2.a.iii Health Home At-Risk Intervention Program

Project Response & Evaluation:

1. Project Description and Justification

1a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

New York State (NYS) Health Homes currently provide critical care management services to Medicaid beneficiaries with multiple chronic conditions and complex medical and behavioral health needs. However, there are many other Medicaid beneficiaries who, while they do not meet NYS Health Home eligibility criteria, stand to benefit from care management services or may otherwise suffer from worsening and unattended health issues.

 We analyzed a sample (n=119,212) of Medicaid managed care enrollees to estimate the population in our region who would be eligible for expanded Health Home services if services were expanded to beneficiaries with a single dominant chronic disease. Beneficiaries with this clinical status accounted for 28% of the sample population and 31% of total costs, representing a cost index of 1.1 (compared to 1.0 for entire population). These beneficiaries also experienced 94 hospital admissions annually per 1,000, and 327 ED visits annually per 1,000, compared overall population averages of 93 and 290, respectively. Within this population, 33% of inpatient stays were for behavioral health conditions compared to 24% for the population as a whole and several studies suggest behavioral health issues are markedly underdiagnosed as a comorbidity in patient with chronic diseases.

Geographically, we identified several hot spots of increased clinical risk including nine zip codes in communities (e.g. Kingston, Yonkers, Middletown) where close to 10% of the dual and non-dual Medicaid population had a behavioral health diagnosis in 2012.

To meet the needs of the described at-risk Medicaid population, we will develop new resources and adapt existing ones. Principally, our initiative will expand the current Health Home infrastructure to include the at-risk population, as well as work closely with primary care providers (PCPs) and behavioral health providers. We will create short-term care management services that emphasize patient activation, closing gaps in care, and mitigating risk factors for decreased health status, in an effort to avoid a patient's conversion to "full" Health Home status. Although the existing NYS Health Home program is not expanding per se as part of this initiative, the three Health Homes in our region will be called upon to expand their capacity to: (a) provide care management services to a new population, the Health Home at-risk group, and (b) develop a new set of short-term care management services supported by care teams that

include medical, behavioral health, care managers, health educators, community health workers, and pharmacy professionals.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

This project will target Medicaid patients attributed to our PPS who have one or more chronic diseases and who are not known to be enrolled in a NYS Health Home. Identified beneficiaries will also be assessed relative to their Area Deprivation Index (ADI), a well-accepted measure of neighborhood socioeconomic disadvantage, which links a patient's zip code to an index of the broader social and environmental risk factors and inform patient care decisions.

The Health Home at-risk initiative will be implemented through primary care and behavioral health providers in our region, starting with PCMHs affiliated with our PPS. Based on our CNA findings, we expect there will be concentrations of increased clinical risk in several areas with high levels of poverty. Our PPS will establish a registry to track identified eligible beneficiaries and notify PCPs and behavioral health providers to arrange for assessments of their at-risk patient population. After a beneficiary completes an initial assessment, a Health Home care coordinator will create a comprehensive care management plan to be shared with the patient and their provider(s).

The precise components of the comprehensive care management plan will be collaboratively developed by our PPS Quality Committee, but are expected to include: notation of patient strengths and personal goals, an assessment of patient activation such as the 13-question Patient Activation Measure (PAM), an estimate of social needs based on the ADI, need for medication reconciliation, and status of applicable quality metrics. The plans will also describe processes to address each identified beneficiary need, detailing the role of a beneficiary's PCP, behavioral health provider(s), Health Homes, local health departments (Local Government Unit/Single Point of Access), and others as needed. Patients with low activation scores on the PAM will be referred for tailored health coaching, and those with high ADI scores (i.e. patients who live in zip codes with an index above their resident county's mean index) will be referred to appropriate social services. Through this approach, our PPS will bring needed community-based and social service support into primary care practices leveraging Health Homes' existing networks and, ultimately, expand services to the target population.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

The existing NYS Health Home and PCMH infrastructure in our region provides a strong foundation to improve the connection between Health Homes and primary care practices and target Medicaid beneficiaries at risk for declining health status. Seventeen practice sites in our PPS, including FQHCs, are accredited NCQA PCMHs, and they will be co-developers of the Health Home At-Risk Intervention Program. This project will begin with PCMH recognized primary care practices and FQHCs located within or near hot spots, and then spread to include all primary care practices. These organizations, through their familiarity with patient-centered care, cultural competence and health literacy, rapid cycle evaluation, and other quality improvement work, are well-positioned to pilot the Health Home at-risk intervention program. Importantly, all three Medicaid Health Homes in our region (Hudson Valley Care Coalition, Community Health Care Collaborative, and the Institute for Family Health) are part of our PPS network and are affiliated with PCMH-accredited FQHCs.

Our PPS will need to work closely with our provider partners to develop supportive workflows to enable practices to assess at-risk patients and refer them for short-term Health Home care management services. At the same time, our PPS will work closely with our region's Health Homes to increase their capacity to accept and manage this additional population. New communication protocols and procedures, data collection, and reporting capabilities will need to be developed and implemented. Existing PCMH-accredited primary care practices will be mobilized both to pilot the at-risk intervention program and serve as subject matter experts on outreach, care team formation and communication, and other elements of effective care coordination.

Health Homes in our region are currently able to share patients' care plans via a shared platform, called InsightPlus, which is used by over 40 local care management agencies and hundreds of individual users. InsightPlus is expected to establish import/export capabilities with our local RHIO, HealthlinkNY, in 2015. Our PPS will leverage HealthlinkNY's functionality – expanding it beyond Health Homes where feasible – to facilitate data sharing among providers for any population, including and with an initial focus on the Health Home at-risk population. This project will also build on existing health information technology (IT) and exchange (HIE) infrastructure to facilitate the sharing of care summaries and secure messages between PCPs, hospitals and other providers. By DY 3, all affiliated PCPs will meet PCMH Level 3 and Meaningful Use requirements and will be connected to HealthlinkNY and the SHIN-NY. Other Health Home care team members, including behavioral health providers and community-based organizations, will be called upon to connect to HealthlinkNY through their EHRs or via a provider portal. Direct connections will also be expanded to facilitate the communication of clinical information for specific patient care purposes.

A comprehensive care management plan for at-risk patients remains to be developed and will be a focus of the cross-PPS Regional Clinical Council. A comprehensive care management plan will be created for each patient to engage him/her in their care, promote self-management

behaviors, and reduce identified social and environmental risk factors. The comprehensive care management plan will also serve to alert providers to their patients' strengths and personal goals and to key medical issues that may be overlooked, particularly for patients with severe or chronic behavioral health conditions.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project, and describe how these challenges will be addressed. Examples include issues with patient barrier to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Successful identification, screening, and follow up for Health Home at-risk patients will require workflow changes for both Health Homes and providers. Even with additional resources, the logistics of a new workflow and increased focus on a target population can be challenging. Our PPS will utilize Plan-Do-Study-Act evaluation cycles to rapidly test alternative workflows and evaluate options for administering the PAM, ADI, and other assessments via tablets, computers, and other mobile technologies. In accordance with our imperative to develop culturally appropriate tools and materials, our PPS will make available assessments in English and Spanish at the 3rd grade reading level.

While InsightPlus provides significant functionality for sharing care plans among care team members and tracking members enrolled in Health Homes, its functionality will need to be customized for the Health Home at-risk population, whose care management requirements will vary from that of Health Home patients. Technology development cycles can be lengthy; it could take several months for new functionality to be tested and made widely available. However, we are actively creating functional requirements as part of the program development process and expect the vendor to begin development concurrent with our workflow, training, and other implementation efforts. The new functionality will be tested and refined before a system-wide rollout.

The identification of patients and their providers must rely on valid data and data insufficiencies/quality will be a barrier to implementation. Using disparate data sources and complex algorithms to find at-risk patients will be challenging, especially as available information may be incomplete or out of date. We recognize that refining our PPS's population-level analyses will be iterative and that accuracy will improve over time as we bring more EHR data online and refine logic based on feedback from outreach efforts. In the interim, we will work closely with NYS, Health Homes, PCPs and behavioral health providers to use available data sources and collaboratively define assumptions to inform Health Home and provider workflow and interactions with patients.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve and overlapping service area. If there are no other PPS within the same service area, then no response is required.

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and state. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council that supports the development of a regional system of efficient and effective care, patient safety, and continuous quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project and implementation plans and make recommendations to align overlapping project approaches. Region-wide coordination, common requirements, and similar expectations will minimize providers' implementation burdens and create consistent, high quality experiences for patients. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating proven and promising clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and its payers.

Continuing the cooperation that resulted in the creation of a common Community Needs Assessment, the PPSs in our region have embraced cross-PPS collaboration throughout the selection, design, and development phases of their respective DSRIP projects. To date, the PPSs have committed to coordinate implementation in three critical areas: behavioral health crisis intervention and coordination with local county departments of health and mental health; protocols for patient consent and physician connectivity to HealthlinkNY (RHIO); and a tobacco cessation public health campaign.

This project requires a significant degree of coordination. All three area Health Homes are participating in all the region's PPS, and several FQHC PCMH and behavioral providers are participating in more than one PPS with similar projects. We do not anticipate that all PPSs will design and implement the project in the same manner, but the Regional Clinical Council will provide a forum for vetting implementation issues of concern with all providers participating with more than one PPS.

2. Scale of Implementation

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

2a. Please indicate the total number of sites, programs and/or providers the PPS intends to include in the project by the end of Demonstration Year (DY), or sooner as applicable. These numbers should be entered in the table as Total Committed.

See accompanying Speed & Scale Excel document

b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the Expected # of Actively Engaged Patients. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4.

See accompanying Speed & Scale Excel document

3. Speed of Implementation/Patient Engagement

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet foals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

3a. Please indicate the Demonstration Year (DY) and Quarter by which all participating PCPs will achieve project requirements. Project speed is measured by how fast all the project requirements for all chosen locations are met.

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS "total committed" scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

See accompanying Speed & Scale Excel document

b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of targeted patients will be actively engaged by the end of Demonstration year 1, 50% by the end of Demonstration year 2, etc.

4. Project Resource Needs and Other Initiatives (750 word limit, Not Scored)

4a. Will this project require Capital Budget funding? (Please mark the appropriate box below)

Yes	No
X	

Please describe why capital funding is necessary for the Project to be successful.

In order to contact and engage a target population beyond the Health Home program's current patient base, capital funds are needed to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations. This capability will be shared across all 11 DSRIP projects and is central to our IDS development.

Capital funding will also be needed for the acquisition of new hardware, including tablets and computers that facilitate administering the PAM survey tool in providers' waiting rooms.

4b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
X	

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Cedar Manor Nursing & Rehabilitation	Health Homes for Medicaid Enrollees and	2015	ongoing	New York's Health Home program provides a suite

Center	Chronic Conditions			of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Family of Woodstock, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	2014	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mental Health Association in Orange Co., Inc.	Health Homes for Medicaid Enrollees and Chronic Medical Conditions	2013	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Hudson River Healthcare	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management

				services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mount Vernon Neighborhood Health Center Network	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid

				enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Ulster-Greene ARC	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Westchester Jewish Community Services (WJCS)	Health Homes for Medicaid Enrollees and Chronic Conditions	2014	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Dominican Sisters Family Health Service, Inc.	Community-based Care Transitions Program	2013	2017	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other

				settings and reducing readmissions for high-risk Medicare beneficiaries.

4c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

Our PPS's Health Home at Risk Intervention project will focus on individuals how are not currently eligible for Health Homes to connect them with needed care and community support services. The experience and capacity of our participating Health Homes and downstream care management agencies is a strong foundation for many of our DSRIP projects, and especially this one. This project will build on this work, but will serve a larger group of Medicaid patients, particularly those who are not currently eligible for Health Home services, and specifically Medicaid beneficiaries who have a chronic condition requiring ongoing management, are at risk for deteriorating health status, and/or are likely to be hospitalized or use the emergency department (ED). The proposed project will develop comprehensive care plans for eligible patients and connect patients to necessary referrals and resources.

The Community based Care Transitions program targets Medicare patients. Our PPS will build on Participants' experiences and expertise to establish a health home at-risk program for Medicaid patients. The proposed project will develop comprehensive care plans for eligible patients and connect patients to necessary referrals and resources, but will be focusing on a different population.