2.a.iii. HEALTH HOME AT-RISK INTERVENTION PROGRAM

Proactive management of higher risk patients not currently eligible for Health Homes through access to high-quality primary care and support services

INTRODUCTION

The Health Home At-Risk Project seeks to address the complex needs of individuals who *do not* meet New York State eligibility requirements for Health Home participation, but *do meet* federal eligibility participation criteria.

There is a gap in Health Home eligibility criteria between federal health home regulations and New York State (NYS) criteria, which is more restrictive. As a result, NYS seeks to leverage DSRIP funds to provide support to individuals who do not qualify for Health Home participation in NYS but otherwise meet federal eligibility criteria.

Federal regulations originate from "The Affordable Care Act of 2010, Section 2703, that created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 of the Social Security Act. CMS expects state health home providers to operate under a 'whole-person' philosophy. Health Home providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person."[1]

New York State has instituted a Health Home program in accordance with CMS guidelines.

ELIGIBILITY FOR A HEALTH HOME UNDER FEDERAL STANDARDS[2]

Health Homes are for people with Medicaid who:

- Have two or more chronic conditions;
- Have one chronic condition and are at risk for a second;
- Have one serious and persistent mental health condition.

Chronic conditions listed in the statute include mental health, substance abuse, asthma, diabetes, heart disease, and being overweight. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval.

- States can target health home services geographically.
- States cannot exclude people with both Medicaid and Medicare from health home services.

ELIGIBILITY FOR A HEALTH HOME UNDER NEW YORK STATE STANDARDS[2]

New York State's Health Home eligibility definition is as follows:

- Two (2) chronic conditions or
- One (1) single qualifying condition (HIV/AIDS or SMI).

If an individual has HIV or SMI, (s)he does not have to be determined to be at risk of another condition to be eligible for Health Home services. Substance use disorders (SUDS) are considered chronic conditions and do not by themselves qualify an individual for Health Home services. Individuals with SUDS must have another chronic condition to qualify.

MAY 2017

Table A: Comparison of Federal, NYS and NYS DSRIP eligibility criteria for Health Home Participation

Criteria	Federal HH	NYS HH	NYS DSRIP Health Home At-Risk
Two or more chronic conditions	X	X	
One chronic condition and are at risk for a second	X		X
One qualifying condition (HIV/AIDS or SMI)		X	
One serious and persistent mental health problem	X	X	
Approved chronic condition	MH, SA, Asthma, DM, Heart Disease and Obesity (HIV/AIDS may be considered by CMS)		

NYS DSRIP ELIGIBILITY FOR HEALTH HOME AT-RISK

For the Health Home At-Risk program, NYS DSRIP has defined program eligibility to be for Medicaid beneficiaries who do not quality for health home services in NYS, but would otherwise qualify for health home services under the federal definition of eligibility. Specifically, this includes:

- One chronic condition and are at risk for a second;
- Non-HIV,
- Non-SMI.

HEALTH HOME SERVICES REQUIRED BY CMS[3]

The following services are required to be provided by designated Health Homes under federal legislation:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care/follow-up;
- Patient & family support;
- Referral to community & social support services.

HEALTH HOME PROVIDERS[4]

States have flexibility to determine eligible health home providers. Health home providers can be:

- Designated provider: May be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or another provider.
- Team of health professionals: May include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, and can be free-standing, virtual, hospital-based, or a community mental health center.
- Health team: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractors, licensed complementary, and alternative practitioners.

CARE MANAGEMENT PLAN

"The Care Management Plan for the Health Home At-Risk patient should be comprehensive and consistent with those developed for a standard health home member."[5]

The Care Management Plan for Health Home At-Risk patients will contain the following elements:

- Care managers and/or primary care providers create, document, execute, and update an individualized, person-centered plan of care for each individual.
- A comprehensive health assessment that identifies medical, behavioral health, (mental health and substance use) and social service needs is developed.
- The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long-term care, and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager, and other providers directly involved in the individual's care.
- The individual (or guardian) plays a central and active role in the development and execution of the plan of care and should agree with the goals, interventions, and time frames contained in the plan.
- The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks, and supports that address his/her needs.
- The individual's plan of care clearly identifies family members and other supports involved in the individual's care. Family and other supports are included in the plan and execution of care as requested by the individual.
- The individual's plan of care clearly identifies goals and timeframes for improving the individual's health and health care status and the interventions that will produce this effect.
- The individual's plan of care must include outreach and engagement activities that will support engaging individuals in their care and promoting continuity of care.
- The individual's plan of care includes periodic reassessment of individual needs and clearly identifies the individual's progress in meeting goals and changes in the plan of care based on changes in patient's need.

OBJECTIVE

To link community primary care services and community-based organizations for high-risk individuals who do not qualify for Health Homes (HH) under current NYS Health Home standards. Such patients show patterns of repeated hospital and emergency department (ED) utilization that often reflect the effects of social determinants of health and unmet medical and behavioral health needs – including substance abuse issues. In the absence of a formal health home to provide supportive services, this project brings an array of integrated care management support services to address these needs.

DESCRIPTION OF SERVICES

This project addresses the high-risk population that has a single chronic condition and are at risk for developing a second chronic condition, but do not suffer from HIV/AIDS or SMI. Typically, these patients are identified through diagnosis codes recorded in the problem list within the primary care physician's electronic medical record (EMR) or disease registries within meaningful use management platforms. Alternatively, these patients may be identified through claims data from NYS feeds to ACP or from data exchange with Medicaid Managed Care Organizations (MMCOs).

ACP is working with 3-M/Treo Solutions to contract for their CRG Grouper to further identify patients in Health Status 5 indicating a single significant chronic disease. 3M software will also help identify potentially preventable ED visits (PPVs), admissions, and readmissions (PPAs, PPRs). Often, these patients have unmet needs and manifest as super-utilizers. They display a pattern of using expensive healthcare resources, especially use of the ED and inpatient setting, often for potentially preventable conditions for reasons related to social determinants of health (e.g., financial, nutritional, housing insecurity; inadequate health literacy or inadequate social supports). Without a Health Home At-Risk intervention, this group is likely to demonstrate deterioration of their clinical status and ultimately meet criteria for admission to a formal Health Home program in the near future.

Most PCMHs do not have the range of resources or time to adequately meet this group's needs; however, ACP's Health Home At-Risk program offers options to primary care providers working to manage their patients' condition appropriately. Identifying and addressing this group of Medicaid beneficiaries and linking PCMHs with an interdisciplinary team is intended to mitigate their pattern of avoidable and expensive health care services.

MAY 2017

KEY COMPONENTS

All ACP Primary Care Physicians (PCPs) who are or will participate in this project must already be an NCQA (2011) accredited Patient Centered Medical Home, level 3, and commit to achieving NCQA 2014 Level 3 PCMH or becoming an Advanced Primary Care practice before the end of 2017.

ACP performed a community needs assessment to identify service area sectors of higher risk patients with insufficient access to and use of primary care services. Using utilization and quality data about PCP engagement, at-risk patients will be identified who do not already have access to care management services nor are engaged with the care management team. The team will work with Health Home At-Risk members to develop a comprehensive care management plan to engage them in care, to reduce their risk factors, and to address the social determinants of health that are leading to inappropriate and preventable use of health care resources. The care management plan should be comprehensive and consistent with those developed for a standard Health Home member.

ACP is expanding its workforce to develop primary care capacity in identified shortage areas based on the community needs assessment. This may include not only community-based services and Health Home care management services linked to PCMHs, but also services in congregate living sites such as assisted living facilities.

ACP will help the PCP with Health Home at-Risk patients to provide linkages with needed services that include behavioral health providers, pharmacists, nurse educators, care managers, as well as social services that are necessary to meet patient needs in that community. It is expected the provider will work with local government units such as housing service coordinators like supportive housing Single Point of Access (SPOA) programs and public health departments where appropriate. ACP has re-evaluated its network of Community Based Organizations to enrich the services available to ACP practices and care management staff for referrals. ACP profiled each of its network community based organizations in terms of services to make this information available for referral purposes. ACP has targeted gaps in social service needs and is recruiting additional community based organizations to address these needs.

ACP providers will employ evidence-based practice guidelines to address risk factor reduction (e.g., smoking cessation, immunization, substance abuse identification, and referral to treatment/depression and other behavioral health screenings) as well as to ensure appropriate management of chronic diseases (e.g., diabetes, cardiovascular disease, asthma). Assessment of social determinants of health will be integral to these activities. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population.

Secure instant messaging and alerts programs will be implemented to ensure timely sharing of critical patient information across key clinical members of ACP, and a dashboard of outcome metrics will be established to monitor the care provision and ensure rapid cycle improvements can be made.

ACP's Clinical Quality Committee will monitor utilization and outcome metrics monthly and implement improvements when actual results fall outside of expected targets and benchmarks.

This program will exemplify cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation, including addressing issues of health disparities.

HEALTH HOME AT-RISK CORE MODEL

ACP's Health Home At-Risk project will provide Health Home-like services to individuals who have active Medicaid and meet diagnostic eligibility criteria but do not meet the specific criteria to be a member of the Health Home.

The goal of ACP's Health Home At-Risk Intervention initiative is to:

- Provide chronically ill patients with quality health care that decreases progression of disease and increases the quality of life;
- Ensure the best patient experience;
- Enhance population health within our communities;
- Improve quality of services to improve performance outcomes, and
- Foster a patient-centered family/caregiver care model that encourages patient preferred decision-making.

ACP will ensure these services are provided to patients by:

- **Identifying Health Home and Health Home At-Risk members by using claims data from EHRs, NYS Claims data, MMCO data, and 3M/Treo risk stratification data.** The priority will be to first find patients in CRG Health Status 5 (single significant chronic disease, but not HIV or a SMI) who show a need for enhanced care management by their repeated use of ED visits for potentially preventable reasons (PPVs) and hospital admissions and readmissions for potentially preventable diagnoses (PPAs and PPRs). When

Health Home-eligible members are found, the PCP office will be helped to coordinate care with the Health Home.

- **Engaging Health Home At-Risk members:**

  Outreaching to the Health Home At-Risk member for implementing the individualized care plan. In essence, the ACP strategy to engage patients in this project is two-fold: (1) identify individuals with either a single chronic condition as documented in claims and encounters; (2) work directly with PCP practices to search their "problem list" in the EMR to identify individuals eligible for Health Home At-Risk.

  PMO staff will review the list of identified eligible Health Home At-Risk patients with each PCP. When validated by the PCP, the clinician will be helped to create a Health Home-like care plan and explained how ACP can help coordinate the resources available to address unmet needs and the social determinants of health.

- **Providing Health Home At-Risk Support to PCP Offices:** ACP will provide back office support to ACP providers to model Health Home quality practices and care management for patients who would benefit but are not eligible. Health Home elements to be incorporated in standard practice for eligible patients include:

  - » Comprehensive care management
  - » Care coordination and health promotion
  - » Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
  - » Individual and family support
  - » Referral to community and social support services as appropriate
  - » Use of Health Information Technology (HIT) to link services
  - » Social and behavioral factors
    - Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission)
    - Lack of or inadequate social/family/housing support
    - Lack of or inadequate connectivity with healthcare system
    - Non-adherence to treatments or medication(s) or difficulty managing medications
    - Recent release from incarceration or psychiatric hospitalization
    - Deficits in activities of daily living such as dressing or eating and
    - Learning or cognition issues.

- **Evaluating the effectiveness of the care plan in reducing PPAs, PPRs, and PPVs among the Health Home At-Risk cohort.**

ACP CARE MANAGEMENT SERVICES FOR AT-RISK PATIENTS

Care management will be implemented for all patients identified by the ACP partner as being at risk of progressing to Health Home eligible status but who do not currently meet the eligibility criteria.

A. Health Home At-Risk Clinical Criteria: Individuals with one chronic progressive condition and/or at risk for developing another chronic condition and those individuals with low to moderate mental illness. The target population includes ACP patients within ACP's geographical catchment area and disease types (e.g., Diabetes, Hypertension, Angina, COPD, Congestive Heart Failure, Asthma, moderate Behavioral Health diseases) who have a pattern of using preventable ED and hospital services.

B. Patient Care: Care Management and Care Coordination are at the core of the management of these chronically ill patients.

Care Managers will assist the patient in compliance with medications, disease monitoring and management, obtaining refills, and home self-management techniques. In addition, Care Managers will work with Community Based Organizations to address unmet social determinants of health.

OUTCOME METRICS

- The number of participating patients who completed a new or updated comprehensive care management plan and who are not in a Health Home.
- A count of patients who meet the above criteria over a one-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
- The trend in percent of ACP Health Home At-Risk patients with PPVs, PPAs, and PPRs.

/REFERENCES

[1]Health Homes. (n.d.). Retrieved January 20, 2017, from https://www.medicaid.gov/medicaid/ltss/health-homes/index.html
[2]https://www.medicaid.gov/medicaid/ltss/health-homes/index.html
[3]https://www.medicaid.gov/medicaid/ltss/health-homes/index.html
[4]Ibid.
[5]https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2015-1028_actively_engaged_definitions.pdf

MAY 2017