Sun River Health

Improving Patient Intake for Hudson Valley Health Home

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Planetree Institute, Sun River Health
Lean Program, Session 1 2021

Project Charter

Project Information

Project Name:
Improving Patient Intake for Hudson Valley Health Home

Process:
Identify eligible, existing patients and enroll them into the health home program.
Criteria needs to be met in order to move forward with enrollment. Once enrollment is approved, consent will be signed, and the care manager will work 1:1 with the patient throughout the process.

Focus Area:
Community Engagement (Health Home)

Cost of Poor Quality (CPQ):
Missed opportunity in revenue for our health home

Project Benefits:
- Increased revenue
- Patient retention
- Streamline process

Goals and Objectives:
- Increasing patient enrollment for Hudson Valley Health Home
- Build robust in-reach systems
- Work with stakeholders to mirror processes already in place
- Leverage Cognos to identify possible candidates for health home
- Increase Care Management capacity to handle new enrollments

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Project Charter

Business Case

The Health Home Program is a group of healthcare and service providers who collaborate to ensure that patients with complex chronic illnesses and or behavioral health disorders receive necessary care and services to lead healthful lives. We have seen the success in HH enrollment in both the NYC and Suffolk regions. We want to ensure that HV has the same opportunity of success. Success will be measured by an increase in percentage of enrollment in the program. Health Home is able to assist us with streamlining patient care, increasing revenue, and assist with patient retention.

Problem Statement

Number of Participants

Only 30% of eligible patients in the Hudson Valley are enrolled in the Health Home Program.

Enrollment Census

We want to increase enrollment by 25% in the first quarter after roll out.

We would like to establish transparency and standardize the process of referrals for the health home enrollment process.

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Picture Frame Exercise

Patient Interest

Building Trust

Creating reports to identify patients

Develop patient education on HH

Educating staff on internal programs

Patient Interest from medical care coordination

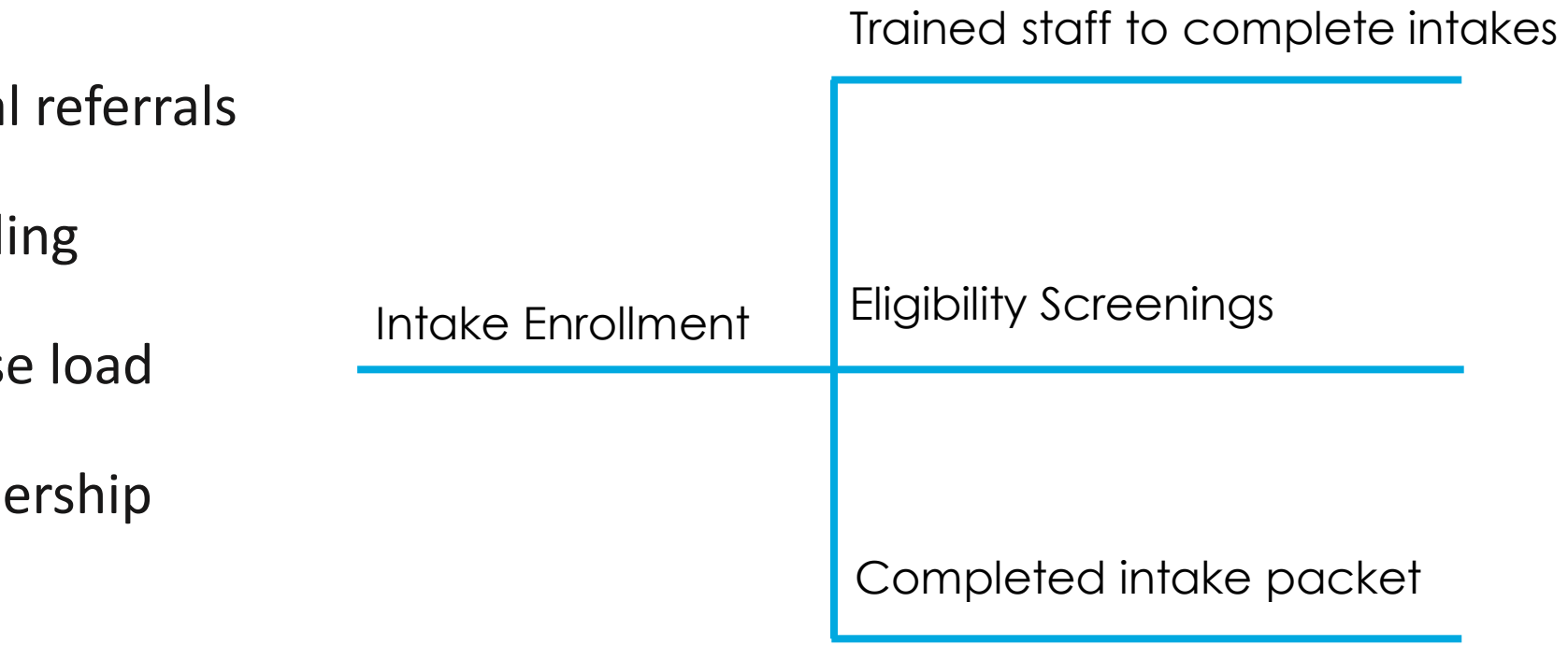
Recruit and Train new Staff

Engagement staff creating intake packets

Voice of the Customer

- Providers making internal referrals
- Patient engaged in enrolling
- Care Management of case load
- HH Leadership/ QIS Leadership

Critical to Quality (CTQ) Tree



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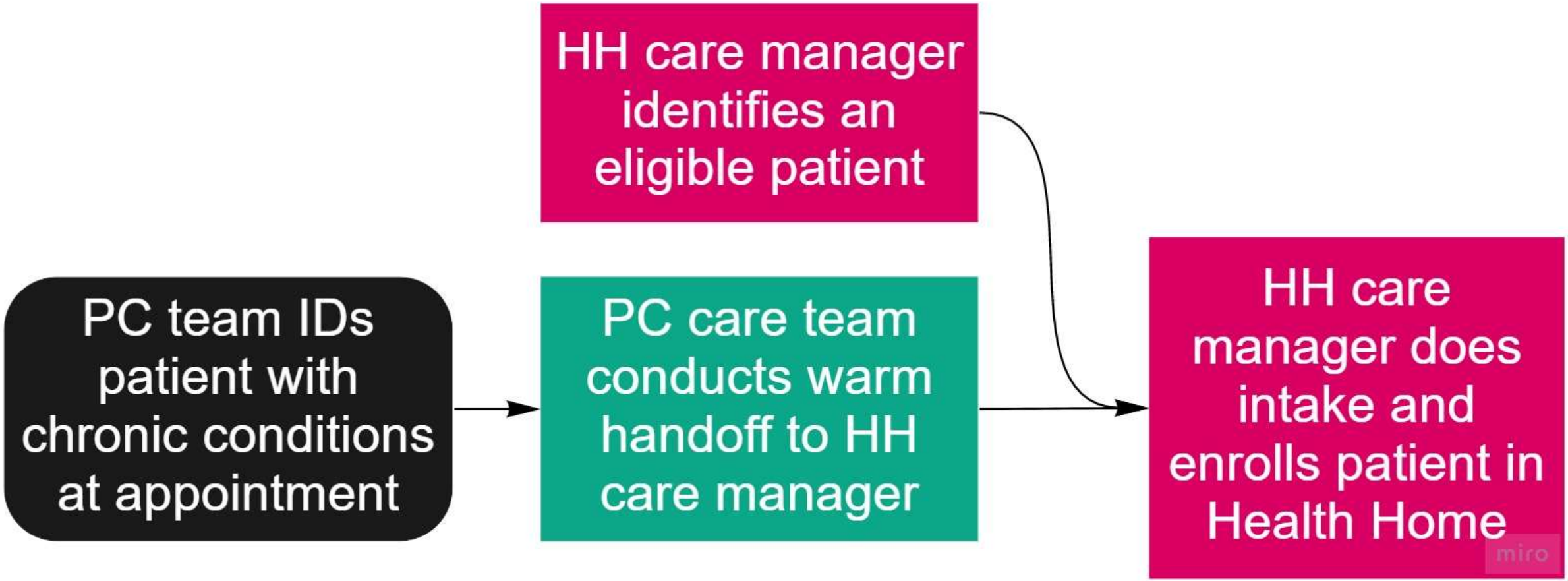
SIPOC

S	I	P	O	C
HH Team Care Managers Providers QIS CHWs CE ECW Salesforce	Intake packet ECW Trainings MAPP (Enrollment Portal) Cognos Epaces (Medicaid eligibility) Foothold (HH Database) Psyckes (BH database)	Create Process Map Screening (report, eligibility) Outreach to patient for intake Intake (consents etc) Accepted by Lead Enrollment Case Assignment	Enrollment Engagement with care coordination Assessment and care plan creation	Patient PCP Community Partners Referral of Patient (internally and externally)

Current State Process Map



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Data Collection

Primary Measurement: Number of patients in the Health Home Program

Secondary Measurement: Current patients who are eligible but not currently in the program

Data is pulled the 3rd week of every month by Jamie Guzman, Associate Vice President of Community Engagement, of the Suffolk County Health Homes Team

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Data Collection Instrument

Cognos Report

eCW Patients eligible for Health Home

Patients with a visit from: 2021-04-01 to: 2021-04-30
Total HH eligible patients: 2,798

Region	HH Eligible	HRH HH Global Alert	PatientID	Medicaid ID	LastName	FirstName	Patient DOB	Facility Name	Phone_Mobile	Provider Name	LastDOS	A31	HIV	Asthma	COPD	DM	CardioVasc	HTN	Obesity	MH	Tot ChrDx
Hudson Valley	Yes		[redacted]								4/30/21			Yes	Yes				Yes	Yes	3
Hudson Valley	Yes										4/6/21			Yes	Yes	Yes		Yes			4
Hudson Valley	Yes										4/15/21				Yes	Yes	Yes	Yes	Yes	Yes	5
Hudson Valley	Yes	Health Home Patient									4/7/21							Yes	Yes		2
Hudson Valley	Yes										4/6/21			Yes			Yes	Yes		Yes	3
Hudson Valley	Yes										4/14/21				Yes	Yes	Yes	Yes		Yes	4
Hudson Valley	Yes										4/1/21						Yes	Yes		Yes	2
Hudson Valley	Yes										4/20/21					Yes		Yes	Yes		3
Hudson Valley	Yes										4/15/21					Yes		Yes	Yes	Yes	3

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Summary of Measure Findings

Primary Metrics: How many HH Patients in HV

Secondary Metrics: How many HH Patients not currently enrolled but are eligible

Last Visit Location	Total Patients
Amenia A28	20
Beacon A28	33
Bedford Avenue A31	15
Haverstraw A28	37
Monticello A28	41
Peekskill A28	37
Peekskill Pathways A32	1
Poughkeepsie Family Partnership A28	14
Poughkeepsie Washington Street A28	52
Poughkeepsie Washington Street Urgent Care A28	4
Yonkers Park Care A28	21
Yonkers Valentine Lane A28	41
Yonkers Valentine Lane Urgent Care A28	1
Overall - Total	**1,372**

Jun 28, 2021

* Cognos Report showing Hudson Valley patients that have Health Homes Global Alert in eCW chart.

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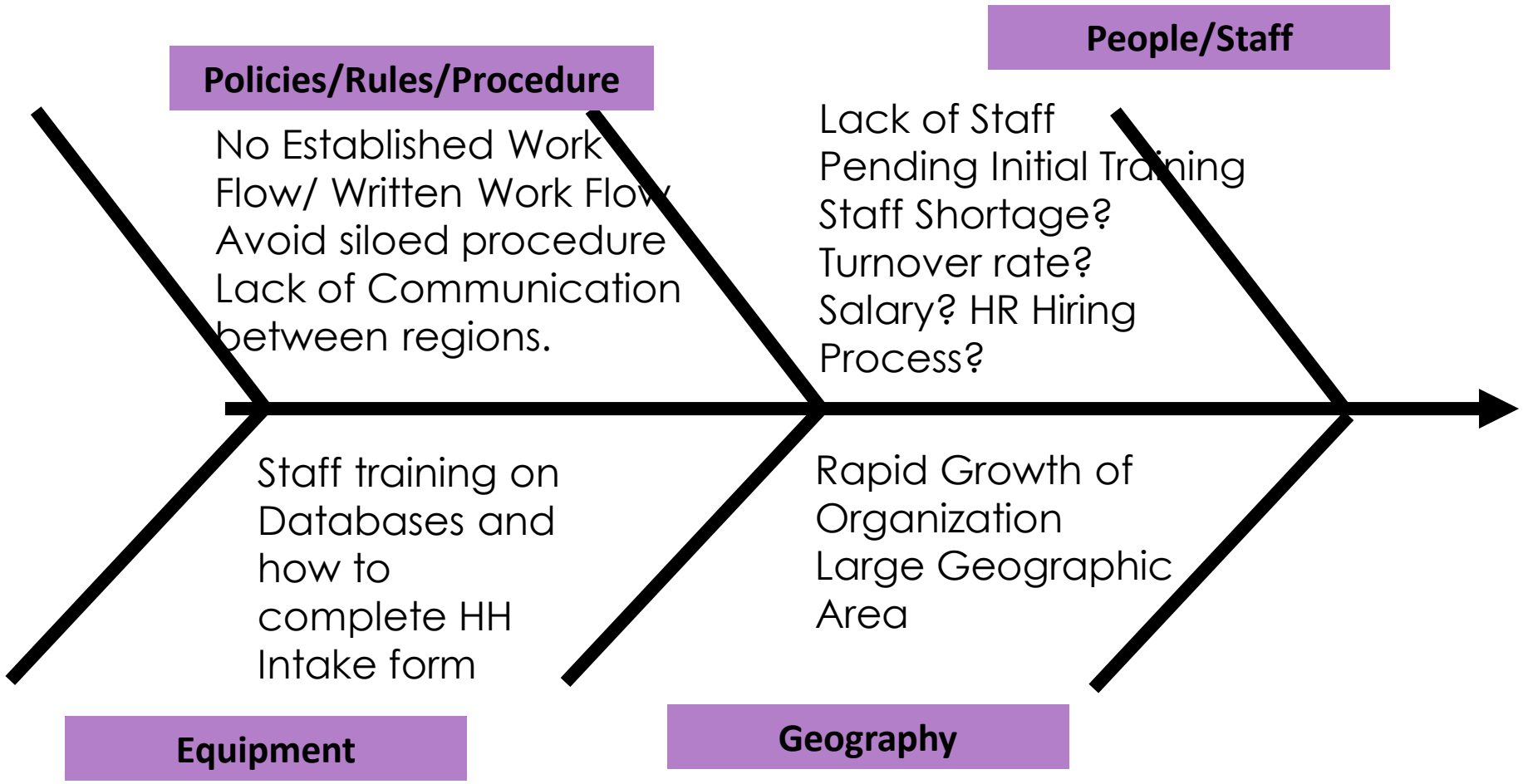
Fishbone Diagram



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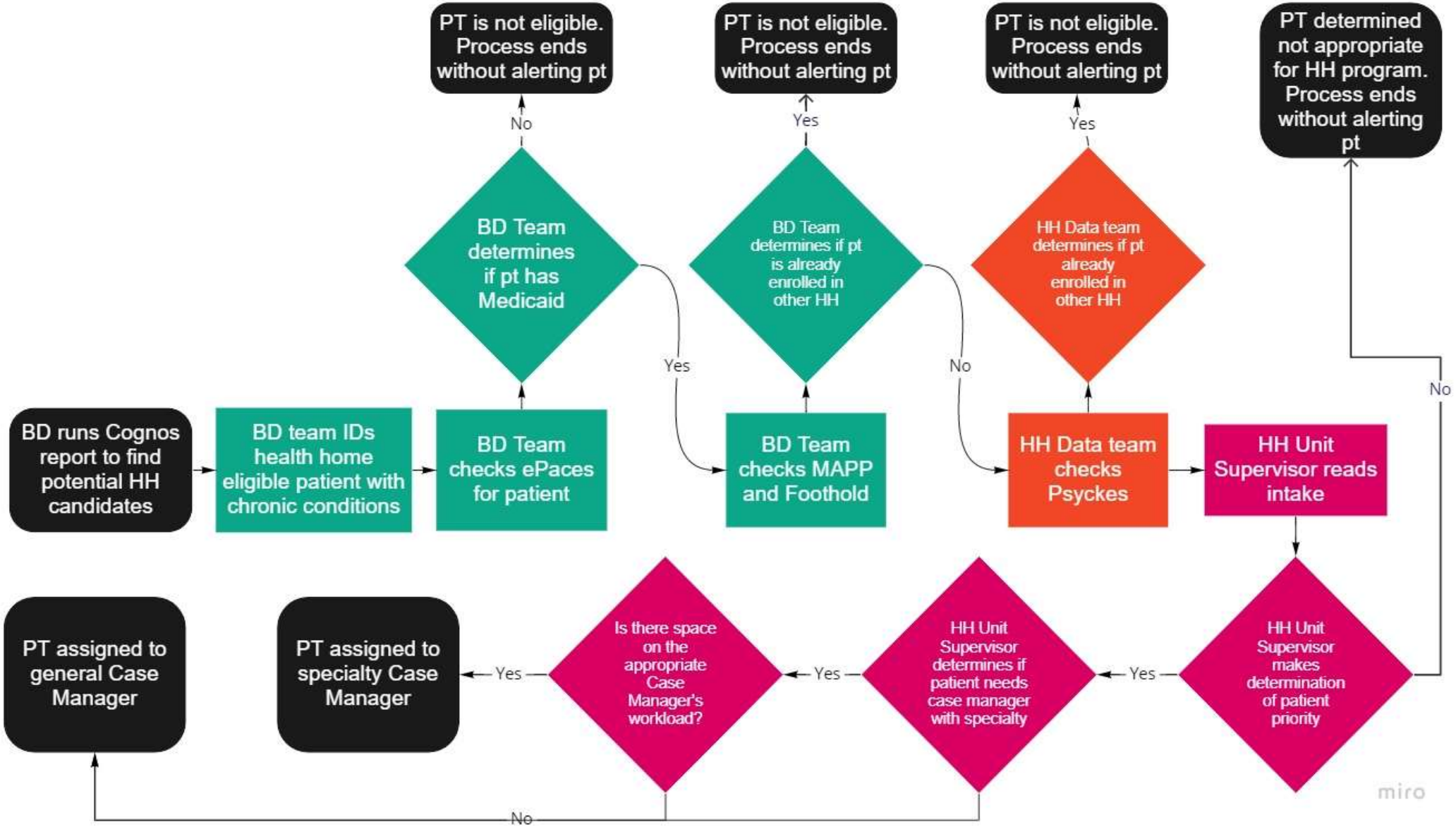
Future State Process Map



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Data Re-Collection Plan

Primary Measurement: Number of patients in the Health Home Program and retention

Secondary Measurement: Current patients who are eligible but not currently in the program and engagement/enrollment

Data to be pulled the 3rd week of every month by Hudson Valley Health Homes team member

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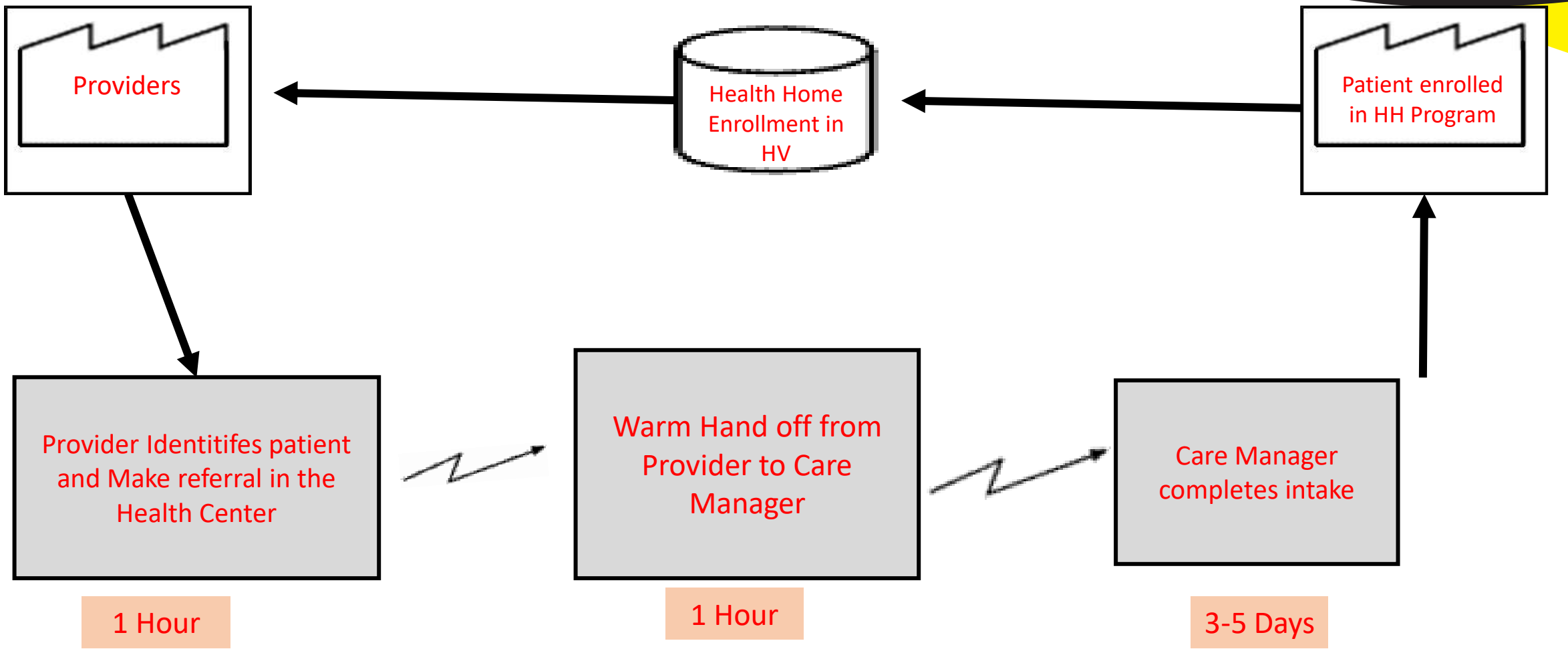
Current State Value Map



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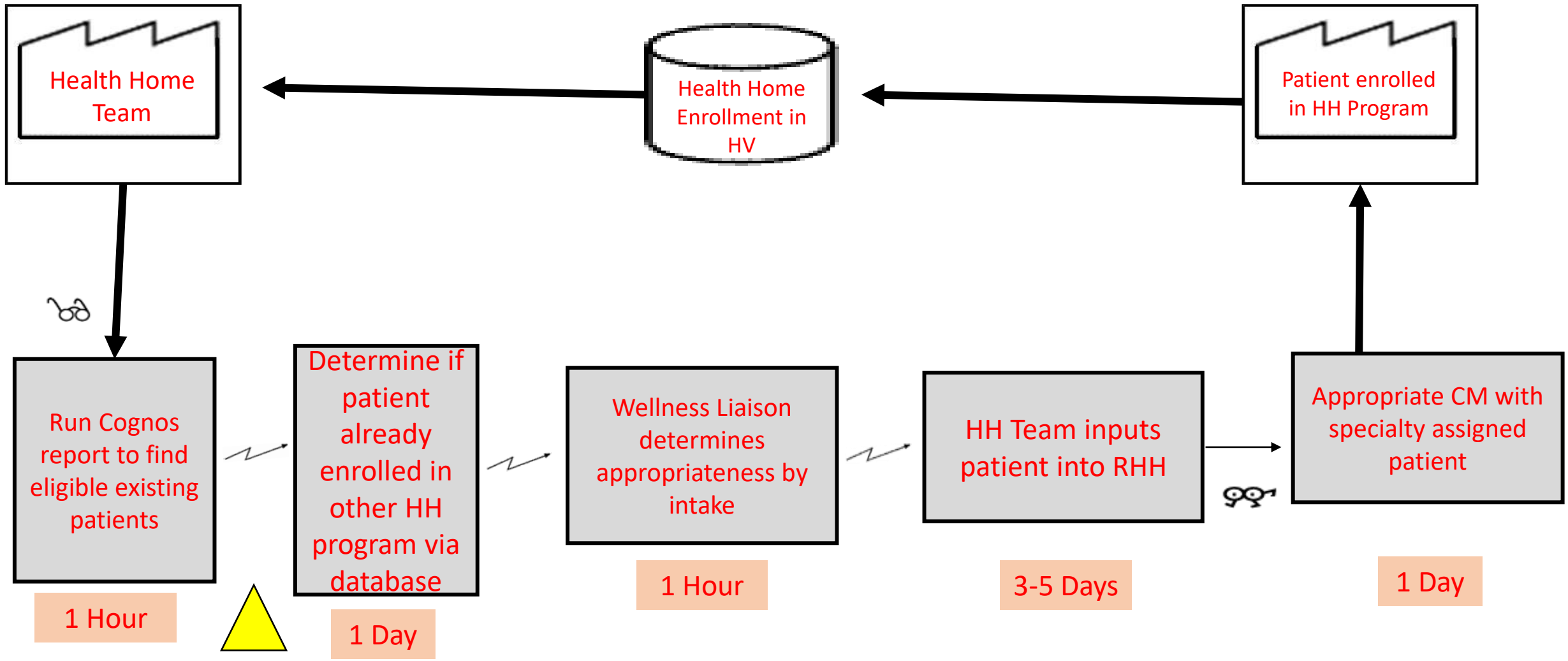
Stakeholder Resistance Plan

Stakeholder	Resistance	Strategies for Resistance
Care Managers	High	Suffolk County Roll Out, Tradition, no incentive to change
Middle Managers	Medium	Resistance from their staff
Senior Leadership	Low	Streamlines functions across system
External Partners	Medium	Less External Referrals, Tradition
Patients	Medium	Increased access to services, but potentially delays in receiving services

Future State Value Map



Project Impact Summary

Upon Implementation:

- Streamline Functions within organization
- Automate Data Collection
- Build robust in-reach systems

Lasting Impact:

- Increase number of patients in HH Program
- Increase profits
- Build out Health Home Team in Hudson Valley
- Increased Patient Satisfaction

METRIC	OPERATIONS DEFINITION	SPECIFICATION / GOAL	WHO WILL AUDIT	HOW OFTEN	INTERVENTION
Enrollments	Number of people who have completed intake and enrollment into Hudson Valley Health Home	Goals: 30% enrollments Cognos report to be pulled every month	Health home data team	Every month	LEAN team and health home management

Control Plan

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