IFIC Ireland - Advancing Integrated Care in Ireland

Session 6: Innovative Approaches to Delivering Integrated Care

December 10, 2019
Background

Common issues plaguing our US healthcare system

- Unrestrained health care expenditures
- Fragmentation and inequality of health and social services
- Underinvestment in community-based services and preventative / primary care
- Significant workforce capacity / training issues
- Siloed medical and acute care focus lacking patient-centered care coordination
- Suboptimal use of information technology
- Poor understanding of patient population and inadequate risk stratification / profiling
Overview of Montefiore Health System
Montefiore Einstein Fully Integrated Academic Health System

11 Hospitals, including Burke Rehabilitation Hospital
32,000+ Employees
6,200+ Providers
3,111 Total Beds - Including 166 Rehabilitation Beds
150 Skilled Nursing Beds
200+ Sites Including

- Hutchinson Campus – Hospital without Beds
- 1 Freestanding Emergency Department - First in New York State
- 65 Primary Care Sites
- 18 Mental Health/Substance Abuse Treatment Clinics
- 91 Specialty Care Sites
  - 3 Multi-Specialty Centers
  - 8 Pediatric Specialty Centers
  - 9 Women’s Health Centers
  - 13 Rehabilitation Centers
- 9 Dental Centers
- 8 Imaging Centers
- Care Management Organization
- Home Health Programs
Our Population Health Journey
Goals of Population Health Management: “Quadruple Aim”

Guiding design and measurement of population health management initiatives

- Timely access
- Patient-centered care

- Reduction in total cost of care
- Decreased utilization of resource-intensive care settings

- Better outcomes and functional status
- Reduced disease burden and risk of incidence

- Improved employee satisfaction
- Increased work-life balance
Montefiore’s Journey to Population Health Management

1996
Established the Montefiore IPA and CMO to facilitate risk contracts

2000
Major expansion of risk membership

2009
Montefiore leads creation of Bronx RHIO

2011
Montefiore selected as Pioneer ACO

2012
Formation of Montefiore-led Medicaid Health Home Program

2013
Creation of Montefiore HMO (MLTC) and expansion of Pioneer ACO

2014-2016
DSRIP planning / implementation; development of commercial ACOs; NextGen; Expansion to Health Home serving Children; All-payer ACO approval

2017-2018
Medicaid Innovator; LOI for Health Home expansion for persons with disabilities; NCQA certification

Sunset of NYS all-payer hospital reimbursement

Managed Care Expansion

Affordable Care Act

Performance-Based Culture
Our Core Services

Services integrated into delivery system infrastructure to aggressively manage total cost of care and utilization

- Population identification / stratification
- Whole-person care
- ED triage
- Care transitions
- Disease management
- Utilization management

- Behavioral health program stratification
- Behavioral health co-management with accountable care manager
- Primary care and behavioral health integration

- Outcomes management
- HCC / CRG
- HEDIS stars
- CAHPS, NCQA support
- State, Federal quality measures
- Clinical documentation improvement

- Provider contracting
- Provider services
- Facility/Provider Support Services
Typical Care Coordination Environment

- Fragmentation of care
- Poor coordination across continuum
- Disjointed clinical pathways
- Lack of unified care plan and longitudinal record
CMO: Serving as “Air Traffic Control”

- Centralized coordination of care to ensure seamless patient experience
- Proactively targeting populations via ongoing data analytics and surveillance
- Cross-continuum view of specific chronic illness
Our Population Health Model
Population Health Management Foundational Architecture

Developed over twenty years of experience managing highly complex and diverse patient populations

- Whole Person Care Model
  - Integrated Medical / Behavioral Health
  - Social determinants of health
  - Episodic and Longitudinal Care Management

- Clinical Programs
  - Focused clinical care designed to treat advanced needs
  - Cancer, Renal, Cardiac, Respiratory, Transplant, etc.

- Network Care Setting
  - Acute care
  - Sub-acute and post-acute care
  - Transitions to home

- Enabling Technology
  - Seamlessly connect providers, patients and caregivers
  - Consumer-centric platforms to improve patient experience
Assessment “Big Data” Is Not Enough

Analytics alone will not be able to identify underlying drivers influencing clinical condition

8% Generate 55% of Medical Expense

Unstable Housing

Substance Abuse

Mental Health

Financial Distress
Care Guidance™ Process Lifecycle

Time-limited interventions averaging six months aiming to stabilize individual in a community-based setting

- **Identify & Prioritize**
  - Identify members requiring care coordination services
- **Enroll**
  - Enroll highest risk individuals
- **Monitor & Update Care Plans until Discharge**
  - Link individual to services and organizations to provide care coordination
- **Develop Personalized Care Plans Stratify into Programs**
  - Develop personalized care plan based on intensity of services needed
- **Assess**
  - Understand member’s medical, behavioral, and social needs (Baseline and ongoing)
Care Guidance™: Core operational foundation

Establishes program foundation for initiating transitioning into PHM environment

ED Triage
- Transition potential hospital admissions to appropriate care setting
- Reduce admissions from ER

Care Transitions
- Identify population at risk for ED visit, re-admissions
- Ensure patient has PCP and appropriate community supports in place

Intensive Care Management
- Monitor progress, identify barriers, goals, interventions to prevent admission
- Keep patient in appropriate level of care and community-based setting
Overview – Behavioral Health Integration Program (BHIP)

University Behavioral Associates
• Addresses most severe BH conditions
• Care coordination on psych admissions and discharges
• Engages with specialty provider network

• ACM manages Complex patients or those not responding to treatment
• Case management and phone psychotherapy; psychiatrist collaboration with PCP or specialists

• Co-management with accountable care manager (ACM)

• Population health model
• Patients screened and treated in PCMH integration model
• Enhanced Referrals made as appropriate
Clinical and Community provider networks constantly evolving to meet population needs
Example Initiatives to Support Vulnerable Populations

Community-Based Organizations (CBOs)

- Housing at Risk
  - “Real Time” flagging of individuals who present in the ED or are admitted to the hospital

- Healthy Food Options
  - Working with community bodegas to increase supply, improve promotion, drive demand for fresh fruits/produce, water/low-cal beverages, healthy snack options

Clinical Delivery Network

- Primary Care Resources
  - Enhanced staffing and systems to address patients’ mix of medical and psychosocial issues

- Integrated Behavioral Health
  - Evidence-based model for treatment of depression and/or alcohol abuse with chronic medical conditions
Pushing boundaries with leading-edge IT solutions

Incremental “point” solutions offer specialized functions to enhance core Epic EHR

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<tr>
<th>Technology</th>
<th>Goals and Objectives</th>
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<tr>
<td>Diabetic Retinopathy Screening</td>
<td>• Leveraging advanced medical equipment for screening &amp; Ophthalmology follow-up</td>
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<tr>
<td>Population Health Management Analytics Toolkit (3M)</td>
<td>• Real time analytical tools to alert PCPs and care managers about patient status, gaps in care, prioritized care management workflow</td>
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<td>Patient Engagement</td>
<td>• Comprehensive member outreach tool leveraging integrated voice response (IVR), live calls and multi-media messaging</td>
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<tr>
<td>Chronic Kidney Disease / ESRD management</td>
<td>• Comprehensive patient identification, workflow and artificial intelligence platform for CKD, transplant, dialysis and ESRD management</td>
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<td>Telehealth for remote behavioral health therapy</td>
<td>• Smartphone app, interactive voice response and videoconferencing tools to maximize resources and improve between visit care</td>
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<td>Community-based organization (CBO) directory / referrals</td>
<td>• Enables ability to locate CBOs to match the needs of our patients (age, location, time of day)</td>
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Monthly Executive and Operational Dashboards

- Monthly refresh enables benchmarking
- Macro and micro trend identification
- Proactive and predictive management

Legend

- Monthly refresh enables benchmarking
- Macro and micro trend identification
- Proactive and predictive management

Workflow Compliance

Capacity and Throughput

Data Quality

[Graphs and charts illustrating various performance metrics and trends.]