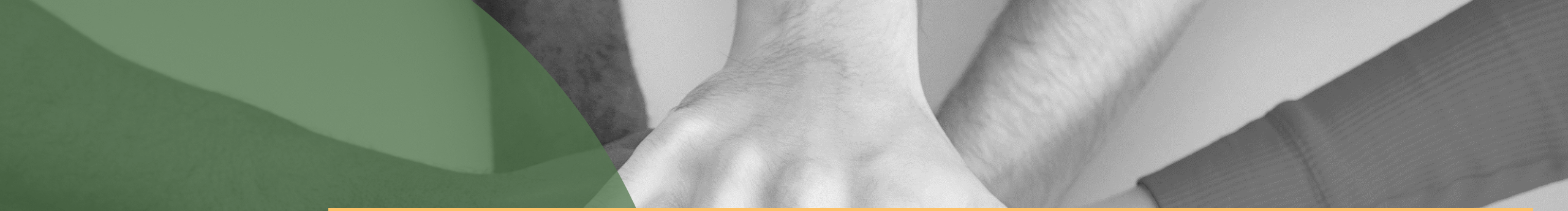

Leveraging Data to Improve Outcomes Through Partnerships in Care Coordination

CAREdesign NEW YORK

YAI
Seeing beyond disability.

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Matthew Northrup	Care Design NY, AVP of Quality & Analytics
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Ravi Dahiya	YAI, Chief Program Officer
Yvonne Patrick	YAI, Bronx Regional Director
Rosemarie Cavaliere	YAI, Behavior Intervention Specialist Supervisor
Lesly Sandoval	CSIDD/NYSTART, Coordinator Region 4

Care Coordination Organization/Health Home (CCO/HH)

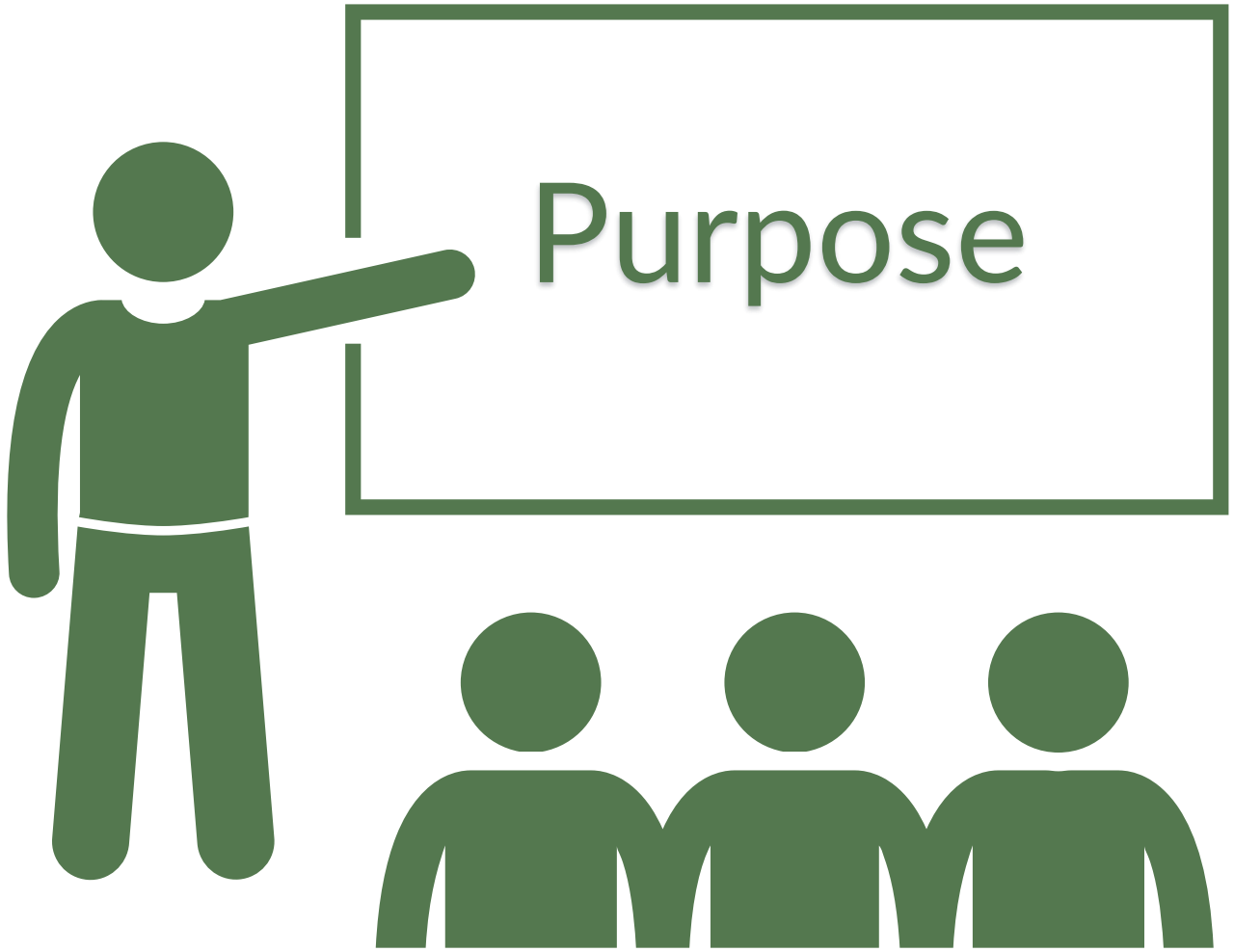
Our **mission** is to assist individuals with I/DD to access supports to **live healthy and fulfilling lives**. CCO/HHs employ over 3,000 Care Managers and coordinate care for over 110,000 individuals across NYS.

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.

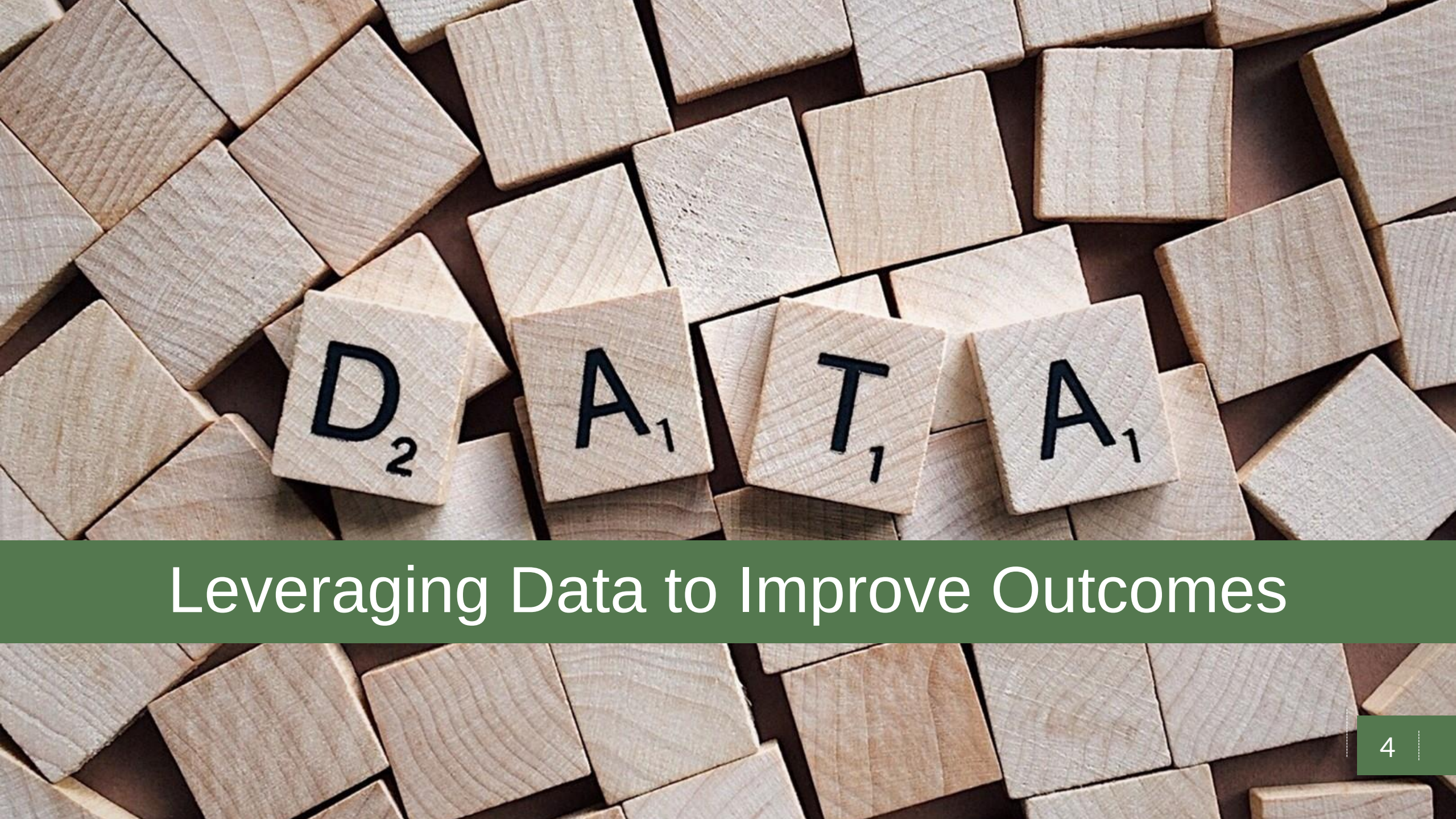
Presentation Objectives



Spotlight several examples of CCO/HH use of data to improve health and other outcomes.

Present a case study of a provider and CCO/HH collaboration to address the needs of an individual with complex needs and frequent hospitalizations and ER visits.

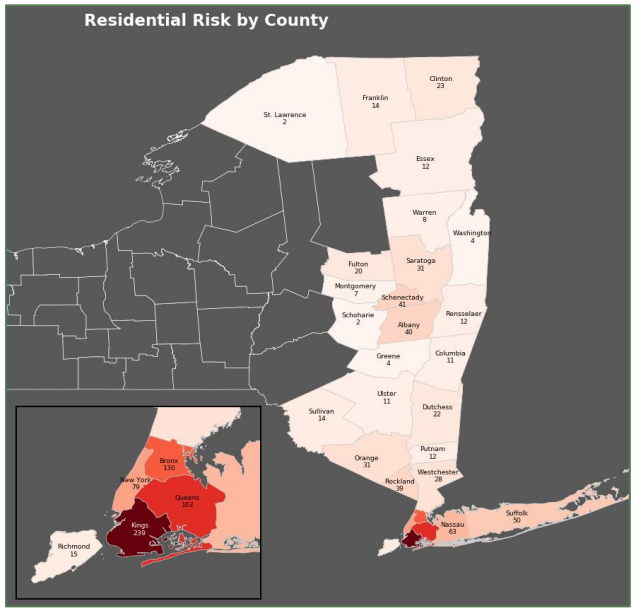
Highlight additional ways that CCO/HHs and Providers can work collaboratively to meet the needs of individuals we support and address system challenges and barriers.



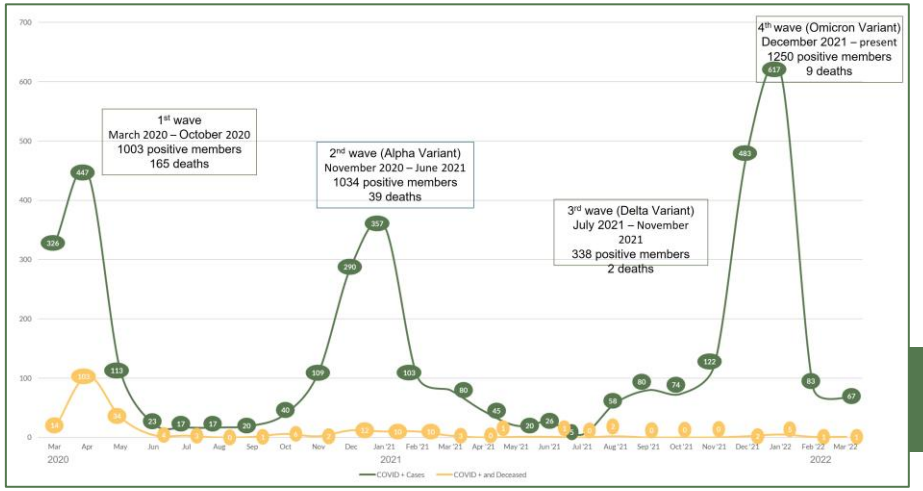
Leveraging Data to Improve Outcomes

Data Driven COVID-19 Response Coordination

- Monitoring & Support Screening (MAS) Tool
  - All CCO/HHs with OPWDD
  - Service Disruption
  - Social Determinants of Health
    - Housing, food, daily living supports
  - Data driven resource allocation

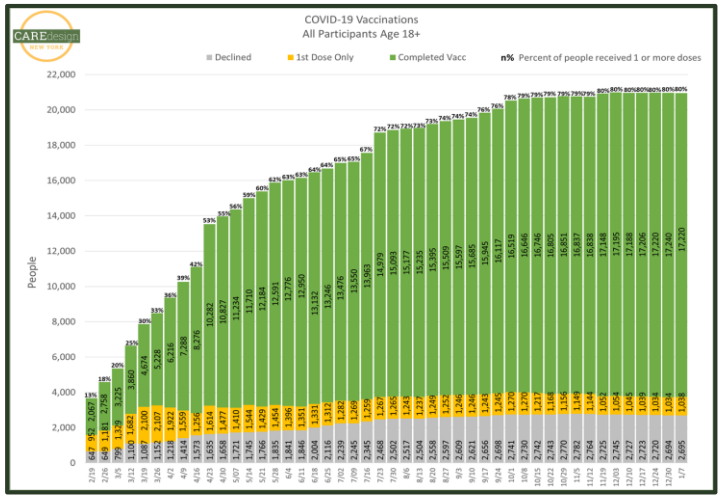


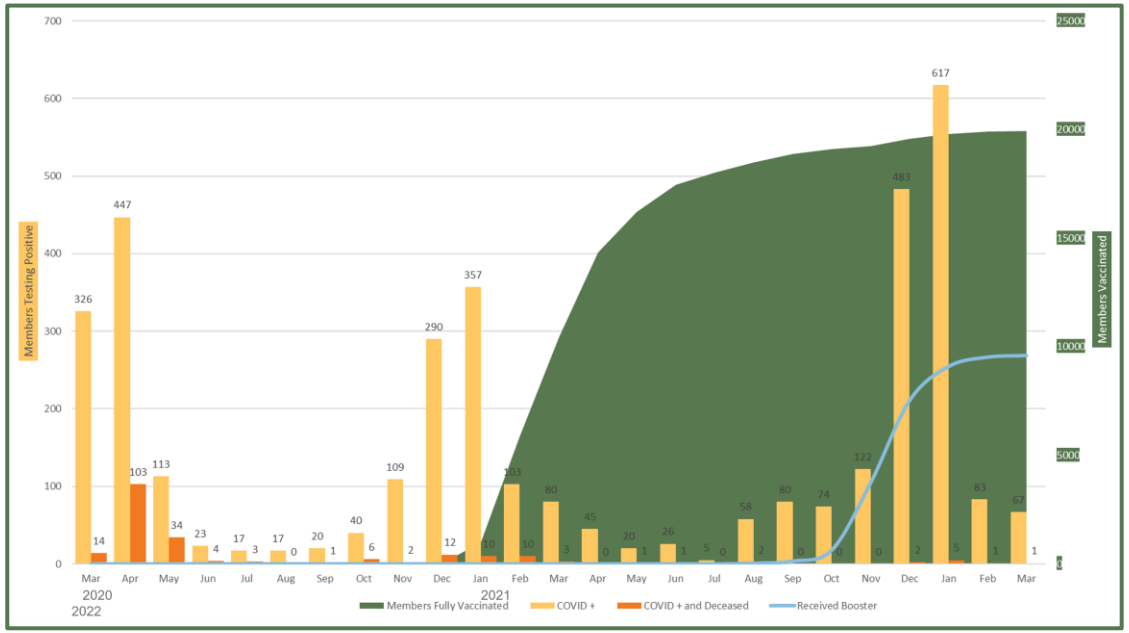
- Case Outbreaks
  - All CCO/HH Collaboration to inform NY State
  - Infection, hospitalization, and deceased rates



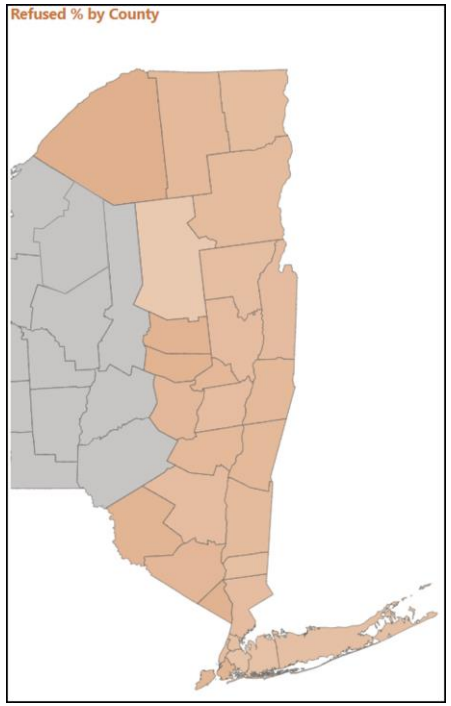
Data Driven COVID-19 Vaccination Coordination

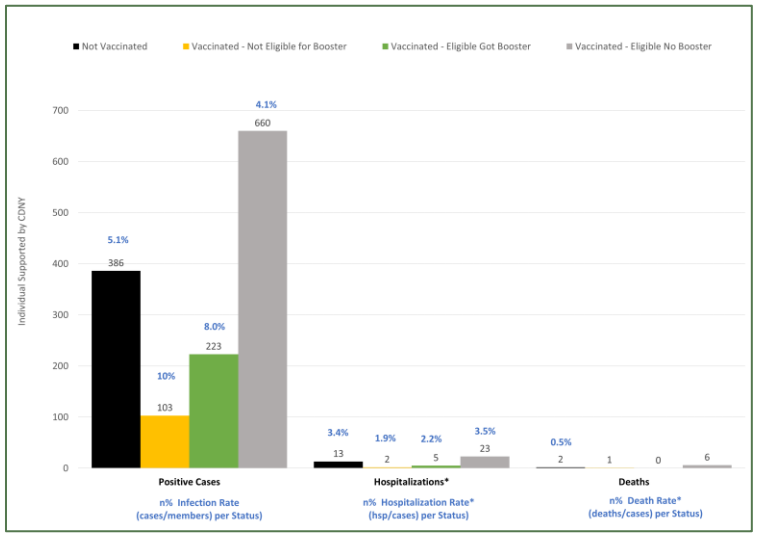
- Advocated for priority access
- Appointment Coordination
- Identify trends of those in need
- Access to State and City Immunization Registries
- Person-centered education and coordination for hesitancy
- Stand-up clinics with over 35 Provider partnerships

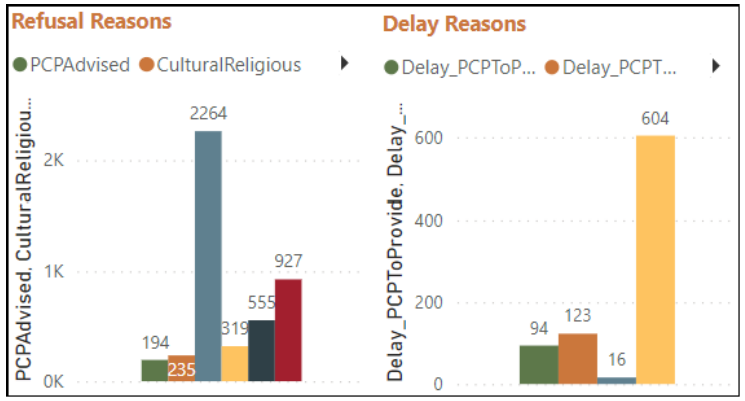


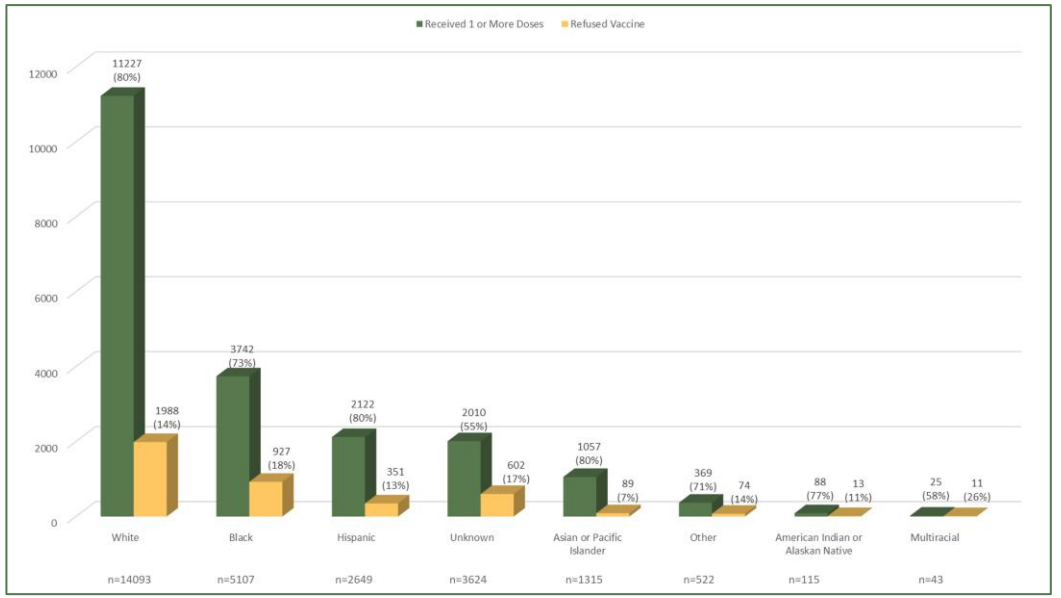


COVID-19 Vaccination Sample Reports







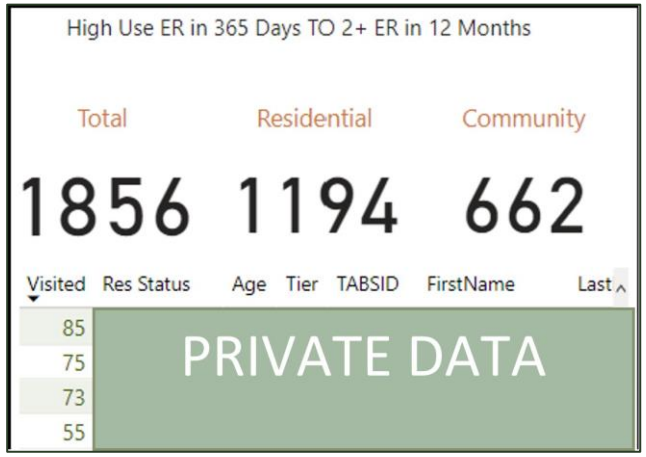


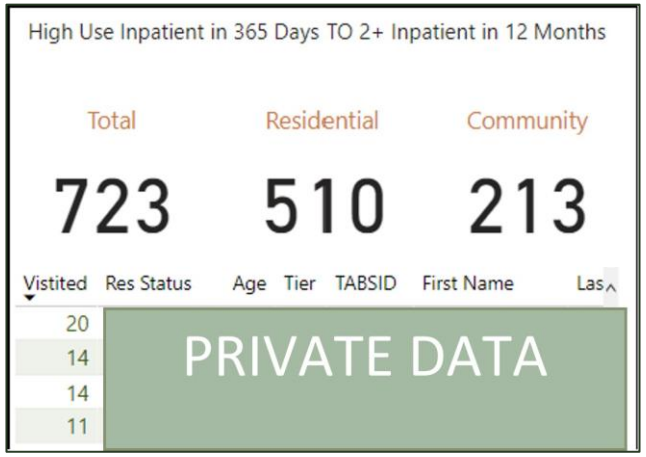
Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)

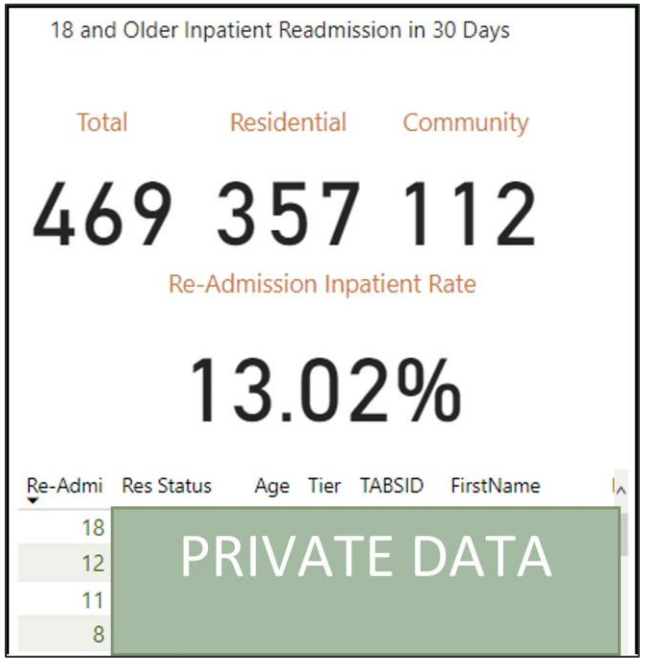
- Population level performance measures and quality indicators
- Clinical case level detail
- High Risk Identifiers
- Methodology
  - 37 Cases of Readmission in 30 days post-MH ED/Inpatient
  - Behavioral Health clinical reviews with Care Managers
  - Ensure/Implement services
- Decrease in ER visits and Hospital admits 6 months post-intervention
  - ER: 45% of cases saw decreases
  - Inpatient: 53% of cases saw decreases
- 2022 Goals
  - Polypharmacy, High utilization of ER & Inpatient, and other high-risk needs

RHIO Data

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



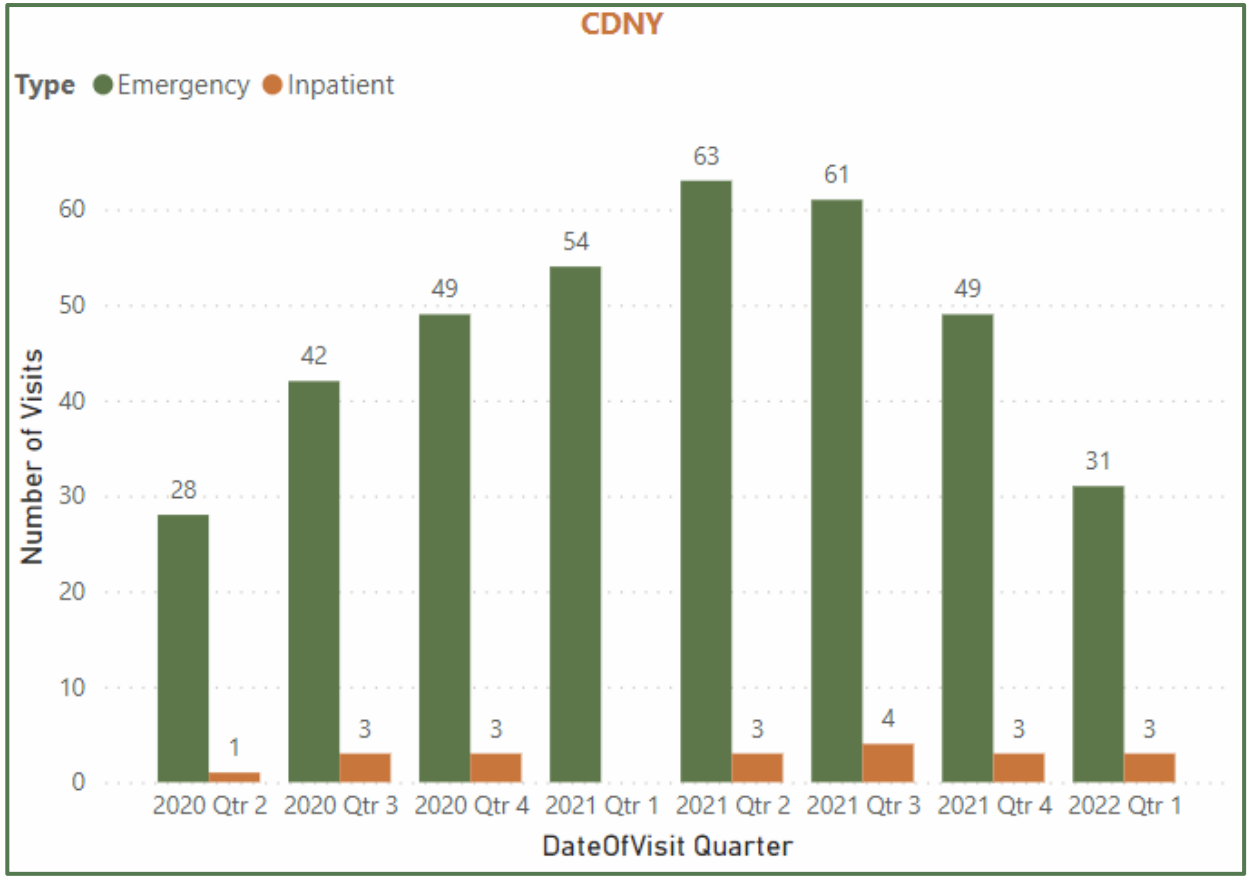





Case Study

Case Study - Roseanne

- Woman, in her late 30s
- Living in YAI residence for almost 20 years
- Complex behavioral health needs
  - Challenges contribute to high dysregulation
  - Difficulty managing daily stressors
- Extremely high use of Emergency Department and
  Hospital Inpatient Stays
- Comorbid Diagnoses – 5+ including physical and behavioral health
- Clear communication verbally and behaviorally
- Unhappy at current home
  - Over-stimulating
  - Hypervigilance and difficulties coping
  - Leads to triggering traumatic responses
  - Extensive exploration for alternative settings



Case Study - Roseanne

- Care Design NY Collaboration
  - Care Manager
  - Leadership
  - Clinical Support Team
  - Behavior Health Team
  - Data Analytics Team
- Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD)
- Care Design NY data findings strengthened advocacy for:
  - Interdisciplinary Team
  - CSIDD
  - Psychologist
  - Psychiatrist
- Data Reports
  - Identified trends over time and correlations
  - Strengthened understanding and supports
  - Present the needs as facts

Strategies used to Support Roseanne

- Staff Training
  - Behavior Support Plan
  - Traumatic Brain Injury
  - Trauma Informed Care
  - Borderline Personality Disorder
- CSIDD
- Mental Health Providers
- Hospitals
- Care Manager Certified Residential Opportunity (CRO) application
- Care Manager explored multiple agencies for appropriate alternative setting

CSIDD Supports for Roseanne

Seeing beyond disability.

Kings County Unit (KCU) at Brooklyn Hospital Behavioral Health Psychiatric Inpatient

- Safe and supportive environment to focus on the individual's specific needs
- Inpatient visits up to a month
- Exploring the validity of current diagnoses
- Medication protocol for effectiveness in treating diagnosis
- Functional Behavior Analysis
- Develop a Behavior Support Plan (BSP)
- Art and music therapy
- Comfort/sensory room
- 1:1 engagement as needed
- Mindfulness/meditation techniques

NYSTART (CSIDD)

- Strength -based and person-centered approach
- Develop an extensive support plan (living document)
- Collaboration with support systems
- Periodic systems meetings, in-person visits and regular telephonic communication
- NYSTART's 24-hour Crisis Hotline

START Therapeutic Supports

Resource Center:

- Alternative setting to a mental health in-patient admission
- Assessment of support needs
- Support following a discharge from a mental health in-patient facility
- Provide ongoing support to an individual who resides with their family and cannot access or benefit from traditional respite programs.
- Therapeutic recreational experiences
- Hosts individuals on planned weekend/weekly visits and emergency crisis visits up to two weeks
- Roseanne has visited the RC frequently, including a two-week emergency visit last month.

START Coaching (STC):

- Supports for individuals living at home or in residential settings
- Once/twice weekly sessions for up to six weeks
- STC promotes person-centered coaching and training for individuals, families and caregivers using positive approaches and other therapeutic tools, including the use of multi-modal clinical assessments.
- Roseanne received STC support in 2021.

Collaboration and Data

Roseanne's clinical profile is complex:

- At the end of 2019, Care Design NY's Clinical Team began working with the Care Management Team to explore additional ways to support her.
- We started meeting with YAI and CSIDD regularly to explore ways to assist Roseanne, which then led to this situation being escalated.
- We have been able to use the PSYCKES and RHIO data to strengthen the collaborative efforts to improve Roseanne's quality of life and explore additional supports including:
  - CSIDD Resource Center
  - Kings County Unit stay
  - OPWDD for alternate Residence

PSYCKES Data

PSYCKES data showed:

2020

- Roseanne visited the Emergency Room 148 times going to different hospitals.
- There were 12 days in which she visited 2 hospitals in a day.
- She was hospitalized 19 times plus an additional 20 days at the Kings County Unit.

2021

- Roseanne visited the Emergency Room 216 times, 68 times more than the previous year.
- There were 15 days that she went to 2 different hospitals in a day and was hospitalized 36 days.
- The 2021 ER increased visits seem to correlate with the ongoing pandemic, not able to access the Resource Center and her inability to secure alternate Residential opportunity despite her clearly communicating her unhappiness in the current residence.

2022

- Between January-March, Roseanne had 23 visits to the Emergency Room and 31 days Hospitalized.

This data was used to provide evidence of unmet needs and advocate for more person-centered residential setting.

Support Provided by Care Management

Care Management Team provided support to coordinate care and advocate for Roseanne:

- Complex Care Committee
- Collaborative IDT Planning
  - CSIDD
  - Residential provider
  - Behavioral Health providers
  - Medical providers
- Consulted with OPWDD
- Explored opportunities for an alternative residence


YAI

YAI Perspective

- This process was an excellent example of great teamwork and collaboration.
- However, ‘Roseanne’ is just one example of many out there in need of alternative models of care not currently available.
- CCO/HH and Provider advocacy is needed to ensure the system offers “out of the box” strategies in meeting the needs of all people within I/DD in NYS.

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, Serious Mental Illness, criminal involvement, and other risk factors.
- ✓ Utilization of data to illustrate the breadth of needs and for advocacy purposes.

CDNY Resources Available to CMs

CDNY Individual and Family Advisory Board CDNY Self-Advocacy Group	Educational materials/ health care resource library Subject matter experts	Clinical Supports • Complex Care Committee – assistance for members with complex needs • Clinical Rounds – reviews members in hospital and clinical settings	Network and Provider Relations "Spotlight on Providers" and provider webinars

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!

Seeing beyond disability.

For more information, please feel free to contact:	
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Questions?