LCHP PERFORMANCE HUB *IMPACT*

Each County Performance Hub identified, selected, and focused efforts on a specific patient population in order to directly impact PPV visits. Below is an example from each county's PPV target and identified SDoH target.

Madison County Performance Hub

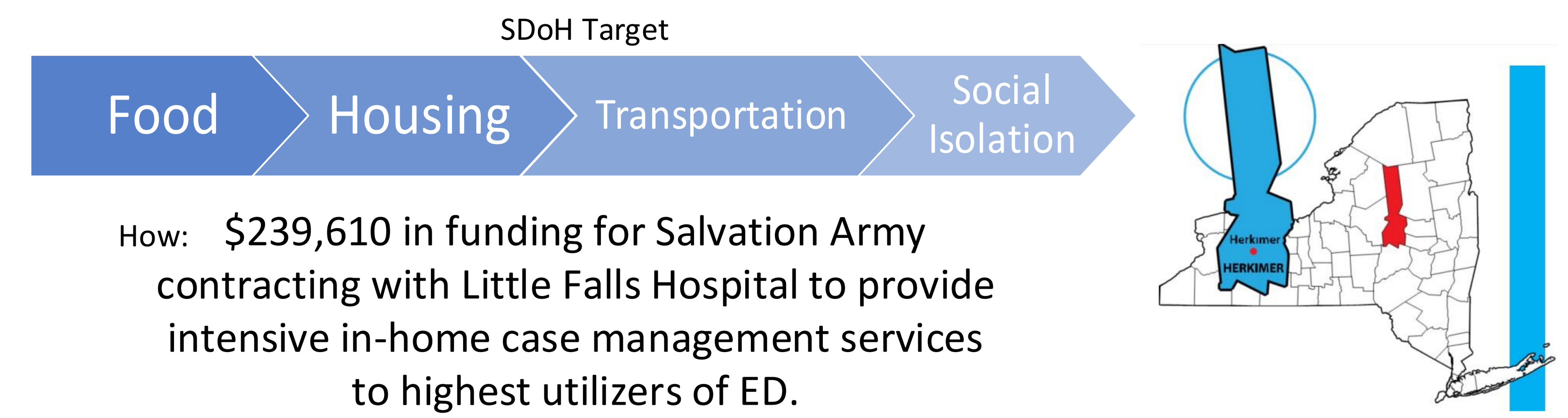
Workgroup: PPV BH, Residents South of Route 20 GOAL: Reduce Total Visits by 30%

Clarify Problem:
In Madison County we have 6 patients with BH diagnosis who have 20 ED visits which are otherwise avoidable.

Develop Ideas/Countermeasures:
1. Mobile Crisis
2. Health Home enrollment

Break Down the Problem:
1. Not using prime care
2. Drug abuse
3. Dental pain
4. None enrolled in Health Home and Care Management
5. There is no financial reason for patient to avoid the ED

Implementation:
1. Enroll in Health Home (HH)
2. Follow-up with the HH for enrollment status
3. Get in touch with Fidelis Rep. to get their care mgrs. engaged
4. Review ED data of high utilizers
5. Compare data of previous high utilizers who are no longer using ED unnecessarily after intervention



How: $239,610 in funding for Salvation Army contracting with Little Falls Hospital to provide intensive in-home case management services to highest utilizers of ED.

Herkimer County Performance Hub

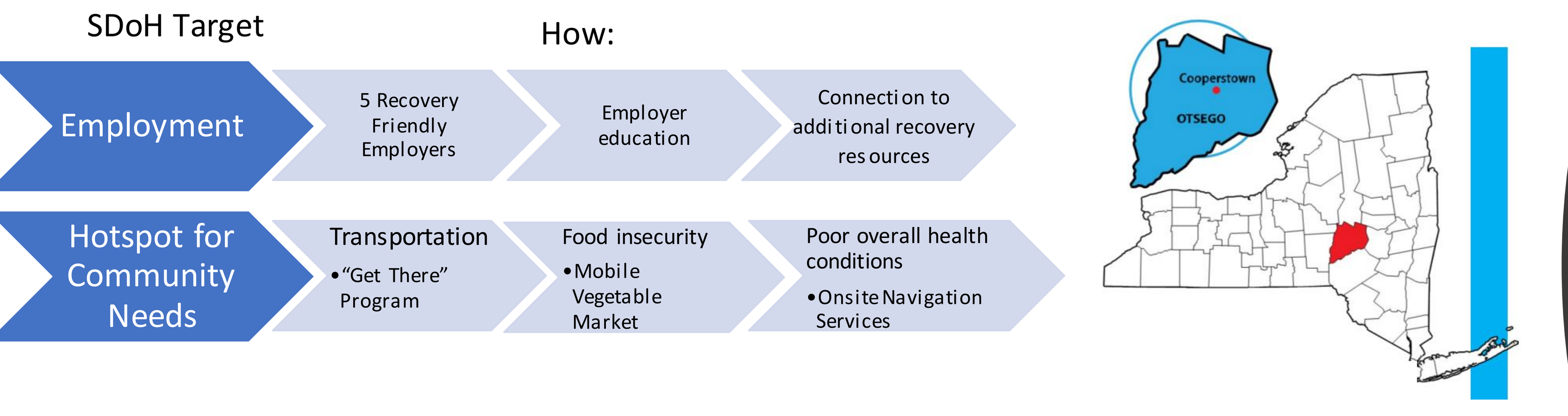
Workgroup: PPV BH 2+ Visits GOAL: Reduce Total Visits by 30%

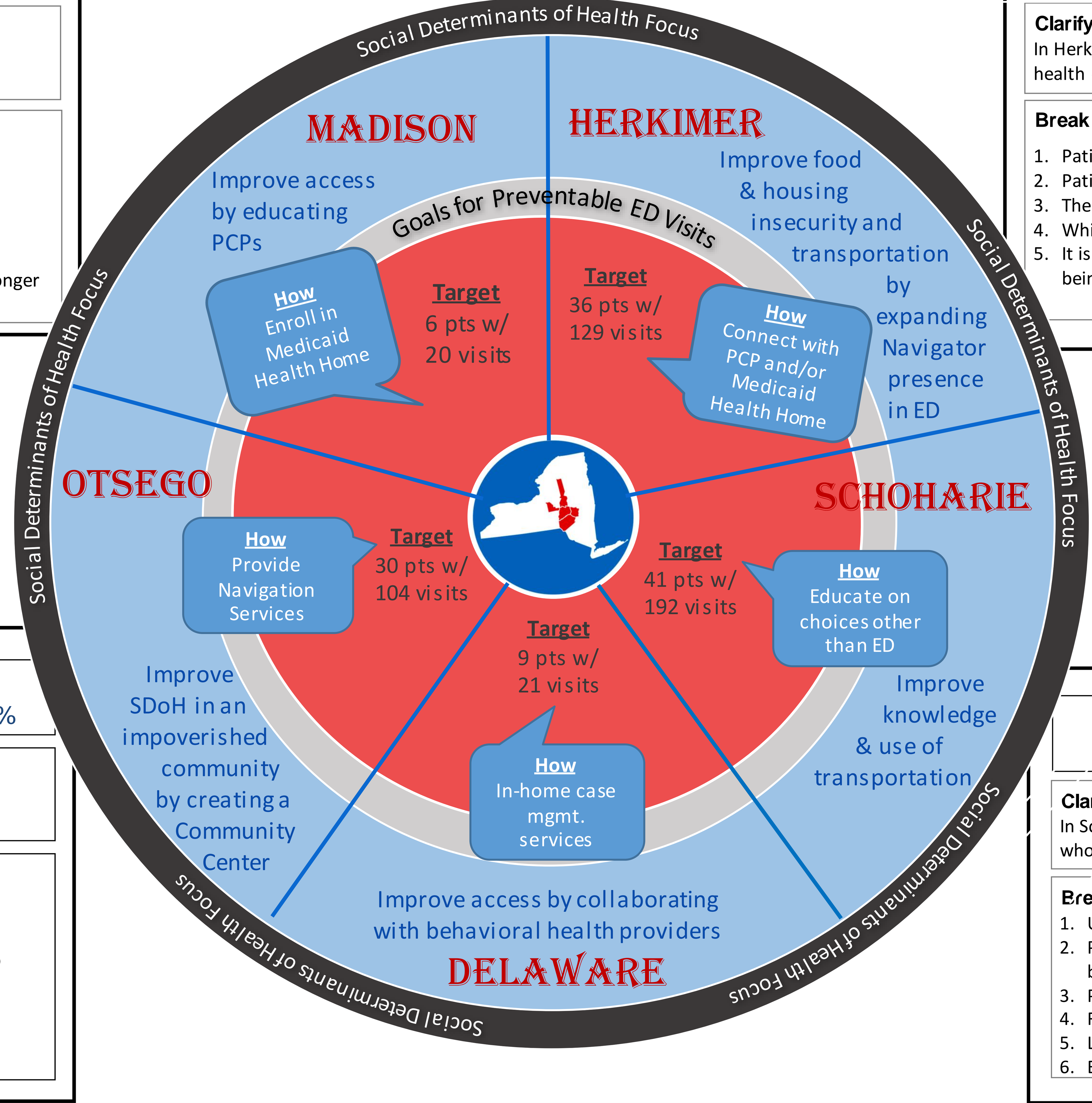
Clarify Problem:
In Herkimer County we have 36 patients with a behavioral health diagnosis who have 2+ ED visits totaling 129 visits

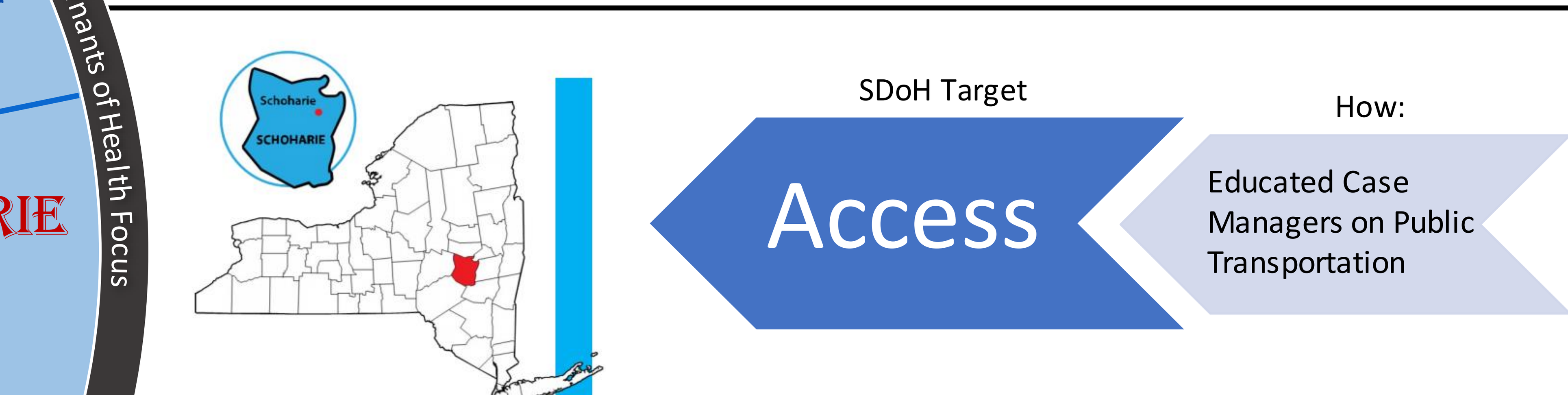
Develop Ideas/Countermeasures:
1. Identify agency covering patient
2. Connect patient with PCP
3. Have Health Home connect with patient frequently
4. Follow up with MH clinic weekly

Break Down & Analyze the Problem:
1. Patients are not enrolled in a Health Home
2. Patients are not established with a PCP
3. There are gaps in referrals from providers to MHH
4. Which ED patients are using is unknown
5. It is unknown as to why are patients going to the ED and being flagged as a PPV-BH visit

Implementation:
1. Contact covering CBO to inform of frequent use of ED
2. Schedule patient with PCP
3. Weekly visits with Mental Health Clinic
4. Weekly visits with Health Home
5. Educate patient on use of convenient care in Herkimer instead of ED







Otsego County Performance Hub

Work Group – PPV BH 2+ visits, Oneonta Residents GOAL: Reduce Total Visits by 50%

Clarify Problem:
In the City of Oneonta, we have 30 patients with a behavioral health indicator who had 104 potentially avoidable ED visits.

Develop Ideas/ Countermeasures:
Enroll all eligible patients in care coordination and refer to lower acuity services if appropriate

Break Down the Problem:
1. 17 of these patients do not have a Health Home
2. Health Homes have some referral and engagement challenges
3. Lack of transportation and housing
4. Lack of patient interest
5. Lack of engagement with a PCP
6. Lack of embedded Navigator in ED

Implementation:
1. Identify list of patients
2. Patient outreach to lower acuity services
3. Create flow chart for outreach, referral and follow-up

Schoharie County Performance Hub

Workgroup: PPV BH 3+ visits GOAL: Reduce total visits by 35%

Clarify Problem:
In Schoharie County, we have 41 patients with BH diagnosis who have 3+ visits totaling 192 visits

Develop Ideas/ Countermeasures:
1. Develop a reference tool to include resources which can be used to educate ED users of available resources
2. Individual support/ warm handoff & follow up

Break Down the Problem:
1. Unknown patient resources- both patients & providers
2. Patients want immediate attention (will not wait for call back, resulting in ED usage)
3. Patients needing/ wanting tender loving care
4. Food insecurity
5. Lack of urgent care in Schoharie County
6. Education/ comprehension of diagnosis

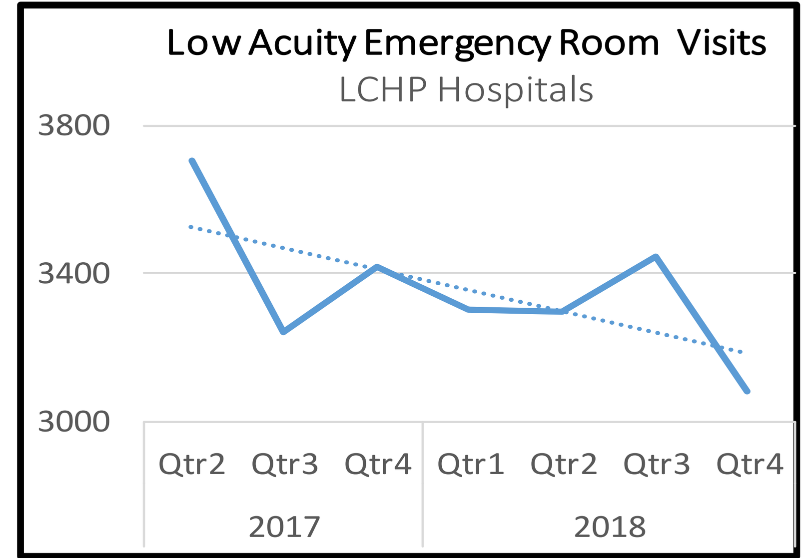
Implementation:
1. Develop a brochure educating the patient on when to use ED and which resources to use based on need
2. Include zone tools specific to prevalent chronic conditions
3. Focus group meeting for a smaller subgroup to get feedback on the developed brochure and zone tools

Low Acuity = Less Urgent and Non Urgent Visits

Q4 shows **reduction of 9.8%** from 2017 to 2018

Reduction of **1332 visits/year**

Source: Bassett Healthcare Network (Business Intelligence)



Delaware County Performance Hub

Workgroup – PPV BH 0-9 yr., Sidney residents GOAL: Reduce Total Visits by 50%

Clarify Problem:
There are (10) 0-9 year old patients in Sidney who have (22) combined potentially avoidable ED visits
A sub-set of (9) of these patients belongs to one PCP (non-partner) with (21) visits

Develop Ideas/Countermeasures:
Provide In-Home case management services through existing partner program to provide care coordination and connect families to resources for social determinants

Break Down the Problem:
1. Lack of family involvement in prime care or other preventative care
2. No mental health follow up after BH diagnosis
3. There is no financial reason for patient to avoid the ED
4. Immediate gratification received at ED vs. Prime Care
5. Lack of interoperable EHR for out of network/ out of PPS providers

Implementation:
1. Referral from patient list
2. Trigger referral for new low acuity users
3. Patient Engagement/ Connection
4. Reporting
5. Tracking