Morris Heights Health Center

Putting Technology to work for the patient

Who We Are

- FQHC
- Joint Commission Certified
- Six Health Centers in the Bronx, Specialty facility, School Based Health Program
- Member of the BAHN Health Home

HEALTH HOME DEFINED

- Health Home is a New York State Medicaid Care Coordination program for chronically ill beneficiaries
- Generally defined as a system of care delivery which:
  - *All providers who are involved in a beneficiary's care communicate with each other so that all needs are addressed in a comprehensive manner*
  - *Directs person-centered care: A "care manager" coordinates and oversees access to all services a beneficiary needs*
  - *~~Focuses on reducing unnecessary emergency room visits or inpatient~~ stays*
  - *Health records shared among providers to avoid duplication or neglect of services*
  - *Services provided through partnerships between healthcare providers, health plans and community-based organizations*
- Strives to improve health outcomes through care coordination and comprehensive care management
- Facilitates and coordinates care across a continuum of medical, behavioral, chemical dependency and social services

How does Health Home Differ from Patient Centered Medical Home

PCMH

- Started in 2009
- Led by physician practices
- Seeks to strengthen physician-patient relationship
- Replaces episodic care with coordinated care amongst healthcare providers
- Members can be in PCMH and HH; both HH and PCMH will receive payment

HEALTH HOMES

- Started in 2012
- Led by health and community providers
- Seeks to strengthen relationship between medical and behavioral/mental health providers
- Builds on PCMH concept of coordinated care with linkages to broader array of community and social support services

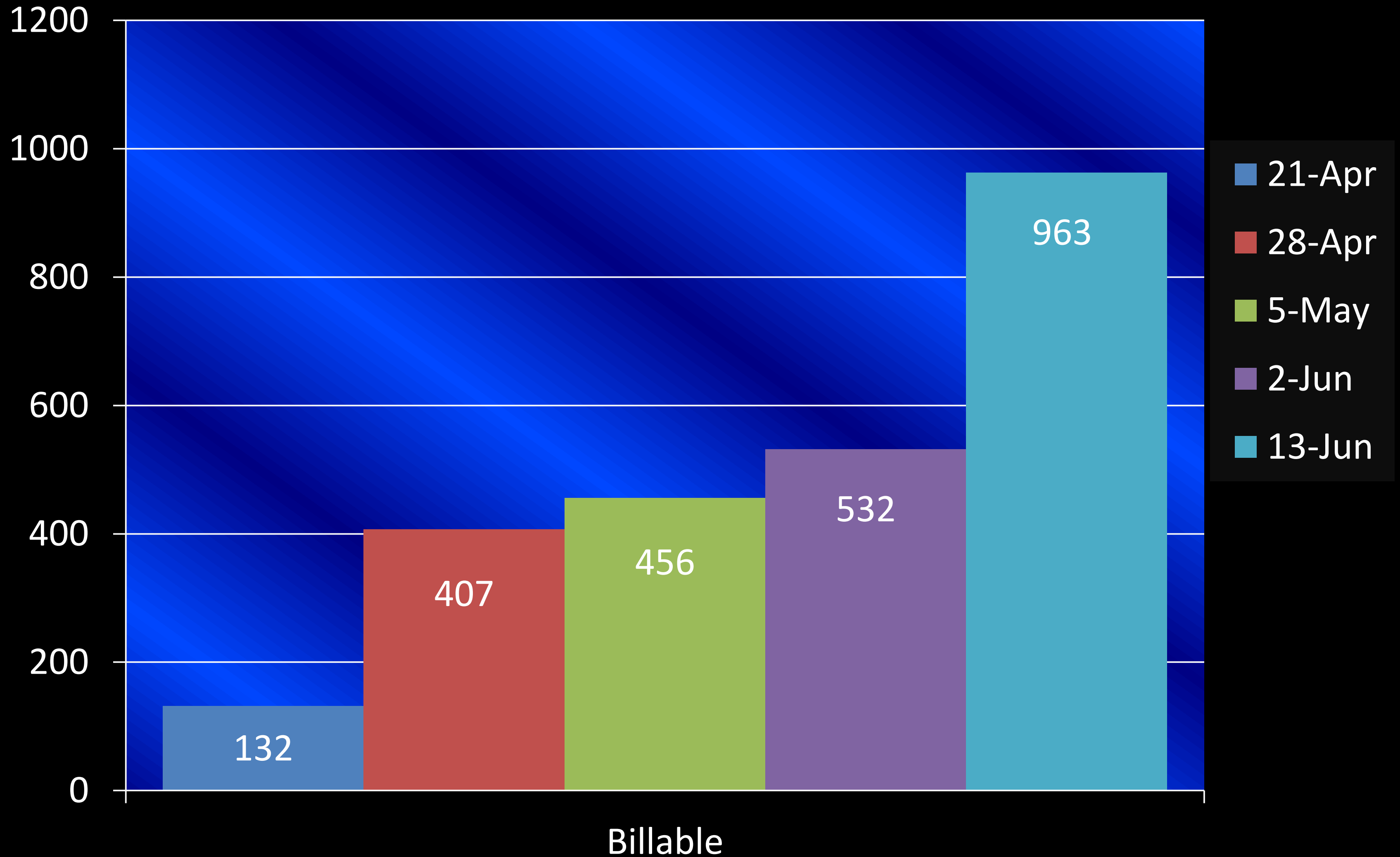
Vision

- Revenue enhancement
- Increase enrollment
- Outreach & Increase enrollment with MHHC patients.
- Focus on quality indicators
- Provide quality care coordination
- Decrease hospitalizations rates
- Cost containment
- Increase resources and support for Care Management personnel

April 21, 2014

APRIL 21 2014			
TrackingSheetStatus			
WorkStatus			
ACM			
Members	Billable		
Monthly bill status	N	Y	Grand Total
Enrollment	95	43	138
Eligible	471		471
(blank)			
Outreach	413	89	502
Outreach Non-Billable	245		245
Grand Total	1224	132	1356

BILLABLE ENCOUNTERS



Morris Heights Health Home Journey

- Before – No real tracking methodology, poor outreach and follow up, multiple points of data entry needed
- After – Tracking now done, outreach technologically enabled, data entry now simplified and centralized

Audit Results 2013

- **2013 survey results showed the following need for improvements:**

✓ Patients were lost after the initial three months of outreach

✓ Staff not assignment clients in a timely manner

✓ Care plans were on paper

✓ Uploading plans and assessments to the lead agency was creating double work

✓ Clients goals could not be tracked

✓ Staff activities could not be adequately monitored

✓ Billing was time consuming due to inputting manually into AIRS.

Integrated Care Delivery Platform

- In 2013, we partnered with Zenith Technology Solutions to develop a software package designed specifically to address the needs to coordinate care.
- Specifically we needed a platform that will:
  - Streamline care coordination processes
  - Deliver comprehensive care management
  - Maximize revenue
  - Improve efficiencies, drive down costs
  - Implement systems to report and manage key metrics

* Comprehensive Care Management

* **Maximize Revenue**

* **Improve efficiencies, drive down costs**

* **Metrics**

In summary,

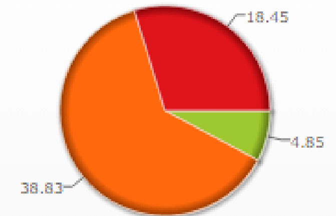
- ✓ Improved staff productivity
- ✓ Improved billing process so that billing happens in a more timely manner. We are able to better track out revenue
- ✓ Improved management of care plans and assessments
- ✓ Able to follow patients as they cycle in and out of the outreach process
- ✓ Most importantly, able to improve patient outcome through improve glucose control, BP control, kept appointments, patient satisfaction and the like.

Screenshots of MHHC's Care Coordination system

CARE MANAGER SUMMARY

Care Manager	# Cases	OutReach Activity	High Risk Cases	Initial assessments complete	Care plans documented	Assessments reviewed	Care plans reviewed	Overdue assessments	Overdue care plans
AGUGLIARO, NICOLE	12	63	0	10 83%	10 83%	10 83%	10 %83	3 25%	3 3%
ALVARADO, WENDY	14	431	1 7%	14 100%	12 85%	14 100%	12 %85	1 7%	1 1%
BASS, LAVETTE	23	257	2 8%	20 86%	21 91%	19 82%	14 %60	3 13%	3 3%
CEDENO, DENISE	19	97	2 10%	18 94%	16 84%	9 47%	14 %73	4 21%	4 4%
COOKE, LORETTA	9	32	0	9 100%	9 100%	6 66%	7 %77	1 11%	1 1%
HAMBY, LASHEMA	15	59	1 6%	14 93%	14 93%	3 20%	12 %80	2 13%	2 2%
ORTIZ, MARTA	11	125	0	8 72%	8 72%	7 63%	2 %18	0	0

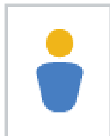
CASE LOAD



CARE MANAGER : AGUGLIARO, NICOLE

My high-risk cases (2) | **My Active Cases (11)** | Outreach (1) | Pre-Hiatus (0) | Post-Hiatus (1)

Case ID	Patient Name	Risk Class	PCP	# Needs	# Goals	# Interventions	Recent Care Plan	Last Intervention	Last Assessment	
225	,		AGUGLIARO, NICOLE	0	0	0				
221	,		AGUGLIARO, NICOLE	9	28	0	10/10/2014 11:09		10/09/2014 10:10	
205	,	MEDIUM	AGUGLIARO, NICOLE	9	22	22	09/09/2014 10:16	09/16/2014 08:58	09/16/2014 10:32	
202	,	MEDIUM	AGUGLIARO, NICOLE	9	21	21	09/08/2014 10:48	09/16/2014 12:08	09/23/2014 09:40	
177	,		AGUGLIARO, NICOLE	9	30	60	09/26/2014 11:36	09/26/2014 14:54	09/19/2014 12:12	
110	,		AGUGLIARO, NICOLE	9	15	16	09/18/2014 11:30	09/26/2014 12:27	08/26/2014 10:39	
75	,	HIGH	AGUGLIARO, NICOLE	9	11	19	09/15/2014 10:09	09/16/2014 15:41	04/03/2014 15:01	
63	,	MEDIUM	AGUGLIARO, NICOLE	9	19	3	07/15/2014 09:41	10/08/2014 14:24	03/26/2014 15:04	
55	,		AGUGLIARO, NICOLE	9	6	9	09/25/2014 08:51	09/25/2014 09:03	04/23/2014 09:27	
31	,		AGUGLIARO, NICOLE	9	36	51	10/06/2014 15:40	10/06/2014 15:50	03/18/2014 14:08	



HNO ID: MRN:

Female, /1966 (48)

Patient Summary

MOOD OR ANXIETY DISORDER	SUBSTANCE USE DISORDER	OBESITY	OTHER PROBLEMS
03/20/2013	03/04/2013	07/24/2013	

Care Alerts	0	Recent Hospital Use	0	Inpatient Visits	0	Inpatient Days	0
Emergency Department Visits	0	OPPH	7	OPBH Professional	1	OPBH Non Professional	0

ALLERGIES: N/A

BP BMI HEART RATE PULSE RATE

Back | Referral | Patient Education | Clinical View

CCD

ID	75	Status	Assigned	Care Manager	AGUGLIARO, NICOLE
Assigned	03/25/2014 18:29	Last assessed		Last care plan	

my dashboard >> care summary

SUMMARY | CARE PLAN | CASE REVIEWS | ASSESSMENTS | OTHER

PATIENT OUTREACH

Contact Status	Contacted	**Contacted by**	AGUGLIARO, NICOLE
Contacted Date	04/03/2014 14:44		

Activity Date	Mode	Type	Activity by	Contactee Type	Contactee Detail
No outreach activity recorded.					

ELIGIBILITY FOR CARE MANAGEMENT SERVICES

Eligibility Status	Eligible	**Evaluated by**	AGUGLIARO, NICOLE
Evaluation Date	04/03/2014 15:01	**Eligibility Date**	07/01/2014 11:43

PATIENT CONSENT

Consent Status	Consent Given	**Updated by**	AGUGLIARO, NICOLE

RISK CLASS

CONTACT INFO.

Address

, BRONX , NY -10467

Language Pref.: **English**

Best time to contact: **Morning**

Best mode of contact: **Home Phone**

CARE TEAM

Care Manager

AGUGLIARO, NICOLE

MHHC

FAMILY/SUPPORTS

Son

SUMMARY | CARE PLAN | CASE REVIEWS | ASSESSMENTS | OTHER

PLAN OF CARE

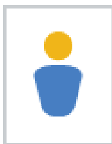
Recent Care Plan	09/15/2014 10:09	**Last Assessment**	04/03/2014 03:01
Signed by	AGUGLIARO, NICOLE Unsign	**Signed date**	09/15/2014 14:18
Approved by	POLANCO, CARMEN	**Approved date**	09/16/2014 10:19

Medical/Physical Needs 3

Evaluated? **yes** Date of evaluation: **08/18/2014** Problem(s) identified? **yes**

Problem: **Hypertension**

Intervention/Tasks	Owner	Status	Date Assigned	Due Date	Date Completed	# Actions	Last Action
Goal: **Patient will adhere to medication regimen**, Assignee: **AGUGLIARO, NICOLE**, Start Date: **08/18/2014**, End Date: **11/18/2014**, Status: **Scheduled** Schedule Time: **11/18/2014 15:30**							
Intervention	AGUGLIARO, NICOLE	Scheduled	06/24/2014 09:09			2	09/16/2014 15:33
Goal: **Patient will maintain blood pressure within acceptable range <120/80**, Assignee: **AGUGLIARO, NICOLE**, Start Date: **08/18/2014**, End Date: **11/18/2014**, Status: **Scheduled** Schedule Time: **11/18/2014 15:35**							
Intervention	AGUGLIARO, NICOLE	Scheduled	08/28/2014 15:02			2	09/16/2014 15:38
Goal: **Patient will recognize signs and symptoms of high blood pressure**, Assignee: **AGUGLIARO, NICOLE**, Start Date: **08/18/2014**, End Date: **11/18/2014**, Status: **Scheduled** Schedule Time: **11/18/2014 15:22**							
Intervention	AGUGLIARO, NICOLE	Scheduled	04/03/2014 16:38			1	09/16/2014 15:25
Goal: **Patient will be knowledgable of low salt foods/diet/intake**, Assignee: **AGUGLIARO, NICOLE**, Start Date: **08/18/2014**, End Date: **11/18/2014**, Status: **Scheduled** Schedule Time: **11/18/2014 15:37**							
Intervention	AGUGLIARO, NICOLE	Scheduled	08/28/2014 15:03			2	09/16/2014 15:40



Female, /1978 (46)

Address	N/A

Mobile Phone	N/A
Home Phone	
N/A	

Specialist:

INTERVENTION HISTORY

Date	Name	Mode	Comments	Completed By
07/22/2014 10:32	Intervention	Phone	Patient will continue to decrease her smoking on a daily basis.	AGUGLIARO, NICOLE

Service : Comprehensive Care Management

INTERVENTION

Intervention Name

Intervention

Mode

Select

Next Intervention Date

10/17/2014 10:07

Health Home Core services

- Comprehensive Care Managemer
- Care Coordination and Health Prc
- Comprehensive Transitional Care
- Patient and Family Support

Comments

Submit | Cancel

HEALTH RISK ASSESSMENT

English | Español

- Demographics
- Social
- Medical/Behavioral
- Chemical Dependency
- Care Access
  - Appointment Adheren…
  - Barriers to Care Access
- Life Planning/ Advanced D…
- Member Eligibility for Care…

5 of 7

CARE ACCESS

APPOINTMENT ADHERENCE

How good are you at making and keeping your medical and behavioral health appointments:

- ○ Consistently
- ● Inconsistently
- ○ Rarely

Reasons for Non-Adherence?

Homebound	Physical Limitations	Transportation Issues
○ Yes	● Yes	○ Yes
● No	○ No	● No

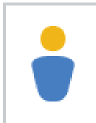
Lack of Escort	Forgets Appointments	Doesn't like to go
○ Yes	● Yes	○ Yes
● No	○ No	● No

Other Reason (Specify):

Appointment Adherence Comments:

BARRIERS TO CARE ACCESS

Housing	Transportation	Physical Health/Disabilities
○ Yes	○ Yes	● Yes
● No	● No	○ No



Female, 1 /1967 (46)

Patient Summary

HNO ID: MRN:

DIABETES	HYPERTENSION	DEPRESSION	OBESITY	MOOD OR ANXIETY DISORDER	ACUTE LOW BACK PAIN
01/09/2013	06/18/2013	02/07/2013	10/03/2013	03/14/2014	03/14/2014

OTHER PROBLEMS

Care Alerts	6	Recent Hospital Use	0	Inpatient Visits	0	Inpatient Days	0
Emergency Department Visits	0	OPPH	22	OPBH Professional	0	OPBH Non Professional	0

ALLERGIES: N/A

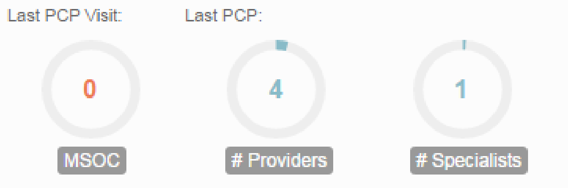
BP BMI HEART RATE PULSE RATE

Back Referral Patient Education

my dashboard >> longitudinal health record

CARE COORDINATION

Last PCP Visit: Last PCP:



ACTIVITY STREAM

had a visit with TRAVER, DIANE
05/07/2014 12:00:00

had a visit with MARVILLE, JILLIAN
04/23/2014 12:00:00

had a visit with NORDIN, CHARLES
04/08/2014 12:00:00

had a visit with TRAVER, DIANE
03/27/2014 12:00:00

HEALTH MAINTENANCE

EYE EXAM
10/07/2013 Source: *EMR*

LAB TESTS

- URINEMACROALBUMIN
- A1C 02/14/2014 Source: *EMR*
- TSH AND LFT
- LIPID PROFILE
- CREATININE GFR

MEDICATIONS

CONTOUR TEST STRIPS
05/07/2014, 5 months ago Source *EMR*

RISK CLASS

RECENT VISITS

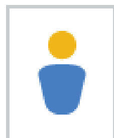
09/30/2014, OTHER RESPIRATORY ABNORMALITIES

09/12/2014, DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED

07/08/2014, DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED

07/01/2014, OTHER RESPIRATORY ABNORMALITIES

06/23/2014, DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR



HNO ID: MRN:

Male, /1956 (58)

Patient Summary

DIABETES
09/26/2014

OTHER PROBLEMS

Care Alerts	5	Recent Hospital Use	0	Inpatient Visits	0	Inpatient Days	0
Emergency Department Visits	0	OPPH	3	OPBH Professional	0	OPBH Non Professional	0

ALLERGIES: N/A

BP BMI HEART RATE PULSE RATE

Back | Referral | Patient Education

CCD

my dashboard >> longitudinal health record

CARE COORDINATION

Last PCP Visit: Last PCP:

0	1	0
MSOC	# Providers	# Specialists

ACTIVITY STREAM

had a visit with CAMPBELL, KATARI
09/23/2013 12:00:00

had a visit with CAMPBELL, KATARI
07/31/2013 12:00:00

had a visit with CAMPBELL, KATARI
07/15/2013 12:00:00

Prev 1 Next

HEALTH MAINTENANCE

EYE EXAM
09/26/2014 Source: *EMR*

LAB TESTS

-	A1C
-	CREATININE GFR
-	LIPID PROFILE
-	URINEMACROALBUMIN
-	TSH AND LFT

MEDICATIONS

NO SIGNIFICANT DATA

RISK CLASS

RECENT VISITS

09/23/2013, OTHER CHRONIC ALLERGIC CONJUNCTIVITIS

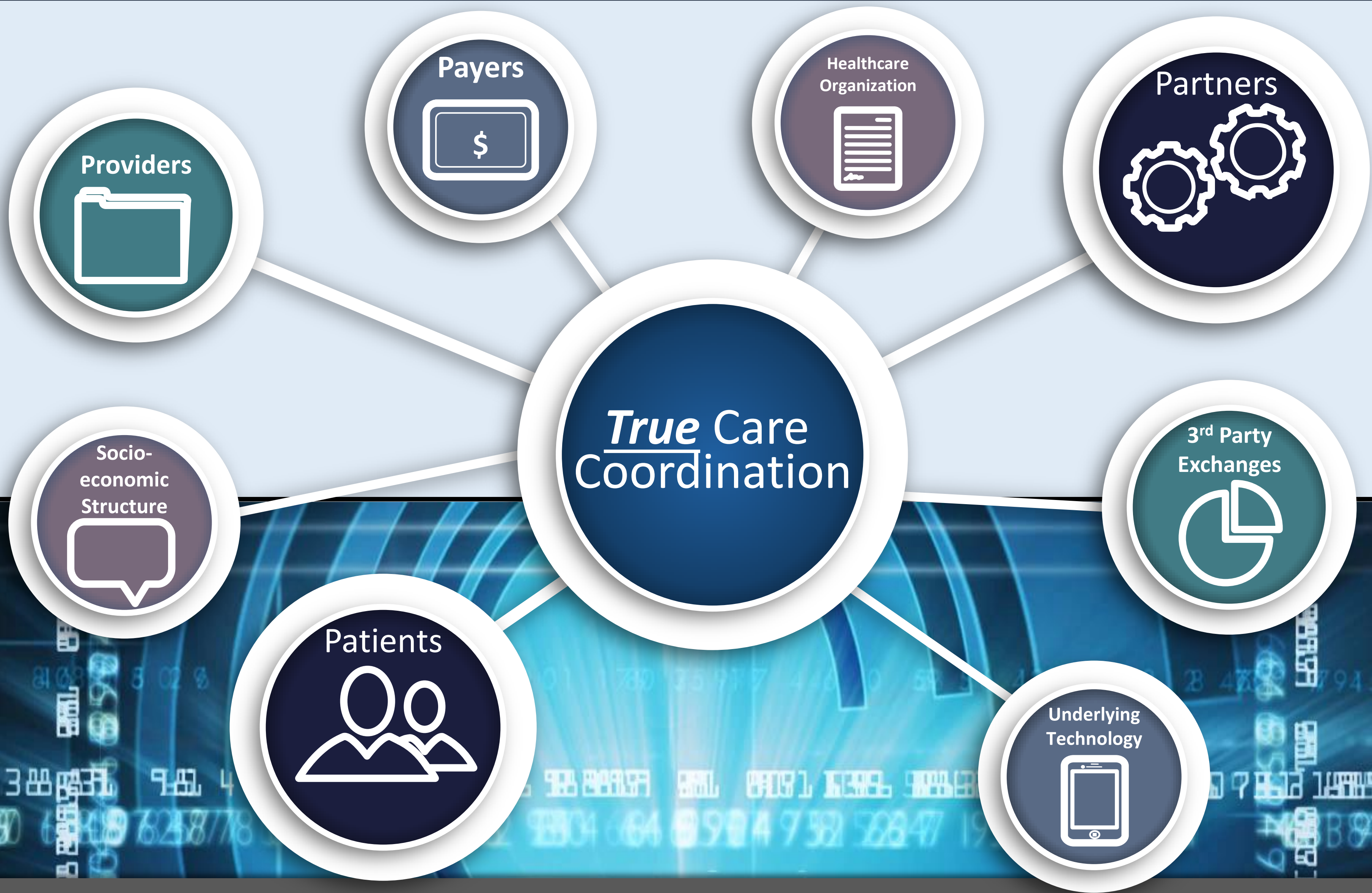
07/31/2013, OTHER CHRONIC ALLERGIC CONJUNCTIVITIS

07/15/2013, OTHER CHRONIC ALLERGIC CONJUNCTIVITIS

PROGRAMS

NO PROGRAMS

True Care Coordination…what does it look like?



What does true care coordination look like?

The hub of care coordination is surrounded by numerous spokes, some traditionally thought of as the "center" of care.

Patients

The literal center of care coordination, the patients are the core. This means more then a passive “being seen/being cared for”, but requires active involvement in their care for the model to work. What does this look like? Using home medical measurement devices such as blood pressure readers, glucometer and activity monitors that can easily transmit data to healthcare organizations care coordination platforms. In addition, the patients family and social network must be integrated into the process. Mobile apps and internet care coordination portals are all tools to be leveraged for such efforts.

Collaboration with Healthcare Partners

Referral partners, reference labs external radiology providers and specialty providers are all examples of external healthcare entities organizations must be able to successfully collaborate with in order to provide true care coordination. In the case of referrals, the loop must be able to be easily opened and closed with a referral made to an external provider for a patient. Basic things like making an appointment, tracking a patients arrival and results of the referral are often a heavily manual process between healthcare entities. Such workflows must be tightly electronically integrated to deliver true patient care.

Care Coordination Hub and Spoke Breakdown

Patients and Partner Healthcare Organizations

Providers

Delivering the core care for the patients along the care coordination spectrum, doctors, PA's, nurses, medical technicians and the like are at the forefront in delivering medical care to the patient. Electronic medical records are currently the predominant way this area of care coordination stores its data and records its efforts. However, EHR's are not built to meet the needs of true care coordination. While an important part of the ultimate data infrastructure needed for care coordination, EHR's become a spoke to the hub of true care coordination's complete data hub.

3rd Party Data Exchanges

External sources of information which can serve as data providers for information that may otherwise take additional resources and time to develop. Though true care coordination calls for providers and healthcare organizations to be truly self sufficient data brokers and exchanges, current 3rd party information exchanges such as local HIE's and cross-entity data warehouse collaborations can act as useful sources of data in the near term as the notion of true care coordination takes hold in healthcare organizations.

Care Coordination Hub and Spoke Breakdown

Providers and 3rd Party Data Exchanges

Socio-economic Structure

One of the most important, yet sadly often overlooked spokes in the hub-spoke model of true care coordination is that of the overall socio-economic structure around the patient. Without taking into account these factors (and being able to divine data from them), the true picture of a patients health outlook can not be measured. Homeless shelters, local employment agencies, construction agencies, schools and other community organizations and support infrastructure must not only be included in, but tightly integrated with, the rest of the patients care coordination meta-structure for the model to work. Notions like "predictive analytics" in factoring a patients risk score can not true have merit if the fact that the patient may be homeless or may have been incarcerated in the last few years is not taken into account.

Healthcare Organization Itself

How can care coordination work if healthcare organizations are not able to operate in a manner matching the true meaning of integrated and coordinated care delivery? Indeed, in order to deliver to the tenants of true care coordination, healthcare organizations must have the "people" infrastructure in place to deliver the needed care. Technology can help to piece together the data stream and speed the processes of care coordination, but ultimately healthcare organizations are only going to be able to coordinate care as well as their clinical, operational and community based staff can function.

Care Coordination Hub and Spoke Breakdown

Socio-economic Structure and the Healthcare Organization Itself.

Payers and Funding Sources

In order to meet the needs the true care coordination brings to bear in terms of both technological and people infrastructure, payers must become more then simple sources of funding, but literal partners in the coordination of care of patients. Payers can become valuable sources of external information around a patient, such as ER admit data that may not be otherwise easily available directly to primary care providers. Building synergies between payer organizations and providers has already begun to show promise in the realm of population management, and is crucial to the delivery of true care coordination.

Underlying Technical Infrastructure

The only way to deliver true care coordination is to have an infrastructure capable of the kind of integration it requires. People, organizations and support networks must all be tightly tied together around the care of the patient. A integrated, cross-functional technology infrastructure will be the crucial foundation for care coordination. EHR's, while an important part of this, must not be seen as the technology hub at the center of care coordination, but rather an important spoke connected to it. Care coordination systems built with integration as a core tenant of their design are the true hub.

Care Coordination Hub and Spoke Breakdown

Payers and Underlying Technical Infrastructure.

Next Steps

Linking with hospital for referrals

Linking with HIEs

Fully linking with managed care companies for hospitalizations, claims, costs, etc.

Patient Care Coordination with Technology

Getting to true care coordination will be a process, and one which will require a technology infrastructure to meet the needed multiple points of integration along the care spectrum.

QUESTIONS?

True Care Coordination

Technology will be at the core of the needed integration.