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

Project Objective: This project will expand access to community primary care services and develop integrated care teams (physicians and other practitioners, behavioral health providers, pharmacists, nurse educators and care managers from Health Homes) to meet the individual needs of higher risk patients. These patients do not qualify for care management services from Health Homes under current NYS HH standards (i.e., patients with a single chronic condition but are at risk for developing another), but on a trajectory of decreasing health and increasing need that will likely make them HH eligible in the near future.

Project Description: There is a population of Medicaid members who do not meet criteria for Health Homes but who are on a trajectory that will result in them becoming Health Home super-utilizers. This project represents the level of service delivery and integration for the complex super-utilizer population who fall in between the patient-centered medical home and the Health Home general population. Some risk stratification systems refer to these patients as "the movers." Early intervention through this project shall result in stabilization reduction in health risk and avoidable service utilization.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH PCPs in care coordination within the program.
2. Ensure all participating primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH or Advanced Primary Care accreditation by Demonstration Year (DY) 3.
3. Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.
4. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards.
5. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
6. Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.
7. Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.
8. Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local

government units (such as SPOAs and public health departments).

9. Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

a. 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.

The CNA detailed the total observed risk-adjusted expected ratio ("risk-adjusted O/E") of PPV EDs for NYC neighborhoods. Of 10 neighborhoods with the highest PPVs, five are in the Bronx (Highbridge-Morrisania, Crotona-Tremont, Hunts Point/Mott Haven, Fordham-Bronx Park, Pelham-Throgs Neck), three are in Brooklyn (Bedford-Stuyvesant-Crown Hts, E. New York, Williamsburg-Bushwick) and two are in Queens (Jamaica, W. Queens).

The CNA also provided data for certain risk-adjusted Medicaid Prevention Quality Indicators (PQIs). PQIs are a set of measures developed by the Agency for Healthcare Research and Quality for use in assessing the quality of outpatient care for a set of ACSC conditions. For chronic obstructive pulmonary disease (COPD) or asthma in adults ages 40 and older, the risk-adjusted O/E is 1.05 for NYC and 1.06 in our service area. Twenty neighborhoods were higher than NYC, including: Manhattan (Central Harlem/Morningside Hts, Washington Heights/Inwood, Upper W. Side, E. Harlem, Chelsea/Clinton); Brooklyn (Flatbush/E. Flatbush, Bedford/Stuy/Crown Hts, Canarsie/Flatlands, E. New York, Williamsburg/Bushwick, Downtown/Hts/Slope, Greenpoint); Bronx (NE Bronx, Highbridge/Morrisania, Crotona/Tremont, Hunts Point/Mott Haven, Fordham/Bronx Park, Pelham/Throgs Neck, Kingsbridge/Riverdale); and, Queens (Rockaway).

The PQI diabetes composite had a risk-adjusted O/E of 1.11 in our service area, the same as NYC overall. Twenty-two neighborhoods exceeded this ratio, including: Manhattan (Chelsea/Clinton, Central Harlem/Morningside Hts, E. Harlem, Upper W. Side, Gramercy Park/Murray Hill, Washington Hts/Inwood, Upper E. Side, Lower Manhattan); Brooklyn (Flatbush/E. Flatbush, Bedford/Stuy/Crown Hts, Canarsie/Flatlands, E. New York, Downtown/Hts/Slope, Williamsburg/Bushwick); Bronx (NE Bronx, Highbridge/Morrisania, Hunts Point/Mott Haven, Crotona/Tremont, Fordham/Bronx Park, Kingsbridge/Riverdale); and, Queens (Rockaway, SE Queens).

With regard to congestive heart failure (CHF), the CNA provides a citywide analysis of the percentage of Medicaid beneficiaries with one all-cause admission. Our service area is slightly higher than NYS (61.5% compared to 61.2%). The Bronx and Manhattan are higher than NYS, with rates of 67.7% and 65.0% respectively.

For Medicaid beneficiaries with a substance abuse clinical risk grouping condition, the prevalence across NYS is 6.4% compared to 6.1% in our service area. Manhattan has a particularly high rate in comparison, with a prevalence of 11.2%.

Results from CNA primary data collection indicate that community members lacked resources to assist with basic social needs and that providers often failed to recognize or address these issues, focusing instead to a "quick but possibly ineffective medical solution" (CNA need 5).

Our PPS selected Project 2.a.iii because of the need to comprehensively address chronic conditions in NYC (see CNA needs 1, 5). This includes expanding the availability of care management services and ensuring that social determinants of health are addressed in the care of those with chronic disease (see CNA need 5). We will emphasize patient navigation and establish linkages to community support services (see CNA needs 3, 5). Our PPS understands that in a rising risk model, patients who go without these services are likely to having decreased outcomes and increased utilization (see CNA needs 1, 2, 5).

> We intend to develop a Health Home At-Risk Intervention program that deploys a set of services including assessment, care plan development, outreach and education, support for patient self-management and action plan development (as indicated by the patient's diagnosis), linkages to community services and social supports, and navigation services. This program will be supported by a robust IT-enabled care management solution that is currently undergoing a procurement. It is expected to expand on existing IT functionality (e.g., registry, care plan, alerts/reminders) within the PPS.

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.

Our PPS will design the intervention to engage the following patient population in care: individuals with a single chronic disease who are unable to effectively manage their condition due to illness severity, poor control, or other barriers to care plan adherence that could result in a heightened risk of condition exacerbation or development of a second chronic condition (see CNA need 5). Our PPS will focus particularly on diagnoses that currently drive ED and hospital utilization in the patient population and less engaged individuals who do not have an established PCP or have been frequent ED users.

Specifically, we expect to engage populations that have a single diagnoses of a chronic disease (e.g., CHF, COPD, end-stage renal disease, diabetes, substance use disorder, asthma) and have at least one additional risk factor which affects their ability to manage their condition: primary or secondary diagnosis of a behavioral health condition, age, disability, functional status, and social determinants of health (e.g., poverty, homelessness, criminal justice history) (see CNA need 5).

> Our PPS intends to inform implementation using a detailed understanding of geographic clustering and neighborhood characteristics, based on CNA findings. Particular neighborhoods of focus for outreach include Upper Manhattan, the Brooklyn neighborhoods of Bedford-Stuyvesant-Crown Heights, Downtown-Heights-Slope, and East New York, Northeast Bronx and

Fordham-Bronx Park, and Southeast Queens and Jamaica.

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.

Our PPS has a breadth of assets and resources that we intend to mobilize as part of DSRIP implementation. As described in 2.a.i, we are developing a CSO to provide an integrated platform to manage DSRIP projects and initiatives. The CSO will have a population health orientation and will also focus on the core DSRIP goal of achieving a 25% reduction in avoidable hospital use over five years.

The CSO will collaborate with both Health Home and PCMH teams within the PPS to develop a common framework for the deployment of care management and care coordination services. We have four Health Homes within our PPS, including HHC, Coordinated Behavioral Care (CBC), Community Healthcare Network (CHN), and Community Care Management Partners (CCMP). Total active enrollment across all Health Homes within our PPS is more than 14,000. A significantly greater number have been included in formal outreach efforts. The experience in outreach, active engagement, and care management will be a significant asset to our PPS. This will be bolstered by our relationships with Health Home subcontracted agencies. We also intend to leverage HHC's Health and Home Care Division, which provides care management services through a home-based model within a Certified Home Health Agency and through a telephonic House Calls program. Another PPS partner, Doctors On Call, also has a robust home visit program. Combined, our PPS will have the capability to ensure that the target population has access to the full continuum of care.

Additional assets and resources include chronic disease management and care management learnings from the MSSP and the Center for Medicare and Medicaid Innovation (CMMI) ED Care Management initiative to prevent avoidable ED and inpatient use. The latter project uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. Our PPS will also leverage the expertise of MetroPlus and its respective care management activities and expertise as well as expertise derived from care management services provided to our HIV population.

A majority of our PPS's primary care sites have achieved 2011 NCQA Level 3 PCMH recognition and a smaller subset have achieved 2011 Level 2 PCMH recognition (four sites located in Brooklyn; those sites will apply for Level 3 recognition in April 2015). These sites have experienced staff and workflows in place to support care management. HHC's PCMH activities focus on a range of chronic conditions (e.g., HIV, obesity, asthma, smoking cessation) and also have additional depth around managing patients with hypertension and depression. HHC will expand upon these assets through this project, in particular by building capacity to address other chronic diseases (e.g., diabetes) in similar depth.

Our PPS will leverage existing communication channels in order to conduct outreach and education to the target population and will enhance its already extensive resources to ensure that all patients, regardless of geography, have access to resources that span the continuum of care. In particular, our PPS will continue its partnership with the NYC Department of Health.

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 barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

While our PPS has significant assets, it anticipates major challenges related to lack of coordination between providers, recruiting and workforce issues, limitations and lack of standardization of health IT capabilities among partners, and limited capacity and strategies to address social determinants of health. As referenced in the CNA, these issues have historically impeded hospitals' and providers' ability to provide effective discharge and follow-up services, in turn limiting their ability to reduce avoidable readmission rates. In addition, PPS providers have a number of care management programs with different and often overlapping, populations and program structure. These programs also vary in terms of implementation, where they sit organizationally, staffing models, and specific activities. We anticipate that the CSO will address many of these concerns through the development and deployment of: (1) consistent care management services to the target population; (2) clear delineation of roles and responsibilities; and, (3) standard policies, procedures, care pathways and clinical protocols related to care transitions, referrals management, team-based care, and data sharing and reporting.

Our PPS is also concerned about patient engagement, particularly related to care plan completion. In addition, gaining consent to share patient information, especially from those with behavioral health needs, has been a persistent problem in other programs (e.g., the MSSP). As such, our PPS will make investments in PCMHs and work collaboratively with partner Health Homes to enhance capacity to serve the target population. Our PPS will also conduct culturally proficient patient education and outreach regarding the benefits of PCP, PCMH and Health Home engagement (see CNA needs 3, 4).

Finally, it will be challenging to recruit and train sufficient care management staff of various types and levels. HHC will work with CBOs to identify a pipeline of care management staff. Our PPS intends to contract with the 1199 SEIU Training and Employment Funds and other workforce training organizations (e.g., our PPS Partner, SUNY Downstate Medical Center) to ensure that care management staff are adequately trained.

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

As part of our planning activities to date, our PPS has collaborated with BPHC and CCB. We have achieved a number of important goals, including aligning project selection for this and other projects, and to begin identifying areas for collaboration during implementation and operations.

During implementation and operations, we intend to continue our collaboration with BPHC and CCB. We expect this collaboration to focus on: ensuring alignment and coordination of standardized protocols; developing common risk assessment methodologies; adoption of common core partner contracting vehicles; development of workforce strategy, including common job descriptions and functional capabilities; workforce training efforts; data sharing; and, selection of culturally competent patient education resources to support this project.

Post-application, we also intend to broaden our collaboration efforts to include other PPSs in our service area. We believe this coordination will be crucial to reduce the burden on providers and CBOs, by addressing key capacity and workforce needs, improving clinical outcomes and patient experience.

2. Scale of Implementation (Total Possible Points - 40):

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:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

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 goals. 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:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

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

Yes	No
☐	☒

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

b. 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
☒	☐

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.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	Health and Recovery Plan (HARP)	2014	Ongoing	HHC facilities have applied to the NYS Office of Mental Health to become approved HARP providers. It is expected that all HHC facilities currently offering BH services will participate with MCOs and specifically HARPs once BH is transitioned to managed care.
New York City Health & Hospitals Corporation (HHC)	Center for Medicare and Medicaid Innovation (CMMI) Grant, Round 2: ED Care Management Initiative: Pr	September 2014	August 2017	HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from the ED. The target population for this initiative is patients with ambulatory sensitive conditions.
New York City Health & Hospitals Corporation (HHC)	NYS Hospital-Medical Home Demonstration Program	2011	2015	The purpose of this program is to improve the coordination, continuity, and quality of care for individuals receiving primary care services in outpatient primary care settings.
SUNY Downstate	NYS Hospital-Medical Home Demonstration Program	2011	2015	The purpose of this program is to improve the coordination, continuity, and quality of care for individuals receiving primary care services in outpatient primary care settings.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
New York City Health & Hospitals Corporation (HHC)	CMS Innovation Center Health Care Innovation Awards (HCIA)	April 2014	March 2017	As part of this CMMI Round 2 grant (ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use), HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. The target population for this initiative is patients with ambulatory sensitive conditions.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
CAMBA	CMS Innovation Center Health Care Innovation Awards (HCIA)	2012	2016	CAMBA provides Health Home care management services, under subcontract, to individuals with serious mental illness as part of Maimonides Medical Center HICA initiative.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to between 300 – 900 members per month.
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.
Harlem United (HU) /Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United (HU) provides services under subcontract to the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home program.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home care management entity under subcontract with 4 NYS Health Home providers.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children.
MetroPlus	Health and Recovery Plan (HARP)	2015	Ongoing	Creation of HARPs for the severely mentally ill population.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

c. 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.

The Hospital-Medical Home (H-MH) Demonstration Program supported many of our PPS facilities in achieving NCQA 2011 PCMH recognition and in implementing Collaborative Care. As part of DSRIP, we will build on this expertise to support these facilities in meeting 2014 Level 3 recognition. Our PPS will also expand the use of Collaborative Care to other disease states, beyond the focus areas supported by the H-MH program.

The NYS Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This DSRIP project will build on this existing infrastructure, but will serve a different and larger group of Medicaid patients who are not eligible for Health Home services. Similarly, our work in this project will build on work that our partners have begun through HARP and HCIA, expanding Health Home services to a wider population than is currently served by these programs.

With regard to HHC's ED Care Management initiative, the DSRIP Health Home At-Risk Program does not have as one of its activities to develop an ED Triage approach. The Health Home At-Risk Intervention can leverage promising practices and lessons learned from this CMMI grant.

5. **Domain 1 DSRIP Project Requirements Milestones & Metrics:**

   Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

   PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

   a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.