Implementation Methodology:
Using the Model for Improvement
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 |

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Our largest 7 partners
GOVERNANCE STRUCTURE
BPHC Governance Structure

Composition and Guiding Principles

- **Executive Committee**
  - Finance & Sustainability
  - Quality & Care Innovation
  - Information Technology
  - Workforce

- **Subcommittees**
  - 7 Clinical Workgroups
  - Cultural Responsiveness Workgroup
  - 3 Workforce Workgroups

- **Nominating Committee**

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

Central Services Organization (CSO)
Staff supports the governing committees (PAC)
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?

<table>
<thead>
<tr>
<th>What do they track?</th>
<th>“Domain 1” Project Requirements</th>
<th>“Domain 2-4” DSRIP Measures</th>
<th>Patient Engagement Metrics</th>
<th>Rapid Cycle Evaluation (RCEs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of project programmatic milestones</td>
<td>BPHC’s performance on DSRIP measures</td>
<td># ‘engaged’ patients by project</td>
<td>Progress toward requirements and measures Will change based on implementation phase</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who defines the measures?</th>
<th>NYS</th>
<th>Nationally-recognized measures (HEDIS, AHRQ etc)</th>
<th>NYS</th>
<th>IWG</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How are they reported?</th>
<th>CSO/sites submit quarterly reports to NYS</th>
<th>NYS measures claims and CAPHS data and provides it to BPHC</th>
<th>Sites/CSO using EHR and RHIO data</th>
<th>DPD submits to site data to CSO in monthly reports</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How are they evaluated?</th>
<th>Reviewed by NYS</th>
<th>Reporting only (DY1); some linked to performance (DY2 -5)</th>
<th>Meet patient engagement targets</th>
<th>Reviewed by IWG and CSO</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Performance impacts funding?</th>
<th>Yes</th>
<th>Yes—some double as EPP measures</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
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

<table>
<thead>
<tr>
<th>Metric example</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients seen during the month for whom a PHQ-2 screen is administered</td>
<td>[PCBH]</td>
</tr>
<tr>
<td>% of patients seen during the month with a positive PHQ-2 screen that received a subsequent PHQ-9</td>
<td>[PCBH]</td>
</tr>
<tr>
<td># of referrals to a.i.r bronx in the past month</td>
<td>[Asthma]</td>
</tr>
<tr>
<td>% of asthma patients seen in the last month with an up-to-date Asthma Action Plan</td>
<td>[Asthma]</td>
</tr>
</tbody>
</table>
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

Hunches, Theories, Ideas:
- teach back and MI Qs

Very Small Scale Test: one patient, one session

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

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

Implement Change:
- new procedure, training, job descriptions

Changes That Result in Improvement

Learning from data
# Performance Reporting & Performance Improvement Training Plan

<table>
<thead>
<tr>
<th>Date</th>
<th>Duration</th>
<th>Audience</th>
<th>Event Title</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/7</td>
<td>3 hour</td>
<td>DPDs &amp; PMs</td>
<td>Overview of the Model for Improvement</td>
<td>- QI self assessment&lt;br&gt;- What is QI/PI? The Science of Improvement&lt;br&gt;- PDSA&lt;br&gt;- Aim Statements&lt;br&gt;- Evaluating Improvement</td>
</tr>
<tr>
<td>7/26</td>
<td>3 hour</td>
<td>DPDs &amp; PMs</td>
<td>Aim Statement Sharing &amp; Using Data for Improvement</td>
<td>- Measurement for Improvement&lt;br&gt;- Run charts&lt;br&gt;- Concept of a “family of measures”</td>
</tr>
<tr>
<td>8/16</td>
<td>All day</td>
<td>DPDs &amp; PMs</td>
<td>Facilitating Improvement: selecting and testing changes, data interpretation &amp; coaching strategies</td>
<td>- Reviewed revised Aim Statements&lt;br&gt;- Selecting and Testing Changes&lt;br&gt;- PDSA review and practice&lt;br&gt;- Coaching QI teams</td>
</tr>
<tr>
<td>9/16</td>
<td>All day</td>
<td>DPDs &amp; PMs SSITs</td>
<td>Overview &amp; application of the Model for Improvement to advance work on project- and site-specific aims</td>
<td>- Team sharing: referrals to a.i.r. bronx.&lt;br&gt;- Model for Improvement and PDSA review and simulation&lt;br&gt;- PDSA Design, Share; and Feedback</td>
</tr>
</tbody>
</table>
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

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

MHVC Contracting Process

AIM Measure Change PDSA

Data to Drive Improvement

DSRIP Projects & Work Streams
MHVC Contracting Process
Process Mapping & Project Design
Output from future-state vision session

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

<table>
<thead>
<tr>
<th>Stakeholder Type</th>
<th>Hospital</th>
<th>PCP/Ped</th>
<th>CBO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
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.

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.

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**Future State Roles by partner type per project**

<table>
<thead>
<tr>
<th>Project</th>
<th>Hospital</th>
<th>PCP/Pediatrician</th>
<th>CBO</th>
</tr>
</thead>
</table>
| 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 |
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

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

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

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

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

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

- PDSA applications
- PDSA Workshop Tools & TA (HRD PHC)
- Quit Line Referrals (Planned Parenthood)
- Cancer Screening Rates
- Asthma Action Plan Workflows
- BHI Model 2 (Access/HRH) MAX
- High Utilizers 2 Teams (MAX)
- High Performance Metrics strategies
- Psych ED visits (Nyack)
- BAP & MI Staff Training across organizations (TTT Program)
- CBO VBP strategy TA by NYAPRS (30 CBOs)
Our Clinical Improvement Team

Cross Training

Provider Relations Specialists

Medical Director

Director Quality & Innovation

Director Practice Transformation

Performance Improvement Specialists

Project Specialists

PCDC (PCMH vendor)

Process Improvement Coaching (Field work)

Project Management

PCMH Practice Coaching
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)
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
# PDSA Template

1. **Pilot Organization**
   - Please also specify the site name.

2. **PDSA Topic/Project Title**
   - 

3. **AIM Statement**
   - **Instructions:** Remember that AIM statements must be S.M.A.R.T. (Specific, Measurable, Achievable, Relevant, and Time-bound).
   - 

4. **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**:

5. **Stakeholders**
   - 

6. **PDSA Total Duration**
   - **Target Start Date (MM/YYYY)**: 
   - **Target End Date (MM/YYYY)**: 

7. **PDSA Objective**
   - **What is the importance of this issue? What issues are you trying to address?**

8. **Prediction Statements**
   - **What do we hope the potential outcomes will be?**

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**Bruce Rapkin**:

- **AIM**: 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 might want to train staff, improve outside referrals to screening providers, and modify your EHR. Each of these 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).

- **Data Collection**: 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's great to have multiple indicators of outcomes.

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

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

- **PDSA Objective**: 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.

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**Montefiore Hudson Valley Collaborative**
9. Reflect and establish future plans
   9.1 What did we learn?
   9.2 What other actions are required?

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?

7. Study the results
   7.1 To what extent did our actions lead to improvement?

6. Implement the theory for improvement
   6.1 Are we collecting data as we go?

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.

4. Analyse
   4.1 What are the metrics of variation and control?
   4.2 What are the changes needed?
   4.3 What are the data saying about current performance?

3. Study the current situation
   3.1 What data are needed to measure performance now?
   3.2 How will the data be collected?
   3.3 What are the data saying about current performance?

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?

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?

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?
**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

**PLAN**
- **Step 1:** Identify patients with asthma and no AAP
- **Step 2:** Understand current state AAP data & Processes
- **Step 3:** Determine which patients went to the ED in the baseline period

**DO**
- **Step 4:** Determine when patients last visited their PCP
- **Step 5:** Strategize and develop plan to connect patients with their PCP for an AAP

- **When Patient presents to the ED or PCP office, ensure AAP developed or updated**
- **Modify workflows to address gaps**

**STUDY**
- **Track data weekly for baseline and new patients**
- **Expect the number of patients without AAP to decrease!**

**ACT**
- **Develop a process and performance sustainability plan**
BH Integration
Project 3ai
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

## Integration Continuum

<table>
<thead>
<tr>
<th>Key components of integrated care</th>
<th>DSRIP Model 1 (Co-location)</th>
<th>DSRIP Model 3 (IMPACT)</th>
<th>Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identification of patients and referral to care</strong></td>
<td>Patient/Provider identification of those with symptoms in clinic system</td>
<td>Systematic screening of patients with symptoms in clinic system</td>
<td>Systematic screening of all patients with follow-up for assessment and engagement</td>
</tr>
<tr>
<td><strong>Referral facilitation and tracking</strong></td>
<td>Referral to external BH specialist/psychiatrist</td>
<td>Enhanced referral to outside BH specialist/psychiatrist through a formal agreement with engagement and feedback strategies employed</td>
<td>Clear process for referral to BH specialist/psychiatrist (see trusted or referral) with &quot;no one turns away&quot;</td>
</tr>
<tr>
<td><strong>Care team</strong></td>
<td>PCP and patient</td>
<td>PCP, patient and ancillary staff member</td>
<td>PCP, patient and BH specialist</td>
</tr>
<tr>
<td><strong>Multi-professional team (including patients) approach to care</strong></td>
<td>Communication with BH specialist driven by necessity or urgency</td>
<td>Formal written communication (doctor/nurse report) between PCP and BH specialist on complex patients</td>
<td>Regular formal meetings between PCP and BH specialist</td>
</tr>
<tr>
<td><strong>Availability for interprofessional contact between PCP and BH specialist/psychiatrist</strong></td>
<td>None or very limited interpersonal interaction (occasionally using a patient as a conduit)</td>
<td>Consistent interaction, possible through ancillary staff members (e.g., nursing staff)</td>
<td>In-person, phone, email interaction on a regular basis</td>
</tr>
<tr>
<td><strong>Ongoing care management</strong></td>
<td>Limited follow-up of patients provided by office staff</td>
<td>Proactive follow-up to ensure engagement or early response to care</td>
<td>Maintaining a registry with ongoing measurement and tracking and proactive follow-up with active provider and patient reminder system</td>
</tr>
</tbody>
</table>

**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 for patients in the PC practice
- Ancillary staff member refers to non-clinical personnel, such as office staff, receptionists, and others

---

Montefiore Hudson Valley Collaborative
# BHI Framework Domains

## 8 BH Integration Domains

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Finding, screening and referral to care</td>
</tr>
<tr>
<td>2</td>
<td>Multidisciplinary professional team to provide care</td>
</tr>
<tr>
<td>3</td>
<td>Ongoing care management</td>
</tr>
<tr>
<td>4</td>
<td>Systematic quality improvement</td>
</tr>
<tr>
<td>5</td>
<td>Decision support for measurement-based, stepped care</td>
</tr>
<tr>
<td>6</td>
<td>Culturally adapted self-management support</td>
</tr>
<tr>
<td>7</td>
<td>Information tracking and exchange among providers</td>
</tr>
<tr>
<td>8</td>
<td>Links between community/social services</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Key components of integrated care</th>
<th>DSRIP Model 1 (Co-location)</th>
<th>DSRIP Model 3 (IMPACT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-based guidelines/treatment protocols</td>
<td>None or limited training on BH disorders and treatment</td>
<td>Standardized use of evidence-based guidelines for all patients, Tools for regular monitoring of symptoms</td>
</tr>
<tr>
<td>Decision support for measurement-based, stepped care</td>
<td>PCP training on BH guidelines for common behavioral health diagnosis and treatment</td>
<td>Systematic tracking of symptom severity, Protocols for intensification of treatment when appropriate</td>
</tr>
<tr>
<td>Use of pharmacotherapy</td>
<td>PCP initiated, limited ability to refer or receive guidance</td>
<td>PCP managed with prescribing BH specialist/psychiatrist support</td>
</tr>
<tr>
<td>Access to evidence-based psychotherapy treatment with BH specialist</td>
<td>PCP initiated, and referral when necessary to prescribing BH specialist/psychiatrist for follow-up</td>
<td>PCP-managed with CM supporting adherence between visits and BH prescriber/psychiatrist support</td>
</tr>
<tr>
<td>Systematic quality improvement</td>
<td>Supportive guidance provided by PCP</td>
<td>Brief psychotherapy interventions provided by BH specialist only</td>
</tr>
<tr>
<td>Use of quality metrics for program improvement</td>
<td>Available off-site through pre-specified arrangements</td>
<td>Brief interventions provided by BH specialist (with formal QI training) as part of overall care team with exchange of information as part of case review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ongoing systematic quality improvement with monitoring of pop, level performance metrics and implementation improvement projects by designated QI team</td>
</tr>
</tbody>
</table>
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
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
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
Diagnosis profile is unique:
High concentration of Schizophrenia and Psychotic Disorders

NYACK: ER Diagnosis
MH/SUD Cohort

- Developmental Disorders
- Psychoactive Substance Use
- Anxiety & Other NonPsychotic
- Mood Disorders
- Schizophrenia & Other Psychosis

June 1- June 30, 2016
2700 presentations to ED for BH issues
Diverse Presentation Paths:
# of police and group home referrals of note

NYACK: ER Presentation Mode
MH/SUD Cohort

- Bikur Cholim
- RPC
- Jawonio, MHA, ARC, VCS
- MH Clinic
- Other Hospital
- Nyack Hospital
- School/BOCES
- Primary Care MD
- Behavioral Health Response Team
- Self, Family, Friend
- Police
- Ambulance
- Group Home

Opportunities for focused interventions
Referrals from Group Homes: Targets for Intervention

- Site A
- Site B
- Site C
- Site D
- Site E
- Site F
- Site G
- Site H
- Site I
- Site J
- Site K
- Site L
- Site M
- Site N
- Site O
Rapid Performance Improvement Project
Nyack ED Behavioral Health Visits

Project Team Identified (Multidisciplinary)
Weekly Meeting x6 weeks
Action Periods between meetings

Week 1
Orientation, Review of Data, Map Areas of Inquiry

Week 2
Data Analytics, Patient Flow Mapping

Week 3
Identify Root Causes

Week 3
Identify Solutions

Week 4
Implement Solutions & Data Monitoring

Week 5
Final Performance Assessment
Data Monitoring, Barriers

Week 6
Ongoing Performance Monitoring
Finalize Briefing Report
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
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
ED Care Triage
Project 2biii
ED Care Triage (2biii)

**GOAL**
Decrease Preventable ED Visits

Identify High Utilizers

Link High Utilizers to PCP and CM

MAX Series
St. Luke's-Cornwall/Cornstone/Access/Horizon
St. Joseph’s
  - Identify HU cohort
  - Focused Care Management strategy
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
- 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
- Cohort of High Utilizers
- 125
- 87 pts 70%
  - Presented to ED
- 28 pts 32%
  - Engaged by Care Manager
- 19 pts 21%
  - Connected to Social Services
  - Connected Back to Dialysis Center

20% ED Visits
88% Admissions

3x (280%)
Engagement with Care Coordination Team
MAX Series:
St. Joseph’s

Report Out Presentation
MAX Series: SLCH/Cornerstone/ASFL/Horizon Medical
Multidisciplinary “Action” Team

Target Patient Population
3 or more IP Admissions
6 or more ED visits

High Utilizer Cohort

2015 Baseline Data
1,226 ED Visits
492 IP Admissions

2016 Outcomes
ED Utilization (by cohort group)
33%

Intervention
Quarterbacks from 3 partners and the hospital’s care transition team connect patients to PCP/BH providers based on associated needs
MAX Series:
St. Luke’s-Cornwall / Cornerstone/Access/Horizon Health

Report Out Presentation

[Image of a group of people in a meeting room, looking at posters and taking notes]

NAME OF ACTION PLAN: Communication Between Agencies

<table>
<thead>
<tr>
<th>ACTION ACTIVITIES:</th>
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<tbody>
<tr>
<td>WHAT NEEDS TO BE DONE?</td>
</tr>
<tr>
<td>Identify agencies (establish point person)</td>
</tr>
<tr>
<td>Meet regularly with CAAs</td>
</tr>
<tr>
<td>Role define, communication protocol development, shared care planning</td>
</tr>
<tr>
<td>Define timelines intake criteria/processing</td>
</tr>
<tr>
<td>Joint workflow between agencies</td>
</tr>
<tr>
<td>“Close the loop”</td>
</tr>
<tr>
<td>Schedule care plan meetings</td>
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</table>

<table>
<thead>
<tr>
<th>WHEN?</th>
<th>BY WHOM?</th>
</tr>
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<tr>
<td>8/19/16</td>
<td>MM</td>
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</table>

[Note: RF at the bottom]
Questions?
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
## Example: Provider Caseload Statistics

### Active Patients

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<tr>
<th>Flags</th>
<th>Patient ID</th>
<th>Name</th>
<th>DOB</th>
<th>Status</th>
<th>PHQ-9 First</th>
<th>PHQ-9 Last</th>
<th>GAD-7 First</th>
<th>GAD-7 Last</th>
<th>AUDIT-C</th>
<th>I/A</th>
<th>F/U</th>
<th>P/N</th>
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</table>
# Example: Site Caseload Statistics

## Case Load Statistics

<table>
<thead>
<tr>
<th>Clinic</th>
<th># of Pr.</th>
<th>Initial Assessment</th>
<th>Follow Up</th>
<th>Psychiatric Consultation Note</th>
<th>50% Improved or &lt; 10 after &gt; 10 wks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>#</td>
<td>Mean PHQ</td>
<td>Mean GAD</td>
<td>Mean #</td>
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<tr>
<td></td>
<td>148</td>
<td>148 (100%)</td>
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</tr>
<tr>
<td></td>
<td>120</td>
<td>120 (100%)</td>
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<td>12.7</td>
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<td>122 (100%)</td>
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<td>3.4</td>
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<tr>
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<td>108</td>
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<td>11.4</td>
<td>6.0</td>
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<td></td>
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<td>14.0</td>
<td>2.8</td>
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<tr>
<td><strong>All</strong></td>
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<td>781 (100%)</td>
<td>14.2</td>
<td>13.0</td>
<td>4.0</td>
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