are missed, we have also found general availability of appointments within 30 days, which meets the NJ-QIP Medicaid requirement (at times appointments may take longer if a client is only interested in seeking care at a specific agency).

In addition to tangible process successes such as workflow changes and appointment access, we have also seen the implicit impact of deepening relationships across partners. ED staff and providers report increased feelings of hope that individuals they treat will be able to access appropriate

community supports, while our community partners are encouraged by the collaboration and responsiveness of the ED staff. We have no doubt these relationships will not only continue to strengthen our behavioral health ecosystems and improve various pathways to behavioral health resources, but also lead to other impactful collaborations.

Next steps

Moving forward, the goal for Pledge to Connect is to continue to expand the work to three other regional hospital partners (Virtua, Jefferson and Inspira) to codify this workflow into discharge-planning so that more patients have conversations and identified next steps with someone within the ED rather through follow-up calls. In addition, another regional CCBHC run by Ascenda Integrated Health has agreed to join the partnership.

The Pledge to Connect team is also working to respond to peer liaison, community stakeholder, and clinical partners' suggestions to share out the



appointment availability information more broadly. We are hoping to do this by building a shared community- and provider-facing information system and create functionalities in the Coalition's social service search, linkage, and referral platform called [My Resource Pal](#) (powered by findhelp) that allows both patients and providers to find community behavioral health providers with available appointments based upon patient factors (e.g., services desired, insurance type, language preference).

We will continue to report on the pilot over the next year, including outcomes information about people that interacted with the program.

For information, please contact:

Dayna Fondell
dfondell@camdenhealth.org

Sharif Braxton
sbraxton@camdenhealth.org

Mouy Van Galen
mvangalen@camdenhealth.org

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