



# Data Empowerment: Using Data to Understand and Support People's Needs

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# Care Coordination Organization/Health Home (CCO/HH)



Our **mission** is to assist individuals with I/DD to access supports to **live healthy and fulfilling lives**. CCO/HHs employ over 3,000 Care Managers and coordinate care for over 110,000 individuals across NYS.



While our priority is on developing **person-centered Life Plans** that address members needs and social determinants of health, CCO/HHs have **developed infrastructures** that includes Health Information Technology Systems, Data Analytics, and Health/Clinical team supports to **enhance Care Management**.

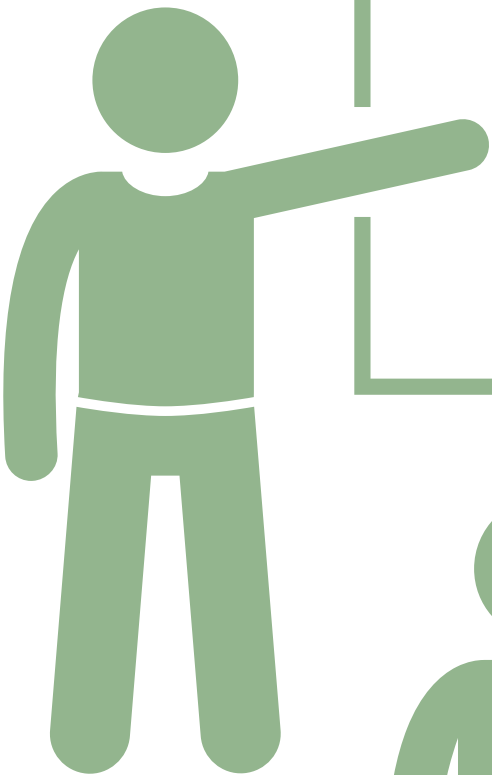


The **goal** of **CCO/Health Homes** is threefold – to improve care and health outcomes, lower costs, and reduce preventable hospitalizations and emergency room visits.



CCO/HH's focus on individual's health and quality of life outcomes but also on **population health initiatives and quality improvement**. Since start up in 2018, CCOs continue to develop this capacity.

# Presentation Objectives



Spotlight several examples of CCO/HH use of data to improve outcomes for people we support.

Demonstrate OPWDD/DOH implementation of Quality Performance Measures to assess CCOs in achieving their goals

Highlight additional ways that CCO/HHs and Providers can work collaboratively to meet the needs of individuals we support together and address system challenges and barriers.



# Leveraging Data to Improve Outcomes



# Emerging Opportunities

5.07 Strategic Plan  
Objective 2.2

“Improve technology  
and how OPWDD  
uses data to make  
services better.”

Holistic  
Assessment  
& Life Plan  
Data

‘Between-  
Encounter’  
Supports

Population  
Health Data

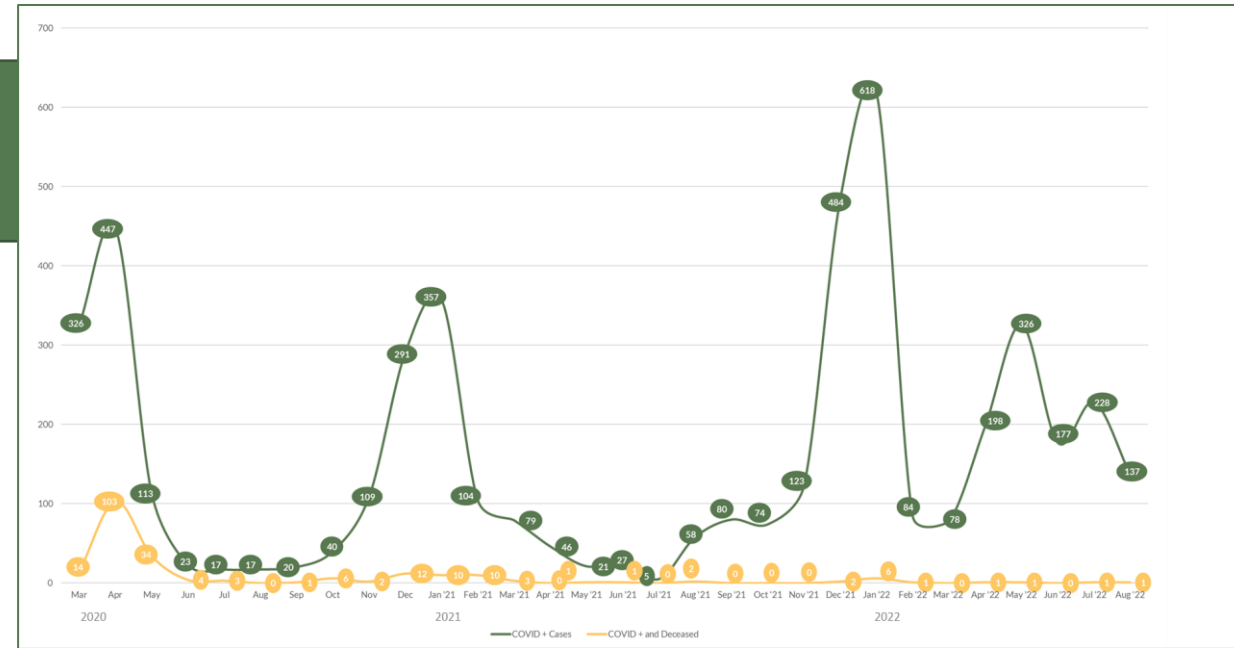




# Data Driven COVID-19 Response Coordination

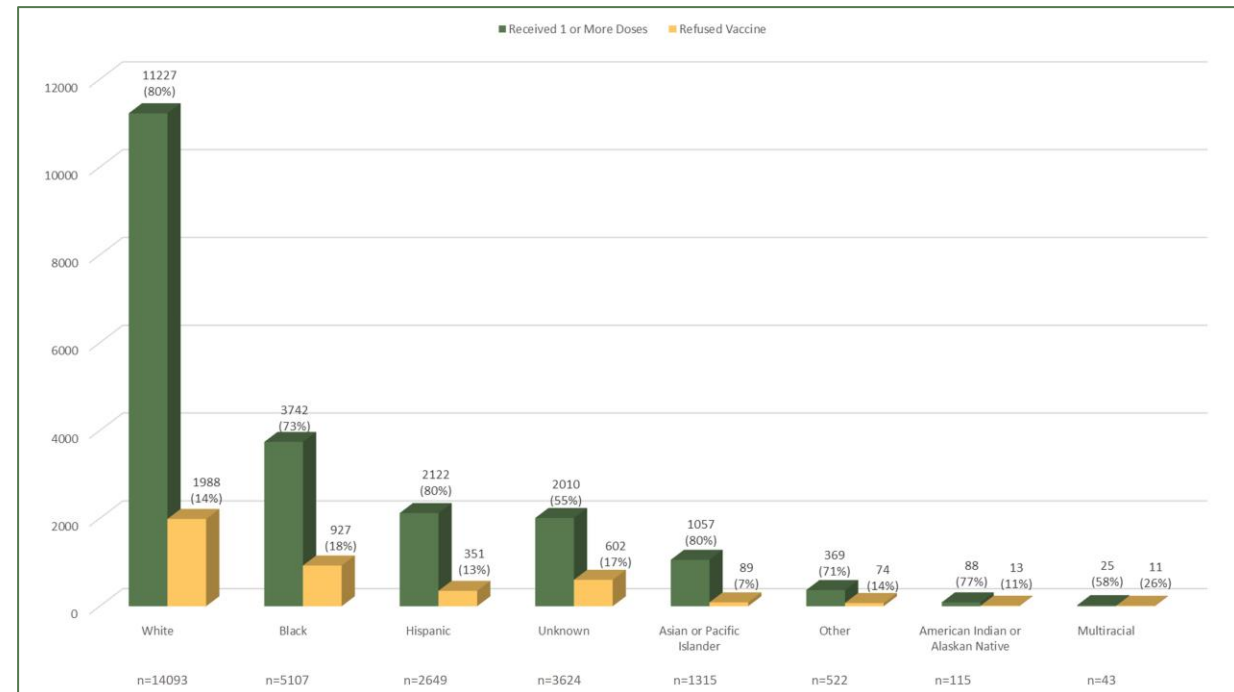
## • Case & Outcomes

- April – June 2018 All CCO/HH Collaboration to inform NY State
- Infection, hospitalization, and deceased rates



## • Care Design NY

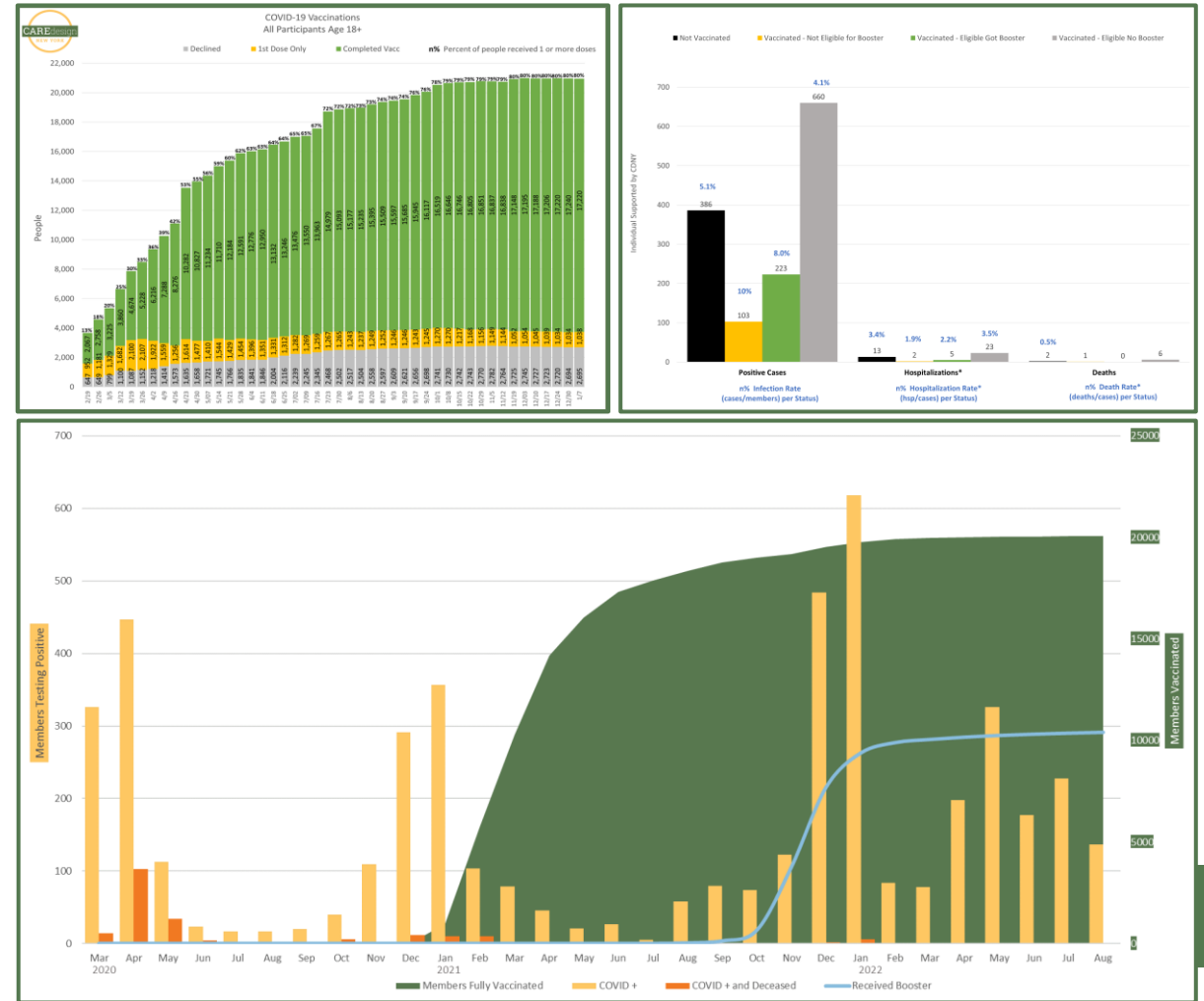
- Multi-factor Analysis
- Risk Mitigation





# Data Driven COVID-19 Vaccination Coordination

- Advocated for priority access based on outcome data
- Faster and easier appointment access
  - Stand-up clinics with over 35 Provider partnerships
  - Appointment Coordination
- Accessed State and New York City Immunization Registries
- Identify trends of those in need
- Person-centered education and coordination for vaccine hesitancy





# DOH – HH Quality Performance Measures

The performance measures monitor overall quality and the degree to which the CCO/HH model, as authorized under the ACA, is meeting its goals, including:

- Improving preventive care;
- Improving disease-related care for chronic conditions;
- Improving transitional care;
- Reducing utilization associated with inpatient stays;
- Reducing utilization associated with avoidable (preventable) inpatient stays;
- Reducing utilization associated with avoidable (preventable) emergency room visits; and
- Improving outcomes for individuals with I/DD through care coordination (health as well as personal/social outcomes);

## Preventive Care

- Annual well, dental, cancer screenings, etc.

## Chronic Care

- Diabetes, asthma, hypertension, etc.

## Mental Illness

- Med adherence, ER/Hsp follow up, etc.

## Substance Use Disorders

- ER/Hsp follow up, treatment, etc.

## Utilization

- ER/Inpatient rates, MH utilization, etc.

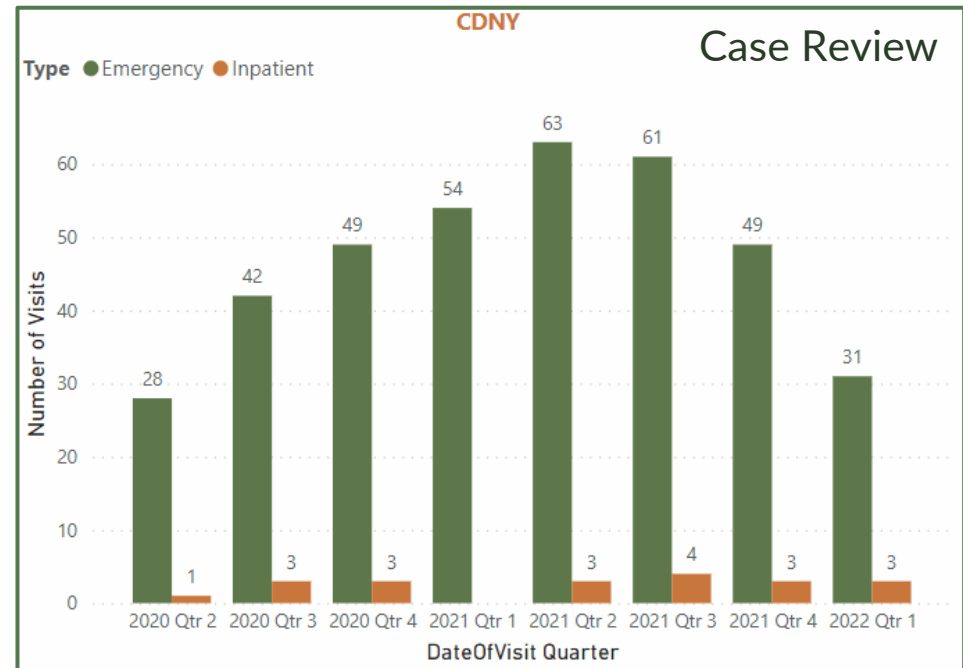
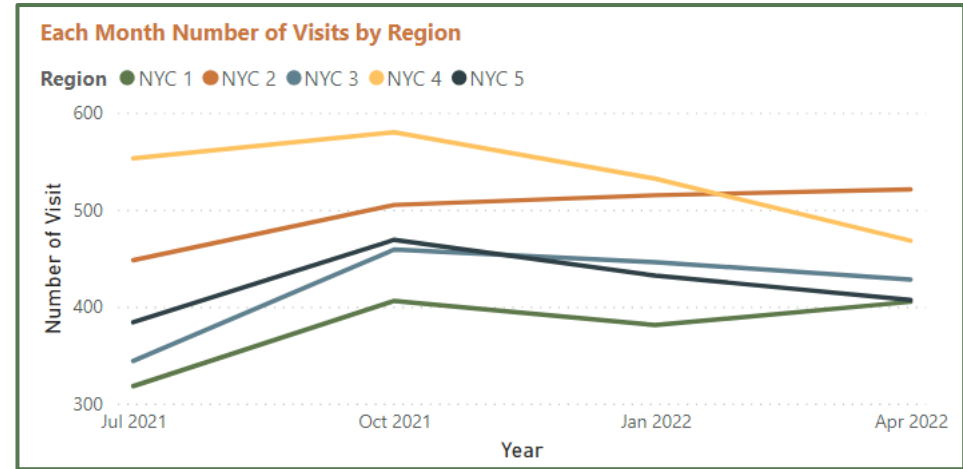
## Avoidable Utilization

- 30 day readmit, avoidable ER, etc.



# RHIO Data

- Population Views
- Person-level Views
  - Identify trends in rising concerns and improvements
- System Trends
  - Community vs. Residential
  - Regions
  - Diagnoses
  - Other quality indicators, e.g., medication adherence





# RHIO Data

- Care Manager Notification to Coordinate Transition of Care
- Clinical Viewer
- Population Utilization Analysis
- High Utilization
  - Clinical Supports

High Use ER in 365 Days TO 2+ ER in 12 Months

Total	Residential	Community
2103	1323	780

Visited	Res Status	Age	Tier	TABSID	FirstName	Last
182						
101						
50						
43						

PRIVATE DATA

High Use Inpatient in 365 Days TO 2+ Inpatient in 12 Months

Total	Residential	Community
723	510	213

Visited	Res Status	Age	Tier	TABSID	First Name	Last
20						
14						
14						
11						

PRIVATE DATA

18 and Older Inpatient Readmission in 30 Days

Total	Residential	Community
469	357	112

Re-Admi	Res Status	Age	Tier	TABSID	FirstName	Last
18						
12						
11						
8						

PRIVATE DATA



## Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)

- Population level performance measures and quality indicators
- Clinical case level details
- High Risk Identifiers
- Methodology
  - 37 Cases of Readmission in 30 days post-MH ER/Inpatient
  - Behavioral Health clinical reviews with Care Managers
  - Ensure/Implement services
- Decrease in ER visits and Hospital admits 6 months post-intervention
  - ER: 45% of cases saw decreases
  - Inpatient: 53% of cases saw decreases

# 2022 PSYCKES-Based Quality Improvement Projects



Polypharmacy, Three or more antipsychotics



Lack of Medication Adherence for Mental Health



High Utilization of ER & Inpatient for Mental Health



No A1c Screening in 1-year, for those with diabetes



Clinical Summary Reports

# Data Supported Provider Collaborations





# Opportunities and Resources

- ✓ More than 70% of our highest ER and inpatient stays are individuals living in certified residential settings.
- ✓ Reports for high-risk members with homelessness or housing insecurity, Serious Mental Illness, criminal involvement, and other risk factors.
- ✓ Utilization of data to illustrate the breadth of needs and advocate for systemic solutions.

## CDNY Resources Available to CMs

CDNY Individual and Family Advisory Board	Educational materials/ health care resource library	Clinical Supports	Network and Provider Relations “Spotlight on Providers” and provider webinars
CDNY Self-Advocacy Group	Subject matter experts	<ul style="list-style-type: none"><li>• Complex Care Committee – assistance for members with complex needs</li><li>• Clinical Rounds – reviews members in hospital and clinical settings</li></ul>	

# Opportunities and Next Steps



CDNY and Provider Leadership Team Meetings will continue and expand to:

- Identify ways to collectively improve outcomes for individuals we support
- Focus on individuals with the most complex needs (CDNY outreach to involved providers)
- Enhance timely problem identification and resolution
- Share strategies/interventions for quality improvement



# Thank You!

For more information, please feel free to contact:

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Questions?

