Suffolk Care Collaborative

PROJECT ADVISORY COMMITTEE (PAC)

Monday, September 26, 2016

1:00pm-3:00pm

Islandia Marriott Long Island

Hosted by the Office of Population Health at Stony Brook Medicine

Suffolk Care Collaborative

WELCOME REMARKS

Presented by

Joseph Lamantia

Chief of Operations for Population Health, Stony Brook Medicine &
Executive Director, Suffolk Care Collaborative

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AGENDA

1:00 pm – 1:15 pm	**Welcome Remarks**	***Joseph Lamantia,*** *Chief of Operations for Population Health, Stony Brook Medicine & Executive Director, Suffolk Care Collaborative*
1:15 pm – 1:45 pm	**Building Health Home Linkages & Care Coordination**	***Hope Glassberg,*** *VP of Strategic Initiatives and Policy at Hudson River Healthcare &* ***Ann Ferguson****, Senior Director of the Northwell Health Solutions Health Home Program*
1:45 pm – 2:00 pm	Break	
2:00 pm – 3:00 pm	**DSRIP & Value Based Payment Reform: An Update**	***Jason Helgerson, Medicaid Director*** *Office of Health Insurance Programs NYS Department of Health*
3:00 pm	**Closing Remarks Question & Answers**	***Joseph Lamantia,*** *Chief of Operations for Population Health, Stony Brook Medicine & Executive Director, Suffolk Care Collaborative*

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KEY THEMES – "BUILDING A FOUNDATION"

March 2015	**Information Technology Interoperability** **Care Management Services**
June 2015	**Community Based Organizations** **Patient Centered Medical Home Model**
October 2015	**Cultural Competency & Health Literacy** **Value Based Purchasing**
December 2015	**Partner Onboarding Program (Provider Contracting)**
March 2016	**Behavioral Health & Primary Care Integration**
June 2016	**Performance Reporting & Improvement Program**
September 2016	**Building Health Home Linkages & Care Coordination**

"These key themes have and will continue to shape and provide form, function and purpose to the SCC"

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SCC CONTRACTING UPDATE

Suffolk Care Collaborative	Contracted Entities	PCP's	Hospitals	SNFs	BH Facilities
Count Targeted for Contracting	**183**	532	11	43	15
Initiated Contracting Process - Entities Count	**132**	471	11	43	15
Actual Count Contracted	**73**	304	10	36	7
% Complete	**40%**	**57%**	**91%**	**84%**	**47%**

- **Contracting Entity** is defined as the organization that is engaged in a formal participation agreement. Contracting Entities may represent one or a number of different providers.
- Our contracting targets are subject to change as we're engaging our PPS-Network

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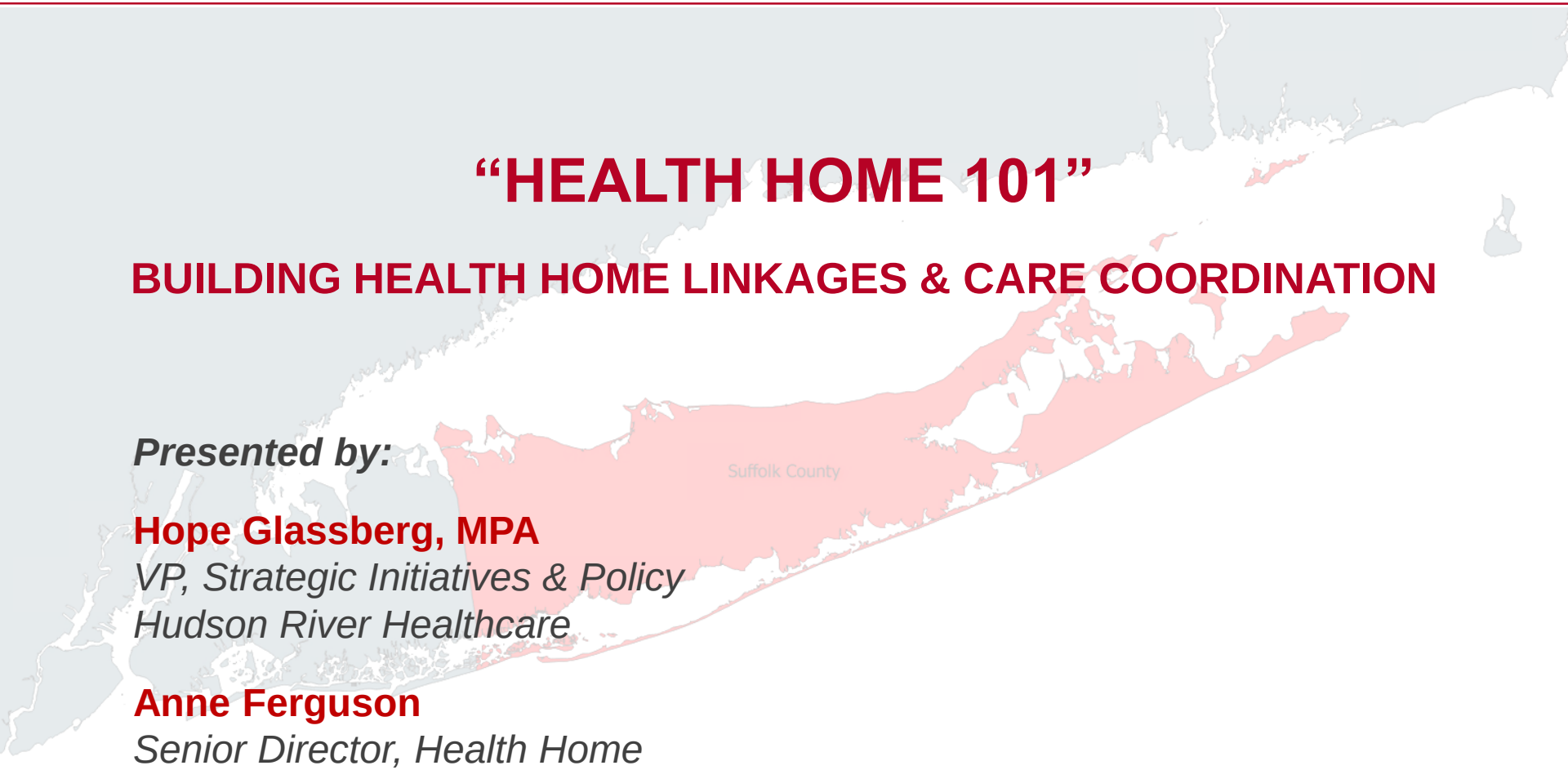
"HEALTH HOME 101"

BUILDING HEALTH HOME LINKAGES & CARE COORDINATION



Presented by:

Hope Glassberg, MPA
VP, Strategic Initiatives & Policy
Hudson River Healthcare

Anne Ferguson
Senior Director, Health Home
Northwell Health Solutions

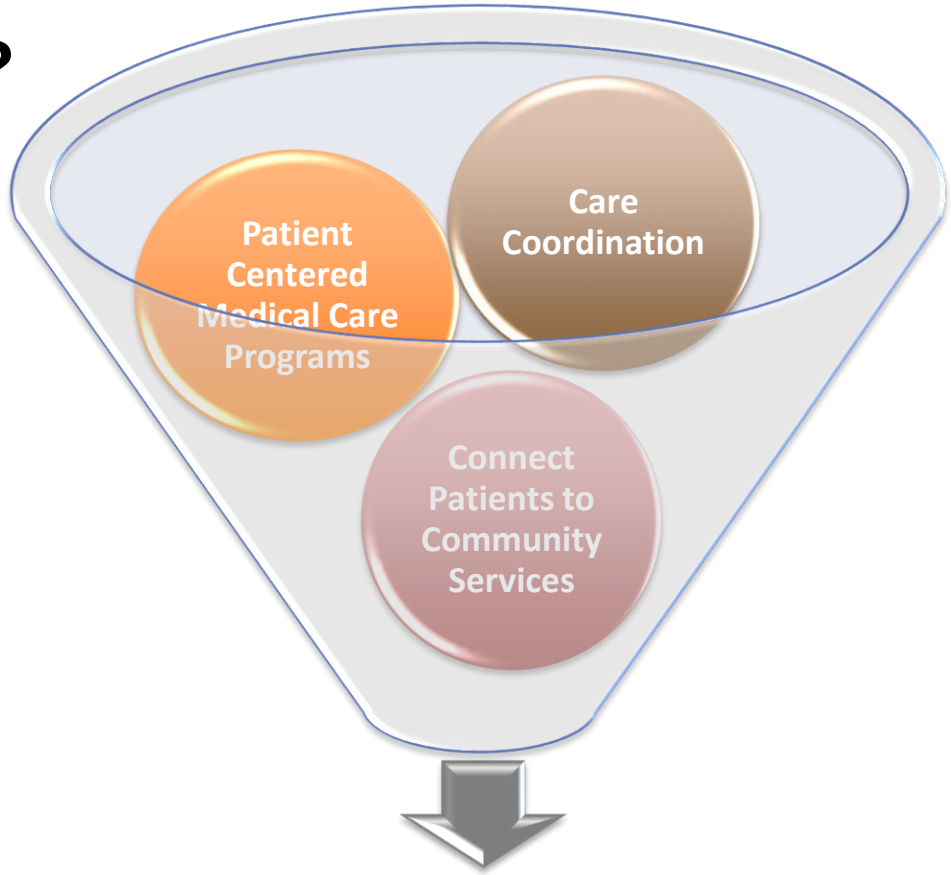
- What is a Health Home?
- What are the Services Provided by a Health Home?
- Health Home Workflow
- Health Home Referral Process
- Behavioral Health and HARP
- Opportunities for Improvement
- Questions

What is a Health Home?

- Under the Affordable Care Act (ACA), States may amend their State Plans to develop Health Homes
- Health Home provides Care Coordination Services to Medicaid members with chronic conditions
- Nationally, states have a variety of models and focuses:
  - Care Management Network
  - Medical Home Extension
  - Specialty Provider
- NYS State Plan Amendment for Health Home was approved in 2011

What is a Health Home?

Health Homes are comprised of a network of health and community based agencies who partner to provide care coordination to high-risk Medicaid beneficiaries with complex chronic medical, behavioral health and substance abuse needs.



Health Home Goal

Improve the Health of our members while reducing Avoidable Emergency Department Visits & Inpatient Stays

Health Care Reform: The Triple Aim

- Decrease Cost of Healthcare
  - New York State- 4th highest health spending nationally
  - Rate of health care spending increasing % per year
- Increase Access to Healthcare
  - Individuals with multiple chronic conditions cost up to 7x's more then individuals with a single chronic condition
  - 5% of individuals account for 50% of healthcare spending
- Increase Quality of Healthcare
  - In 2007, $27+ billion was spent on avoidable hospitalizations

NYS Health Home Model

- ✓ **Purpose:** care coordination and patient navigation services for chronically ill Medicaid members.
- ✓ **Goal:** achieve better health outcomes, improve linkage to services and reduce cost.
- ✓ **Target Population:** chronically ill and at risk for functional decline due to limited social supports and community engagement

NYS Health Home Population

- More than five million Medicaid members in New York State
- 805,000 individuals meet the federal criteria for HH's
  - Current enrollment 170,000
  - 32 HH's serving 62 counties across the State

NYS Health Home Networks

- Health Home Networks include 2 categories of providers:
  - **Care Management Agencies (CMA**) directly provide care coordination services
  - **Network Providers -** all other entities that provide Medicaid covered services. They do not directly receive funding for HH care coordination, but serve as a potential member of the care team for the Health Home member
  - **CMAs** may have special areas of expertise: mental health, HIV/AIDS, primary care, substance abuse, etc.

Health Home Services

1. Comprehensive care management:

- Using a comprehensive health risk assessment, a comprehensive and individualized plan of care is created to meet to meet physical, mental health, chemical dependency and social service needs.

2. Care coordination and health promotion:

- One care manager will ensure that the care plan is followed by coordinating, monitoring and re-evaluating the patient and their care.

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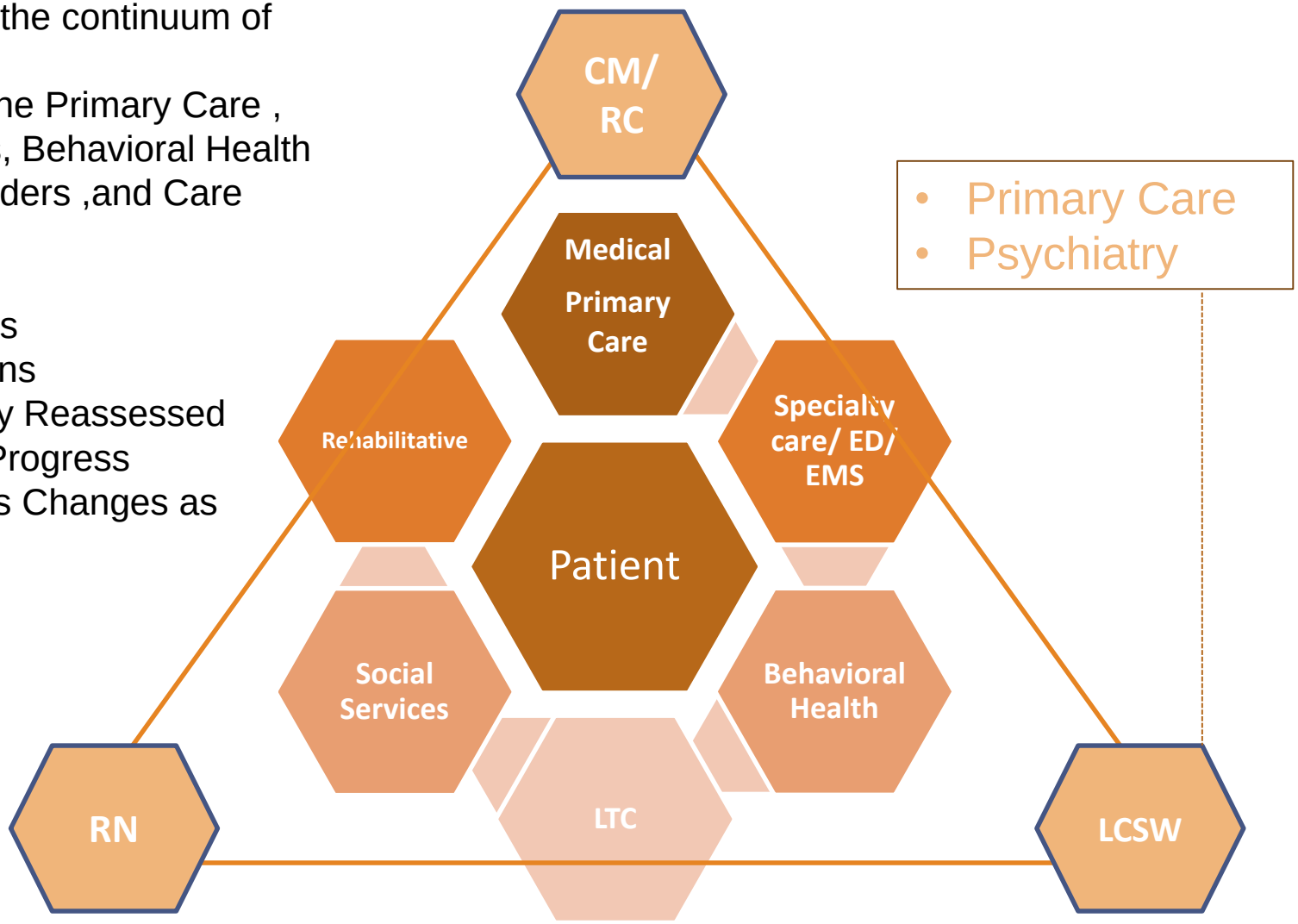
CARE PLAN DEVELOPMENT: AN IMPORTANT HEALTH HOME TOOL

- Integrates the continuum of Care
- Identifies the Primary Care , Specialists, Behavioral Health Care Providers ,and Care Managers
- Goals
- Timeframes
- Interventions
- Periodically Reassessed
- Identifies Progress
- Documents Changes as Needed



Health Home Services

3. Comprehensive transitional care

- Prevention of avoidable readmissions to inpatient facilities and oversight of proper and timely follow-up care

4. Patient and Family Support:

- Individualized care plan must be shared with patient enrollee and family members or other caregivers. Patient and family preferences are considered

5. Referral to Community and Social Supports

Health Home Workflow

- Enrollment Process
  - Brief Assessment
  - Consent
  - Comprehensive Assessment
  - Creation of Care Plan
- Ongoing Care Management
  - Core Health Home Services
  - Monitoring Care Plan
  - Re-Assessment as Needed

Health Home Enrollment

- **3 mechanisms for becoming part of a HH:**
  - **Legacy Programs**: previously received targeted case management services (COBRA, OMH, MATS, CIDP)
  - **DOH/MCO:** identify HH candidates
  - **Community referrals**: including hospital inpatient units, outpatient programs, EDs, primary care providers, CBOs, housing facilities, self-referral etc.

Health Home Eligibility

- **Dx Criteria:**
  - 2 chronic illnesses (mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI > 25, or other) OR
  - HIV/AIDs OR
  - Serious mental illness
- **Risk/acuity * (see next slide)**

Referrals
Quantifying Risk/Acuity

- No primary care practitioner (PCP)
- No connection to specialty doctor or other practitioner
- Poor compliance (does not keep appointments, etc)
- Inappropriate ED use
- Repeated recent hospitalization for preventable conditions either medical or psychiatric
- Recent release from incarceration
- Cannot be effectively treated in an appropriately resourced patient centered medical home (PCMH)
- Homelessness

Health Home Community Referral Process

- *Who can make a community referral?*
  - Anyone can make a community referral: a family member, provider, hospital, county or state entity, self-referral
- *How do I make a referral **HRHCare**?*
  - Call CommunityHealth Care Collaborative (CCC) member services hotline at 1-888-980-8410 to ensure member is not already enrolled
  - Complete a CCC Community Referral Form – visit our website
  - Fax a referral form to 914-606-3328
- *How do I make a referral **Northwell Health Solutions**?*
  - Call Toll Free: 888-680-6501
  - Referral Mailbox: Healthhomecommunication@northwell.edu

Behavioral Health Transition into Managed Care

- NYS Medicaid Redesign Team Initiative to achieve Triple Aim
- Elimination of “carve out” of Behavioral Health Services as Fee-for-Service
- Members with mental health and substance abuse needs will have the option to enroll in a new benefit package, Health and Recovery Plans (HARP)
- Some HARP members will be entitled to receive Home and Community Based Services (HCBS)
- HARP plans requirements:
  - ✓ Connection to local providers and communities
  - ✓ Address social issues, not just health issues
  - ✓ Provide specialized behavioral health services, either by contracting or directly hiring staff
  - ✓ Recovery focused

What is HARP?

- HARP is a type of Medicaid Managed Care Plan that is:
  - Designed for people with serious mental health conditions and substance use disorders.
  - Covers all benefits provided by Medicaid Managed Care Plans, including expanded behavioral health benefits.
  - Provides additional specialty services to help people live better lives, go to school, work, and be part of their community. HIV Special Needs Plans
- Individuals currently enrolled in HIV Special Needs Plans (HIV SNPs) meeting the serious mental illness (SMI) and substance use disorder (SUD) targeting criteria and risk factors for HARP will also be eligible to receive HCBS while enrolled in their HIV SNP.

Goals of HARP

- Promote improvements in the Behavioral Health System
  - Movement towards Recovery Based Model:
  - Optimized quality of life
  - Reduction of symptoms of mental health and substance use disorders
  - Empowerment and choice through treatment, education, housing, vocational training, etc.
- HARP members work with a care coordinator who facilitates the integration of physical health, mental health, and substance use services for individuals requiring specialized approaches, expertise and protocols that are not consistently found within most managed care plans.
- All HARP members are eligible for Health Home Care Coordination
- If HARP member declines Health Home enrollment, HARP plan will provide services directly

Role of Health Home in HARP

- All HARP Members are Eligible for Health Home Care Management
- Health Home Completes NYS Community Mental Health Assessment to determine HCBS Eligibility
- Health Home Creates and Maintains Plan of Care for;
  - HCBS Services
  - Core Health Home Services

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OPPORTUNITIES

- Ongoing Health Home Education and Re-education
  - Front line staff, providers, care mgmt. organization, PPS…
- Identification of an individuals Health Home Status (enrolled, eligible)
- Enhancing referral and communication process between provider community and Health Home and Care Management Agencies
- Linkages to VBP
- Expand partnership between Health Homes and PPS
  - Collaborate with HH Care Mgmt Agencies on Care Mgmt best practices
  - Co-manage enrolled patients linked to DSRIP Domain 3 projects
  - Facilitate transition of care and referrals (PAM, TOC)
  - Reduce avoidable hospitalization

Any questions?

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FOR MORE INFORMATION…

General Health Home Information:
New York State DOH Health Home link:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Hudson River Healthcare, CommunityHealth Care Collaborative (CCC):
Gina La Serra MS. Ed, CRC
Suffolk Health Home Regional Manager
glaserra@hrhcare.org
www.hrhcare.org

Northwell Health Solutions Health Home Program:
Anne Ferguson
Senior Director
AFerguso@northwell.edu

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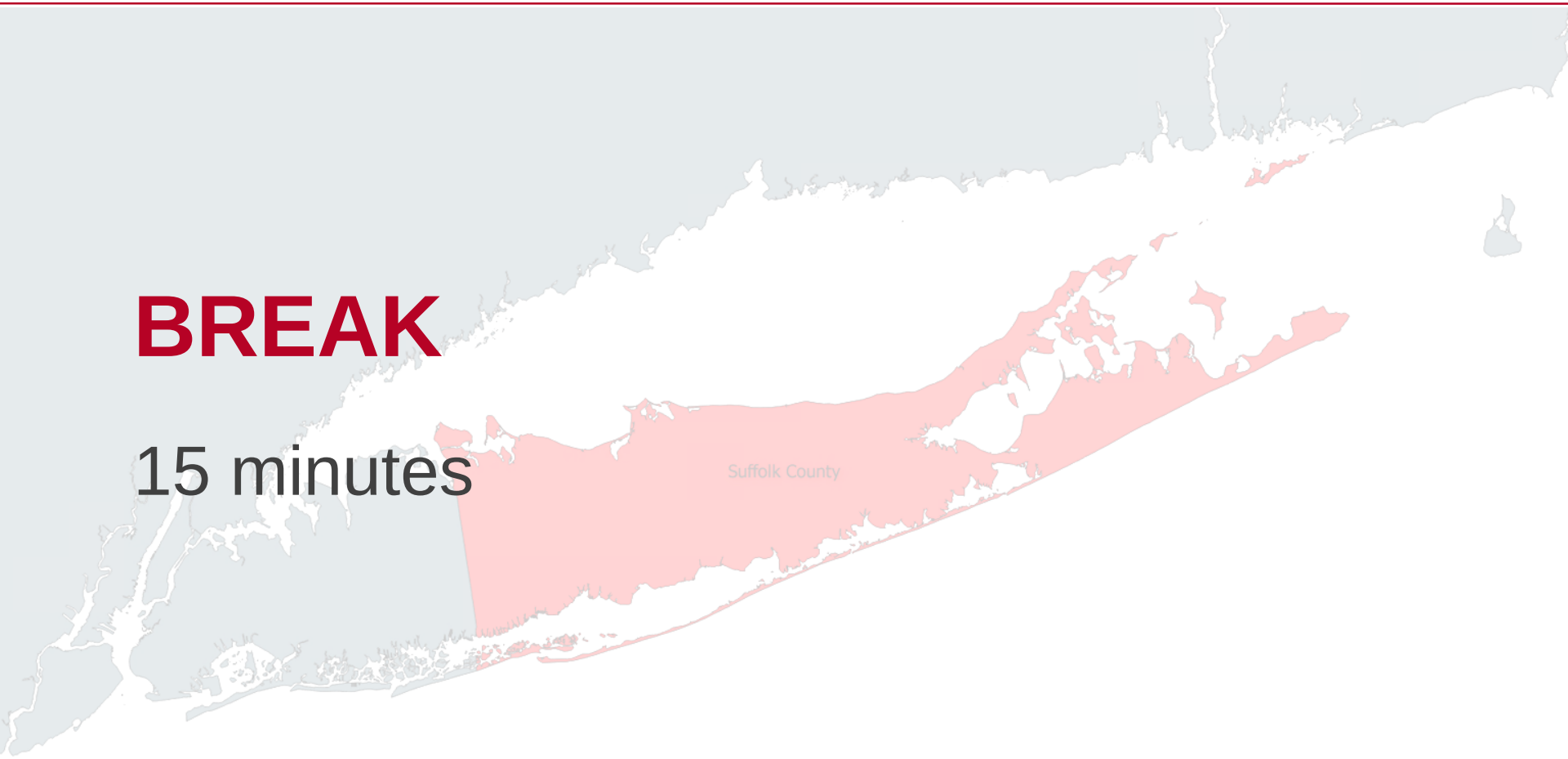
BREAK

15 minutes



CLOSING REMARKS

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COMING SOON…
THE LAUNCH OF THE SCC'S COMMUNITY WEBPAGE

We are excited to share an announcement of the upcoming SCC community webpage! Our existing webpage has primarily been provider-facing. This newly designed webpage will be community-facing and more user friendly. Community members will be able to access our new community webpage to obtain information that is of interest to them.

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LAYOUT & FEATURES

Discovery Area

- **Educational Materials:** Cardiovascular wellness, tobacco cessation, cancer prevention, obesity prevention
- **Programs & initiatives:** Learn about DSRIP programs SCC is working on

Community Resources

- **HITE Partnership**
- **Social Services:** Application forms for commonly used services
- **Hotline Quick-links:** Crisis hotline website links and phone numbers in one place
- **Get involved:** Learn about ways to help out in the community

Community Calendar

- Visit Long Island Health Collaborative's community calendar on SCC's community webpage
- Contain events across Nassau and Suffolk County for community members
- Walking/exercise, community wellness, social service programming, and LIHC events.

Additional Features

- **Readability and accessibility**
  - Easy to read font style
  - Larger font size
  - Better color contrast
- **Relatable to community members**
  - Use of photos from community events in Suffolk County and Long Island

HITE

LONG ISLAND Health COLLABORATIVE
connecting you to better health

HITE Partnership

- HITE (Health Information Tool for Empowerment) is a free online resource directory of health & social services
- SCC has partnered with HITE to include more Suffolk County Resources
- Accessible through the SCC Community Webpage