NEW YORK STATE | Department of Health | Medicaid Redesign Team

Implementation Methodology:

Using the Model for Improvement

BRONX PARTNERS FOR
HEALTHY COMMUNITIES

SBH
Health System
BRONX

Implementation Strategies: Using the Model for Improvement

New York DSRIP 2016 Statewide Learning Symposium

September 20, 2016

BPHC Profile

Bronx Partners for Healthy Communities PPS

SBH Health System (lead)

- 150 years of serving the Bronx
- Over 70% Medicaid patients

Member organizations

225 organizations, 1200 sites
~35,000 employees

- Hospitals
- FQHCs
- D&TCs
- Health Homes
- Home Care
- Behavioral Health
- TCs
- IPAs
- CBOs
- Hospices

Patient Population

- 357,424 attributed patients

Acacia Network
ROOTED IN THE COMMUNITY SINCE 1969

SBH Health System BRONX

BRONX UNITED IPA, INC.

UNION COMMUNITY HEALTH CENTER
CARING FOR THE BRONX FOR OVER 100 YEARS

MORRIS HEIGHTS HEALTH CENTER

THE INSTITUTE FOR FAMILY HEALTH

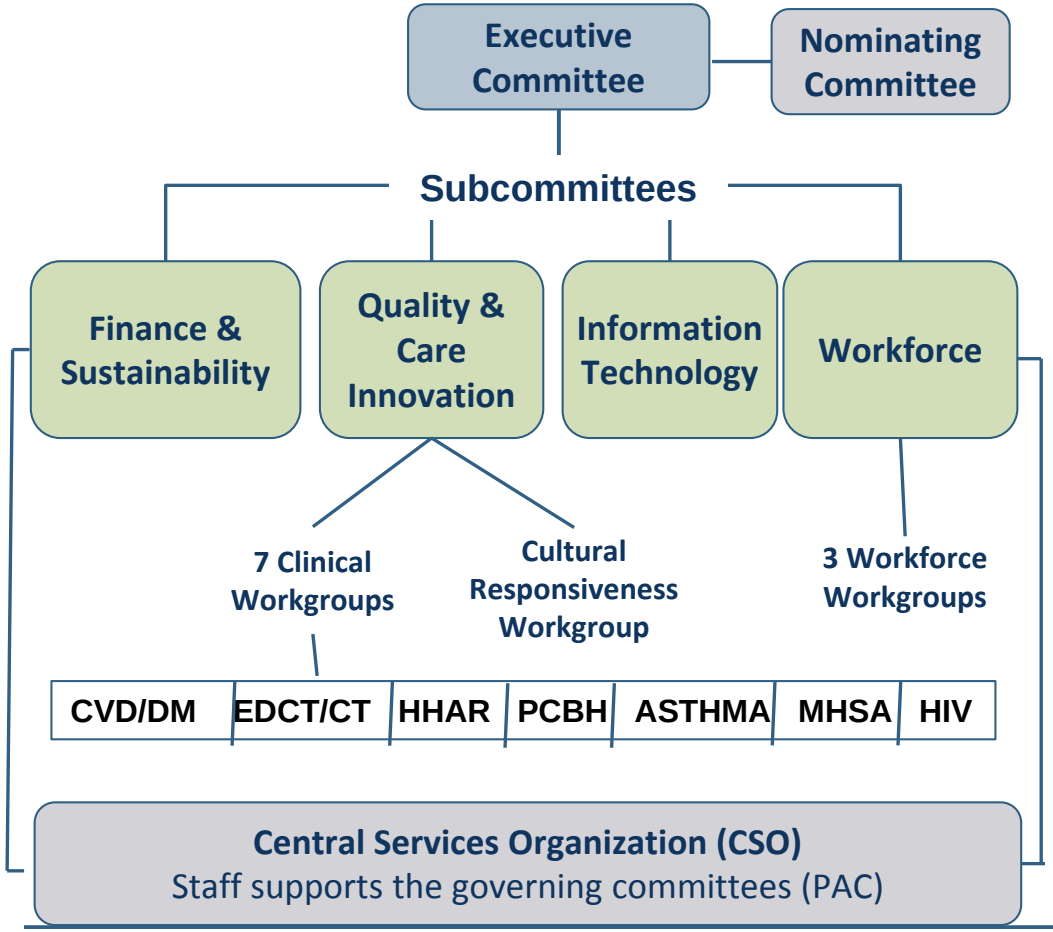
Montefiore

Our largest 7 partners

GOVERNANCE STRUCTURE

BPHC Governance Structure

Composition and Guiding Principles



Governance committee members reflect the diversity of BPHC's member organizations

- 75 committee and subcommittee seats
- 69 workgroup seats

Include clinical and non-clinical stakeholders

- Executive Committee includes: primary care providers, hospitals, FQHCs including practitioners, CBOs
- CBOs have seats on all committees, subcommittees and workgroups

Promote transparency, collaboration & continuity

- Planning, transition and implementation workgroups
- Frequent and targeted communications
- Monthly committee meetings
- Meetings with subcommittee co-chairs

Clinical Work Groups

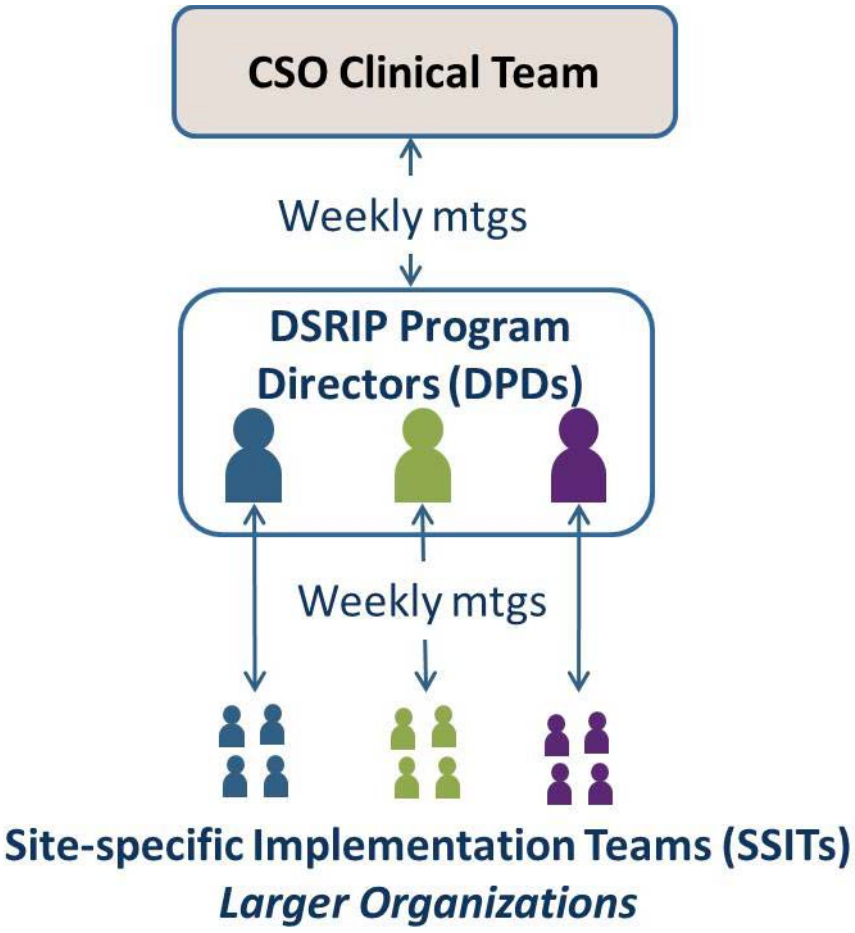
- Clinical Work Group membership consists of thought leaders from the major practitioner groups and CBOs, who develop engagement strategies specific to the PPS quality improvement agenda and DSRIP projects.
- Meet approximately every other month, led and staffed by the CSO Project Leads in charge of the respective projects.
- Serve as **project clinical quality councils**, and report up to the Quality & Care Innovation Subcommittee (QCIS) for major decision-making items.
- High-level feedback on implementation and review of metrics and measures, including Rapid Cycle Evaluation (RCE) metrics
- Current IWGs: ED/Care Transition, Health Home At-Risk, PC/BH Integration, CVD/DM2, Asthma, HIV, MHSA.

PROJECT IMPLEMENTATION STRUCTURE

Site-Specific Implementation Teams (SSIT)

- SSITs formed at all partner organizations that are directly engaged in project implementation.
- Practices/sites chose their SSIT members. Larger practices encouraged to include leadership, operations staff, a PCP, nursing staff, and care management staff.
- The largest primary care organizations have hired DSRIP Program Directors (DPDs) who work full-time at the partner sites and play the management, coordination and liaison roles between the SSIT and the CSO.

Site-Based DSRIP Program Directors (DPD)



- Embedded within BPHC's seven largest partner organizations
- Report to clinical or administrative leadership of the member organization and to CSO
  - Serve as liaison between partner organization and CSO
- Oversee site-specific DSRIP project implementation, monitoring, reporting, communication and coordination to ensure project success
  - **Work with SSIT to address barriers that may affect programmatic progress and performance**
- Ensure adoption and adherence to policies and procedures described in the Clinical Operations Plan (COP)
- Collect RCE metrics

PERFORMANCE IMPROVEMENT STRATEGY

Data Limitations At Outset

- Claims data initially not available from state due to delayed "opt-out" period
- SSP workbooks delayed on BPHC side
  - Now complete but in review and not yet approved.
- Even once available, rolling claims data up into *practice level* not so easy.
- We are working with Bronx RHIO on a schedule for release of reports.
  - Contracting delays from both sides led to design and delivery delays.

How Is Performance Measured?

	"Domain 1" Project Requirements	"Domain 2-4" DSRIP Measures	Patient Engagement Metrics	Rapid Cycle Evaluation (RCEs)
What do they track?	Completion of project programmatic milestones	BPHC's performance on DSRIP measures	# 'engaged' patients by project	Progress toward requirements and measures Will change based on implementation phase
Who defines the measures?	NYS	Nationally-recognized measures (HEDIS, AHRQ etc)	NYS	IWG
How are they reported?	CSO/sites submit quarterly reports to NYS	NYS measures claims and CAPHS data and provides it to BPHC	Sites/CSO using EHR and RHIO data	DPD submits to site data to CSO in monthly reports
How are they evaluated ?	Reviewed by NYS	Reporting only (DY1); some linked to performance (DY2 -5)	Meet patient engagement targets	Reviewed by IWG and CSO
Performance impacts funding?	Yes	Yes—some double as EPP measures	Yes	No

Rapid Cycle Evaluation (RCE) Metrics

- Developed to focus on PPS progress through project and program implementation.
- Will change over time: moving from process measures to outcome measures;
  - Where outcomes measures cannot be evaluated without claims/CAHPS data, we will use proxy measures for outcomes; or
  - Where outcomes measures are “lagging” rather than “driving” metrics, we will use proxy measures to drive change.

Metric examples
% of patients seen during the month for whom a PHQ-2 screen is administered [PCBH]
% of patients seen during the month with a positive PHQ-2 screen that received a subsequent PHQ-9 [PCBH]
# of referrals to a.i.r bronx in the past month [Asthma]
% of asthma patients seen in the last month with an up-to-date Asthma Action Plan [Asthma]

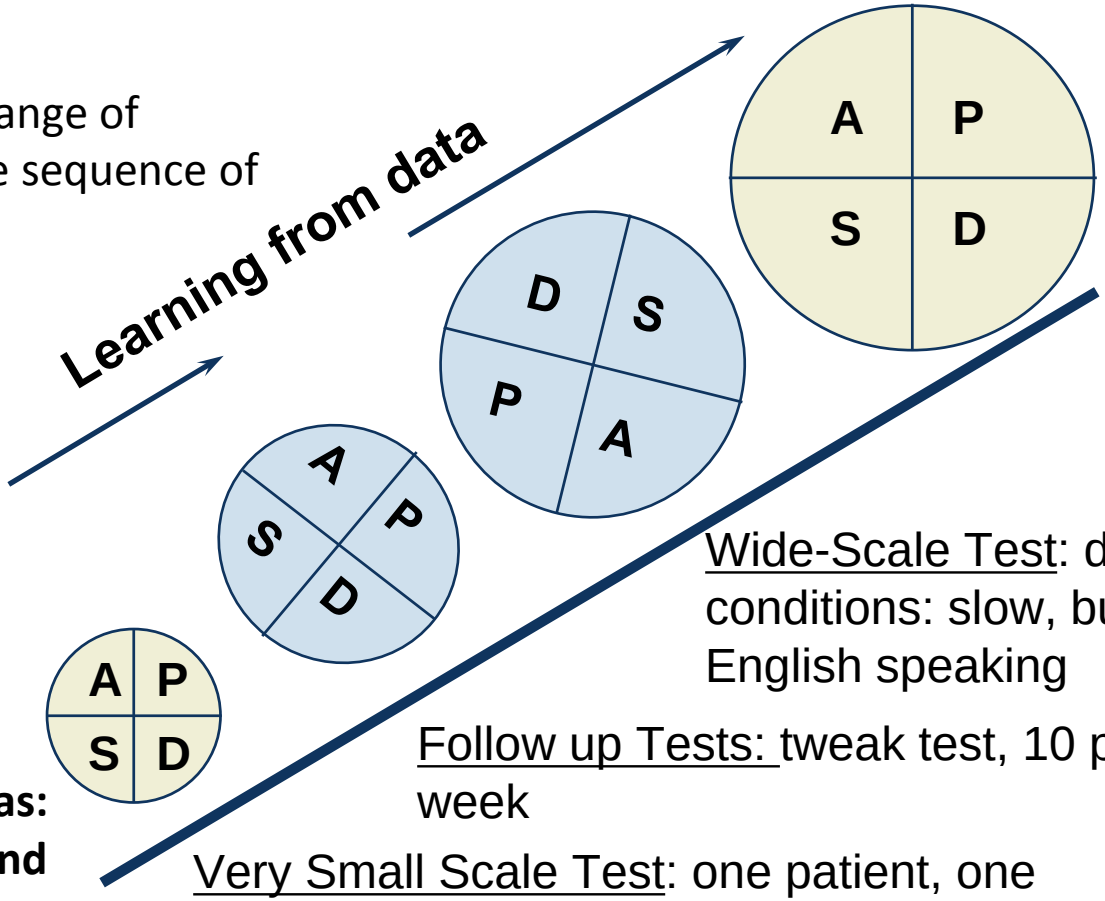
Performance Reporting & Performance Improvement Training

- Partnered with Joslyn Levy Associates (JLA) to develop a train-the-trainer model
- Hands-on, practical training using IHI's Model for Improvement
- Aimed for less didactics and a setting where we work on real improvement and not just theory
- Started with BPHC CSO staff and DPDs
  - Began with Aim statement writing and asked participants to choose depression screening or asthma (best data for those)
  - All DPDs chose asthma
  - Quickly realized we have a wide range of CQI experience represented by DPDs and CSO staff: beginner to expert
- At the end of the second session, DPDs were grouped with CSO staff to create additional support and practice-sharing.

PDSA Ramp – Learning your Way to Results

Sequential building of knowledge

Include a wide range of conditions in the sequence of tests



Changes That Result in Improvement

Implement Change: new procedure, training, job descriptions

Wide-Scale Test: different conditions: slow, busy, non English speaking

Follow up Tests: tweak test, 10 people, one week

Very Small Scale Test: one patient, one session

Hunches Theories Ideas: teach back and MI Qs

Performance Reporting & Performance Improvement Training Plan

7/7	3 hour in-person Training	DPDs & PMs	Overview of the Model for Improvement	• QI self assessment • What is QI/PI? The Science of Improvement • PDSA • Aim Statements • Evaluating Improvement
7/26	3 hour in-person Training	DPDs & PMs	Aim Statement Sharing & Using Data for Improvement	• Measurement for Improvement • Run charts • Concept of a "family of measures"
8/16	All day in-person training	DPDs & PMs	Facilitating Improvement: selecting and testing changes, data interpretation & coaching strategies	• Reviewed revised Aim Statements • Selecting and Testing Changes • PDSA review and practice • Coaching QI teams
9/16	All day in-person training	DPDs & PMs SSITs	Overview & application of the Model for Improvement to advance work on project- and site-specific aims	• Team sharing: referrals to a.i.r. bronx. • Model for Improvement and PDSA review and simulation • PDSA Design, Share; and Feedback

Next Steps

- **PI Project Development and Coaching:**
  - Increase percentage of asthmatic patients with updated Asthma Action Plan
  - Increase number of referrals to a.i.r. bronx

- **Together during Session 4, PDSAs were developed to forward one or both of above PI projects. a.i.r. bronx participated in PDSA design.**
  - November/December: two 1-hour group coaching calls
    - Opportunity for teams to share their work
    - Feedback
    - Best practice sharing

- **Leverage this process to spread CQI work to other projects and processes.**
- **CSO to become improvement support rather than project implementation/reporting support.**

Thank You!

BRONX PARTNERS FOR
HEALTHY COMMUNITIES

SBH
Health System
BRONX

Please visit our website: **www.bronxphc.org**
Contact **info@bronxphc.org** with DSRIP related questions.

Montefiore HUDSON VALLEY COLLABORATIVE

The Montefiore Hudson Valley Collaborative

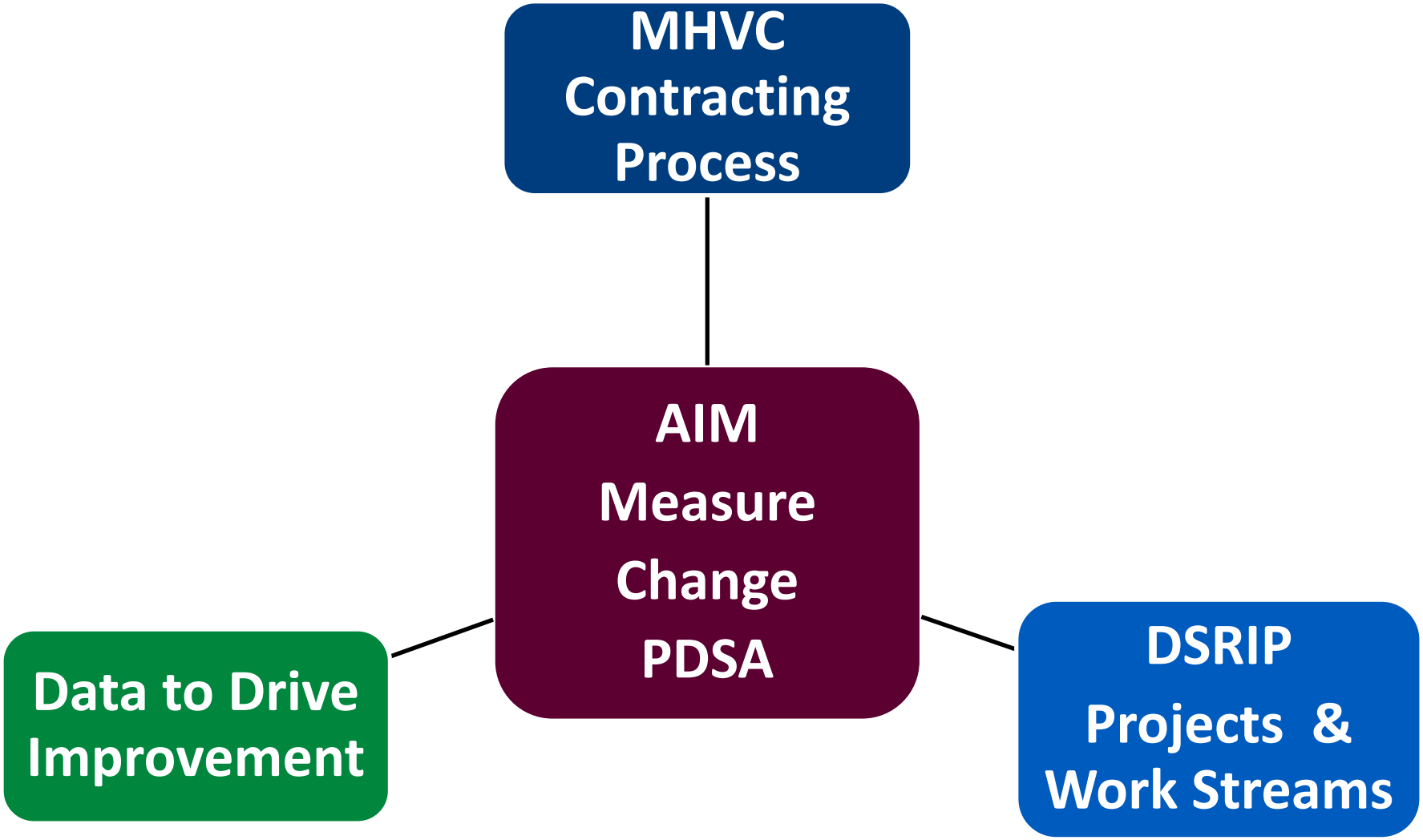
Implementation Strategies:
Using the Model for Improvement

Damara Gutnick, MD
Medical Director, MHVC

Natalee Hill, MPA
Director of Quality & Innovation, MHVC

September 20, 2016

Overview

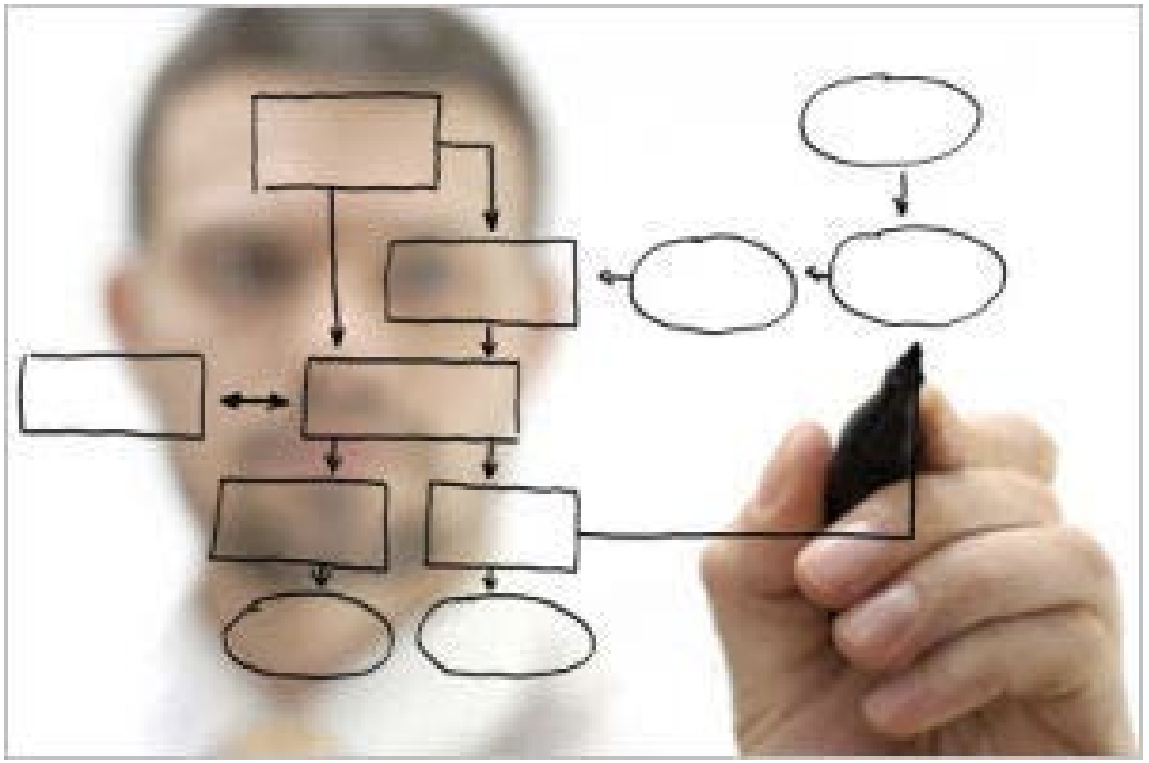


Montefiore HUDSON VALLEY COLLABORATIVE

MHVC Contracting Process

Montefiore
HUDSON VALLEY
COLLABORATIVE

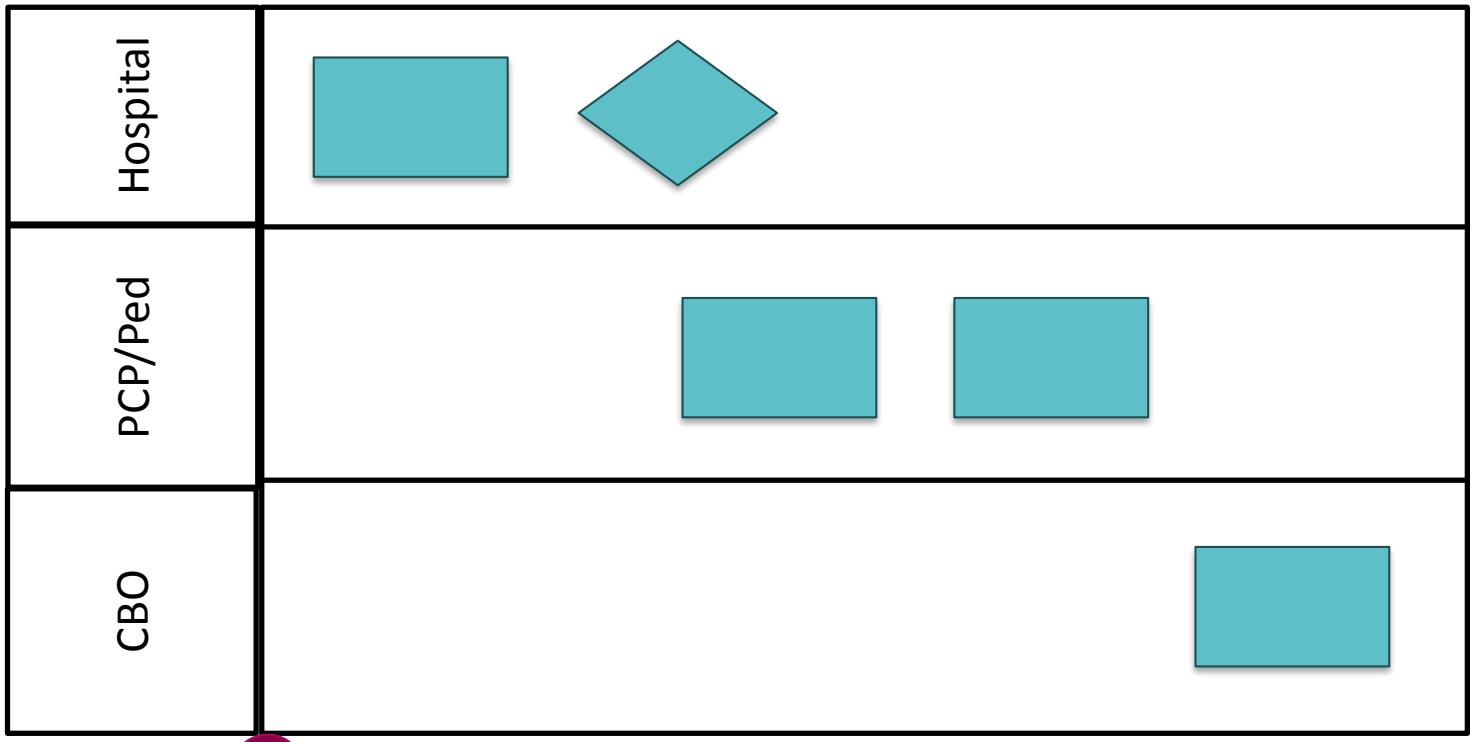
Process Mapping & Project Design



Montefiore
HUDSON VALLEY
COLLABORATIVE

Output from future-state vision session

- Patient Flow Maps with Swim Lanes by Stakeholder Type
- Maps were validated by multiple stakeholders



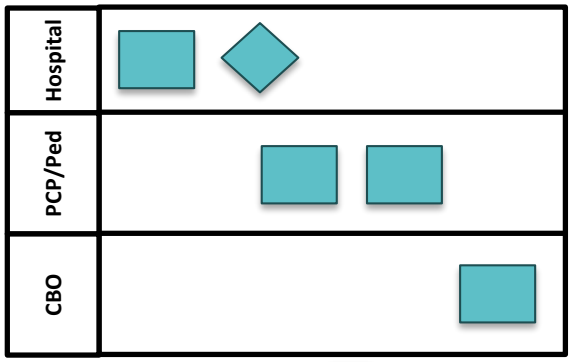
1

Future State IDS visioning sessions produced **patient flow maps** demonstrating overall patient flow through the care system. The maps are established on a **project-by-project** basis.

Montefiore HUDSON VALLEY COLLABORATIVE

Process Mapping Approach

Output from future-state vision session



1 Future State IDS visioning sessions produced **patient flow maps** demonstrating overall patient flow through the care system. The maps are established on a **project-by-project** basis.

Future State Roles by partner type per project

Project	Hospital	PCP/Pediatrician	CBO
2.b.iii	Establish ED Care Triage program for at-risk populations Medical screening examination Navigator in place that collects data on current PCP Schedule apt. with PCP Navigator will assist the patient with identifying and accessing needed community support resources	Relationship with hospital to share schedules Willing to accept Medicaid patients Increased Access Patient no show process for follow up EHR Connectivity to RHIO Encounter notification is installed	Assist in educating patient about appropriate use of ED Provide social services to patient in need

2 Data elements from future state process maps are extrapolated to **definitions of roles and responsibilities** of each partner type in the future state of the IDS. The Roles and Responsibilities are established on a **project-by-project** basis.

Montefiore HUDSON VALLEY COLLABORATIVE

Contract Development – MHVC ties dollars to partner/network achievements to align with our co-created plan for a Hudson Valley IDS

1 **Process-mapping sessions** with partners to define Roles and responsibilities and inform workplans

Role/responsibility	Hospital	PCP	Behavioral Health	Clinic
Health Home Eligibility Assessment Completed	1	1	1	1
Care navigators identify primary care relationship for patients without PCP	1	1	0	1
BHIO Consents	1	1	1	1
PCP trained on common BH diagnosis and treatment	0	1	0	
Relationships established with hospital to share schedules	1	1	1	
Proactive patient follow-up process in place to assure engagement or early response to care	1	1		
Systematically screen target population	0	1	0	

2 **Workplans** highlight milestones and metrics by Provider type

Role	Jul '16	Aug '16	Sep '16
Relationships established with hospital to share schedules		Strategy for improved hospital-PCP collaboration in place to share schedules (PCP and Hospital)	At least 2 meetings set up to determine timeline for finalizing process to share schedules (PCP and Hospital)
Proactive patient follow-up process in place to assure engagement or early response to care	Strategy for improving patient no show process in place (PCP)	Demonstrated initiation of process with well-defined evaluation in place to establish baseline (PCP)	Demonstrated follow-up process in place with 10% increase in patient follow-up from previous month (PCP)

3 **Contractual Metrics** derived from workplans and Domain 1 requirements. Completion of contract metrics tied to earning DSRIP dollars

Montefiore HUDSON VALLEY COLLABORATIVE

Project Implementation Milestones (PIMs)

- Contracting Requirement =PIMs
  - Process measures that incentivize partners to. . .
    - Develop infrastructure to collect, report and share data that will guide future QI work
    - Establish baselines
    - Complete readiness assessments
    - Prepare project plans
    - Participate in training (i.e Webinars, Learning Collaboratives)
    - Define needs and assign staff to roles and responsibilities
    - Agree to adapt EBG and standard screening tools
  - Outcome Metrics

PIM Example: (Project Implementation Milestone = Contracting Metrics)

Project Implementation Milestones		
PIM ID	Partner Responsibility	Due Date
MHVC – P013	**Complete the BH Integration readiness assessment for model 1 and 3** by 7/30/2016	9/30/16
MHVC-P015	Provide at least one month of data for the following: 1. Quarterly report according to clinical and technical specifications for active engagement 2. **Monthly depression screening rate report** 3. **Monthly screening yield report**	9/30/16
MHVC-P016	Provide reports for the following **and demonstrate improvement over baseline** (first three months). If practices are performing at high performance, demonstrate sustainability. SAME REPORTS AS ABOVEMHVC- P015	12/31/16
MHVC-P012	Report project planning efforts, in accordance with PPS toolkit, to implement relevant BH EBG.	12/31/16
MHVC-P014	Provide evidence that appropriate team members participate in MHVC sponsored assigned learning programs	12/31/16
MHVC-P005	Provide evidence that BH providers agree to adopt PHQ-9 or PHQ-a (adolescent) and provide policies and procedures to guide treatment decisions	12/31/16

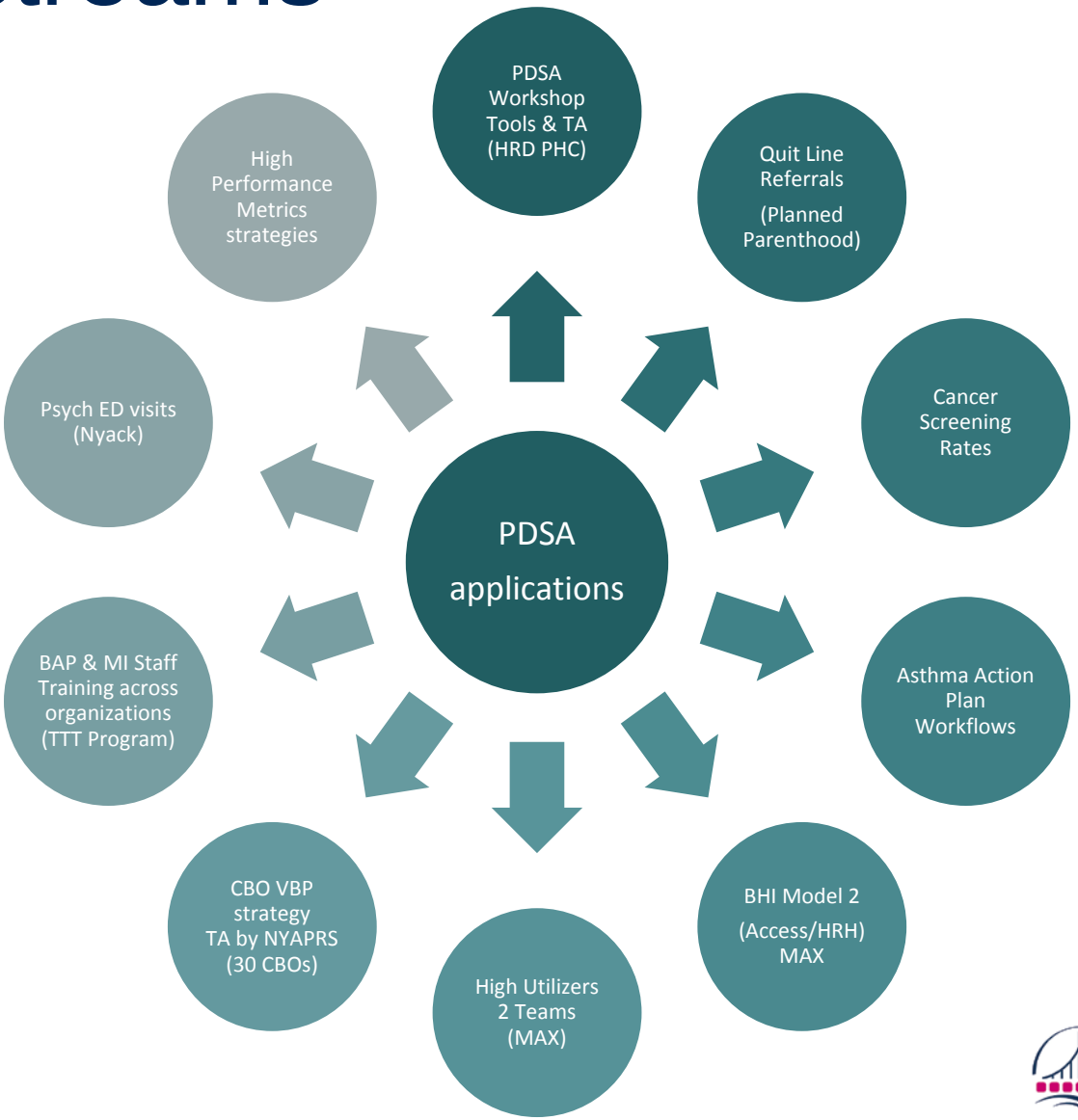
Montefiore HUDSON VALLEY COLLABORATIVE

Establishing Baseline Data

- Align data reporting requirements with Contracting Milestones (PIMs)
  - PHQ-9 Screening Rates and Yield (3ai)
  - Report Cancer Screening Rates (IDS)
  - CBO Surveys (NYAPRs)
  - Access to Crisis Oriented Services Survey
  - Process to Identify High Utilizer Populations (ED)
- Identify improvement opportunities
  - Plan for targeted process improvement projects and coaching

Montefiore HUDSON VALLEY COLLABORATIVE

Applicable to multiple projects and work streams

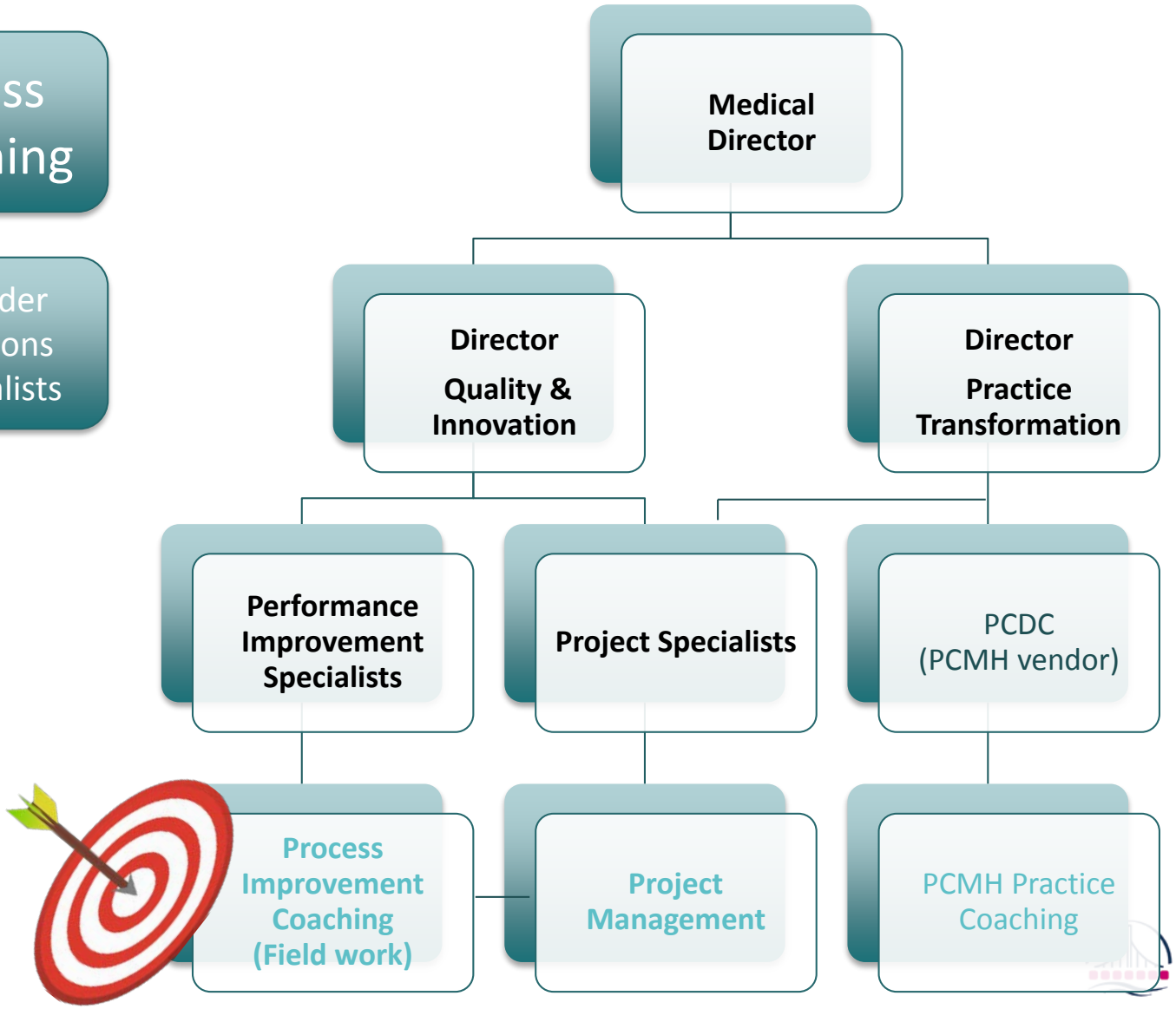


Montefiore HUDSON VALLEY COLLABORATIVE

Our Clinical Improvement Team

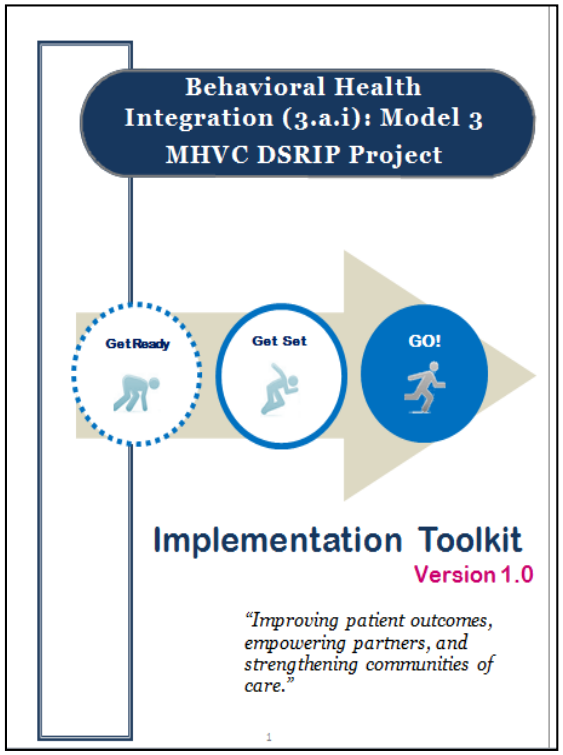
Cross Training

Provider Relations Specialists



Montefiore HUDSON VALLEY COLLABORATIVE

MHVC Launched Project Toolkits on August 5, 2016



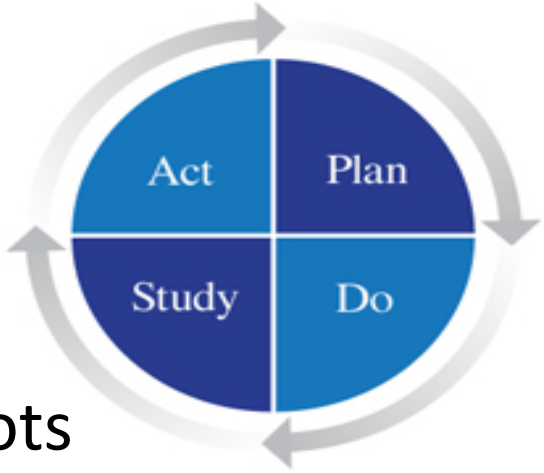
Get Ready, Get Set, Go! Project Toolkits provide partners with…

Partners can access 5 Project Toolkits

- Health Home at Risk (2.a.iii)
- ED Care Triage (2.b.iii)
- Behavioral Health Integration (3.a.i)
- Cardiovascular (3.b.i)
- Asthma Management (3.d.iii)

Montefiore HUDSON VALLEY COLLABORATIVE

Innovations:
PDSA Training for CBOs



- Technical Assistance for PDSA pilots
- Cross PPS Collaboration (MHVC, Refuah, WMC)
  - Natalee Hill, MPA, MHVC
  - Bruce Rapkin PhD, Einstein
    - Division of Community Collaboration & Implementation Science, Dept. of Population Health, Einstein SOM
- PDSA Workshops (5/18, 7/21)
  - PDSA tracking template developed and shared

Montefiore HUDSON VALLEY COLLABORATIVE

PDSA Template

3 Pilot Organization

Please also specify the site name.

4 PDSA Topic/Project Title

5 AIM Statement

Instructions: Remember that AIM statements must be S.M.A.R.T.
SPECIFIC, MEASURABLE, ACHIEVABLE, REALISTIC, and TIMELY

6 Data Collection/Measurable Outcome Source to Support AIM Statement

Data Metric	How is this collected?	Who collects this?	Frequency of Data Collection	Where is this collected? (Data Source)	Notes/Things to consider

7 Stakeholders

8 PDSA Total Duration

Target Start Date (MM/YYYY) | Target End Date (MM/YYYY)

9 PDSA Objective

What is the importance of this issue?/What issues are you trying to address?

10 Prediction Statements

What do we hope the potential outcomes will be?

bruce rapkin: Please Personalize this for your organization – you may focus on all or some of your sites, your staff and your program areas.

Topics may include tobacco cessation as well as cancer screening and early detection. Your PDSA may focus on individual level interventions, staff behavior change, community outreach, changes in policy or practice guidelines,

bruce rapkin: The **AIM** is the trickiest part to figure out. Try to "scale" your aim so that it seems like one piece of work. For example, in order to improve screening (an overall goal) you may want to train staff, improve outside referrals to screening providers, and modify your EHR. Each of those may be needed to reach the overall goal BUT each will likely be carried out by different people in different time frames with specific milestones. Each of these three activities could be treated as its own aim - with a separate PDSA cycle - (cycles within cycles)

bruce rapkin: Outcome data should be something that is directly related to your aim .. If we see X than we know the aim was achieved - When possible, it is great to have multiple indicators of outcomes -

bruce rapkin: Stakeholders should include anyone whose input you would like to have in planning, implementing or evaluating your PDSA.

You should have specific reasons for including each participant. Participants may be involved in different ways - suited to the ways they will be involved

In addition to key staff and leadership, stakeholders might also involve patients, members of your advisory board or board of directors and partner organizations in your community.

bruce rapkin: One of the principles of PDSA is the idea of "rapid cycle" - trying something, seeing how it works, changing it and tweaking it as needed - Another concept is the idea of "failing fast" - not that

bruce rapkin: In this section, it is helpful to spellout your rationale for the AIM - what were the reasons for pursuing the objective, for your outcomes, your time frame and your

Montefiore HUDSON VALLEY COLLABORATIVE

Instructions:

1. Select the team

1.1 What is the team brief?

1.2 Who are the stakeholders?

1.3 Who will participate in this improvement team?

2. Clarify the opportunity for improvement

2.1 Precisely what is the opportunity for improvement?

2.2 Who are the clients and what do they need?

2.3 What is the current process flow, policy and/or state of relationships?

3. Study the current situation

3.1 What data are needed to measure performance

3.2 How will the data be collec

3.3 What are the data saying about cu

4. Anal

4.1 What are th of variation and p

4.2 What ar

5. Develop a theory for improvement

5.1 What are the possible solutions?

5.2 Which solutions will have the greatest impact?

5.3 What are the key actions, who will lead them, what are the timelines and resources?

5.4 Obtain approval from the system or process owner.

6. Implement the theory for improvement

6.1 Are we collecting data as we go?

7. Study the results

7.1 To what extent did our actions lead to improvement?

8. Standardise the improvement

8.1 Should the theory be adopted as the new way or do we need to start again?

8.2 What is required to document, train and enable people to adopt the new way?

9. Reflect and establish future plans

9.1 What did we learn?

9.2 What other actions are required?

Act Plan Do Study

QLA
learning • improvement
www.qla.com.au
© Copyright 2015 QLA. Version 5.0

Plan-Do-Study-Act (PDSA) C

Tool Icons used with permission from *Tool Time for Education* by David Langford of

New Zealand: PO Box 1850, Wellington, 6140 **Phone** +64

Australia: PO Box 624, North Melbourne, Victoria 3051 **Phone** +61 3 9370 9944 **Fax** +61

The Model for Improvement

AIM
What are we trying to accomplish?

MEASURES
How will we know that a change is an improvement?

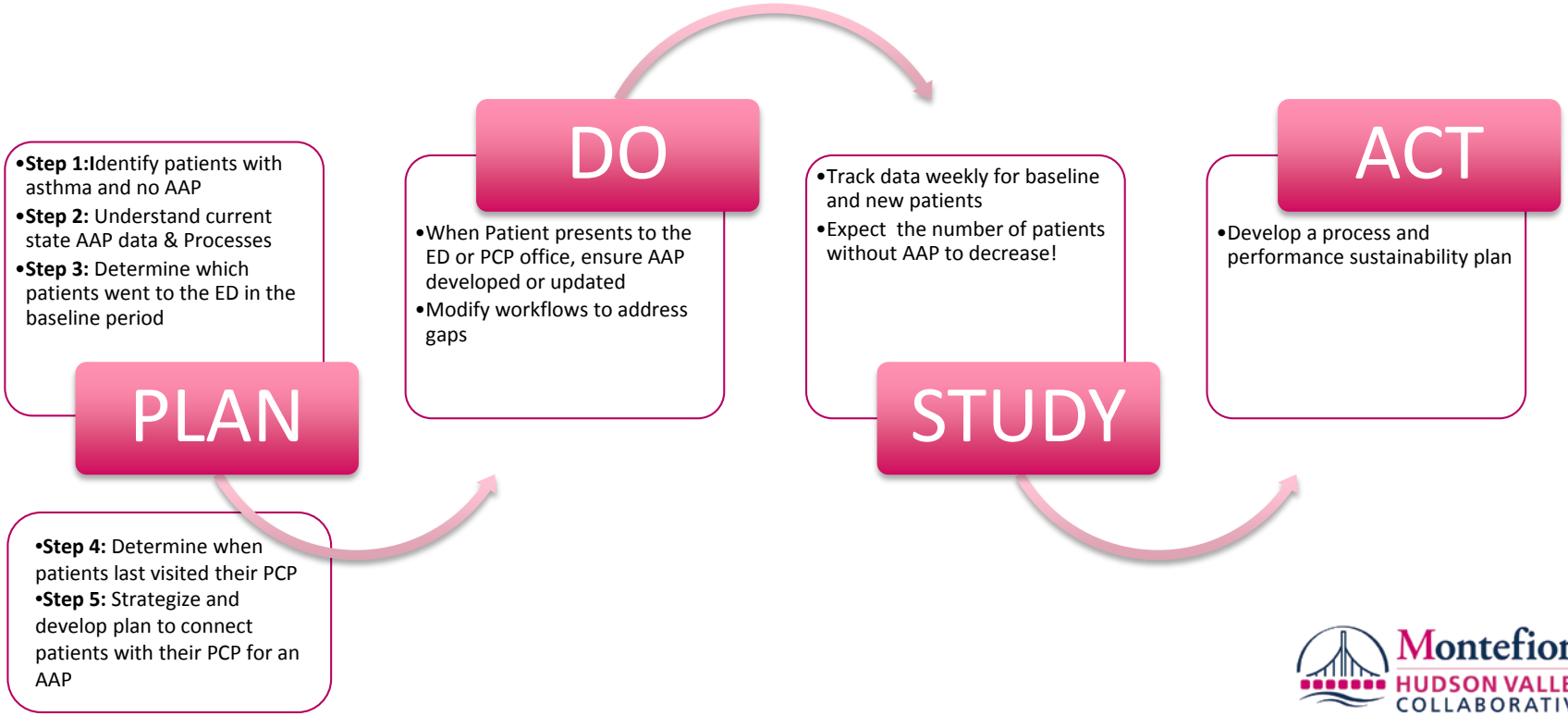
CHANGES
What changes can we make that will result in improvement?

PDSA Template | Project Contacts | PLAN | DO | STUDY | ACT | Reference Documents | Preliminary Questions | +

Montefiore HUDSON VALLEY COLLABORATIVE

Asthma

- Goal: Decrease the % of patients with no AAP
  - Pilot: 6-8 weeks
  - Baseline data: 3 months data prior to PDSA
    - Numerator: # of pts with asthma dx w/o AAP
    - Denominator: # of pts with asthma at 1-2 sites



Montefiore HUDSON VALLEY COLLABORATIVE

BH Integration
Project 3ai

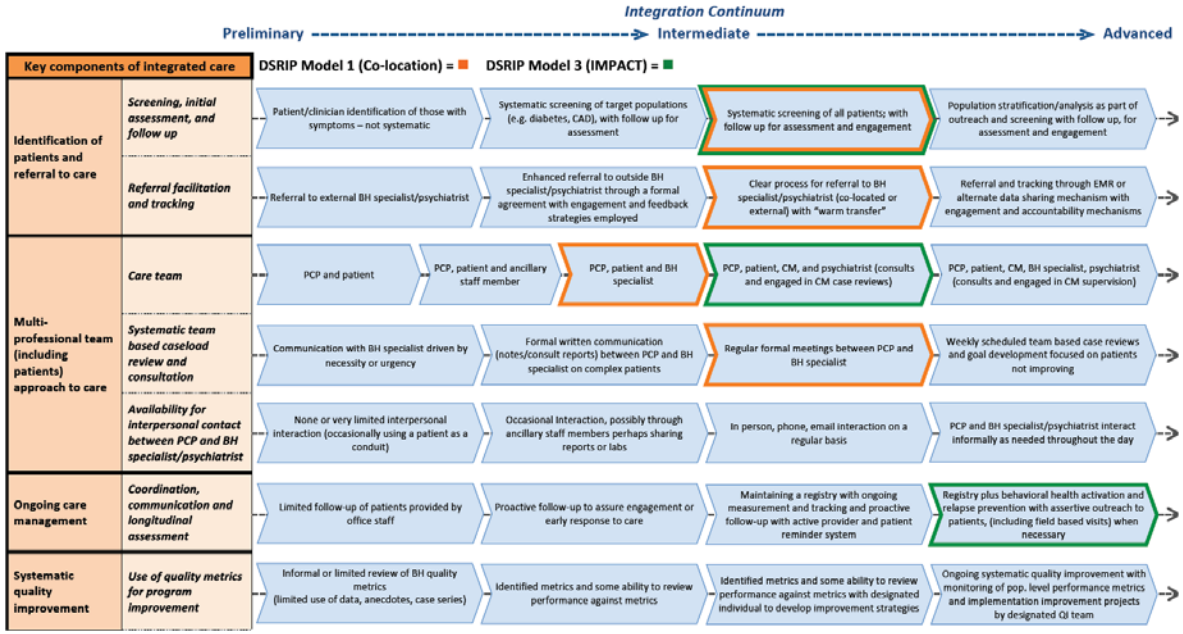
Montefiore
HUDSON VALLEY
COLLABORATIVE

Behavioral Health Implementation Support

- Readiness Assessment will inform learning plans
  - Site level assessments
- Leadership Engagement Webinar
- Toolkits
- Alignment of Contracting PIMs
- Learning Collaborative (18 months)
  - Use data to drive improvement
  - Model, multidisciplinary & role-specific trainings
  - Collaborative benchmarking
- Tracking Registry
- Site-specific coaching

Behavioral Health Readiness Assessment

- Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework
  - Dr. Henry Chung, et al
  - UHF Grant



Notes: ***BH Specialist*** refers to any provider with specialized behavioral health training
CM can refer to a single person, or multiple individuals who have training to provide coordinated care management functions in the PC practice
Ancillary staff member refers to non-clinical personnel, such as office staff, receptionist, and others

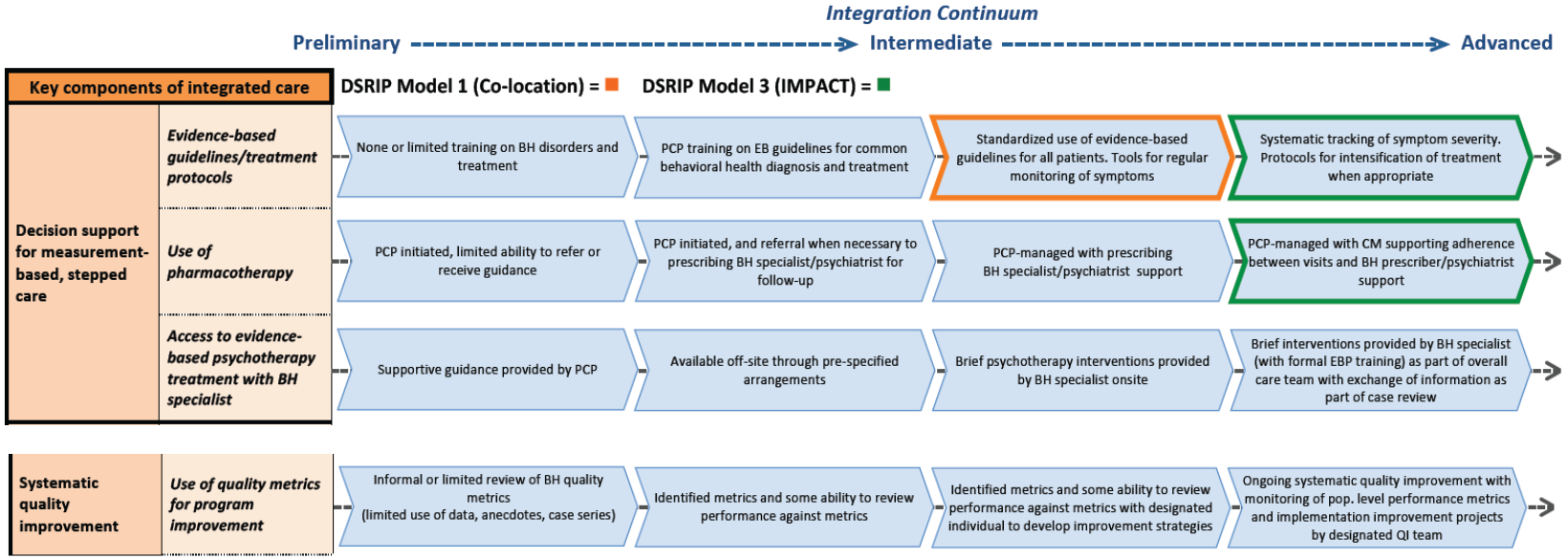
Montefiore HUDSON VALLEY COLLABORATIVE

BHI Framework Domains

8 BH Integration Domains
1. Finding, screening and referral to care
2. Multidisciplinary professional team to provide care
3. Ongoing care management
4. Systematic quality improvement
5. Decision support for measurement-based, stepped care
6. Culturally adapted self-management support
7. Information tracking and exchange among providers
8. Links between community/social services

BHI Framework Domains

Quality Improvement Related Domains
4. Systematic quality improvement
5. Decision support for measurement-based, stepped care
7. Information tracking and exchange among providers



Montefiore HUDSON VALLEY COLLABORATIVE

Learning Collaborative

- Evidence-based guidelines
- BHI best practices
- Multidisciplinary and team-based learning
- Workflow & change strategies for implementing & sustaining local improvements
- Outcomes & data reporting strategies
- Sustainability Strategies

Montefiore
HUDSON VALLEY
COLLABORATIVE

BHI Transformation: The Ideal Dream Team

- Practice Champion
- Behavioral Health Clinician
- RN/ QI Specialist
- Care Manager or Individual responsible for support of the Registry

Makings of a Champion

Actively practicing PCP and team members well respected by peers
Understands the importance of BHI impact on practice and patients
Leadership Potential
Time to Participate

Montefiore HUDSON VALLEY COLLABORATIVE

NYACK Hospital
Quick Look ER Use Profile
MH/SUD Cohort

Woodlock & Associates
Kristin M. Woodlock , CEO
August 24, 2016

Rapid Performance Improvement Project
Nyack ED Behavioral Health Visits

Project Background

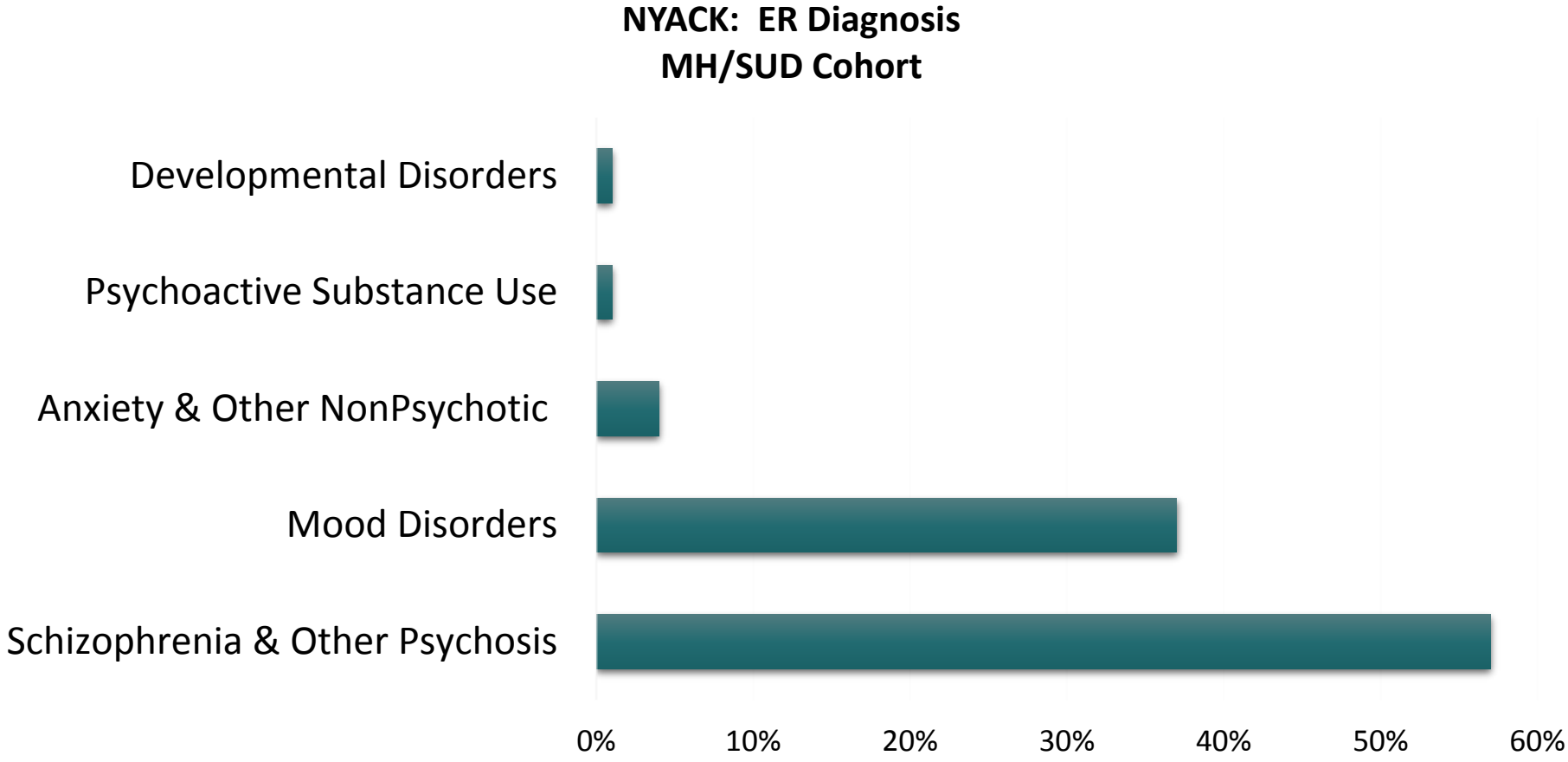
- High numbers of individuals with behavioral health conditions
- Average duration of ED visit = 9.86 hrs
- 12 Months of Data Indicate Presentation Sources: Adult Group Homes, Police & Ambulance (June 1- June 30 2016)

Project Plan

- **Plan:** Define Project, Project Team, Data →Project Scope
- **Do:** Analyze Current State of Presentation Sources, Identify & Address Root Causes
- **Study:** Utilize data to assess resolution impact & Future Performance Target
- **Act:** Ongoing Performance Monitoring

Montefiore
HUDSON VALLEY
COLLABORATIVE

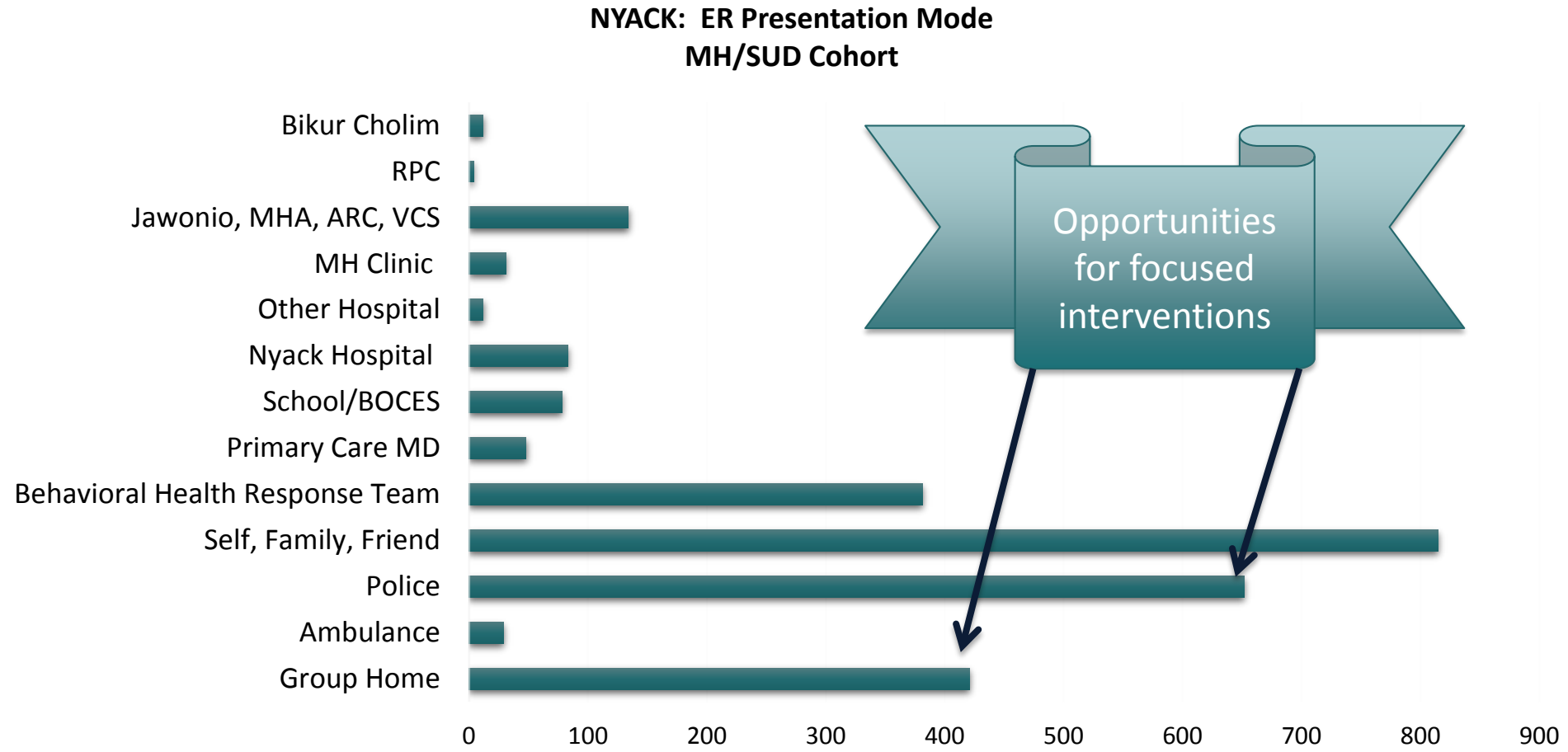
Diagnosis profile is unique: High concentration of Schizophrenia and Psychotic Disorders



June 1- June 30, 2016
2700 presentations to ED for BH issues

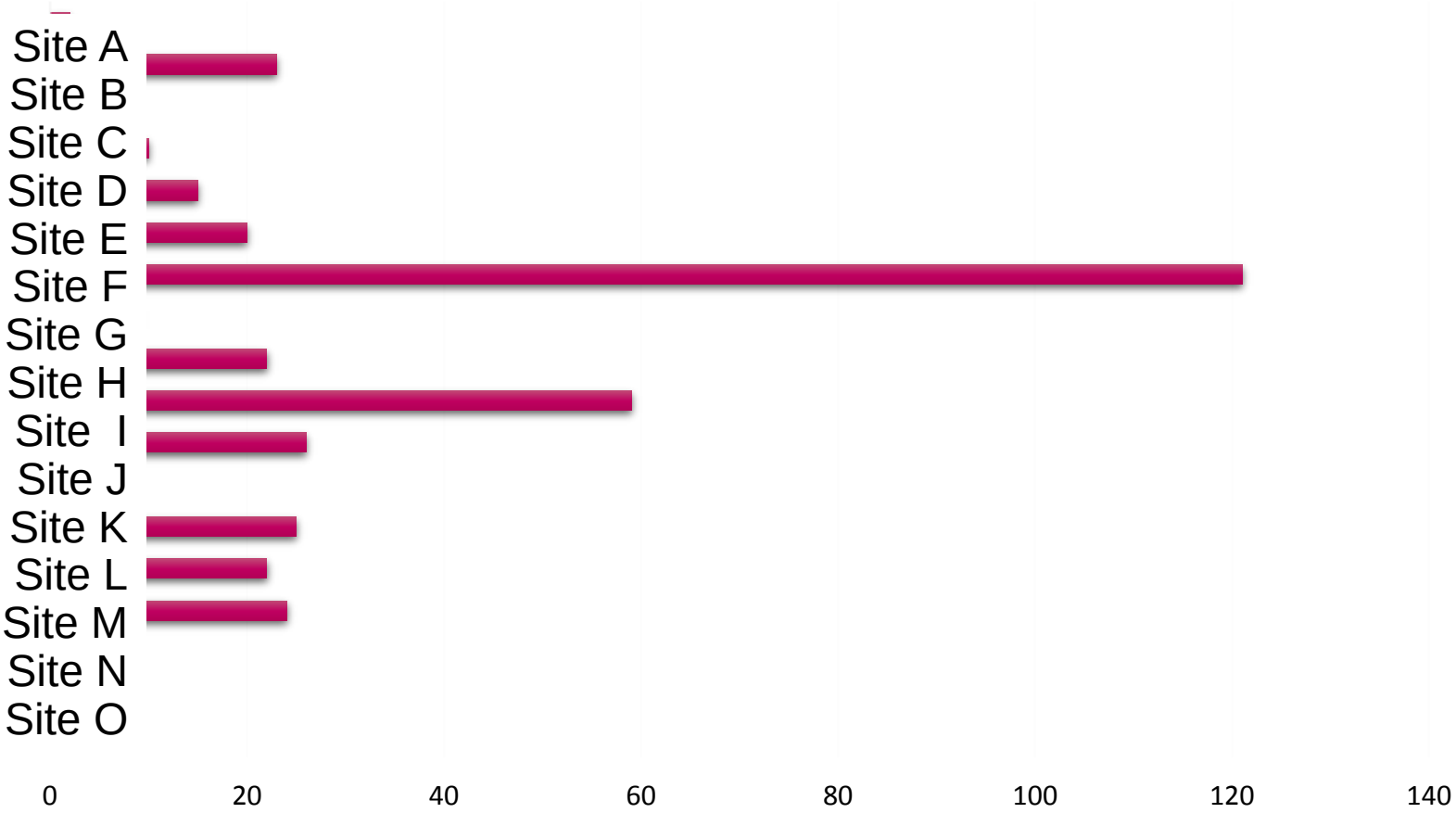
Montefiore HUDSON VALLEY COLLABORATIVE

Diverse Presentation Paths:
of police and group home referrals of note



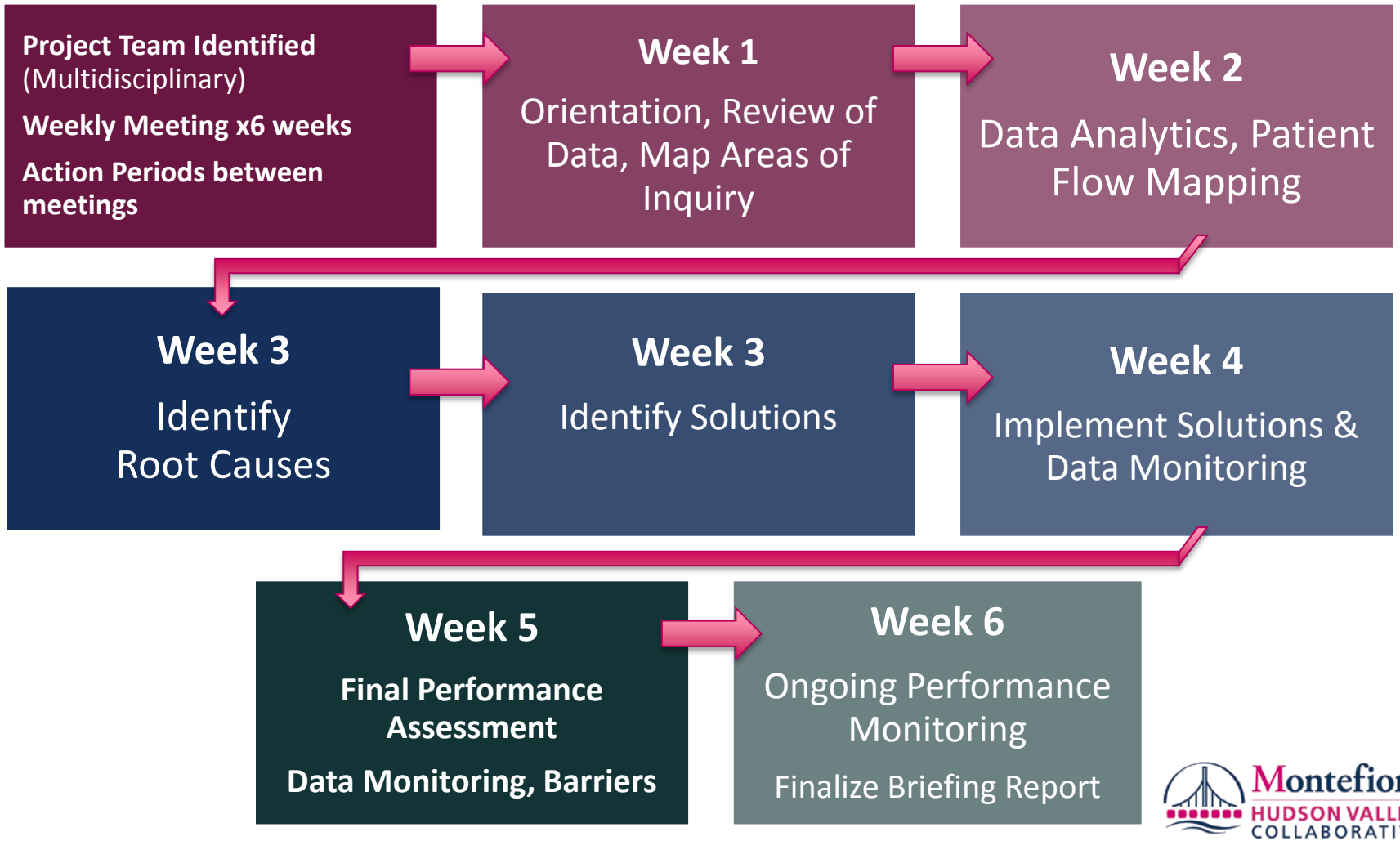
Montefiore HUDSON VALLEY COLLABORATIVE

Referrals from Group Homes: Targets for Intervention



Montefiore HUDSON VALLEY COLLABORATIVE

Rapid Performance Improvement Project
Nyack ED Behavioral Health Visits



Montefiore HUDSON VALLEY COLLABORATIVE

Efficiencies of Shared Learning

An Example:

Nyack data presented to

Clinical Quality Subcommittee

Commissioner, DMH in a neighboring county shared. . . .

-Similar patterns identified in Orange County

-Successful Group Home Education Intervention

Linkages to Experience Made

Montefiore HUDSON VALLEY COLLABORATIVE

Data to Drive Improvement: CBO Strategy

CBO Strategy

- Goal: To move CBOs toward VBP
- Worked with partners to identify key CBO's within their regional "communities of care"
- NYAPRS will be providing Technical Assistance
  - Identified need to use data to drive improvement
  - CBO Managed Care Readiness Assessment
    - PDSA
    - QI Projects

Montefiore
HUDSON VALLEY
COLLABORATIVE

ED Care Triage

Project 2biii

ED Care Triage (2biii)

Identify High Utilizers

Link High Utilizers to PCP and CM

GOAL

Decrease Preventable ED Visits

MAX Series

St. Luke's-Cornwall/Cornerstone/Access/Horizon

St. Joseph's

- Identify HU cohort
- Focused Care Management strategy

Montefiore HUDSON VALLEY COLLABORATIVE

Montefiore
HUDSON VALLEY
COLLABORATIVE

Our Outcomes

Targeting High Utilizers:

The MAX (Medicaid Accelerated Exchange) Series

MAX Series: St. Joseph's Hospital

Multidisciplinary "Action" Team

Target Population

Patients with 4 or more inpatient admissions

125 Inpatient Super Utilizers (Many on Dialysis)

2015 Baseline Data

Hospital

909 ED Visits

637 IP Admissions

11.2% Referred to CM

2016

Health Home and Case Management Team

Intervention

6 months (2016)

OUTCOME_DATA

125 Cohort of High Utilizers

87 pts 70% Presented to ED

28 pts 32% Engaged by Care Manager

19 pts 21% Connected to Social Services

- Housing
- Drug Rehab
- Immigration
- Assisted Living

Connected Back to Dialysis Center

20% ED Visits

88% Admissions

3x (280%) Engagement with Care Coordination Team

Montefiore HUDSON VALLEY COLLABORATIVE

MAX Series:

St. Joseph's

Report Out Presentation

Montefiore HUDSON VALLEY COLLABORATIVE

MAX Series: SLCH/Cornerstone/ASFL/Horizon Medical

Multidisciplinary "Action" Team

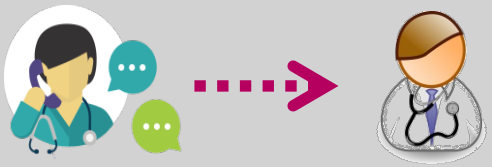
89

High Utilizer Cohort

Target Patient Population

3 or more IP Admissions
6 or more ED visits

Intervention



Quarterbacks from 3 partners and the hospital's care transition team connect patients to PCP/BH providers based on associated needs

2015
Baseline Data

Hospital

1,226 ED Visits
492 IP Admissions

2016
Outcomes

33%

ED Utilization
(by cohort group)

Montefiore HUDSON VALLEY COLLABORATIVE

MAX Series:

St. Luke's-Cornwall / Cornerstone/Access/Horizon Health

Report Out Presentation

Questions?

Montefiore
HUDSON VALLEY
COLLABORATIVE

Patient Tracking Registry

- Web-based application to monitor patient progress and outcomes
  - Patient-Centered Team Care: supports integrated care by sharing information across providers & incorporating patient goals
  - Population-Based Care: tracks patient populations & provides cues/reminders to prevent patients from falling through the cracks
  - Measurement-Based Treatment to Target: tracks outcomes & assists in identifying patients not improving & requiring consultation or stepped-up care
  - Evidence-Based Care: structures clinical workflows & uses validated instruments to track patient progress
  - Accountability: increases accountability for care quality with caseload/site reports

Montefiore HUDSON VALLEY COLLABORATIVE

Example: Provider Caseload Statistics

Active Patients

Report f
Report C

Flags	Patient ID	Name	DOB	Sta-tus	PHQ-9		GAD-7		AUDIT-C	I/A	F/U	P/N	# Sess	Wks since I/A
					First	Last	First	Last						
	0101416	[redacted]	9/28/1953	T	11	5	13	6	0*	9/15/15	7/6/16	5/4/16	15	46
	0101694	[redacted]	2/22/1994	T	21	12	19	9	4	4/12/16	7/29/16	6/7/16	8	16
	0101923	[redacted]	8/1/1993	T	19	21	19	19	1	7/21/16	7/27/16		2	2
	0101981	[redacted]	10/14/1968	T	17	9	8	7	0	11/30/15	7/25/16	6/15/16	17	35
	0101983	[redacted]	7/30/1941	T	10	14	16	15	0*	3/16/16	8/3/16	7/27/16	10	20
	0101986	[redacted]	11/30/1975	T	14	4	17	9	1	7/13/16	7/25/16		2	3
	0102111	[redacted]	12/31/1987	T	14	12	20	11	0	12/10/15	7/19/16	7/20/16	11	34
	0102114	[redacted]	2/14/1984	T	13	5	10	6	0	12/7/15	7/29/16	7/27/16	12	34
	0102125	[redacted]	5/3/1994	T	23	18	10	4	0	4/15/16	8/1/16	6/22/16	6	16
	0102191	[redacted]	11/6/1952	RPP	24	13	19	12	1*	12/17/15	7/6/16	3/28/16	14	33
	0102242	[redacted]	4/20/1959	RPP	24	12	21	13	0*	1/6/16	7/13/16	5/16/16	13	30
	0102282	[redacted]	4/9/1947	RPP	22	11	16	6	0	1/12/16	7/22/16	5/4/16	14	29
	0102429	[redacted]	5/19/1961	RPP	13	6	16	4	0	1/27/16	7/8/16	4/27/16	9	27
	0102669	[redacted]	11/27/1995	T	22	17	16	10	5	2/24/16	7/19/16	7/13/16	10	23
	0102869	[redacted]	7/31/1987	T	12	4	11	4	2	3/16/16	7/22/16	6/1/16	7	20
	0102896	[redacted]	10/5/1964	T	14	3	17	11	2	3/17/16	8/2/16	5/4/16	9	20
	0103071	[redacted]	2/28/1984	T	24	4	18	5	2	3/30/16	7/25/16	4/18/16	11	18
	0103101	[redacted]	7/14/1978	T	17	14	20	16	0*	4/1/16	7/18/16	7/13/16	8	18
	0103104	[redacted]	4/1/1993	T	18	16	9	18	0	4/4/16	7/26/16	7/11/16	9	17

Montefiore
HUDSON VALLEY
COLLABORATIVE

Example: Site Caseload Statistics

Caseload Statistics

Site : Montefiore Medicaed by Clinic)
Report Created on : F16, 12:20PM

Clinic	# of Pt.	Initial Assessment			Follow Up		Psychiatric Consultation Note			50% Improved or < 10 after > 10 wks	
		#	Mean Phq	Mean Gad	Mean #	Mean # Clinic	# Req'd	# w/ P/N	Not Imprv w/o P/N	Phq	Gad
[redacted]	148	148 (100%)	14.8	13.8	3.9	3.0 (76%)	0 (0%)	58 (39%)	1	23 (56%) (n=41)	21 (51%) (n=41)
[redacted]	120	120 (100%)	13.3	12.7	4.0	2.5 (61%)	0 (0%)	68 (57%)	1	29 (69%) (n=42)	28 (67%) (n=42)
[redacted]	122	122 (100%)	15.1	12.4	3.4	2.3 (70%)	1 (1%)	60 (49%)	3	16 (53%) (n=30)	17 (57%) (n=30)
[redacted]	108	108 (100%)	11.7	11.4	6.0	3.9 (65%)	0 (0%)	58 (54%)	1	38 (73%) (n=52)	39 (75%) (n=52)
[redacted]	155	155 (100%)	14.6	13.2	3.6	2.0 (57%)	4 (3%)	79 (51%)	8	35 (64%) (n=55)	32 (58%) (n=55)
[redacted]	129	128 (99%)	15.3	14.0	2.8	2.1 (74%)	9 (7%)	25 (19%)	0	8 (44%) (n=18)	10 (56%) (n=18)
All	782	781 (100%)	14.2	13.0	4.0	2.6 (66%)	14 (2%)	348 (45%)	14	149 (63%) (n=238)	147 (62%) (n=238)