



**Department
of Health**

**Medicaid
Redesign Team**

Leveraging Health Homes to Achieve DSRIP Goals

Department of Health | September 21, 2016

Health Homes in New York State

- 32 Health Homes provide access to Health Home care management (HHs) in all 62 counties of the State
 - Beginning in December 2016, Health Homes will serve children (members under 21) – total number of Health Homes will increase to 35
 - 13 of existing 32 will expand from serving adults to also serve children
 - 3 new Health Homes will also serve children
 - Children's Health Home and contacts:
http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm
- All the PPSs have at least some connectivity to Health Homes
 - Some Health Homes are hospitals/or have tight affiliation with Hospitals (e.g., Bronx Lebanon Hospital/ Bronx Accountable Healthcare Network (Montefiore Hospital), Mary Imogene Bassett Hospital)
- List of Health Homes, Regions they Serve and Contact Info:
 - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm

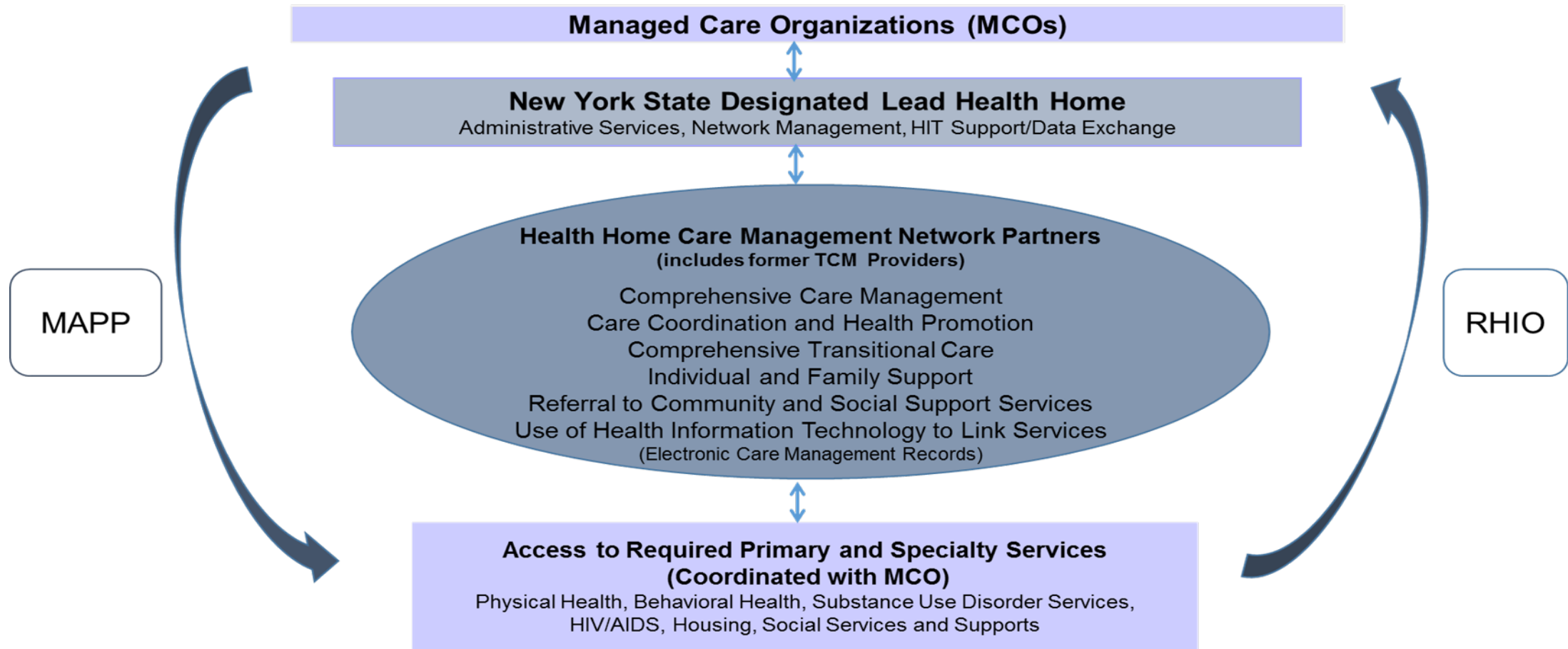


Health Homes are Key Tool for PPSs to Leverage to Achieve DSRIP Goals

- Health Homes work with Plans and multi-disciplinary team of providers to provide comprehensive, integrated (physical and behavioral health, and community and social supports) person-centered **care planning and management** to eligible Medicaid members with Serious Mental Illness (SMI), HIV, or multiple chronic conditions (substance use disorder, diabetes, hypertension, asthma)
 - Members enrolled in HARP (Health and Recovery Plan- specialized Plan line that serves members with significant behavioral health issues) are also eligible for Health Home
 - HARP members are authorized to receive Home and Community Based Services to help them become and remain stable, healthy and in the community (outside of ERs/inpatient)
- Medicaid members eligible for Health Home are the members that “inspired” many of the MRT reforms and DSRIP and are the “frequent fliers” in hospital Emergency Rooms and Inpatient stays
 - PPS connectivity and Hospital connectivity to Health Homes is critical to connecting and engaging members in Health Home care management and is key tool in achieving the Statewide goal of reducing avoidable hospitalizations by 25% by 2020



New York State Health Home Model



MAPP: Medicaid Analytics Performance Portal: NYS System that Tracks Health Home Members



Department of Health

Office of Mental Health

Office of Alcoholism and Substance Abuse Services

Health Homes Provide Comprehensive Person-Centered Care Management that Needs to Be Integrated in PPSs and DSRIP

- **Health Home Care Management** should be a standard referral consideration for all individuals hospitals serve
- **Care coordination** is a vehicle for integrated care, encourages engagement, and improved health outcomes.
- HH Plans of Care are **Person-Centered** and inclusive of **behavioral and medical needs**. Health Homes are charged with providing **Comprehensive Transitional Care** which includes prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient or residential/rehabilitation setting.
- The Health Home **ensures 24 hours/seven days a week availability to a care manager** to provide information and emergency consultation services.
- The Health Home Care Manager will ensure the availability of **priority appointments** to medical and behavioral health care services within their Health Home provider network.
- The Health Home Care Manager identifies available community-based resources and **actively manages appropriate referrals, access, engagement, follow-up, and coordination of services**.



Connecting Members to Health Homes

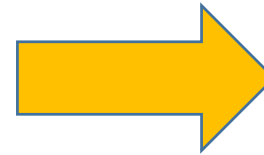
- Members who are eligible for Health Homes are challenging to locate, engage and enroll (Health Home allows for outreach payments)
- Department has been working on several fronts to engage and connect members to Health Homes (best practices, work groups, educating providers about Health Home, Hospitals and CPAP, shelters)
- PPS linkages to Health Homes and the work PPSs are doing are key in making linkages (today's panel)
- Department working to implement ACA requirements that hospitals refer members to Health Homes and integrate Health Homes into hospital discharge protocols



Hospital Health Home Referral Requirements included in ACA and New York's State Plan

Affordable Care Act (ACA) Provisions

“A State shall include in the State Plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.”



Hospitals are required to develop and implement policies and procedures for:

- ✓ *Referring Health Home eligible Patients, **and***
- ✓ *Notifying Health Homes when enrollees access hospital services*

This language is included in New York's State Plan amendment (the document that identifies what services Medicaid will provide, the costs of which are shared with the Federal government (Centers for Medicare and Medicaid (CMS))



Next Steps – Hospital and Health Home Connectivity

- Department and Hospital Associations in -person / Webinar meeting on July 25, 2016
- The Department will be following up with a letter outlining the Health Home notification and referral requirements
 - Includes information on Late Fall Updates of EPACES-EMEDNY to include information about each member's affiliation with a Health Home (more information to come)
- Policy and Procedures to meet these requirements are due to the Department no later than December 1, 2016
- The Department is interested in learning more about current best practices for integrating PPSs and Health Homes to decrease avoidable ED utilization
- Department will be releasing additional guidance on integrating Health Homes in Hospital discharge planning process
- How can the Department help?



PPS Project Linkages to Health Homes

DSRIP Projects Requiring Health Homes & Care Management

- Each PPS is required to work with its area Health Home(s).
- Health Homes are a vehicle for engagement of members for PPSs that selected the following projects:
 - **Project 2.a.iii** - Health Home At-risk Intervention Project for those with single chronic conditions who do not qualify for a Health Home.
 - **Project 2.b.iv** - Care transitions intervention model to reduce 30-day readmissions for chronic conditions.
 - ✓ Connecting members to HH/care management services upon hospital discharge, whether hospitalized for a medical or a behavioral health condition.
 - These include HARP members, who by definition, are HH eligible, and can be engaged during BH admissions.
 - **Project 2.d.i** - Patient activation for Low- and Non-utilizers of Medicaid, and for the uninsured.



DSRIP Projects Requiring Health Homes & Care Management

- **Project 2.b.ii** Development of co-located, primary care services in the Emergency Department (ED)
- **Project 2.b.iii** ED Care triage for at-risk populations.
 - ✓ Connecting members to HH/care management services on ED discharge, whether presenting for a medical or a behavioral health condition.
 - E.g. Maimonides PPS is embedding 6 Health Home Care Managers in network EDs to connect members to Care Management and Primary Care, with the goal to avoid the ED for problems better addressed in other settings the next time.
- **Project 3.a.ii** Behavioral Health community crisis stabilization services
 - ✓ Connecting members to necessary behavioral health services during times of crisis, in places other than the ED or hospital.
 - E.g., Westchester Medical Center is training police to bring people to places other than the ED, for stabilization and “cooling off.”
 - These are screening/triage centers - not where the definitive care is rendered



DSRIP Health Home Measures

Measure Name	Numerator Description	Denominator Description	Performance Goal	Achievement Value	Reporting	Payment: DY 1 through 5
Health Home assigned/referred members in outreach or enrollment	Number of referred and assigned HH eligible members with at least one outreach or enrollment segment during the measurement year	Total number of referred and assigned HH eligible members in the Health Home Tracking System during the measurement year	NA – Pay for Reporting measure only	Reporting on this measure is required in order to earn project Quarterly Progress Report AV	NYS DOH	P4R
Health Home members who were in outreach/enrollment who were enrolled during the measurement year	Number of HH members with at least one enrollment segment in the Health Home Tracking System during the measurement year	Total number HH eligible members with at least one outreach or enrollment segment of in the Health Home Tracking System during the measurement year	NA – Pay for Reporting measure only	Reporting on this measure is required in order to earn project Quarterly Progress Report AV	NYS DOH	P4R
Health Home enrolled members with a care plan during the measurement year	Number HH with a care plan update indicated in any of the four quarters of the measurement year	Total number HH eligible members with at least one segment of enrollment in the Health Home Tracking System during the measurement year	NA – Pay for Reporting measure only	Reporting on this measure is required in order to earn project Quarterly Progress Report AV	NYS DOH	P4R

Panel Discussion

- What are Health Homes doing today to refer and notify?
- How can PPS support these linkages?
- What is on the horizon that will improve hospital/Health Home coordination and patient access to Health Home services
- How can the Department help?



September 21, 2016



New York State DSRIP Statewide Learning Symposium



**Evolving DSRIP
Partnerships:
Leveraging
Health Homes
for DSRIP**

Presenters

Carol Tegas
Executive Director
Finger Lakes Performing Provider System

Adele Gorges
Executive Director
New York Care Coordination Program (Health Homes of Upstate New York)

Deb Peartree
Executive Director
Rochester Integrated Health Network & Greater Rochester Health Home Network

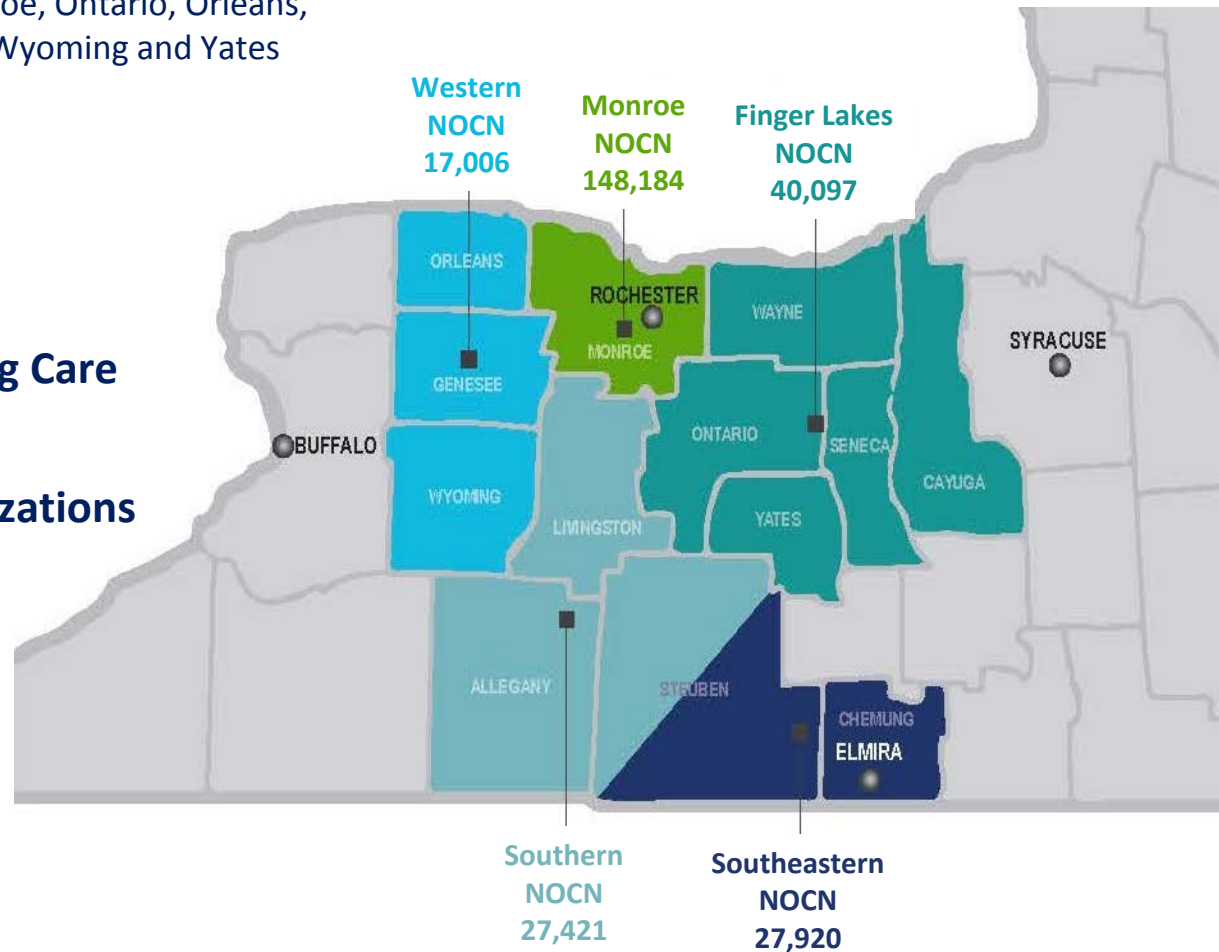
Bruce Nisbet (contributor)
Executive Director
Health Home Partners of Western New York

FLPPS Health Home Collaboration Model

- FLPPS Projects & Health Home Crosswalk
- Health Home Engagement & Education
- Health Home Integration into FLPPS Workgroups
- Project Workflow: Project 3a11
- Health Home Analysis in FLPPS Region
- Health Home Eligibility & Super-Utilizer Enrollment
- Risk Triangle – HARP
- Opportunities & Next Steps

Finger Lakes PPS

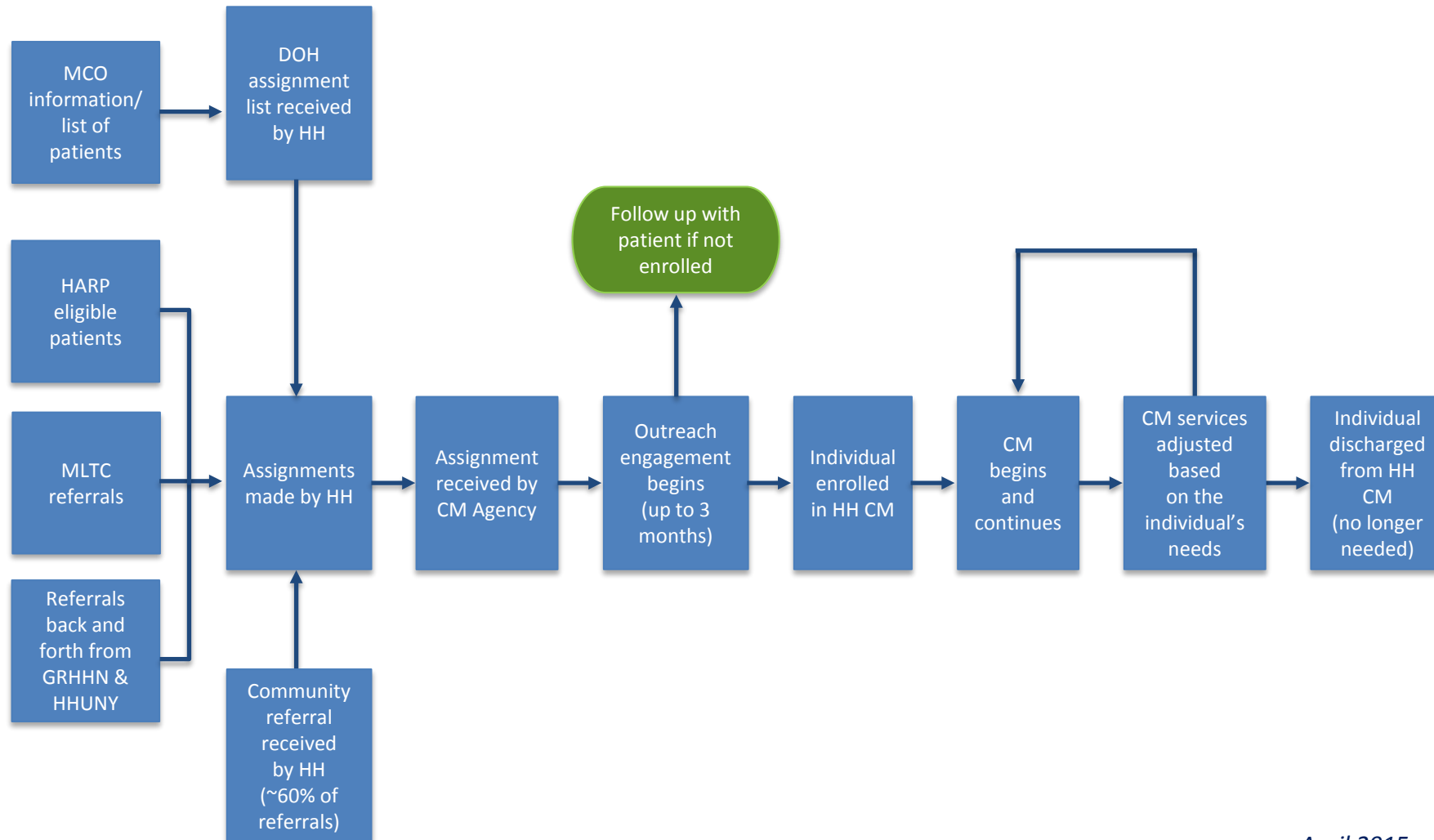
- **13 Counties** - Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates
- **1.5M Population**
- **~400,000 Lives**
(including 100K uninsured)
- **5 Naturally Occurring Care Networks (NOCNs)**
- **~600 Partner Organizations**
- **19 Hospitals**
- **~6,700 Providers**
Primary Care, SNF, Hospice, Specialists, Pharmacies, etc.



FLPPS DSRIP Projects & Health Homes Crosswalk

2ai Integrated Delivery System	2biii ED Triage for At-Risk Populations	2biv 30-Day Readmission Care Management	
2bvi Transitional Housing	3ai Behavioral Health and Primary Care Integration	3aii Community Crisis Stabilization	

Health Home Engagement



April 2015

Health Home Education

FLPPS Internal

- RACI (who is Responsible, Accountable, Consulted, Informed) completed to determine accountability for Care Management Strategy within FLPPS
- 2ai Project Manager meeting regularly with Health Homes, including shadowing with Care Managers to better understand current processes

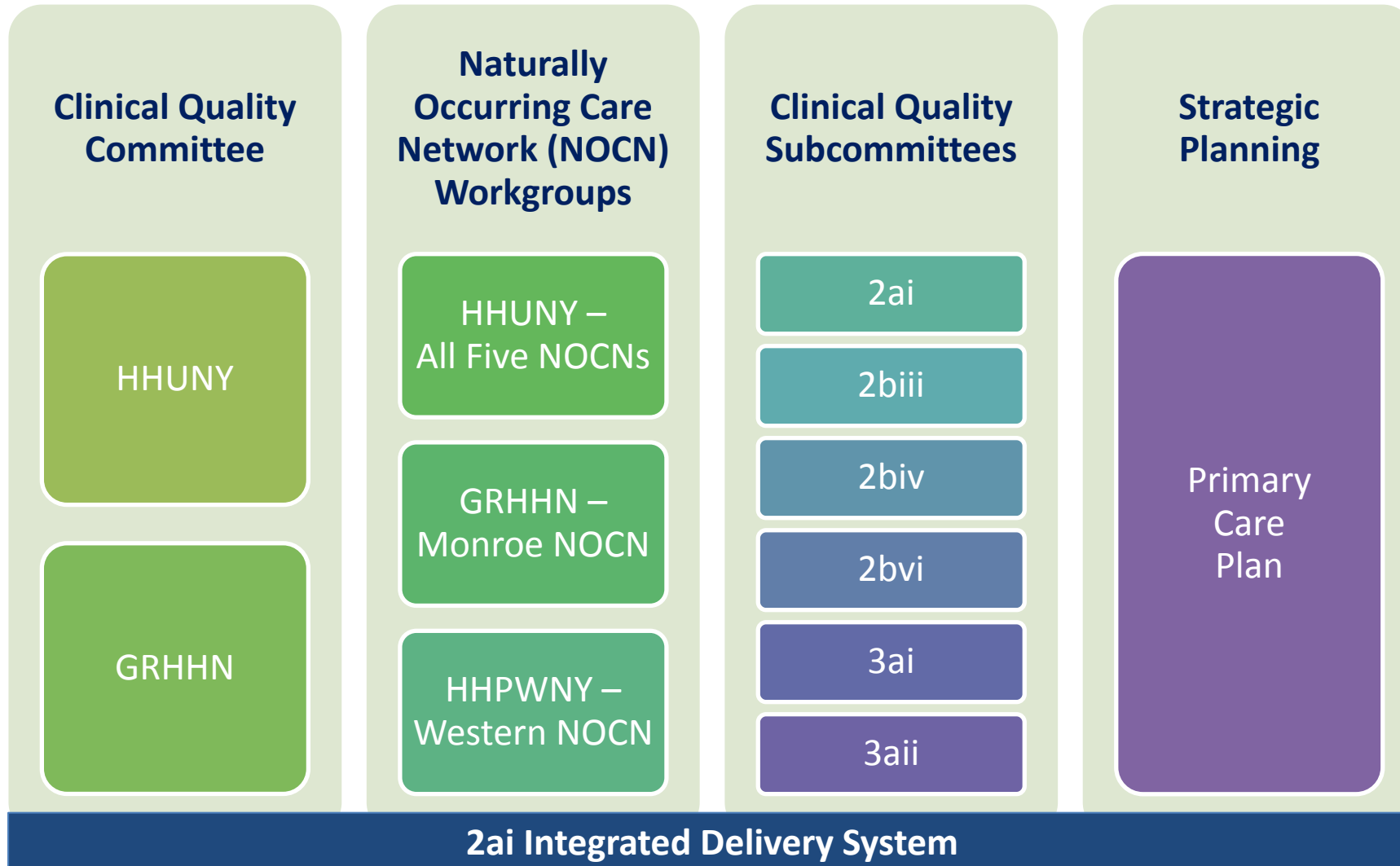
Naturally Occurring Care Network (NOCN) Workgroups

- Explored base knowledge of Health Homes as a resource
- *Health Home 101* provided by FLPPS Partner Relations Team
- Health Home representatives invited as guest speakers to address questions and explore how to collaborate
- Health Home representation expanded across the NOCNs

FLPPS Partnership

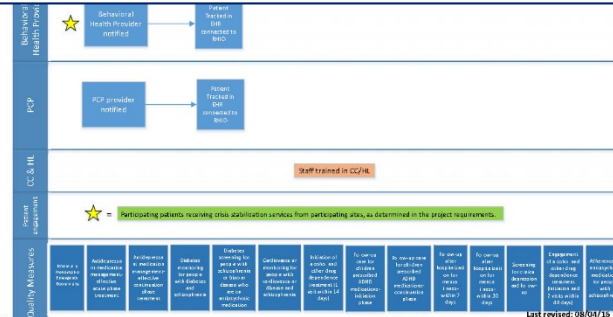
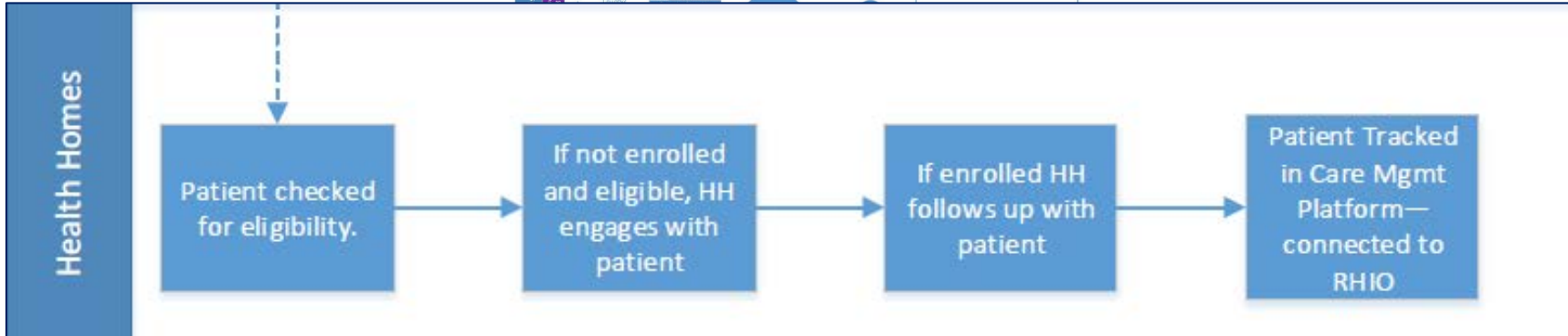
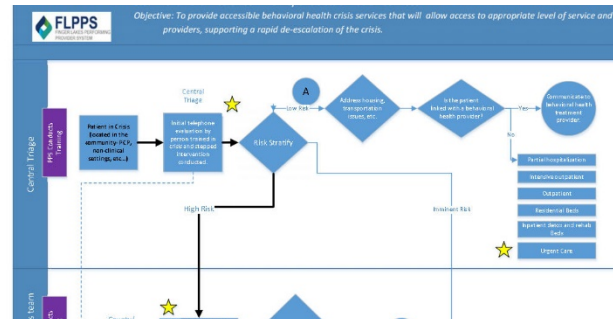
- Regional Information sessions are occurring within each NOCN for all FLPPS Partners

Health Home Integration into FLPPS Workgroups



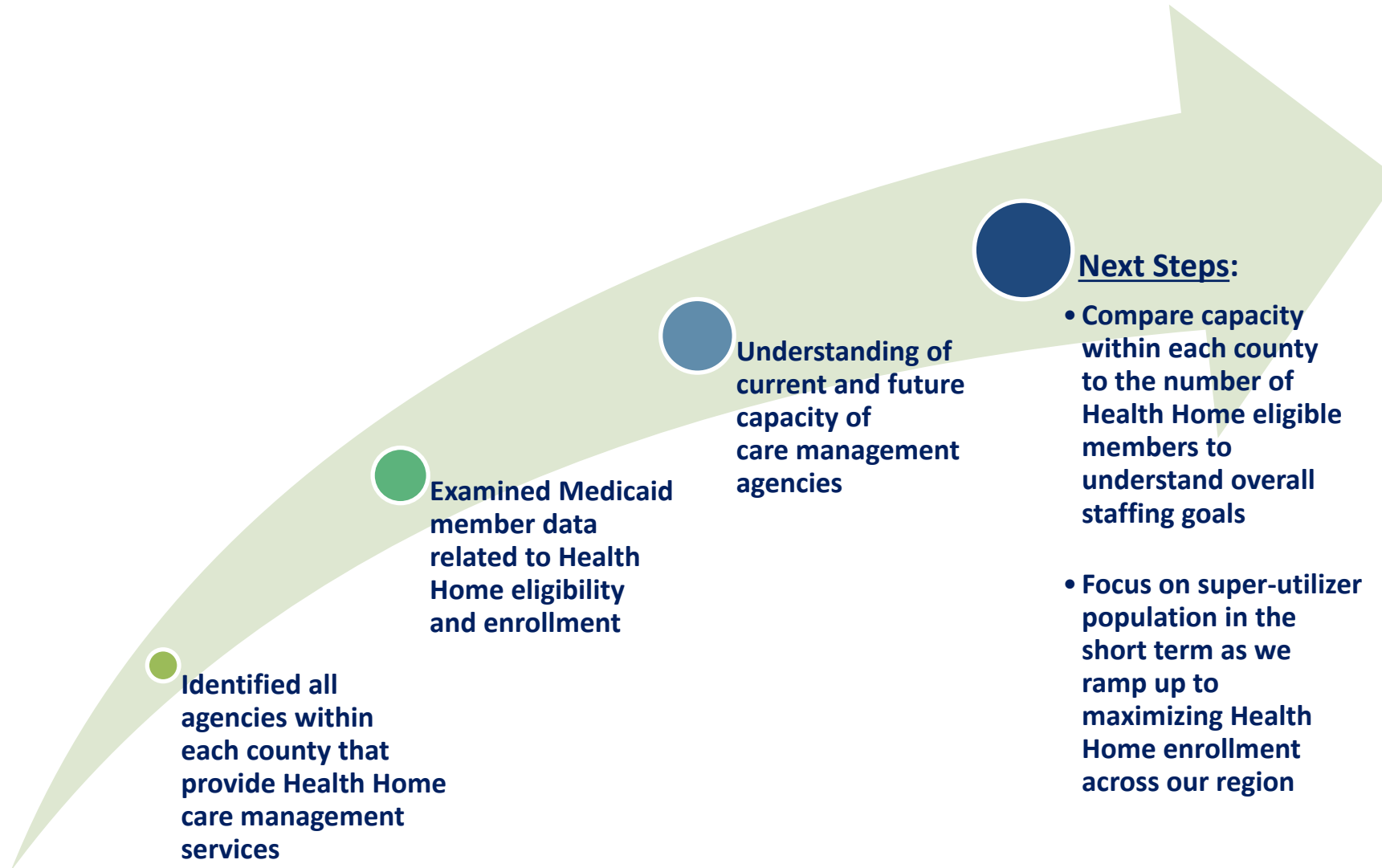
Project Workflow: Project 3a ii

Project 3a ii: Behavioral Health Community Crisis Stabilization Services



Last revised: 08/04/19

Health Home Analysis in FLPPS Region



Health Home Eligibility (full roster)

FLPPS County	HH Eligible	HH Enrolled	% of Eligible Enrolled
Cayuga	160	16	10%
Genesee	1297	147	11%
Orleans	1241	145	12%
Chemung	2613	309	12%
Livingston	1556	188	12%
Wyoming	400	49	12%
Yates	529	80	15%
Wayne	2325	365	16%
Allegany	1027	168	16%
Steuben	2322	400	17%
Ontario	2227	476	21%
Monroe	26395	6367	24%
Seneca	742	211	28%

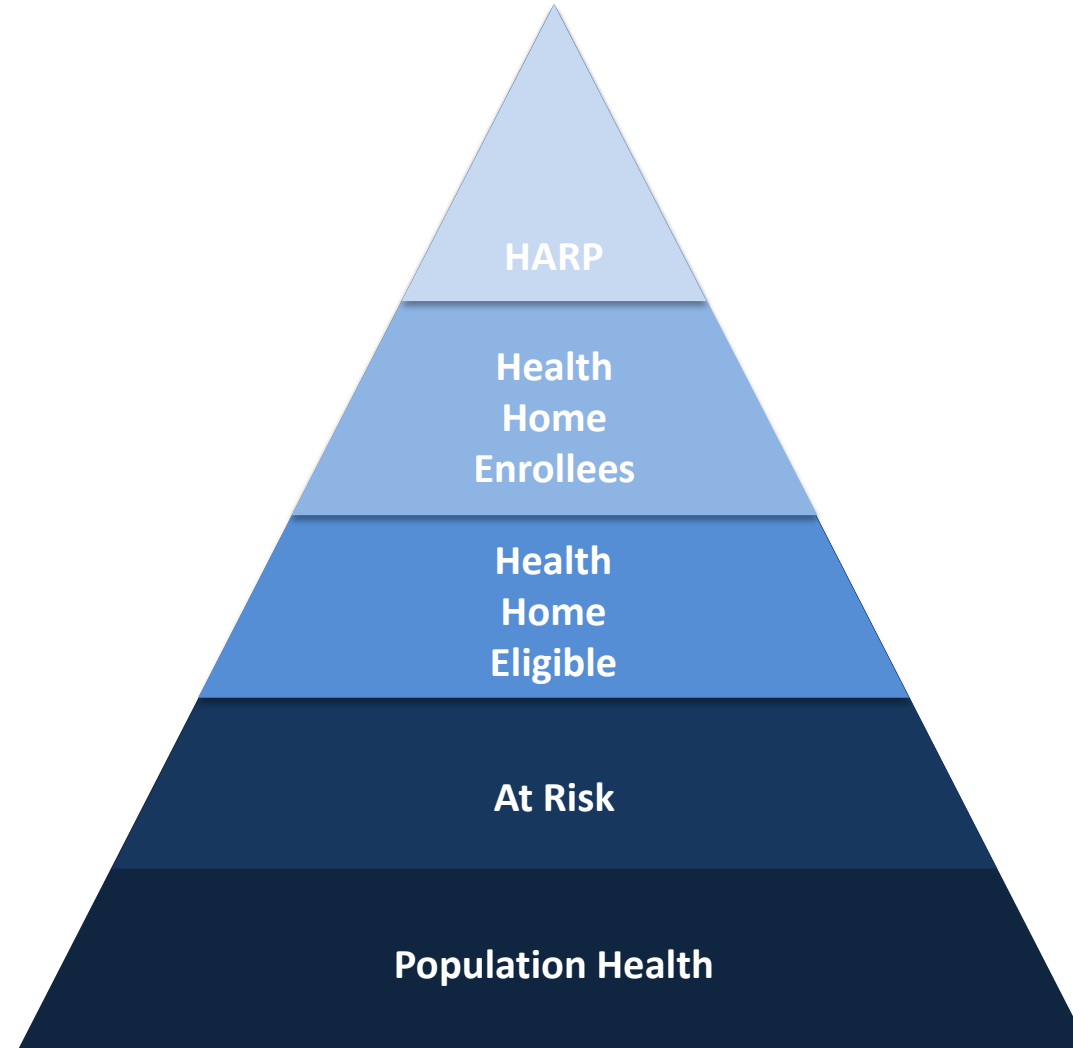
July 2015-June 2016 Data

Health Home Super-Utilizer Enrollment

FLPPS County	SU Not Enrolled	SU Enrolled	% SU Enrolled
Allegany	27	1	4%
Livingston	47	5	11%
Wyoming	9	1	11%
Cayuga	8	1	13%
Chemung	160	24	15%
Yates	13	2	15%
Wayne	93	18	19%
Seneca	20	4	20%
Orleans	27	6	22%
Steuben	90	23	26%
Monroe	1321	338	26%
Genesee	46	12	26%
Ontario	68	18	26%

July 2014-June 2015 Data

Risk Triangle - HARP



Opportunities & Next Steps

Continue Health Home education throughout FLPPS Network via community information sessions

Increase Health Home enrollment for eligible members

Leverage super-utilizer data to focus efforts for greatest impact

Collaborate with Health Homes and care management agencies on best practices for care management delivery



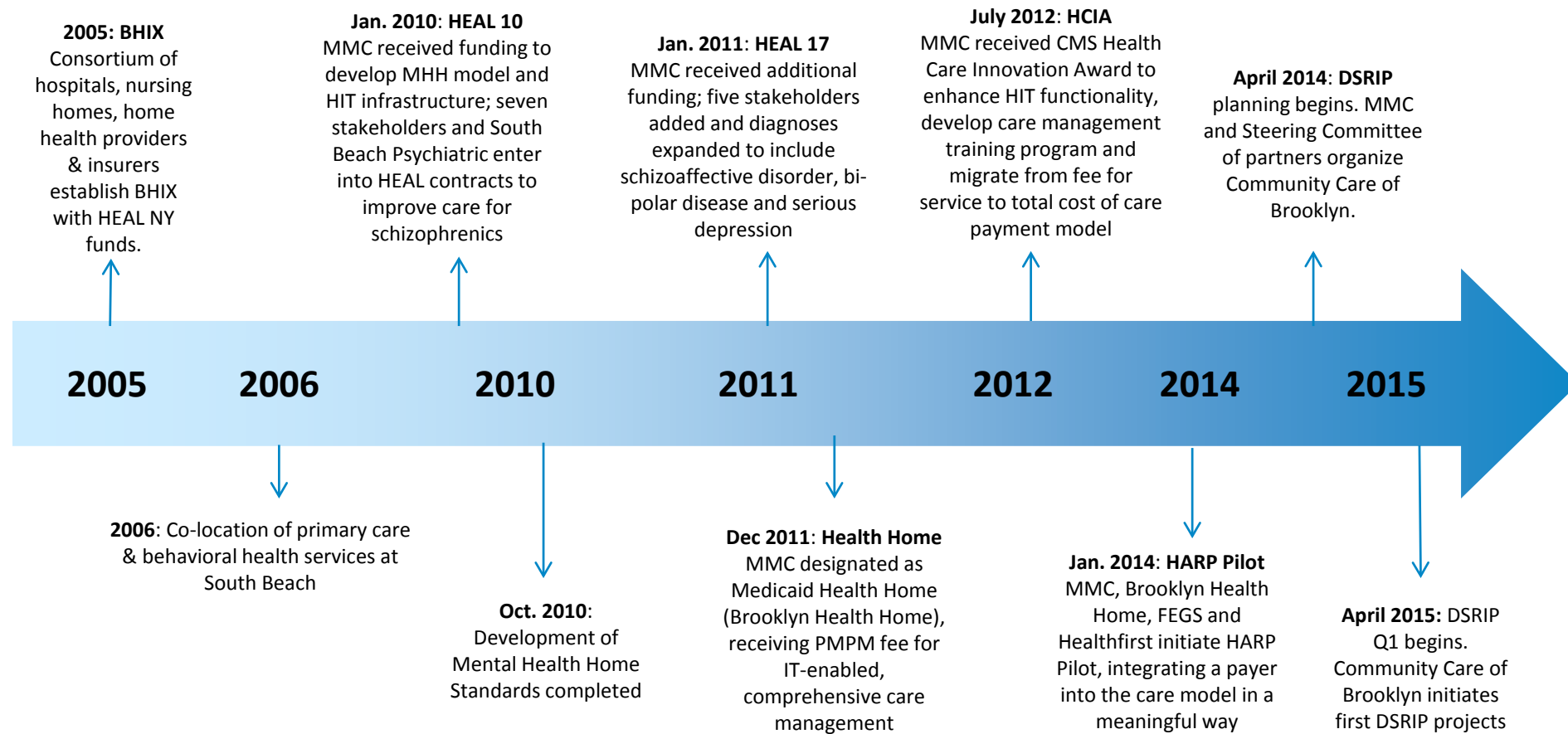
Thank You

LEVERAGING HEALTH HOMES FOR DSRIP: BROOKLYN HEALTH HOME AND COMMUNITY CARE OF BROOKLYN

NY DOH DSRIP Annual Statewide Learning Symposium
Sara Kaplan-Levenson
Maimonides CSO
September 21, 2016



Population Health at Maimonides: Evolution of Model and Technology



Health Homes and DSRIP

Core Belief: Health Homes and PPSs are well positioned to be mutually enhancing and sustaining. Health Homes/Care Coordination is a cornerstone of DSRIP activities. The Health Home and the PPS can each fill gaps the other faces.

Opportunities:

- BHH and CCB are utilizing the same web-based care coordination and population management platform
- DSRIP has the attention of hospitals and clinical providers in the community → *the health home can benefit from wider knowledge of the program and “buy in” to facilitate more meaningful collaboration*
- BHH has a well established network of community-based providers, organizations, and social service agencies → *the PPS can leverage these relationships and partnerships*
- BHH has well defined standards and protocols for community-based care coordination – with evidence of success! → *the PPS can adopt, refine, and implement these standards and strategies*

CCB and BHH Networks

CCB Network

- **3,700+** practitioners, including **1,600** PCP's
- **6** Hospitals and **8** FQHC's
- **500** Community-Based Small Practices
- **350** Social Service Organizations
- Largest Performing Provider System (PPS) in Brooklyn
- **454,000** attributed patients for PPS performance reporting
- Governance through committee structure with consensus-based approach

Brooklyn Health Home Network

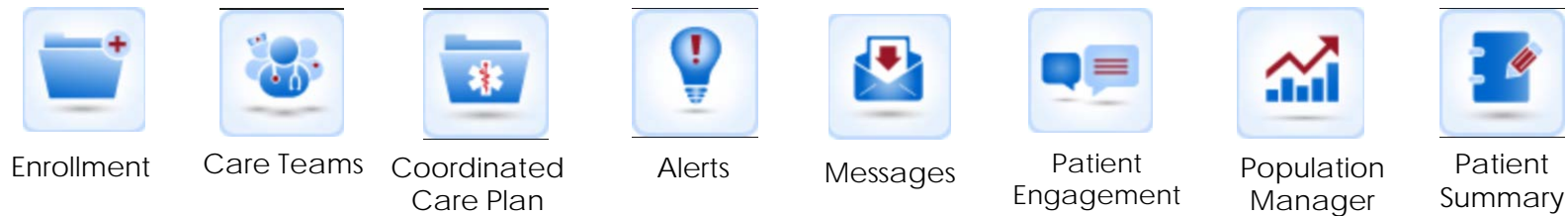
- 23 Care Management Agencies (CMAs)
- 6 Hospitals
- Housing Providers
- Behavioral Health Providers
- Substance Use Providers
- Social Support Services
- Criminal Justice Services

Hospitals in CCB Network

- Interfaith Medical Center
- Kingsbrook Jewish Medical Center
- Maimonides Medical Center
- New York Community Hospital
- New York Methodist Hospital
- Wyckoff Heights Medical Center

Working Together...in Health IT

- GSI Health Coordinator, referred to as 'The Dashboard,' is a web-based platform
- The Dashboard is a centralized, unifying resource for all CCB **AND** Brooklyn Health Home participants, regardless of IT system
- The Dashboard enables data sharing, care coordination, a single unified care plan, and performance reporting across the PPS



Working Together...*in Care Transitions*

- All 6 of the hospitals in CCB are paired with a Care Management Agency which embeds an on-site Health Home Care Manager (HHCM) to facilitate rapid Health Home referrals.
- The HHCM accepts referrals from front-line staff and Transitional Care Teams, proactively identifies patients who may be eligible for Health Home services and enrolls them, and connects care managers for existing Health Home members to Transitional Care Teams.
- The assigned Care Management Agency and the Transitional Care Teams work together to create a comprehensive care plan and collaborate throughout the 30-day transition period.

Working Together...*in Care Management*

- Health Home CMAs are assigned to FQHCs in the PPS to facilitate rapid enrollment and initiation of care coordination services for the most complex patients.
- Patient Navigators in the Emergency Departments (EDs) throughout the PPS are trained to screen for Health Home eligibility and refer to the on-site CMA. This enrollment facilitates connections to primary care and helps reduce future inappropriate ED utilization.
- Health Home care managers will be trained to do environmental home assessments for patients with asthma to identify triggers and mitigation strategies, and provide education and support.

Working Together...*in Primary Care*

- Health Home CMAs are assigned to primary care practices to nurture relationships and facilitate collaboration.
- Practice-based Health Coaches and Health Home Care Managers communicate to ensure patients are in the most appropriate level of care (Health Home or Health Home at Risk). Patients may flow in and out of Health Home Care Management during periods of extreme complexity.
- Health Home Care Managers are trained to support patient-centered medical home (PCMH) programs focused on cardiovascular disease, and the integration of behavioral health and palliative care into the primary care setting.

Successes, Challenges, & Lessons Learned

Hospital-based workflows

- Education and buy-in among both hospital leadership and frontline staff has been essential.
- Health Home Care Management is becoming a more and more routine referral.

Care Management

- We continue to search for and invest in ways to better track patients through and across the continuum of care. More advanced workflows and technology will help “flag” patients when they should be moved into a higher level of care, and allow them to safely step down into a less intense mode once stable. The ability to “flex” care management according to individual needs will facilitate patient-centered care and sustainability.

Technology and Policy

- Visibility/Access limitations in the DOH MAPP system make it difficult for frontline workers to know with which health home (if any) a patient is associated.
- Constraints around consent can make information sharing confusing for both patients and providers and limit real-time collaboration .

Contact

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Q&A



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