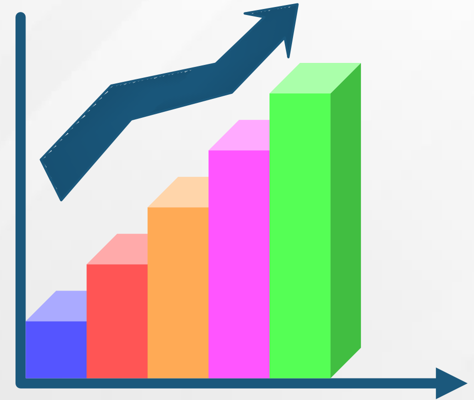

Performance Driven Academy

AGENCY EXAMPLE: EVOLUTION OF DATA COLLECTION WITH ROCHESTER REGIONAL HEALTH

MAY 18, 2018

mctac THE MANAGED CARE TECHNICAL ASSISTANCE CENTER OF NEW YORK

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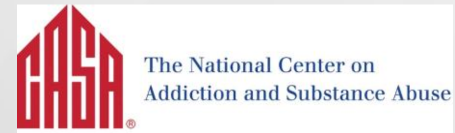


Speaking: Briannon O'Connor, PhD
Associate Director
CCSI's Center for Collaboration in Community Health

ROCHESTER REGIONAL HEALTH BEHAVIORAL HEALTH DEPARTMENT

EVOLUTION OF DATA COLLECTION

May 18, 2018

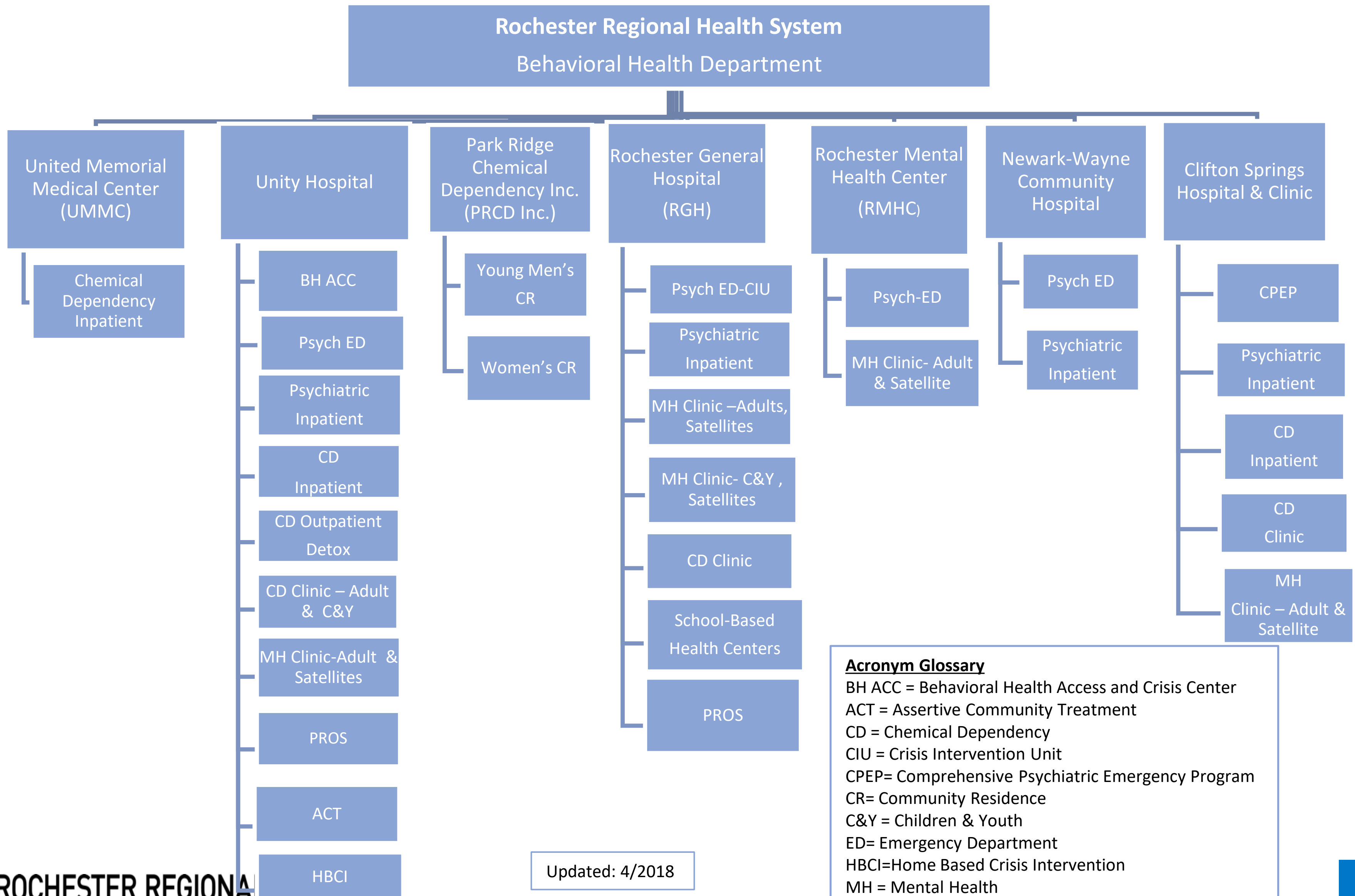
PRESENTATION AGENDA

- RRH Behavioral Health Overview
- Data Roadmap
- Key Performance Metric – Evolution of Data
- Qlikview Demo
- Questions

Behavioral Health overview

ROCHESTER
REGIONAL HEALTH

BH OVERVIEW: LEGAL ENTITIES



Acronym Glossary

BH ACC = Behavioral Health Access and Crisis Center
ACT = Assertive Community Treatment
CD = Chemical Dependency
CIU = Crisis Intervention Unit
CPEP= Comprehensive Psychiatric Emergency Program
CR= Community Residence
C&Y = Children & Youth
ED= Emergency Department
HBCI=Home Based Crisis Intervention
MH = Mental Health
PROS= Personalized Recovery Oriented Services

BEHAVIORAL HEALTH OVERVIEW: KEY SERVICES & STATISTICS

14 Behavioral Health Locations; 4 Counties

370,000 Annual Outpatient Clinic Visits

2,000+ Individuals Enrolled in Home Health Care Management

$75M+ Annual Revenue

4 Emergency Department Access Points (includes CPEP)

2 Chemical Dependency Residential Programs **24 Woman's Beds & 18 Young Men's Beds**

DSRIP - Mental Health Embedded in 13 Primary Care Practices

75 Active Psychiatric Inpatient Beds

92 Addiction Beds

~1000 Staff Members

5 School Based Health Centers

BH CURRENT PROFILE

Behavioral Health	Statistics
Number of Office of Alcoholism & Substance Abuse Services Operating Certificates	11
Number of Office of Mental Health (OMH) Operating Certificates	16
Number of OMH Satellites	15
Number of Department of Health Programs	3
Number of Hospitals	5
Number of Non-Hospital Facilities	17
Number of School Based Health Centers	5
Number of Emergency Access Points	4
Chemical Dependency Licensed Beds / Active Beds	92 / 92
Inpatient Psychiatry Licensed Beds / Active Beds	104 / 75
Medical Staff	94
Team Members (including prescribers)	983
Inpatient Discharges (2017)	4,329
Outpatient Visits (2017)	366,521

Behavioral Health
DATA ROADMAP

ROCHESTER
REGIONAL HEALTH

2017 DATA ACHIEVEMENTS

- Strategic Planning – Data Vision
- Bench Strength Development
  - Clinical Analyst within the business line
  - Technical Training for clinical staff
- Data Inventory Development
- Qlikview Licenses

Data Leveraged

- Qlik Inpatient Dashboard
- Qlik ED Dashboard
- Demographics
- Occupancy %
- Medicaid capital add-ons
- Unweighted visits

Data Acquired

- CPT Code Contracted Reimbursements
- Average visits per episode of care
- Unique enrolled patients
- Newly enrolled patients
- Veteran's Administration

Data Analyzed

- Payer Mix
- Service Mix
- County Opioid Statistics
- Unique patients served
- Prescriber caseloads
- Clinic Access
- Follow-up to Hospitalization

DASHBOARD DEVELOPMENT

DASHBOARD NAME	EXECUTIVE	CLINIC OPERATIONAL	CLINIC ACCESS
SCOPE	A high level snapshot of the Behavioral Health department as a whole containing scorecard-like measures with targets and current progress	An operational dashboard for mental health and chemical dependency outpatient clinics used to monitor key performance metrics	A snapshot of the poignant data points of the care pathways and trajectories of the episodes of CD and MH clients from referral
METRIC*	Occupancy Readmission ALOS Margin Visits Unique patients New patients Willingness to recommend	Unique patients New patients Scheduled visits Completed visits Intakes Visit status Admissions Discharges ALOS (days & visits) Top 10 Diagnoses Discharge Disposition	Average # of visits before admission Days from intake call to first available appt Days from intake call to first completed appt Days from ED visit OP appt Days from IP discharge to OP appt Days from intake to admission

ROCHESTER REGIONAL HEALTH

*Includes demographic analysis- race, sex, zip code, payor

DASHBOARD DEVELOPMENT

DASHBOARD NAME	INPATIENT	SERVICE GAPS
SCOPE	A dashboard displaying key inpatient measures and analyzing readmissions back to BH as well as any inpatient facility within RRH	An analytical tool used to evaluate gaps in services (both geographically and programmatically) that are possible growth opportunities in our communities
METRIC*	Discharges All Cause Readmissions BH Readmissions Readmission % Overall ALOS First ALOS, Readmit ALOS, Restraint/Seclusion	Location of Service Patient Location Waitlist (Demand) Population Density CBO Mapping Patient demographics

*Includes demographic analysis- race, sex, zip code, payor

Key performance metric

ROCHESTER
REGIONAL HEALTH

KEY PERFORMANCE METRIC

Follow Up to Hospitalization (FUH):

patients attending a behavioral health appointment within 7 or 30 days post day of discharge from a behavioral health inpatient program

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patients discharged from a behavioral health inpatient program

Behavioral Health= mental health or chemical dependency unit

FUH ROLL OUT: 2015-2016

Key Program Identification:

- 1 Psych Inpt
- 1 CD Inpt
- 2 CD Outpatient Clinics
- 2 MH Outpatient Clinics

Level Setting Meeting:

Review of metrics and definitions, goal overview, identification of email/paper process for tracking metrics

Data Collection- **Paper/Emails**:

Paper data sheets identifying numerator/denominator information to be emailed to point person each month

FUH STANDARDIZATION

Key Program Identification:

ALL RRH BH Programs

Level Setting Meetings:

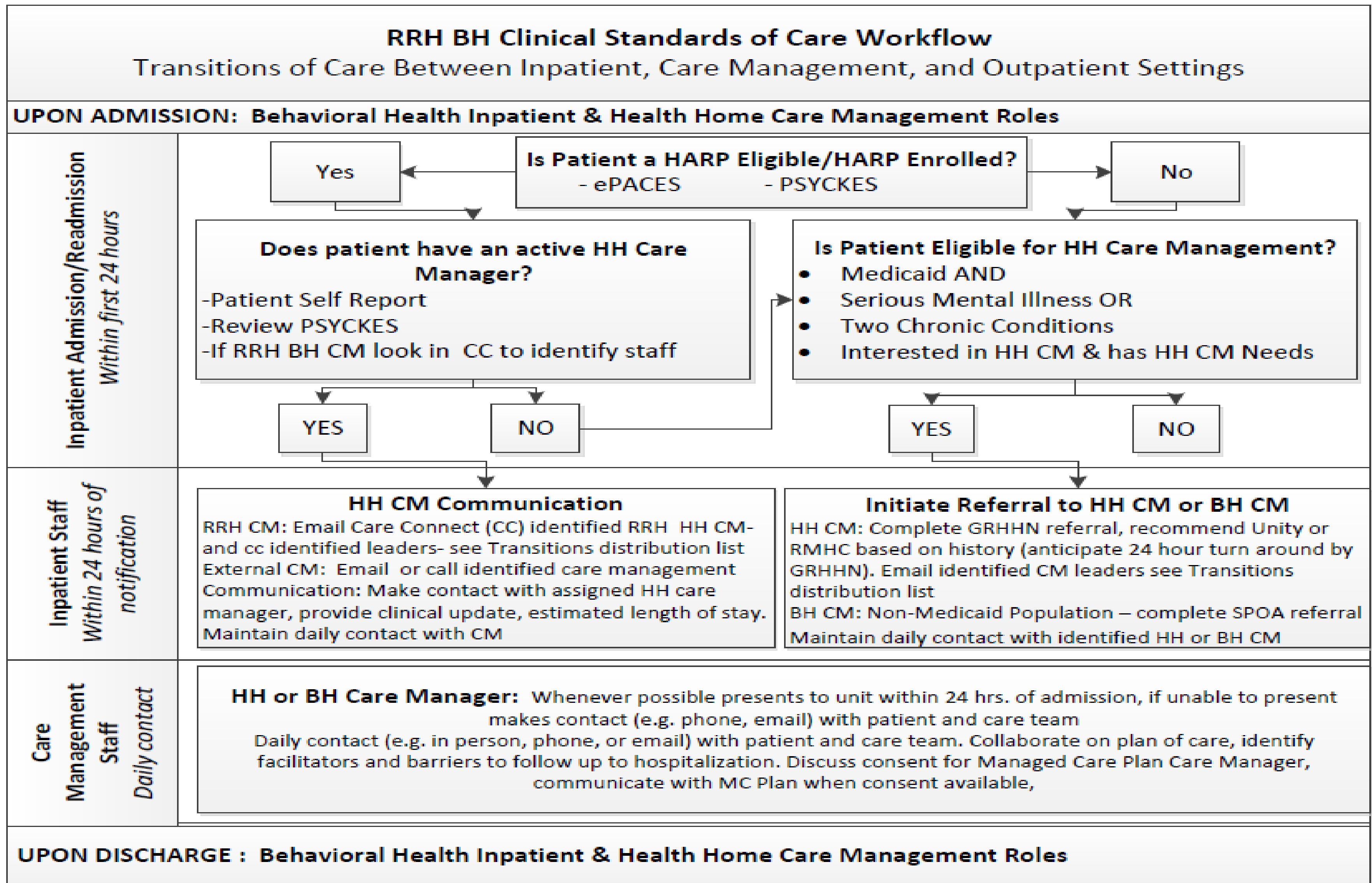
Multiple meetings with various stakeholder groups across levels of care to level set regarding:

- "So What" of the metric & RRH BH vision
- Patient continuity of care
  - Identified best practices to support patient care
  - Identified workflows to support patient care
  - Defined roles & responsibilities of staff at various levels of care

Data Collection- **Excel**:

- Monthly excel files tracking patients discharged from inpatient unit and linked to outpatient
- Monthly RRH BH dashboard populated from excel files
- Review of monthly dashboard data to inform areas of excellence and opportunities for improvement

FUH WORKFLOW



FUH PROGRAM TRACKING

	A	B	C	D	E	F	G	H	I	T	U	V	W
1	Patient name	DOB	MRN	Discharge Unit	Discharge Date	Internal Program Referred to at Discharge	External Program Referred to at Discharge	Date of Appt	Number of Days Between Appointments	Did they attend OP appt within 30 days of discharge from IP?	0-7 days	8-30 days	Not seen in 30 days
2													
3													
4													
5													

- Included drop downs for as many fields as possible
- Manual Process
  - Potential for error
  - Transfer from individual programs to dashboard
- Provided Opportunity to do the work & work out kinks

FUH PROGRAM DASHBOARD

RRH BH Readmission Collaborative Data Dashboard

ROCHESTER REGIONAL HEALTH

Acute Care Hospital Quality Scorecard Most Recent 12 months Last updated 10/2017	Benchmark	UMMC Hope Haven Versus Benchmark	Unity Greece CD Versus Benchmark	CSHC V3 Versus Benchmark	CSHC V2 Versus Benchmark	NWH 1 South Versus Benchmark	RGH G1 Versus Benchmark	Unity-STM 4300 Versus Benchmark
Inpatient Utilization Rates								
Discharges								
CD Discharge Type								
ministrative/Against Medical Advice Discharge								
Behavioral Discharges								
Post-Discharge Referrals								
RRH BH Internal Referral								
External Community Referral								
Population Metrics								
HARP Eligible								
Health Home Care Management Enrolled								
Health Home Care Management Not Enrolled								
e Care Management Referral Made on Inpt Unit								
Warm Hand Off								
Yes								
No								
Was prior Authorization for medication received before discharge?								
Yes								
No								
Did patient receive full supply of all meds?								
Yes								
No								
Does the Patient have a health Home Care								
Yes								
RMHC CM								
UNITY CM								
Community HC								
No								
Was a Health Home Care Management referral								
Yes								
RMHC CM								
UNITY CM								
Community HC								
No								
72 hours?								
Yes								
No								
Did the D/C plan include a high-intensity step								
Yes								
No								

CQI FRAMEWORK

- All stakeholders review RRH BH department performance
  - Share best practices
  - Target supports & intervention to underperforming program
- Identify key process metrics to track and metrics to cease tracking
- Update workflows to support patient care
- Goal- work towards automation of data collection

FUH DATA AUTOMATION

Key Program Identification:

All RRH BH Programs & all BH Programs within RHIO

Level Setting Meeting:

- Identify key workgroup members to inform data specifications document
- Engage EMR Personnel to identify ability to capture data in EPIC/CareConnect
- Identify Scheduled Frequency of Report
- Report Validation

Data Collection- **Qlikview Application**:

Utilization of Data Visualization Software & Care Connect Data to compile data and populate dashboard

FUH QLIKVIEW DEMO

Questions

THANK YOU

Contact Information:

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Frankie Tangredi, Clinical Analyst
Francesca.Tangredi@rochesterregional.org

Mark your calendars and register

MAY

M	T	W	T	F	S	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Webinar (Wednesday, 12-1pm):
Practice Development and Management, 5/23/18

In-person events in late June (10am-2pm)
Register individually, not by agency
Rochester, 6/18
Albany, 6/19
NYC, 6/29

mctac

Send us any questions or feedback

Use the chat box
or
email us at: pda@ccsi.org