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Appendix 1 – Environmental Scan

Executive Summary

In 2015, the Centers for Medicare and Medicaid Services (CMS) awarded the District of Columbia (the District) a State Innovation Model (SIM) grant to develop a strategy to deliver better care, increase efficiency of health care spending, and improve population health. To aid in developing this strategy, this environmental scan aims to present the current state of health care in the District. While the District boasts one of the nation's highest health care coverage rates, disparities continue to exist between health outcomes of many residents. Key challenges to achieving the District's goals are discussed further in the environmental scan and outlined below.

HEALTHCARE DISPARITIES Racial and ethnic groups have significantly poorer health outcomes in key geographic and socio-economic areas	• Average life expectancy in almost 15% higher for White compared to African American DC residents[1] • Diabetes rates in Wards 7 and 8 are nearly twice the national average[2] • Hispanics newly diagnosed with HIV are more likely to be younger than other racial groups[3]
SYSTEM FRAGMENTATION DC is a microcosm of the national disjoined healthcare system, where residents navigate between unconnected sites of care resulting in poor health outcomes	• DC's HIE infrastructure is still maturing, leading to data sharing challenges • ED use and non-psychiatric inpatient admissions decrease by almost 40% once homeless individuals receive Permanent Supportive Housing services[4] • Residents with multiple health and social needs may have 4 or more siloed agencies providing care management [5]
SERVICE UTILIZATION Too often, individuals use the ER for primary care & aren't linked to community-based care after hospital discharge, leading to hospital readmissions	• DC's 30-day Medicare hospital readmission rate is 65 per 1,000, compared to 45 per 1,000 nationally[6] • DC's emergency department utilization rate is almost twice the national rate at 746 emergency department visits per 1,000, versus 423 nationally[7] • 25% of DC residents do not have access to a personal doctor to help them navigate the healthcare system, compared to 18% nationally[8]
DC MEDICAID SPENDING The majority of Medicaid expenditures are from a very small percentage of Medicaid beneficiaries with exceedingly high costs for the fee-for-services (FFS) population	• 5% of Medicaid beneficiaries account for 60% of Medicaid spending in DC, including costs for long-term services and supports[9] • Average per person spending in FFS is almost seven times the per person amount in managed care (~$27,000/year in FFs compared to ~$4,000/year in managed care)[10] • 22% of the FFS population had an inpatient stay compared to 9% in managed care[11]

These challenges demonstrate the District's need for transformation in its healthcare system. The environmental scan details each of these challenges, as well as the current initiatives in place and future initiatives planned to address them.

The environmental scan also describes the District's health system and population health baseline, including population demographics, health risk factors, healthcare utilization, and rates of healthcare coverage. It lays the groundwork for the State Health Innovation Plan (SHIP), which will describe the District's five-year strategy for addressing these challenges through

improvements in care delivery, payment model reform, and enhanced linkages between medical and socially-focused services. The initiatives explained throughout the SHIP will, in addition to addressing these challenges, present a roadmap to improve and reduce disparities in health outcomes by supporting the delivery and payment of high-quality, cost-effective, person-centered health care services to District residents in all eights wards.

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The District's Healthcare Environment

In 2015, the Centers for Medicaid and Medicaid Services (CMS) awarded the District of Columbia a State Innovation Model (SIM) grant to develop a strategy to deliver better care, increase efficiency of health care spending, and improve population health. To aid in developing this strategy, this environmental scan aims to present the current state of health care in the District. While the District boasts one of the nation's highest healthcare coverage rates, numerous barriers exist to achieving the District's healthcare goals; such challenges include:

- **Healthcare Disparities:** The District is a tale of two cities with significant disparities in health outcomes based on race, income, and ward.
- **Inefficient Use of Services:** Too often, both beneficiaries and providers inappropriately use the care delivery system, leading to high costs and mismanagement of chronic conditions.
- **Medicaid Spending:** The majority of Medicaid expenditures stem from a very small percentage of Medicaid beneficiaries with exceedingly high costs for the fee-for-service (FFS) population.
- **Fragmented System:** The District is a microcosm of the national disjointed healthcare system where stakeholders navigate between unconnected sites of care, contributing to poor health outcomes.

These challenges demonstrate both the need for transformation, as well as the barriers constraining transformation. This environmental scan details these challenges, the current initiatives in place to address these challenges, and future planned initiatives.

The scan also describes the District's health system and population health baseline, including population demographics, health risk factors, healthcare utilization, and rates of healthcare coverage. It identifies and discusses several policy initiatives already underway in the District including Medicaid waivers, Permanent Supportive Housing, Health Homes, and health information technology. The environmental scan lays the groundwork for the State Health Innovation Plan (SHIP), which will describe the District's five-year strategy for addressing the challenges to the District's healthcare system through improvements in care delivery, payment reform, and community linkages. These improvements will be underpinned by broad stakeholder engagement and investments in health information technology (HIT), workforce capacity, and quality improvement. The initiatives explained throughout the SHIP will, in addition to addressing these challenges, help the District realize its goals of improving the care delivery system, spending health care dollars more efficiently, and improving patient care and outcomes.

Analysis of the challenges to healthcare transformation, descriptive demographics, healthcare utilization, and outcomes data make the case for the District to develop a health system transformation strategy**.** The SIM process is intended to formulate this transformation strategy and will be described in the SHIP. The strategy will aim to mitigate the challenges summarized above and discussed further in this scan. Furthermore, the strategy design will frame care

delivery, payment reform, and community linkage initiatives to transform the healthcare system and achieve better healthcare outcomes for residents in all eight wards.

The sections of the environmental scan will describe the following topics in more detail:

- Population Demographics and the Provider Landscape
- Challenges Facing the District
- Current State of Innovation in the District
- Looking Ahead: Emerging Innovations in Healthcare for the District of Columbia

Population Demographics and the Provider Landscape

This section of the scan describes the District's population, the key social determinants impacting health outcomes, and the healthcare system landscape that includes providers, payers, and patients. The environmental scan description includes all of the CMS requirements under the SIM grant.

Population Demographics and the Relationship to Health Status

The District's rapidly growing population is younger than the national average and more racially diverse than other similar cities and urban areas. The District of Columbia is home to an estimated 658,893 residents as of 2014, an increase of 9,782 from 2013. This is the ninth straight year of **population growth, during which time the population increased by almost 100,000 residents.**

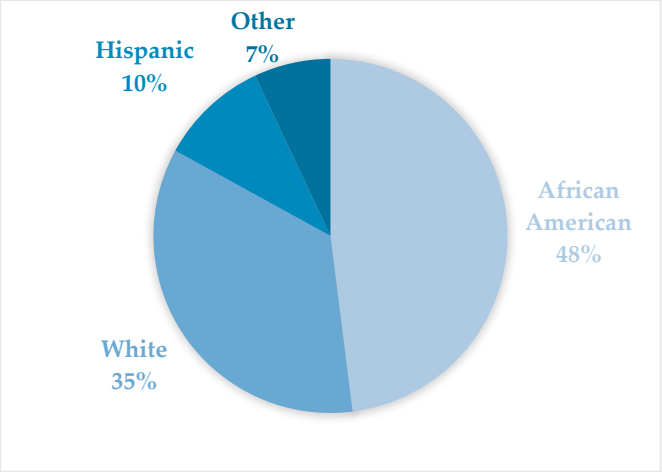
Race, ethnicity, and age impact how people seek care, as well as health outcomes resulting from such care. The District is separated into eight wards of approximately equal population size. However, the makeup of the wards differ greatly in terms of race and income. The populations of Wards 2 and 3 are more than 75% white, while African Americans make up more than 90% of Wards 7 and 8. Wards 1 and 4, in Northwest DC, show the highest degree of racial diversity, including a large Hispanic population.

The examples below illustrate how race, ethnicity, and income are related to health outcomes. Attachment A includes additional details on the District's demographics and socio-economic makeup.

- **Stark differences in race and income between the wards exist for access to healthcare and ability to seek appropriate healthcare at the appropriate time.** The median income of Ward 3 residents is $103,936 as compared to income of $31,422 for Ward 8 residents.
- **The District's predominantly African American population is statistically more likely to experience chronic diseases including diabetes, asthma, and heart disease than is the White population.**[12] African Americans comprise 48% of the total population and are overwhelmingly the largest racial group in the District, followed by whites comprising 35% of the population. Hispanics represent 10% of the population.[13]

- **Despite the young average age of District residents, many chronic health conditions affect the population.** The District has a relatively low average age of 33.7 years compared to the national average of 37.8 years. The District has lower-than-national averages of residents in age brackets of under 20 years of age and of over 45 years of age, but has a particularly high number of individuals in the '25 to 34 year' age bracket.[14]

Figure 1. Population Demographics



Social Determinants of Health have an Impact on Health Status

The social environment can negatively impact health status and create barriers to achieving better health outcomes. Commonly referred to as the social determinants of health, these social factors are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The Healthy People 2020 initiative recognizes five social determinants of health: economic stability, education, social and community context, health and health care, and neighborhood and built environment. For the purpose of this analysis the focus will be on economic stability and housing.

Social determinants of health greatly impact an individual's health status and health outcomes. In the District of Columbia, one of the most prominent factors influencing health status is housing (neighborhood and built environment).

Economic Stability is Associated with Better Health Status. Individuals that have consistent sources of food, housing, and income have better health outcomes.[15] In the District, there are varying degrees of economic stability:

- Wards 2 and 3, located in the Northwest quadrant, have a predominantly white populations and report the highest median incomes among District residents, with earnings of $90,859 and $103,936, respectively.[16] **These wards also report the lowest rate of obesity, high blood pressure, and diabetes.**[17]
- African Americans are the largest demographic group in Ward 5 in the Northeast quadrant, and Wards 7 and 8 in the Southeast quadrant. The latter two wards have the lowest median average incomes in the District, with median incomes at $51,870, $38,807 and $31,422, respectively.[18] **Wards 5, 7 and 8 also report the highest rates of high blood pressure, obesity, diabetes, and smoking.**[19]

Homelessness is Associated with Poor Health Outcomes. Studies have shown that homelessness can lead to new health problems and exacerbate existing ones.[20] According to the National Law Center on Homelessness and Poverty, the leading cause of homelessness is insufficient income and lack of affordable housing.[21] The District has one of the highest poverty rates in the country with 18.6% of the population below the poverty line.[22] Additionally, about 8,000 of the District's residents experience homelessness on any given night in the District. Additionally, one-quarter of the persons counted as experiencing homelessness were chronically homeless, 80% of which were single adults, as seen in Table 1.[23] Someone who is chronically homeless is a person with a disability, are sleeping on the streets or in emergency shelters, and has been homeless consistently for a year or more, or has had four separate episodes of homelessness within the last three years.

Figure 2. Breakdown of District and National Health Coverage Trends, 2009

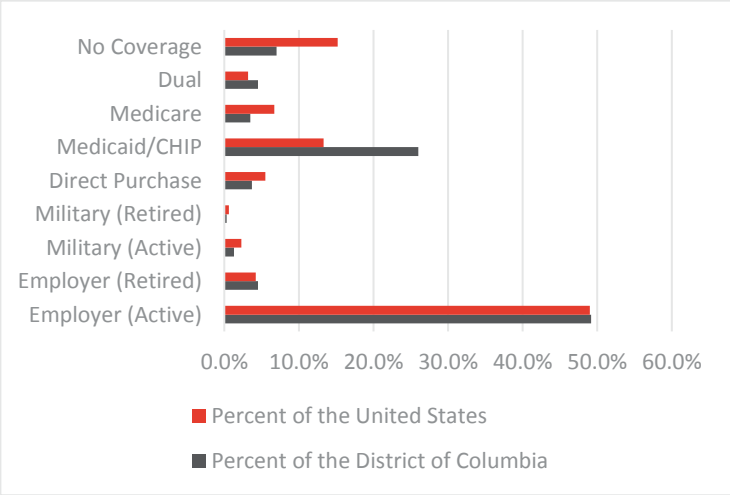


Table 1. The District's Point in Time (PIT) Subpopulation Counts (2010-2014)

PIT Subpopulation Category	2010 Count	2011 Count	2012 Count	2013 Count	2014 Count
Persons in Families*	**--**	--	--	263	420
Individuals	2,110	2,093	1,870	1,764	1,609
Chronically Homeless (total)	2,110	2,093	1,870	2,027	2,029
Veterans**	--	515	531	499	406

*Prior to 2013, the Federal definition of chronic homelessness did not include families. Therefore, the chronic homeless count in 2010-2012 includes single adults only.

**Prior to 2011, HUD did not require a separate count of homeless Veterans.

Affordable housing allows for more household resources to pay for other needs, such as healthcare services and medications, which leads to better health outcomes.[24] Stable and affordable housing is correlated with scheduling doctor appointments, keeping those appointments, and **adhering to medication regiments** for individuals with chronic health conditions.[25] In contrast, poor-quality and inadequate housing are leading contributors to health problems, such as infectious and chronic diseases, injuries, substance abuse, and poor childhood development.[26]

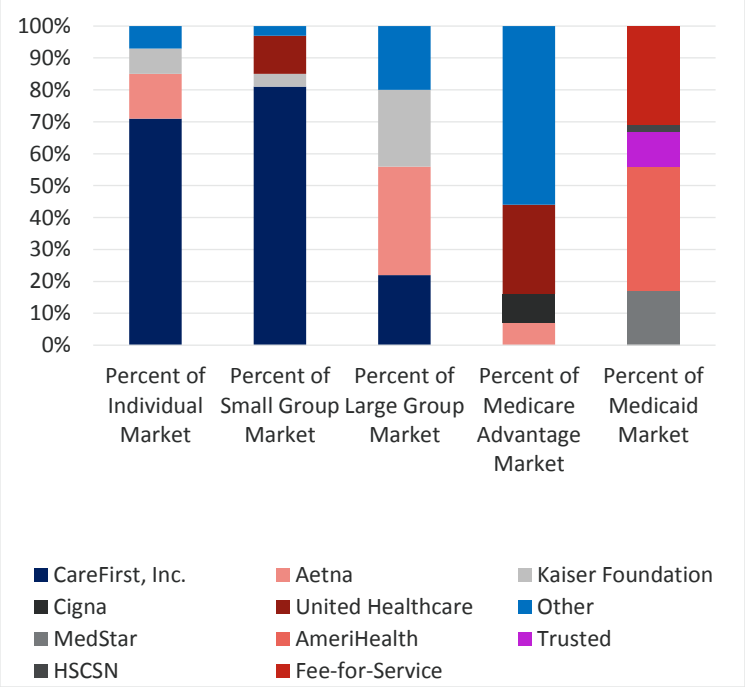
The District supports several housing efforts including rapid re-housing, traditional housing and Permanent Supportive Housing (see footnote reference on Strategic Plan of the District's Interagency Council on Homelessness for more information on these programs).[27] In the District, these programs are working with DC Department of Health, DC Department of Behavioral Health and other District agencies, including the Medicaid program, to strategically distribute savings to re-invest in preventative healthcare, housing needs, and improving social determinants of health.

Access to Quality Healthcare is Key to Positive Health Outcomes

The District's goal is to provide for an efficient and cost-effective healthcare system that provides high quality care and results in positive health outcomes. The majority of residents of the District have health insurance coverage. Many high quality healthcare providers have built their practices in the District and is home to many hospitals and facilities. However, these providers and healthcare facilities are primarily concentrated in a small area of the District creating areas of abundance and other areas of scarcity. To gain a better insight into healthcare access, the District's health insurance and provider landscape is discussed below.

The Majority of Residents Receive Healthcare Coverage through their Employer. The District enjoys one of the highest insured rates, 94.7% in the United States as of 2014, which is second only to Massachusetts and tied with Hawaii.[28, 29] This high insured rate is due to high employer coverage rates as well as Medicaid and DC HealthCare Alliance coverage (a locally funded public insurance program for low-income childless adults). As shown in Figure 2, more than 50% of the population has employer insurance, 25% are covered through Medicaid, followed by Medicare and the individual market.[30] The DC HealthCare Alliance along with the Medicaid expansion through the Affordable Care Act (ACA), have helped to significantly reduce the number of uninsured individuals. As seen in Figure 3, in the commercial health insurance market, CareFirst, Inc. dominates enrollment among 'individual' and 'small group' plans. Comparatively, the 'large group' market has more competition with CareFirst, Inc., Aetna and Kaiser all sharing approximately 24-34% of total market enrollment.[31, 32]

Figure 3. Health Insurance Company Market Share in the District



The District's Medicaid Program Covers 70% of Children and a Third of District Residents. The District's Medicaid program is one of the most inclusive Medicaid programs in the country and has contributed to the District's high rates of both health insurance coverage and access to care.[i] The District covers approximately 250,000 individuals (approximately a third of District residents) through Medicaid.[33] In the District, roughly 70% of children are covered through Medicaid and 97.6% of all Medicaid-eligible children in the District are enrolled in Medicaid.[34] Within the District's Medicaid program, 72% are served through a Medicaid managed care plan and 28% are served through fee-for-service.[35]

Fee-for-service is payment model where services are and paid for separately.

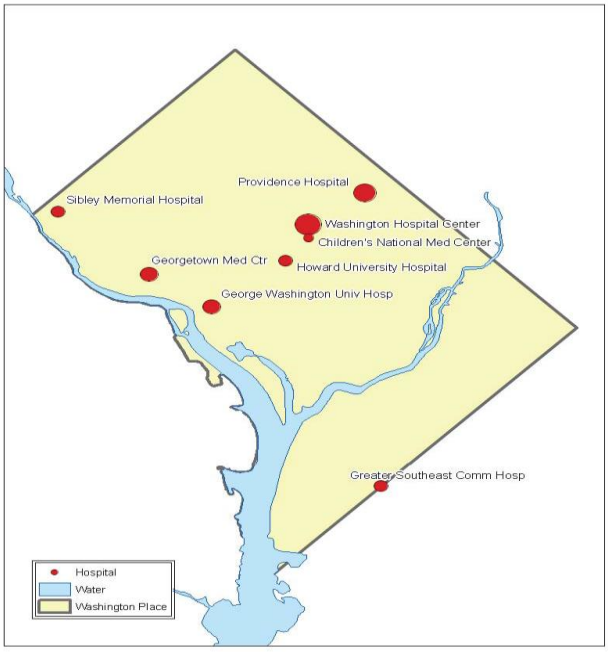
Managed care is a health care delivery system organized to manage cost, utilization, and quality and provides for the delivery of benefits and additional services and accept a set per member per month (capitation) payment for these services.

Prior to the ACA, the District offered Medicaid benefits to childless adults through the DC HealthCare Alliance. Since expanding Medicaid through the ACA, the District has moved over 30,000 newly-Medicaid-eligible DC HealthCare Alliance members to Medicaid.[36]

In addition to covering pregnant women and children, the District also offers Medicaid to subsets of high-risk populations through waiver programs, which provide states with flexibility in the delivery of services. These waivers provide alternatives to institutional care for low-income and disabled residents who would otherwise require institutionalization. Please see Attachment B for a summary of the District's Medicaid waiver programs.

Medical Providers are Concentrated in Small Areas. Availability and access to healthcare providers has a noticeable impact on when and where residents seek care. The eight hospitals, or hospital systems, located in the District are essential to the overall healthcare landscape. **The District's hospitals, as shown in Figure 4, are concentrated in the Northwest and Northeast quadrants of the District.[37]** Many residents reside in wards with few hospital options. Attachment A provides additional information on the concentration of medical providers currently accepting Medicaid in the District. These providers are also concentrated in neighborhoods that are difficult to reach for many residents.

Figure 4. Hospital Locations in the District

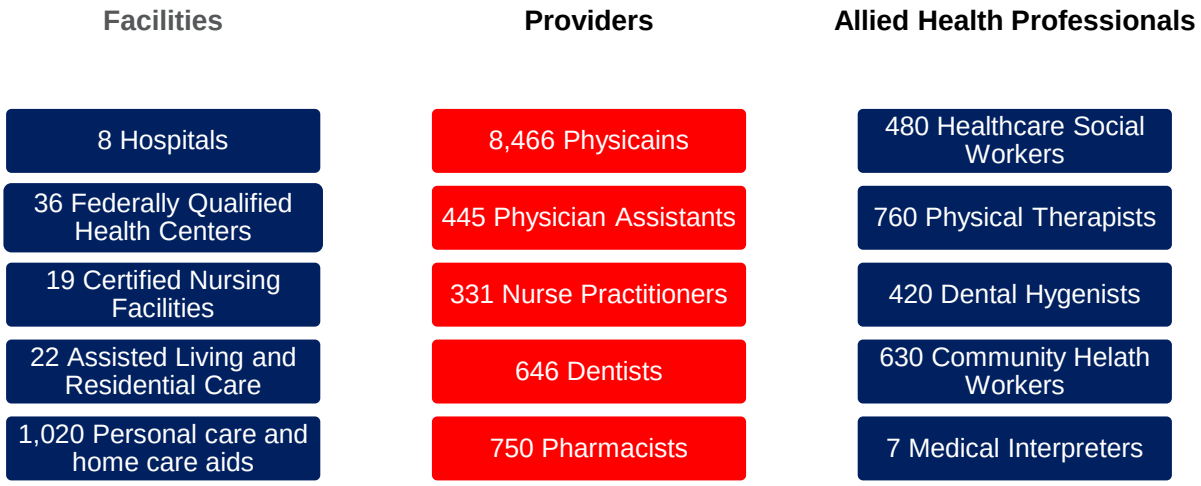


The District is home to a wide range of healthcare providers and allied healthcare professionals; however, these providers are geographically concentrated making it more difficult for residents outside of those areas to seek

[i] Demographic information of the DC Medicaid program can be found in Attachment A.2.

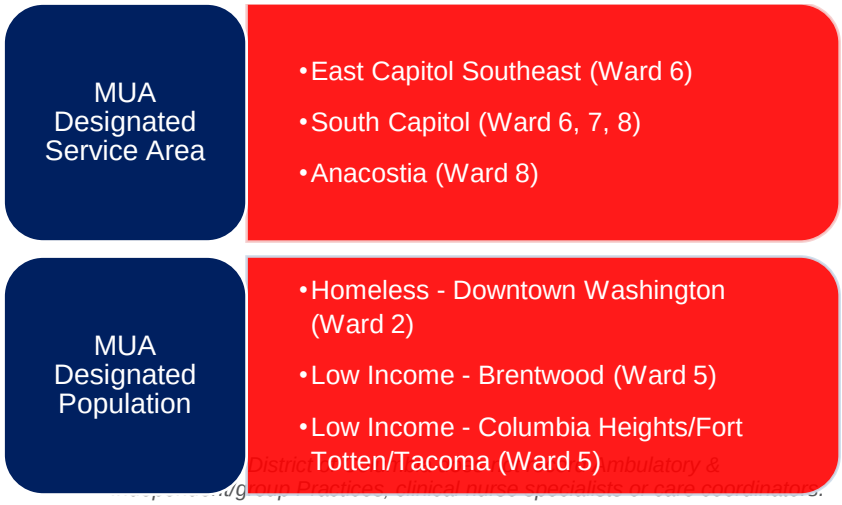
care. Figure 5 shows the number of providers in each category currently practicing in the District.

***Figure 5. Providers by Type in the District, 2012-2014**[38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48]*



Like many other cities and states, the District faces potential shortages and poor distribution of healthcare professionals**. Residents in Wards 7 and 8 in particular have limited access to hospitals and primary care.** In the District there are three service areas and three population groups with Medically Underserved Area (MUA) designation as shown in Figure 6.[49] MUAs are designated by the Health Resources and Services Administration (HRSA) as having too few primary care providers, high infant mortality, high poverty and/or a high elderly population.[50] The MUAs designated by HRSA align with District Wards that also have limited access to hospitals.

Figure 6. Medically Underserved Areas (MUA) in the District



Challenges Facing the District

There are many challenges facing the District that both make healthcare transformation necessary and difficult to achieve. There are health disparities by race, ethnicity, and geographic location that negatively affect how an individual navigates and utilizes the healthcare system. Additionally, inefficient use of services and inappropriate use of the care delivery system by both beneficiaries and providers leads to high costs and the mismanagement of chronic conditions. The majority of Medicaid expenditures subsequently stem from a very small percentage of Medicaid beneficiaries with very high costs most commonly associated with the fee-for-service population. Furthermore, a fragmented system of care creates barriers to coordinating treatment and disease management efforts, and social service supports needed to maintain health. These challenges are discussed in detail below.

District residents collectively have access to some of the best healthcare facilities and practices in the country. However, dramatic health disparities are present across geographic, racial and economic groups.

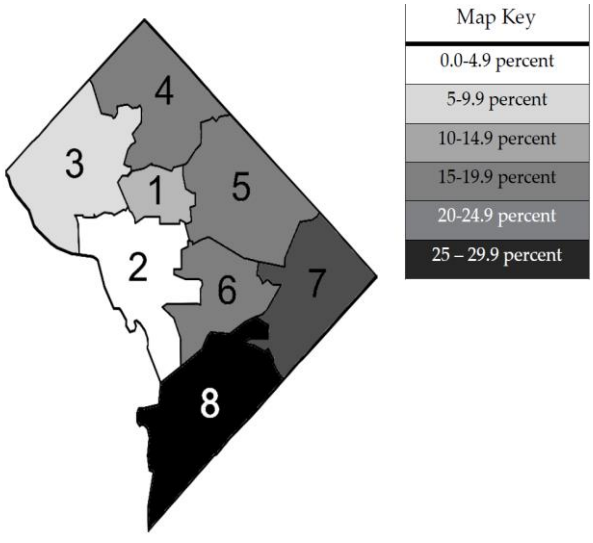
Health Disparities Based on Race, Income, and Ward Negatively Impact Health Status

Health disparities are differences in health status, prevalence of disease, health behavior risk factors and social determinants by sex, race and ethnicity, income, education, disability status, geography and other social and environmental factors.[51] The District is a tale of two cities with significant disparities in health outcomes based on race, income, and ward.

Notable health disparities across wards are shown in Figures 7 and 8, and include the following.

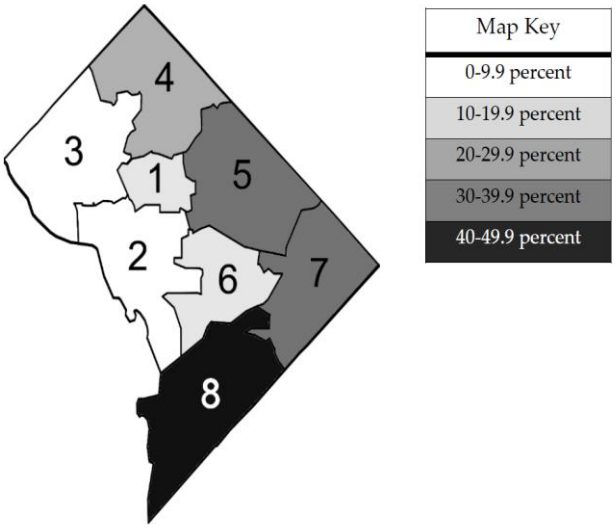
- The average life expectancy is almost 15% higher for White District residents compared to African Americans.[52]
- Hispanics newly diagnosed with HIV were more likely to be younger than other racial groups who have been newly diagnosed.[53]
- African Americans are three times more likely to smoke than White District residents[54]
- The number of heart disease related deaths for African Americans is double the rate for Whites.[55]
- The mortality rate for African Americans in the District is more than double the rate for White District residents; 963 versus 464 deaths per 100,000.[56]

Figure 7. District of Columbia Poor Health Status by Ward, 2013



- Wards 7 and 8 have the lowest incomes in the District and diabetes rates in these wards are nearly twice the national average.[57]
- Wards 2 and 3 have half the national average of smokers; Ward 8 has twice the national average, indicating greater risk of developing respiratory and heart disease for Ward 8 residents.
- Wards 7 and 8 report high rates of diabetes at 14.5% and 16%, respectively, almost twice the national average and three to five times the rates of Wards 2 and 3.
- Overall health status and rates of high blood pressure differ across the wards, as shown in Figures 7 and 8.[58]

Figure 8. Rate of High Blood Pressure by Ward, 2013



The District's overall vision for healthcare transformation is designed to benefit and support all eight wards of the District and to close the health disparities gaps between the wards. Leveraging the SIM grant, the District aims to promote health equity by directing residents to high quality, coordinated healthcare in appropriate settings and at appropriate times. As shown in Table A.2 in Attachment A, the health risk factor rates in each ward convey significant health disparities between disparate areas in the District.

Inefficient Use of Services Leads to Mismanagement of Chronic Conditions and High Costs

Inappropriate utilization of healthcare services, including non-emergency use of the emergency department and preventable inpatient admissions/readmissions, are inefficient uses of healthcare resources that often result in high costs and poor care management. Examples of inefficient utilization in the District include:

- **A 30-day Medicare hospital readmission rate of 65 per 1,000,** compared to 45 per 1,000 nationally[59]
- **Emergency department utilization rate that is almost twice the national rate;** 746 emergency department visits per 1,000 in the District, versus 423 nationally[60]
- A **quarter of residents do not have access to a personal doctor** to help them navigate the healthcare system, compared to the national average of 18%.[61]

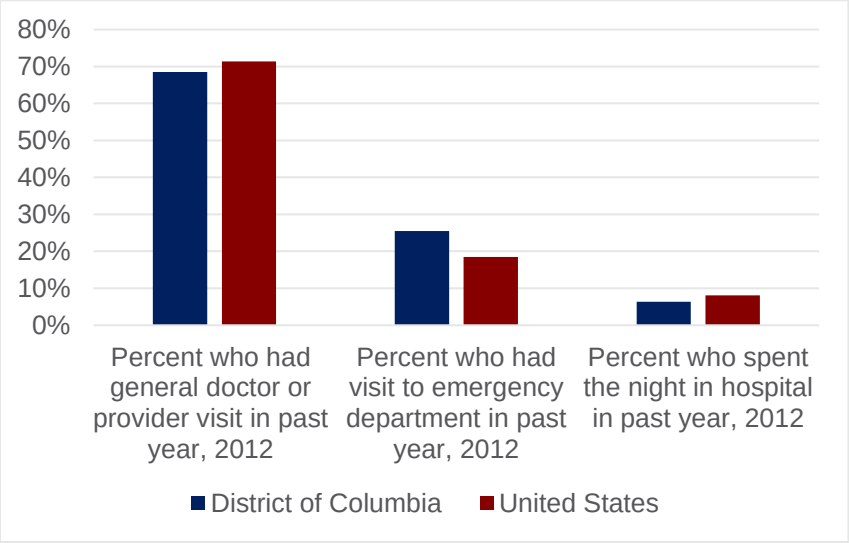
Table 2 and Figure 9 indicate how the District compares to national averages in key healthcare utilization measures.

Table 2. Healthcare Utilization Metrics

Healthcare Utilization Metrics	District of Columbia	United States
Medicare 30-day hospital readmissions per 1,000 beneficiaries, 2012[62]	65	45
Emergency Department Visits per 1,000 population, 2013[63]	746	423
Mortality amenable to healthcare, deaths per 100,000 population, 2012-2013[64]	119	82

Compared to national averages, District residents have lower rates of annual primary care visits and higher rates of emergency department (ED) visits, as depicted in Figure 9.[65, 66, 67] The District's SHIP aims to address these trends and the culture of care that results in District residents seeking ED care for non-emergencies instead of seeing a primary care provider. The District will develop initiatives to change such practices by leveraging consumer education and other payment and care delivery innovations.

Figure 9. Health Utilization in the District

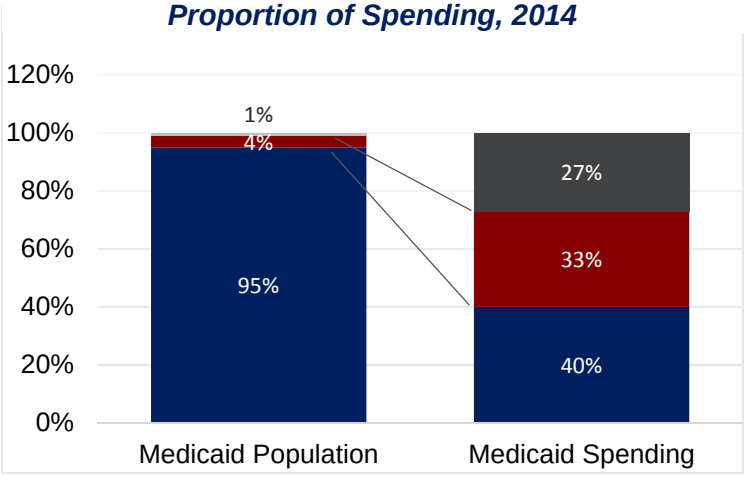


Medicaid Spending: The Majority of Medicaid Expenditures are from a Very Small Percentage of Medicaid Beneficiaries with Very High Costs for the FFS Population

A small number of high-utilizing Medicaid beneficiaries account for a disproportionate amount of Medicaid spending and drive growing program costs. The top 5% of beneficiaries with the highest costs account for 60% of Medicaid spending, including costs related to long-term services and supports as seen in Figure 10.[68] Annual healthcare costs for individuals in managed care average $206,125 which is less than half the average annual costs for those in fee-for-service ($495,861). The fee-for-service population typically suffers from multiple chronic

conditions that would benefit from comprehensive care coordination and disease management programs. Many of the high-cost Medicaid beneficiaries are covered under the fee-for-service program, which generally covers a sicker population and often does not benefit from Medicaid managed care coordination activities.

Figure 10. High-Cost Medicaid Beneficiaries Proportion of Spending, 2014

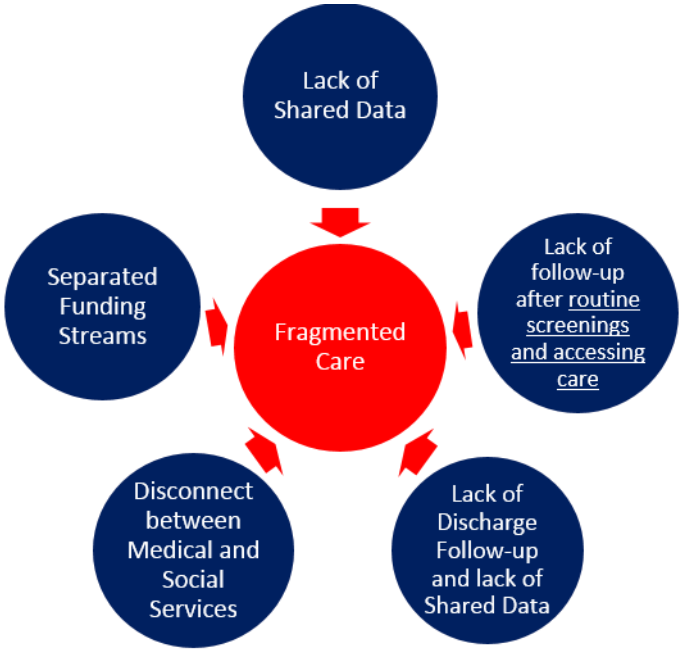


The managed care population is almost twice as likely as the fee-for-service population to have an emergency department visit (42% versus 23%). Alternatively, the fee-for-service population is more than twice as likely to have a costly inpatient stay compared to managed care enrollees (22% versus 9%).[69] The SHIP will discuss the efforts to improve health outcomes for the high-cost, high-need Medicaid population.

Fragmented System: The Disjointed Healthcare System Results in Uncoordinated Care and Poor Outcomes

The healthcare delivery system of the U.S. is characterized as being fragmented at a national, state, community, and practice levels.[70] There is no one entity or set of policies to guide the District's healthcare system. Multiple agencies in the District and providers are accountable for various supports and services which makes it difficult to coordinate care. Furthermore, providers practicing in the same community and caring for the same patients often work independently from one another. The District is a microcosm of the national disjointed healthcare system and Figure 11 illustrates barriers that can make it difficult to coordinate healthcare. One outcome of this fragmentation is that the District has over 30% more deaths before the age of 75 from treatable causes compared to the national rate.[71]

Figure 11. Factors Contributing to Fragmented Care in the District



Residents receiving health care services through the District's Medicaid program may also receive social services to address homelessness, food instability or chronic illness. However, the sites providing these services are siloed. There is limited communication between them and little flexibility in how to use and coordinate funding to best serve these residents. Care is disjointed, coordination and payment is fragmented, and there are limited opportunities to share savings.

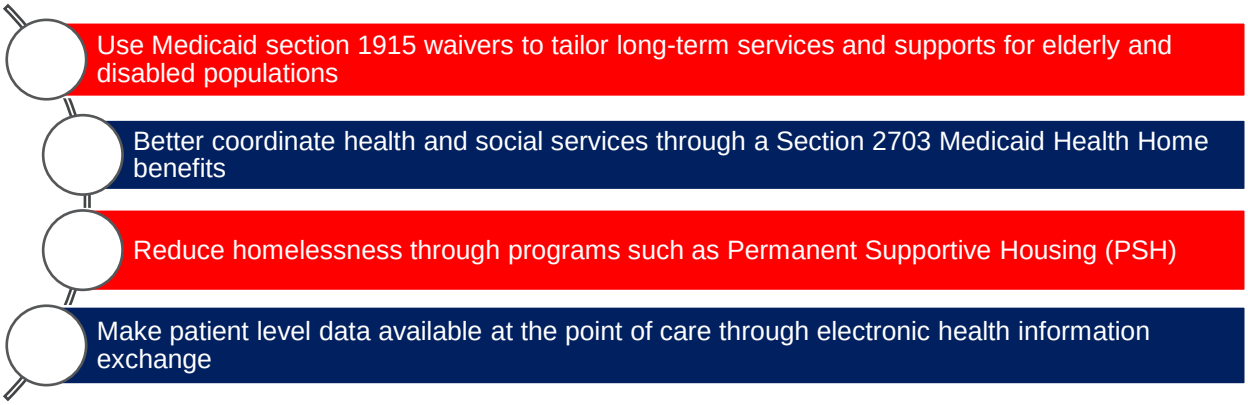
Individuals who receive healthcare services through Medicaid fee-for-service or managed care may also receive non-clinical social services from other District agencies, such as the Department of Human Services. The challenge for beneficiaries and District agencies is to coordinate these efforts effectively and create seamless care for such individuals.

Additionally, the District's health information technology infrastructure (HIT) is still maturing, leading to significant data sharing challenges. HIT helps provide real-time, actionable clinical data for individual patients at the point of care, which improves care coordination and outcomes. HIT, including electronic health records (EHR) and health information exchange (HIE), can be critical tools for improving the coordination and quality of healthcare. While EHRs allow providers to record clinical data and report on quality measures, HIEs allow such data to be shared with care teams across clinical sites to coordinate and manage patient care. Data exchanged through HIE can include patient summaries of care records, ambulatory clinical summaries, discharge summaries, admission-discharge-transfer (ADT) alerts, inpatient problem lists, and test results. HIT can also be used to record, report, and exchange clinical quality data, update patient portals, and inform disease registries.[72]

Current State of Innovation in the District

The District plans to use the SIM grant to reduce health disparities and implement payment reform by expanding upon initiatives currently underway in the District (see Figure 12 below). This section describes these initiatives in more detail.

Figure 12. Current Health Reform Initiatives in the District



Medicaid Waivers for High-Need Populations

The District has developed and implemented waiver programs to provide specialized care and services for specific populations. These waiver programs allow the District to tailor services for

Medicaid beneficiaries who have high needs and complex conditions. The programs include financing long-term services and supports for the elderly and disabled and services for the HIV/AIDS population. A list of these programs is provided in Attachment B. As the District executes the SHIP, these waivers will be coordinated with other new initiatives.

The Health Homes Program

The Affordable Care Act allows states the flexibility to design comprehensive care coordination and disease management initiatives for a select group of Medicaid beneficiaries with chronic conditions under the Section 2703 Medicaid Health Home program. The intent of Health Homes is that improved coordination will result in improved care and outcomes while also reducing healthcare utilization and costs. This will in turn, lead to cost savings that can support Health Home operations.[73]

Recent DHCF findings indicate that emergency department utilization and non-psychiatric inpatient admissions both decrease by almost 40% once homeless individuals receive Permanent Supportive Housing.

The goals of the Health Homes are to:

- Achieve better care coordination and management
- Increase utilization of preventative and wellness management services[74]

Health Homes 1 (My DC Health Home) launched in January 2016 and serves individuals with serious mental illness who have, or are at risk of developing chronic healthcare conditions. It was established jointly by the Department of Health Care Finance (DHCF) and the Department of Behavioral Health (DBH). The program promotes integration of mental health and substance abuse disorder (SUD) treatment with physical health and social supports. Coordination between providers on a care team is supported via DBH's web-based electronic medical record and billing system (iCAMS), which aims to prevent avoidable readmissions and ED visits by enabling timely post-discharge follow-ups.

Eligible individuals have the option to opt-into the Health Home program. Participants are assigned to their current providers to promote continuity of care. Individuals also have the option to choose alternate providers. The District plans to implement a second Health Home program through SIM.

Integrated Housing Initiatives to Combat Homelessness in the District

Mayor Bowser and the District of Columbia Interagency Council on Homelessness enacted the Homeless Initiative, which includes administrative and legislative techniques to improve the District's homeless crisis response system. The Council has put forth a plan and several initiatives to address the homelessness crisis in the District, including:

- Increasing the availability of emergency shelters
- Improving the efficiency of Permanent Supportive Housing
- Minimizing the number of moves a household has to make on their pathway back to permanent housing

- Minimizing the length of stay at any step prior to placement into permanent housing
- Minimizing unit turnover

The District plans to use these guiding principles to continue combating the homelessness and housing crisis in the District. One initiative included in this plan is Health Home 2 (HH2), which will serve chronically ill beneficiaries matched to the PSH program (described in Emerging Innovations below).

Health Information Exchange

Guided by the Health Information Exchange Policy Board under DHCF, the District is making strides to improve its health information exchange infrastructure. Multiple District agencies have incorporated HIT into their program operations to support electronic documentation and management of health information. DHCF, in conjunction with the Department of Health, upgraded public health reporting infrastructure to enable provider and hospital reporting on immunization data, cancer registries, syndromic surveillance, and electronic laboratory data. However significant gaps in HIT access exist among providers serving these populations. The District's progress is exemplified below:

HIT in SIM

Especially important to the SIM initiative is the ability of HIT to aggregate data and performance metrics, to which system and provider payments may be tied. States can also direct SIM funds to providers who are not eligible for meaningful use incentives for EHR systems, such as behavioral health and long-term and post-acute care (LTPAC) providers. Recent CMS guidance expanded our ability to expand health information exchange to providers not eligible for Medicaid EHR incentive payments but these providers are not eligible for EHR incentive payments. SIM funds can be used to help to develop the HIT capabilities for these non-eligible providers to participate in health information exchange.

1 http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-a-look-at-round-2-grantees/

- Electronic Health Records (EHRs) are currently used in 68% of District hospitals.[75]
- Almost 50% of District Medicare and Medicaid providers eligible for the EHR incentive payment program participated in 2014.[76] These providers include physicians, physician's assistance, and nurse practitioners.
- 48% of the District's prescriptions were processed electronically in 2013.[77]

The District connects to several existing HIEs, including Capital Clinical Integrated Network (CCIN), Children's Integrated Quality Network (CIQN), and Chesapeake Regional Information System for our Patients (CRISP), and is working to expand such services through its SIM effort.

Additional Programs Underway

The District has a number of initiatives already in progress that will support SIM goals. These existing programs will provide the foundation on which the SIM will build upon, in addition to providing lessons learned and best practices for multi-payer and HIE reforms. Some of these programs are listed in Tables 3 and 4 below.

Table 3. Multi-payer Primary Care Initiatives in the District

Multi-payer Primary Care	
1	**CareFirst BlueCross BlueShield** has developed a primary care initiative that identifies individuals with a high total cost of care and provides primary care providers with additional resources to better manage their care. The program offers performance bonuses to providers who are able to meet identified outcomes. In the first three years 60-70% of participating primary care groups have beaten the trend in total cost of care.
2	**Federally Qualified Health Centers (FQHCs)** in the District have taken initiative to develop the capacity to provide enhanced primary care services, including extended hours, open access scheduling, a shared electronic health record between most District FQHCs, and enhanced care coordination through the CMMI-funded Capitol Clinical Integrated Network (CCIN).
3	**George Washington University** received $23 million from CMMI to improve prevention and care for individuals with HIV/AIDS. The successful interventions developed under this grant could be made sustainable past the grant period through the financing changes that the multi-payer primary care initiative contemplates.

Table 4. Health Information Exchange Initiatives in the District

Health Information Exchange	
1	**The Federally Qualified Health Centers (FQHCs)** have implemented strategies and protocols to exchange data between FQHC EHR systems. DHCF supports a small health information exchange that can be sustained and built upon.
2	In September 2014, the **Department of Behavioral Health (DBH)** implemented an EHR with care coordination and care planning functionality that is compatible to the majority of mental health providers in the DBH system. This electronic functionality facilitates better integration and electronic data exchange between primary care and behavioral health systems.
3	The **DC Department of Health** has made significant progress in collecting public health and health surveillance data electronically. The newly established connections with providers through the district serve as infrastructure for additional HIE activities.
4	**DHCF, the Department of Human Services and the DC Health Benefit Exchange Authority (HBX)** built an integrated eligibility system for health insurance programs, with plans to expand to all health and human services programs in 2016. The system includes components that support care management.

Looking Ahead: Emerging Innovations in the District

While the District has made improvements to the healthcare system, opportunities for additional improvements remain. Using the findings of the environmental scan, the District will use the SIM process and SHIP to continue to formalize the District's plan to improve health outcomes for vulnerable residents by:

- Implementing the Health Home 2 (HH2) program for the chronically
- Embracing payment and care reform through the implementation of pay-for-performance and value-based payment
- Building additional capacity and interconnectivity between providers across the spectrum of care using the District's HIE

Health Home 2: Addressing Chronic Health Conditions

The District is currently meeting with stakeholders and planning the implementation of a second Health Home to serve the chronically ill. Numerous states have implemented interventions and programs to address the needs of the homeless population. People experiencing housing instability or chronic homelessness often require behavioral health services and community supports in order to sustain housing and improve health status. Many individuals in this cohort are high utilizers of hospital and emergency room services.[78] HH2 will use the Health Homes structure to coordinate care and social services for the individuals with multiple chronic condition using a team based approach to care. The District's locally funded Permanent Supportive Housing program will serve as a starting point for building partnerships among disparate agencies and community supports within the District.

Plans for Payment Reform

The District continues to weigh options for payment reform but has identified a number of tools that will allow the District to achieve its goals of spending Medicaid dollars more effectively, reducing inequalities and improving health outcomes. The District will introduce value-based purchasing initiatives and improve performance measurement to incentivize appropriate use of services and improved outcomes. For example, the District is considering setting a goal for reducing health disparities across the all eight wards. The Health Home initiatives (1 and 2) will help to achieve these goals by promoting better care coordination and case management for patients with chronic illnesses and behavioral health needs. Additionally, the District will develop a system of financial incentives, penalties and bonus payments to spur more efficient provision of care and achieve is goals of reducing inpatient admissions and inappropriate use of the ED.

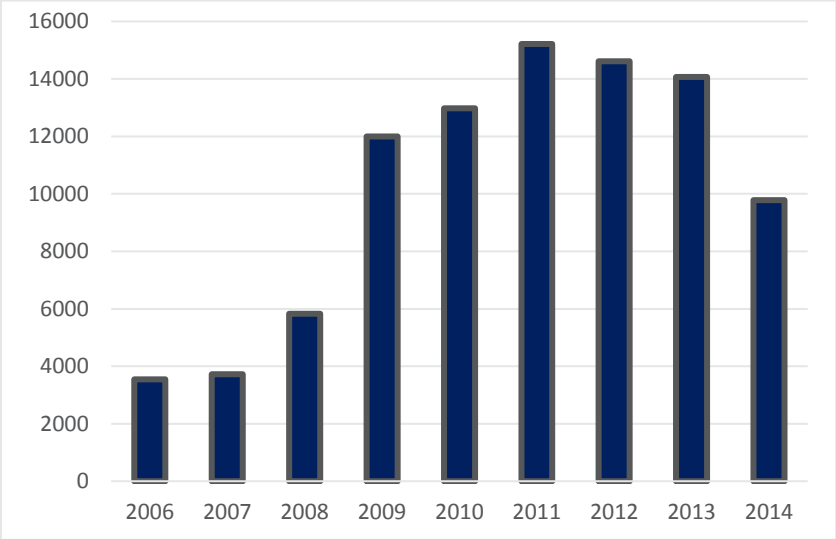
Implement HIE Plan

The District will build upon our current HIE infrastructure, collaborate with healthcare providers and leverage healthcare systems in surrounding states, particularly Maryland, to establish health information exchanges. However, these exchanges do not yet fully capture and exchange information across the entire landscape of providers and sites of care. The District will build on these efforts to create a larger, more integrated information flow that can share data across settings and specialties, including social services providers. Subsequent sections of the

SHIP include detailed discussions of these efforts and a roadmap to successful implementation of expanded HIE connectivity.

Attachment A

A.1. Population Demographics[79,80]



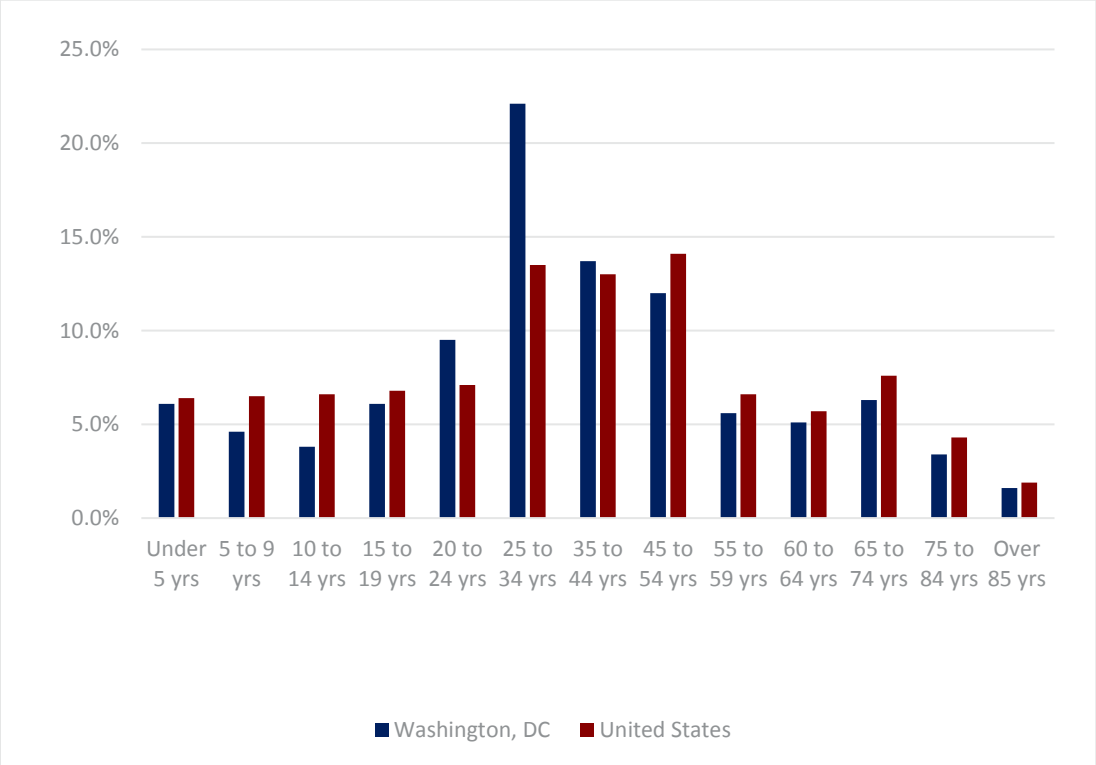


Table A.1. Ward-level Population, Income and Race Data, 2013[81]

	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
Total Population	75,814	75,116	80,344	76,851	75,470	79,119	68,035	75,010
Median Income	$73,006	$90,859	$103,936	$63,085	$51,970	$86,612	$38,807	$31,422
Caucasian/ White	53.6%	76.2%	83.2%	24.6%	14.7%	50.8%	2.0%	4.1%
African American/ Black	33.3%	9.2%	5.2%	60.5%	77.4%	40.6%	95.9%	94.1%
Asian	4.5%	9.1%	6.3%	1.5%	1.4%	4.4%	0.3%	0.3%
Hispanic*	22.0%	9.4%	7.9%	18.3%	7.2%	5.4%	2.0%	1.5%
Native Hawaiian and other Pacific Islander	0.2%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%
American Indian and Alaska Native	0.4%	0.4%	0.4%	0.6%	0.3%	0.4%	0.2%	0.2%
Other Race	6.0%	2.5%	1.5%	10.4%	4.2%	1.3%	0.7%	0.5%
Two or More Races	1.9%	2.5%	3.4%	2.3%	2.1%	2.3%	1.0%	0.8%

*Table A.2. Self-Reported Health Risk Factors by Ward, 2013**[82]

Measure	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8	US
Health Status as Fair or Poor	12.6%	8.9%	4.2%	17.4%	17.0%	7.9%	17.6%	29.5%	16.7%
Adults with High Blood Pressure	28.6%	23.8%	24.0%	32.3%	37.2%	29.6%	42.9%	37.7%	31.4%
Obesity	24.9%	15.3%	12.0%	27.2%	32.1%	22.1%	35.0%	42.8%	29.4%
Current Smoker	15.5%	8.6%	9.3%	14.4%	20.4%	17.3%	24.1%	41.0%	18.8%
Diabetes	6.6%	4.8%	3.1%	8.4%	10.9%	6.5%	14.5%	16.0%	9.7%
*****All data is self-reported through the Behavioral Risk Factor Surveillance System (BRFSS)									

A.2. Medicaid Population Demographics

The District offers a generous set of Medicaid benefits that serves children, parents, the elderly, and childless adults. Figures A.4 through A.11illustrate the Medicaid population in the District compared to non-Medicaid population in the District and the national population.[ii] Key findings of the District's Medicaid population include:

- A disproportionate percentage of Medicaid enrollees are children under 18 years of age.
- The unemployment rate among Medicaid recipients is significantly higher than the non-Medicaid population.

[ii] All information is provided by the U.S. Census Bureau.

- The level of education is diverse among Medicaid recipients while the majority of non-Medicaid residents in the District have a four year college degree or higher.

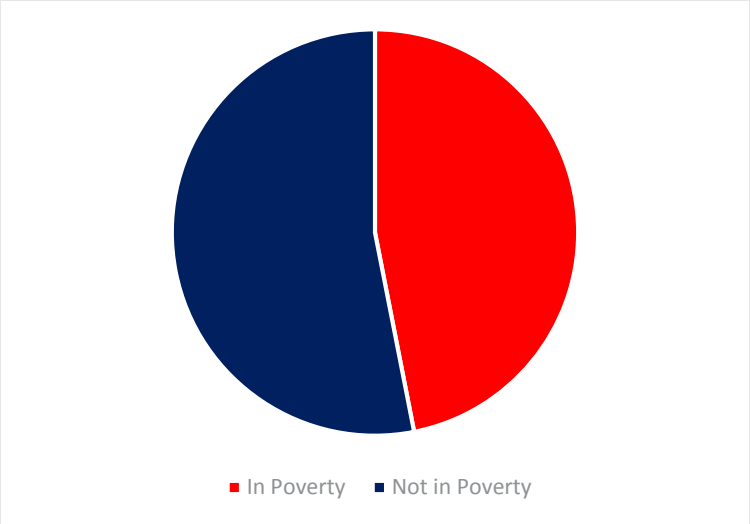


Figure A.4 District Medicaid by Race, 2014

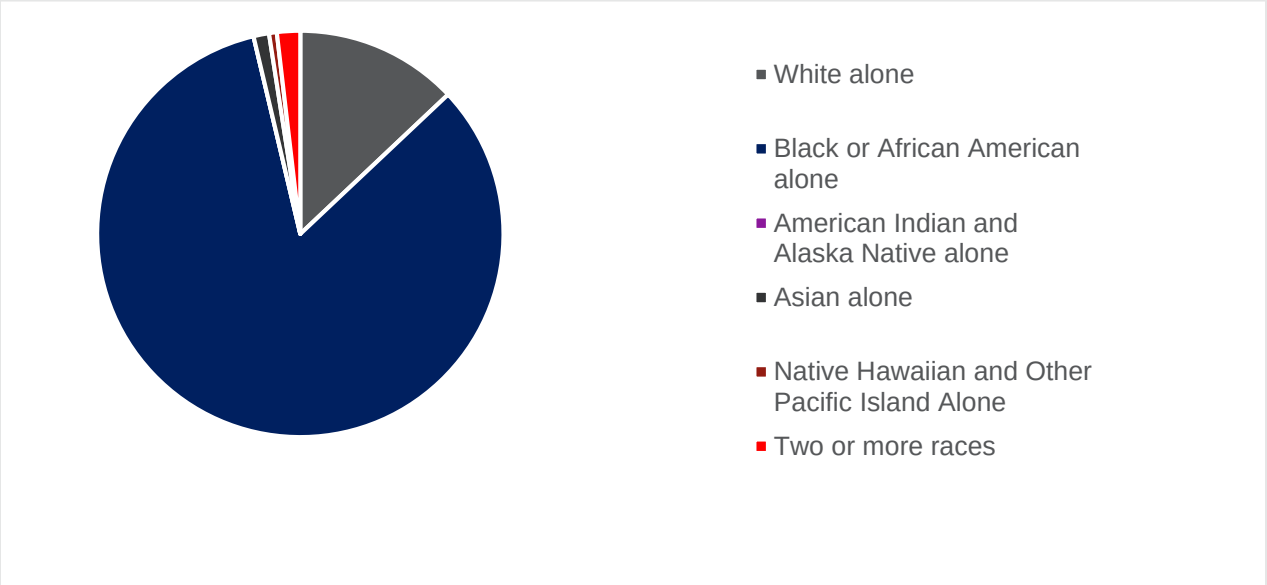


Figure A.5. District Medicaid by Sex, 2015

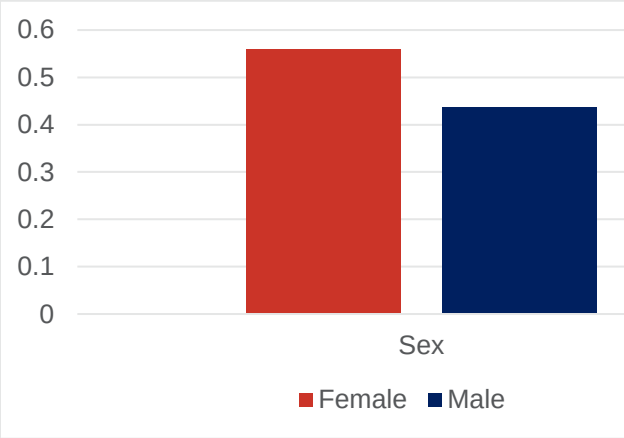


Figure A.6. Marital Status, Medicaid and Non-Medicaid Population in the District, 2015

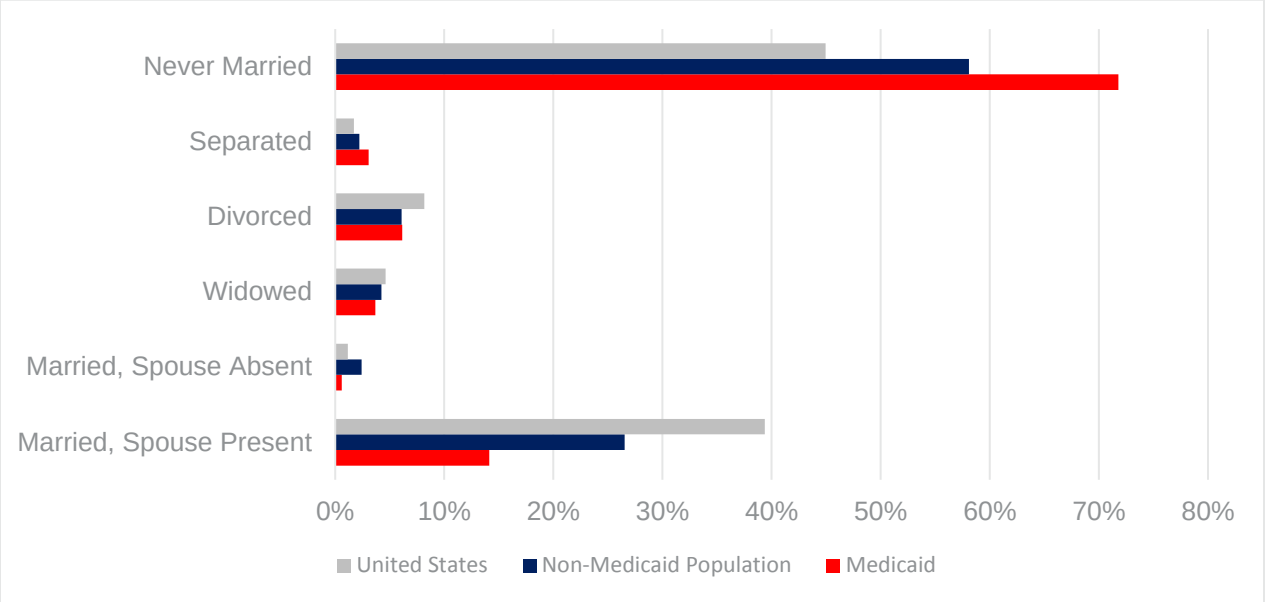


Figure A.7. Employment Status, 2015

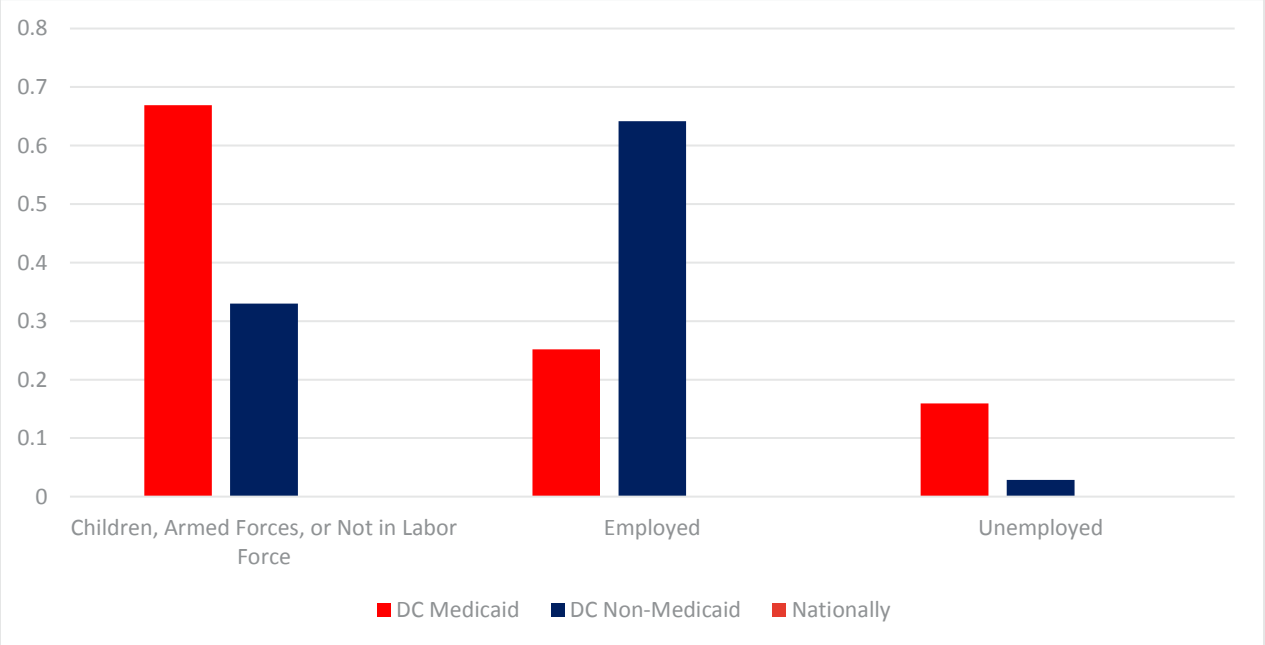


Figure. A.8. District Non-Medicaid Population by Age, 2015

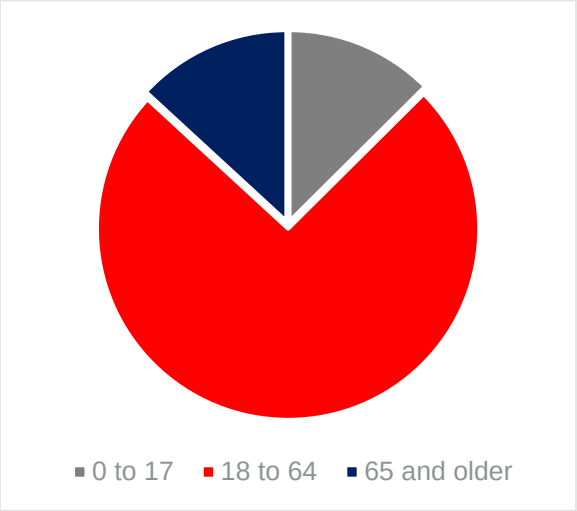


Figure. A.9. District Medicaid Population by Age, 2015

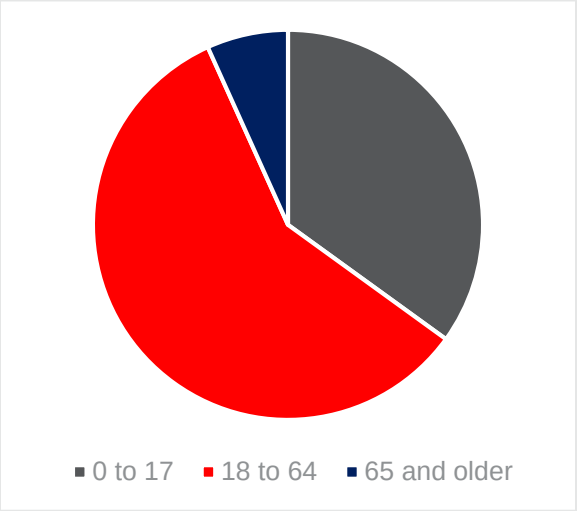


Figure A.10. District Non-Medicaid Education Attainment, 2015

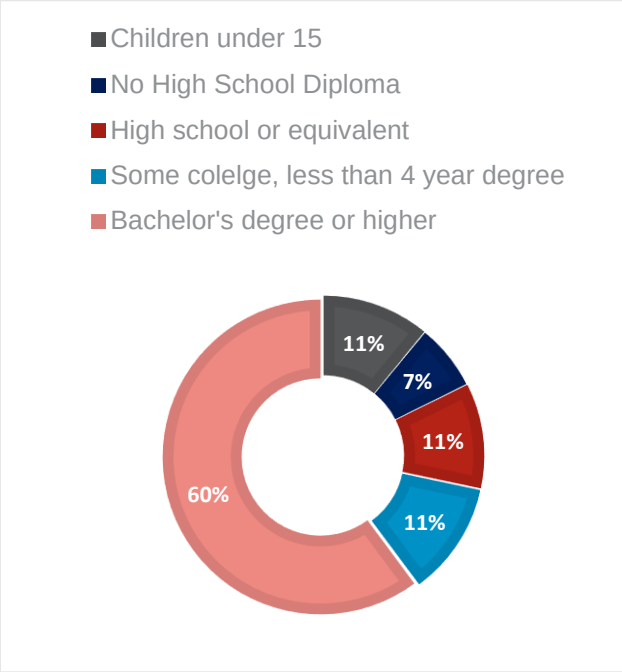
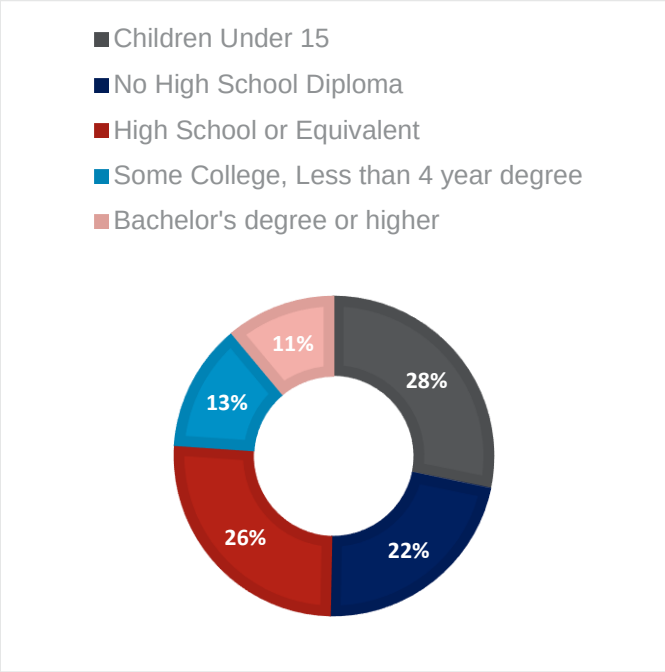


Figure A.11. District Medicaid Education Attainment, 2015



Attachment B

B.1. Medicaid Waivers

Table B.1. District of Columbia Medicaid Waivers[83]

Waiver Title and Type	Waiver Description
District of Columbia MR DD **1915(c)**	Provides day habilitation, employment readiness, in-home supports, residential habilitation, respite, supported employment, personal care, skilled nursing, behavioral supports, companion services, creative art therapies, dental, environmental accessibilities adaptations, family training, host home, individualized day supports, OT, one-time transitional services, PERS, PT, small group supported employment, speech, hearing, and language services, supported living with transportation, supported living, vehicle mods, wellness services to individuals with intellectual disabilities or developmental disabilities ages 18 and over.
District Elderly and Persons with Disabilities **1915(c)**	Provides adult day health, case management, homemaker, personal care aide, respite, assisted living, chore aide, environmental accessibility and adaptation, individual directed goods and services, OT, participant directed community support, PERS, PT for aged individuals 65 and over and physically disabled ages 18 to 64.
District of Columbia Childless Adults **Section 1115**	The District of Columbia Childress Adults 1115 Demonstration provides full Medicaid benefits to non-pregnant, non-disabled adults with incomes above 133% and at or below 200% of Federal poverty limit. The District of Columbia's Childless Adults Demonstration is a statewide section 1115 Demonstration that provides healthcare coverage to individuals to permit early implementation of the expansion required by the Affordable Care Act in 2014.
Distribution and Dispensing of Anti-Retroviral and other HIV-related Medication Services Waiver **1915(b4)**	DHCF with the department of Health, HIV/AIDS, Hepatitis STD and TB Administration (HAHSTA) dispense antiretroviral and other HIV-related medications to eligible District residents who are living with HIV or AIDS and who are enrolled in Medicaid fee-for-service and managed care programs. HAHSTA's network of pharmacy providers meet certain quality standards to dispense HIV/AINDS related-medications to individuals in need who otherwise do not have access to these medications.
District NEMT **1915(b4)**	Provides all non-emergency medical transportation within the Washington, DC metropolitan area, including the city of Washington, DC, the suburbs of Montgomery and Prince George's County in Maryland and Northern Virginia counties of Fairfax, Arlington and the City of Alexandria. Beneficiaries must live in the District or reside in a long-term care facility or nursing home, receive Medicaid and have no other way of going to medical appointments.

Attachment C

C.1. HIE Initiatives in the District

Table C.1: Existing HIE in the District[84]

Existing HIE	Description
Capital Partners in Care – Community Health Information Exchange (CPC-HIE or the Exchange)	The CPC-HIE connects the electronic health records from five District of Columbia community health centers (Mary's Center for Maternal & Child Care, Inc., Unity Health Care, Inc., Bread for the City, La Clínica del Pueblo, and So Others Might Eat) and the CCIN care coordination system, as well as the Emergency Care Center, Outpatient Services and Laboratory and Imaging Specialties of Providence Hospital, a member of Ascension Health, the nation's largest Catholic and non-profit health system. The data exchange is secure and meets all federal requirements for health information privacy. The CPC-HIE gives medical providers across the District of Columbia immediate access to information about their patients' care received at other clinics, allowing them to provide more timely and effective treatment while avoiding expensive duplication of services.[85]
Children's Integrated Quality Network (CIQN)	The Children's Integrated Quality Network (Children's IQ Network) is an effort to integrate the healthcare data of children within DC metropolitan region (which includes areas in Northern Virginia and Maryland). The Children's IQ Network has launched a system enabling physicians to share patient information with other independent area physicians via a secure Internet tool. The Children's IQ Network uses eClinicalWorks' Electronic Health Exchange community health record to provide access to patient demographics, visit histories, lab results, medications, problem lists, immunizations, growth information and encounter summaries. The records are made available to physicians affiliated with Children's National Medical Center's seven primary care clinics, its Washington, D.C., foster care program, and mobile medical vans. In addition, interfaces will be made available for other practices owned by Children's and HealthMaster, the electronic medical records system used by 172 schools in the district. E-prescribing and vaccine registry information also will be made available to schools in Washington, D.C., Maryland and Virginia.[86]
Chesapeake Regional Information System for our Patients (CRISP)	The Chesapeake Regional Information System for our Patients (CRISP) is a nonprofit corporation created to function as Maryland's state-designated health information exchange and the state's health IT extension center. The purpose of the health information exchange is to make clinical data available for treating physicians and nurses at the point of care, anywhere in the state of Maryland, regardless of the source of the data. CRISP was created by Johns Hopkins Medicine, MedStar Health, the University of Maryland Medical System and Erickson Retirement Communities. CRISP receives input from a wide range of sources, including clinicians, hospitals, patients, privacy advocates, payers, and regulators and policymakers.[87] All 47 acute care hospitals in Maryland and six of eight District hospitals share clinical data and current records over 110,000 queries per month. Ten hospitals have enabled 'single sign-on' connectivity to the portal enabling single-click access to data in CRISP

	for more efficient access. Hospitals may auto-subscribe to receive alerts when one of their past discharges is being readmitted within 30 days.

Appendix 2 – State Innovation Advisory Committee and Workgroups

The Advisory Committee includes six high-level District government officials and 10 private stakeholder representatives of health care payers, health service providers, clinicians, and academia to sit on a minimum 16-member committee. Recognizing that the District recently experienced a Mayoral transition, DHCF actively engaged and solidified the support of the Mayor through the Deputy Mayor of Health and Human Services, as well as the support of District Agency Directors within the health and human services cluster and City Councilmembers. To formalize these commitments throughout the District's SIM Design year, the key government stakeholders participated in the SIM Advisory Committee, the governing body of the SHIP development process.

The Advisory Committee is charged with providing guidance to the Core Team within the Department of Health Care Finance (DHCF), its partner District government agencies, and the Workgroups related to the planning and development of the interventions that will be formulated under the District's SIM design initiative. The Advisory Committee met on a quarterly basis throughout the planning year and provided guidance to DHCF regarding project initiatives, necessary policy changes, and how best to influence desired innovation in the private and public sectors.

There are five Workgroups, each dedicated to a specific topic including: care delivery, payment reform, community linkages, quality, and health information technology and exchange. The purpose of the Workgroups is to provide expertise and input on innovative approaches and the feasibility of possible solutions. Each Workgroup has a specific charter related to their scope of work and expected deliverables. Workgroup membership is based on self-identified interests and through targeted outreach by the Core Team to gain the desired subject matter expertise. Each Workgroup held monthly meetings throughout the life of the design process.

Figure 1. Purpose of SIM Workgroups

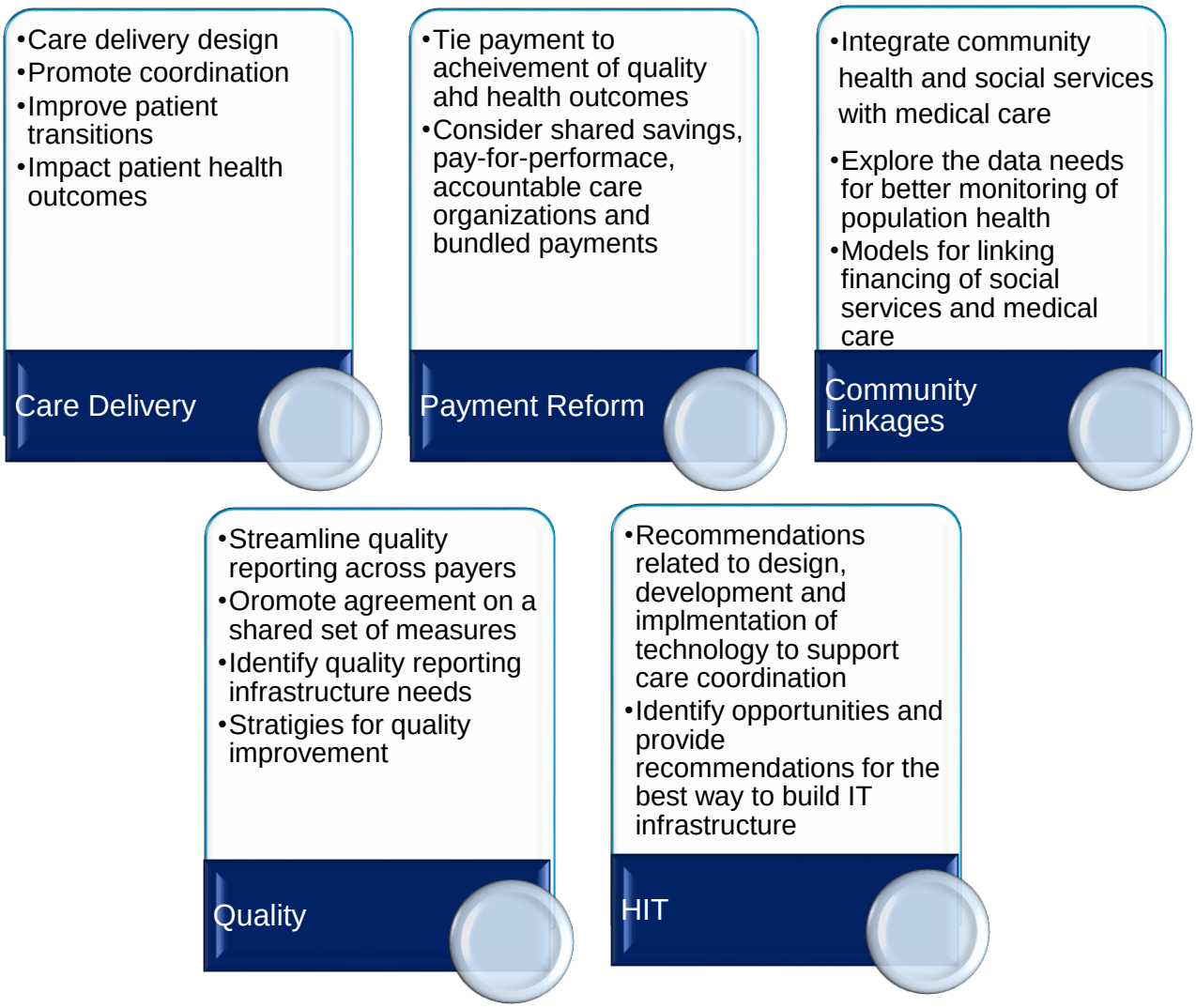


Table 1. Advisory Committee Members

Name	Title	Organization	Organization Type
Amy Freeman	President & CEO	Providence	Provider
Angela Diop	Vice President for Information Systems	Unity Health Care, Inc	Provider
Brenda Donald	Deputy Mayor, Health and Human Services	Executive Office of the Mayor	Government

Name	Title	Organization	Organization Type
Christian Barrera	Policy Analyst	Executive Office of the Mayor	Government
Christine Wiley	Reverend	Covenant Church	Community Organization
Christopher King	Associate Director, Master Health Systems Administration (MHSA) Program; Director, Experiential Learning & Professional Studies; Senior Fellow, Health Research and Educational Trust	Georgetown University School of Nursing and Health Studies	Academia
Christy Respress	Executive Director	Pathways to Housing DC	Community Organization
Claudia Schlosberg	Director	Department of Health Care Finance	Government
Frank Tucker	Reverend	First Baptist Church	Community Organization
Howard Liebers	Health Policy Analyst	Department of Insurance, Securities and Banking (DISB)	Government
Jacqueline Bowens	Chief Executive Officer	DC Primary Care Association	Provider
Jonathan Blum	Executive Vice President of Medical Affairs	CareFirst BCBS	Payer
Jullette Saussy	Medical Director	Fire and EMS Department	Government
Karen Dale	Executive Director	AmeriHealth	Payer
LaQuandra S. Nesbitt	Director	Department of Health	Government
Laura Nuss	Director	Department on Disability Services	Government

Name	Title	Organization	Organization Type
Laura Zeilinger	Director	DC Department of Human Services	Government
Lisa Fitzpatrick	Medical Director	Department of Health Care Finance	Government
Mara Krause Donohue	Consumer	Consumer Representative	Consumer
Maria Gomez	President & CEO	Mary's Center	Provider
Mark Weissman	Division Chief, General and Community Pediatrics	Children's National Medical Center	Provider
Rayna Smith	Committee Director	DC City Council	Government
Richard Bebout	CEO	Green Door	Community Organization
Stephen Taylor	Acting Commissioner	Department of Insurance, Securities, and Banking	Government
Tanya Royster	Director	Department of Behavioral Health	Government
Yvette Alexander	Councilmember	DC Council	Government

Appendix 3 – Consumer Interview Questions, Protocol and Consent Form

Consent Form for State Innovation Model Survey

Purpose and Benefits

The District of Columbia (the District) Department of Health Care Finance (DHCF) is conducting a survey. The purpose of the survey is to learn about your experience getting health care in the District. The information from the survey will help DHCF improve healthcare services and programs offered throughout the District.

Procedures

You will be asked to answer 15-20 questions by a person working with DHCF. The survey will take approximately 10-15 minutes to complete. It will also include questions about your experience receiving health care services in the District including through the Medicaid program.

Risks and Benefits

There are no known risks to you as a person taking this survey. There are also no known direct benefits to you. However, the answers that you provide to the survey questions will help DHCF improve the care that residents receive in the Medicaid program.

Safeguarding Privacy

Any information that you provide during the survey will be kept private. Your name will not be used to record answers or to report results of the survey. Any personal identifying information will be kept confidential. Only project staff at DHCF and Navigant, a consultant to DHCF, will have access to the survey data. Navigant has signed a form agreeing not to share any personal information that you will provide as part of the survey.

Participation

Your participation in the survey is completely voluntary. You may refuse to take part in the survey at any time without penalty. You may also refuse to answer any questions that make you feel uncomfortable. If you decide not to take part in or to stop the survey, you will not lose any of the services that you are currently receiving.

If you have questions about the survey, you may contact DaShawn Groves at (202) 442-8956.

Respondent Agreement

I have read the above information, and have received answers to my questions. I consent to participate in the survey administered by DHCF. I affirm that I am 18 years of age or older or the parent or guardian of a minor on whose behalf I am responding to the survey. I know that I may refuse to participate or to stop the survey at any time without any change to or loss of the health care benefits that I am currently receiving.

_____ _____

Respondent Signature Date

Consumer Interview

Interview Details

Interview ID: _____ Date: _____ Time: _____

Interview Opening Talking Points

☐ **Introduction**

- My name is [your name] and I am [describe title/role]. It is my pleasure to meet you and tell you a little about why we would like you to participate in this interview.
- We are hoping to spend the next 10-15 minutes with you to better understand your opinions of, and experience with, healthcare in DC so we are able to make DC Medicaid program better able to serve its consumers.
- We would like to hear your thoughts about healthcare in DC, what's good, what's not so good, and any suggestions you may have to improve it.
- The District wants to hear from residents like you to help us improve the healthcare experience in DC.
- Your feedback is very important and will be used to help DC change the system to make sure people can get the medical help they need when they need it.
- Would you be willing to share your experience and helping us improve healthcare in DC?
- We would like you to share your experiences so the program can work better for you and for others in the future.
- If you are interested in helping us out and sharing your experiences, please review the following form [hand consent form to individual]. I will go over it with you.

☐ **Consent Form**

[After providing and explaining the consent form to the interviewee, please indicate if the individual is:]

- ☐ **Participating** – Consent Form Received, Reviewed, Signed by Interviewee [continue to Interview]
- ☐ **Not participating** [Thank individual for her/his time]

- Thank you again for participating. We will now continue to the interview.
- This is completely voluntary and we can end it whenever you want or when you start to feel uncomfortable.
- Your participation will be kept confidential and will not be attributed to you in any way.
- As we go into the interview, please know:
  a. I am interested in all of your ideas, comments, and suggestions.
  b. There are no right or wrong answers to the questions.

c. All comments—both positive and negative—are welcome. Please do not worry about offending me with anything you might say—it is important that I know your opinions and feelings.

- I will be taking notes about your responses.

Do you have any questions for me before we begin? [Wait for response and respond if appropriate]

Great, thank you and we appreciate your honesty.

Interview Questions

☐ **General Information**

1. Which ward do you live in [refer to map] or what is your zip code?

a. What is your age?
□ 18 to 24 □ 25 to 34 □ 35 to 44 □ 45 to 54 □ 55 to 64 □ 65 to 74
□ 75 or older □ Decline to answer

b. Do you identify as:
□ Male □ Female □ Transgender, male-to-female □ Transgender, female-to-male □ Transgender, gender nonconforming □ Not Sure □ Decline to answer

c. Are you of Hispanic or Latino origin or descent?
□ Yes □ No □ Not Sure □ Decline to answer

d. What is your race? Mark one or more.
□ White □ Black or African American □ Asian □ Native Hawaiian or Other Pacific Islander □ American Indian or Alaska Native □ Other:____
□ Not Sure □ Decline to answer

2. Are you enrolled in DC Medicaid?
□ Yes □ No □ Not Sure

2a. If **no** to Q2, what insurance do you have? Private? Employer sponsored? Medicare? **[skip to question 3]**

Enter comments, if necessary.

2b. If **yes** to Q2, Do you understand what benefits you receive with DC Medicaid? **[if no or not sure, skip to question 4]**

□ Yes □ No □ Not Sure

2c. Can you tell me a little bit about what you know about the DC Medicaid program? What kind of benefits do you get? [Please describe.]

3. Can you tell me a little about your healthcare? What kind of benefits do you get?

☐ **Access to Primary Care and Provider Satisfaction**

4. Do you have a primary care doctor or provider that you go to on a regular basis? A primary care provider is a doctor or nurse you see when you have medical problems like a cold, regular aches or pain. They may also help you determine if you need to see a specialist like a heart doctor.

□ Yes □ No □ Not Sure

a. If no, where do you typically go for care? [**skip to question 7]**

b. If in a FQHC waiting department, are you here today to see your primary care doctor?

□ Yes □ No

c. When did you last see you primary care provider?

□ In the last year □ In the last two years □ In the last three years □ Over three years

5. On a scale of 1 to 10, please rate how happy you are with your doctor/provider. (1: extremely unhappy and 10: extremely happy)

Extremely Unhappy Neutral Extremely Happy

1 2 3 4 5 6 7 8 9 10

6. On a scale of 1 to 10, tell me how hard or easy it is for you to get an appointment with your doctor [Insert doctor's name if given]? (1: extremely difficult and 10: extremely easy)

Extremely Difficult Neutral Extremely Easy

1 2 3 4 5 6 7 8 9 10

7. Is there someone who helps you with your care such as a home health aide, nurse, or family member? This could be someone there to help you take your medicine regularly, or help you make and keep doctor's appointments.

□ Yes □ No □ Not Sure

7a. if yes, who helps you? Do they have a medical background?

8. Do you have a condition that is one that is not likely to go away such as diabetes/sugar, asthma/ breathing problems, heart problems or high blood pressure? **[If no, skip to question 10]**

□ Yes □ No

9. If you have such condition, do you have help managing it (i.e., monitoring your sugar levels, pain management, classes to help with finding/making healthy food choices and making healthy recipes)?

□ Yes □ No

10. Do you have other needs such as housing, transportation, food, or electricity that make accessing health care difficult?

□ Yes □ No

10a. If yes, what other needs do you have?

□ **Emergency Department (ED) Utilization**

10. Do you ever go to the emergency department first before calling your doctor when you are sick?

□ Yes □ No

11. How often do you go to the emergency department/department if you go? **[If 0 visits a year, skip to question 14] [IF 4 – 5 OR 5+ VISITS PER YEAR, SWITCH TO LONG FORM SURVEY ON PAGE 9 OF THIS SURVEY]**

□ 0 visits a year □ 1 - 2 visit per years □ 3 - 4 visits per year
□ 4 - 5 visits per year □ 5+ visits per year

[IF 4 - 5 OR 5+ VISITS PER YEAR, SWITCH TO LONG FORM SURVEY ON PAGE 9 OF THIS SURVEY] Interview says: ***Do you mind if we spend a few extra minutes talking about your healthcare?***

12. Think back to the last time you went to the emergency department. Why did you go to the emergency department instead of a doctor's office? **[Mark all that apply]** [Take notes on suggestions/explanations]

□ Really sick	□ I don't have a regular doctor	□ The emergency department was closer	□ The emergency department is where I always receive care
□ My doctor's office was closed	□ I was unable to get an appointment at my doctor's office	□ Other:	

13. Think back to the last time you went to the emergency department. Which of the following health issues made you to go to the ER instead of your doctor the last time you went to the emergency department? **[Mark all that apply]**

□ Breathing problems/Trouble breathing (COPD)	□ Alzheimer's	□ Heart problems High Blood Pressure	□ Joint Pain/ Arthritis	□ Accident	□ Mental Health Condition	□ Stroke
□ Pain	□Asthma	□ Diabetes/Sugar		□ Cold or flu	□ Cancer	□ Other:

Notes:

☐ **Gaps in Health Care**

14. Are you able to get the medicine you need?

□ Yes □ No □ Not applicable

a. If no, why can't you get your medicine?

15. Are there any health services that you needed but you could not get?

□ Yes □ No

If yes, what are those services? **[Mark all that apply]**

□ Dental Care	□ Vision Care	□ Physical Therapy	
□ Surgery	□ Doctor's Appointment [get type of doctor/reason for appt]	□ Lab Tests	□ Other:

16. Why did you have trouble getting the care? **[Mark all that apply}**

□ Too expensive	□ Transportation	□ Insurance did not pay for it
□ Could not get an appointment with the provider	□ Did not understand my benefits	□ Other:

☐ **Access to Social Services**

17. Do you receive government assistance/support for housing, transportation, heat, electricity, childcare or food/EBT card? **[If no, not sure or decline to answer, skip to question 21]**

□ Yes □ No □ Not Sure □ Decline to answer

If you do not mind me asking, which service(s) do you receive?

18. Do you think these government assistance/supports improve the quality of your life and health? How? Is there anything you think that would make the services better?

For example, does transportation help you get to and from the doctor? Does childcare assistance help you keep appointments? Does your EBT card allow you to eat a healthy diet?

Likes:

Improvements:

Other:

19. Are there any social services that you needed that you were unable to receive? E.g., assistance with food, housing, heat, electricity, childcare, or transportation?

□ Yes □ No

If yes, what are those services? Do you remember why you were not able to get the services?

☐ **Wrap-up**

20. Overall, how good or bad would you rate your experience in the D.C. healthcare system? (1: very bad and 5: very good)

Very Bad	Bad	Fair	Good	Very Good
1	2	3	4	5

Please explain: (optional)

21. Is there anything else you would like to share regarding the questions that I have asked or something I did not cover today?

□ Yes □ No

Thank you for your time and participation!

Interviewer Comments/Additional Notes

LONG FORM SURVEY

12. Think back to the last time you went to the emergency department. Why did you go to the emergency department instead of a doctor's office? **[Mark all that apply]** [Take notes on suggestions/explanations, see if various visits were for different reasons, same reason]

□ Really sick	□ I don't have a regular doctor	□ The emergency department was closer	□ The emergency department is where I always receive care
□ My doctor's office was closed	□ I was unable to get an appointment at my doctor's office	□ Other:	

13. Think back to the last time you went to the emergency department. Which of the following health issues made you to go to the ER instead of your doctor the last time you went to the emergency department? **[Mark all that apply]**

□ Breathing problems/Trouble breathing (COPD)	□ Alzheimer's	□ Heart problems High Blood Pressure	□ Joint Pain/ Arthritis	□ Accident	□ Mental Health Condition	□ Stroke
□ Pain	□Asthma	□ Diabetes/Sugar		□ Cold or flu	□ Cancer	□ Other:

Notes:

14. Do you think this hospital visit could have been prevented if you were able to see a primary care doctor?

15. What are the advantages and disadvantages to going to the ED over the doctor's office? Need extended hours due to transportation, work, lack of childcare?

16. What transportation did you use the last time you went to the ED?
□ 911 □ Friend/family member □ Public bus/metro □ Other

Gaps in Health Care

17. Are you able to get the medicine you need?

□ Yes □ No □ Not applicable

a. If no, why can't you get your medicine? Transportation? Other costs? Need another doctor visit for refill?

18. Are there any health services that you needed but you could not get?

□ Yes □ No

If yes, what are those services? **[Mark all that apply]**

□ Dental Care	□ Vision Care	□ Physical Therapy	
□ Surgery	□ Doctor's Appointment [get type of doctor/reason for appt]	□ Lab Tests	□ Other:

19. Why did you have trouble getting the care? **[Mark all that apply}**

□ Too expensive	□ Transportation	□ Insurance did not pay for it
□ Could not get an appointment with the provider	□ Did not understand my benefits	□ Other:

☐ **Access to Social Services**

20. Do you receive government assistance/support for housing, transportation, heat, electricity, childcare or food/EBT card? **[If no, not sure or decline to answer, skip to question 21]**

□ Yes □ No □ Not Sure □ Decline to answer

If you do not mind me asking, which service(s) do you receive?

21. Do you think these government assistance/supports improve the quality of your life and health? How? Is there anything you think that would make the services better?

For example, does transportation help you get to and from the doctor? Does childcare assistance help you keep appointments? Does your EBT card allow you to eat a healthy diet?

Likes:

Improvements:

Other:

22. Are there any social services that you needed that you were unable to receive? E.g., assistance with food, housing, heat, electricity, childcare, or transportation?

□ Yes □ No

If yes, what are those services? Do you remember why you were not able to get the services?

23. Do you feel like you live in a supportive environment or community? Why or why not?

24. Do Do you participate in any outside activities, such as church, sports clubs, hobbies, or community events/groups? Do you feel these organizations improve your quality of life?

Wrap-up

25. Overall, how good or bad would you rate your experience in the D.C. healthcare system? (1: very bad and 5: very good)

Very Bad	Bad	Fair	Good	Very Good
1	2	3	4	5

Please explain: (optional)

26. Is there anything else you would like to share regarding the questions that I have asked or something I did not cover today?

□ Yes □ No

Thank you for your time and participation!

Interviewer Comments/Additional Notes

Appendix 4 – Consumer Interview Comparative Population Results

Table 1. Consumer Interview Demographics

Response	All Respondents (n=106)	Health Center (n=66)	Pathways to Housing (n=7)	Emergency Department (n=31)
Ward (Respondents answered with ward number or zip code. Some zip codes are in multiple Wards)				
1	7%	5%	0%	7%
2	1%	0%	14%	3%
3	0%	0%	0%	0%
4	23%	28%	14%	3%
5	5%	6%	0%	0%
5/6	6%	3%	0%	10%
6	12%	3%	14%	20%
6/7	1%	2%	0%	0%
7	17%	17%	0%	10%
7/8	13%	13%	0%	10%
8	13%	23%	43%	37%
Gender				
Male	37%	38%	71%	26%
Female	63%	62%	29%	74%
Age				
18 to 24	11%	14%	0%	7%

Response	All Respondents (n=106)	Health Center (n=66)	Pathways to Housing (n=7)	Emergency Department (n=31)
25 to 34	26%	27%	0%	33%
35 to 44	15%	16%	0%	10%
45 to 54	28%	25%	86%	23%
55 to 64	19%	17%	14%	23%
65 to 74	0%	0%	0%	0%
75 or older	1%	0%	0%	3%
Of Hispanic of Latino descent of origin?				
Yes	11%	18%	0%	0%
No	88%	80%	100%	100%
Not Sure	1%	2%	0%	0%
Race				
White	2%	0%	14%	3%
Black or African American	87%	83%	86%	94%
Hispanic or Latino	9%	14%	0%	0%
Asian	0%	0%	0%	0%
Native Hawaiian or other Pacific Islander	0%	0%	0%	0%
American Indian or Alaska Native	0%	0%	0%	0%
Other	3%	3%	0%	3%
Medicaid consumer?				
Yes	90%	85%	100%	97%

Response	All Respondents (n=106)	Health Center (n=66)	Pathways to Housing (n=7)	Emergency Department (n=31)
No	8%	12%	0%	3%
Not Sure	2%	3%	0%	0%
Do you understand your Medicaid benefit?				
Yes	71%	70%	86%	68%
No	14%	15%	0%	16%
Not Sure	15%	15%	14%	16%

Table 2. Access to Primary Care

Response	All Respondents (n=106)	Health Center (n=66)	Pathways to Housing (n=7)	Emergency Department (n=31)
Has a primary care provider?				
Yes	84%	81%	100%	84%
No	16%	19%	0%	13%
Not Sure	1%	0%	0%	1%
When did you last see your PCP?				
In the last year	98%	96%	100%	100%
In the last two years	2%	4%	0%	0%
How satisfied are you with your PCP?				
1	4%	2%	14%	7%
2	0%	0%	0%	0%
3	0%	0%	0%	0%
4	1%	0%	0%	3%

Response	All Respondents (n=106)	Health Center (n=66)	Pathways to Housing (n=7)	Emergency Department (n=31)
5	7%	8%	0%	7%
6	3%	4%	0%	3%
7	9%	6%	0%	14%
8	12%	13%	14%	14%
9	10%	8%	0%	17%
10	53%	60%	72%	34%
How easy or difficult is it for you to get an appointment (1 as difficult and 10 as easy)?				
1	10%	10%	14%	9%
2	1%	0%	0%	0%
3	2%	2%	0%	4%
4	3%	4%	0%	4%
5	7%	10%	14%	0%
6	2%	2%	0%	4%
7	9%	10%	0%	9%
8	14%	8%	0%	30%
9	7%	6%	14%	4%
10	44%	50%	57%	35%
Is there someone who helps you with your care such as a home health aide, nurse, or family member?				
Yes	17%	11%	0%	32%
No	83%	89%	100%	68%
Not sure	0%	0%	0%	0%
Do you have a chronic condition?				

Response	All Respondents (n=106)	Health Center (n=66)	Pathways to Housing (n=7)	Emergency Department (n=31)
Yes	48%	43%	57%	52%
No	52%	57%	43%	48%
Do you have help managing this condition?				
Yes	56%	58%	50%	50%
No	44%	42%	50%	50%
What services would help you better manage your chronic condition?				
Free text response	1. Nutrition and healthy eating 2. Medication management 3. Disease management 4. Pain management	1. Heathy living habits (nutrition and exercise) 2. Tie: Medication, pain and disease management	1. Social services	1. Tie: Disease management and healthy living habits 2. Tie: pain management and medication management
Are you able to get the medicine you need?				
Yes	84%	84%	86%	82%
No	16%	16%	14%	18%
Why can't you get your medication?				
Free text response	1. Insurance did not cover it 2. Out of pocket expenses were to high 3. Refill limits and pre-authorization policy	1. Out of pocket expenses are too high 2. Refill limits and pre-authorization policy 3. Insurance did not cover it	1. None	1. Insurance did not cover it 2. Out of pocket expenses were to high 3. Refill limits and pre-authorization policy
Are there any health services that you needed but you could not get?				

Response	All Respondents (n=106)	Health Center (n=66)	Pathways to Housing (n=7)	Emergency Department (n=31)
Yes	24%	17%	57%	29%
No	76%	83%	43%	71%
What healthcare services do you need that you are not getting?				
Free text response	1. Dental Care 2. Vision Care	1. Tie: Dental/Vision 2. Tie: Wheelchair, medication, pain management	1. Dental Care 2. Access to specialists (Podiatrist)	1. Dental Care 2. Vision Care 3. Tie: Access to Specialists (Podiatrist and mental health)
Why did you have trouble getting care?				
Free text response	1. Did not understand my benefits 2. Insurance did not cover it 3. Could not get an appointment with my provider	1. Insurance did not cover it 2. Complex medical conditions	1. Tie: Waiting periods, missed appointment, out-of-pocket cost	1. Insurance did not cover it 2. Tie: did not understand my benefits and could not get an appointment with a provider

Table 3. Emergency Department Use

Responses	All Respondents (n=106)	Health Center (n=66)	Pathways to Housing (n=7)	Emergency Department (n=31)
Do you ever go to the emergency department before calling your doctor when ill?				
Yes	54%	46%	57%	67%
No	46%	54%	43%	33%
How many times have you been to the ED in the last year?				

Responses	All Respondents (n=106)	Health Center (n=66)	Pathways to Housing (n=7)	Emergency Department (n=31)
0 visits in the last year	23%	34%	0%	6%
1-2 visits in the last year	57%	52%	57%	64%
3-4 visits in the last year	16%	13%	14%	29%
5+ visits in the last year	3%	0%	29%	0%
Why did you go to the ED instead of a doctor's office or clinic? (top four answers)				
Free text response	1. Really Sick 2. Doctor's Office was closed or Unable to get an appointment 3. The emergency department was closer 4. The ER is where I always get care	1. Really sick 2. Doctor's Office was closed or unable to get an appointment 3. Does not have a regular doctor 4. ER was closer	1. Really Sick 2. Needed emergency prescription refill 3. Mental Health Episode	1. Really Sick 2. Unable to get an appointment or office was closed 3. The ER is closer 4. Recommended by a medical professional to go to the ED
What condition sent you to the Emergency Department? (top three answers)				
	1. Pain 2. Chest Pain/Heart Problem 3. Trouble breathing/Asthma/ COPD 4. Joint pain/Arthritis	1. Pain 2. Pregnancy 3. Tie: Breathing Problems, Arthritis, Allergies	1. Tie: Pain, Arthritis, Chest pain/Heart Problems, Trauma/Violence, Needed a Prescription, Mental Health Episode	1. Pain 2. Chest Pain/Heart Problems 3. Asthma/COPD 4. Arthritis

Table 4. Access to Social Services

Responses	All Respondents (n=106)	Health Center (n=66)	Pathways to Housing (n=7)	Emergency Department (n=31)
Do you received government Assistance/Support for Housing, transportation, or food?				
Yes	55%	47%	100%	65%
No	45%	53%	0%	35%
Do you think these government assistance/supports improve your quality of like?				
Likes	Respondents report EBT and SSI have the largest impact on improving their quality of life.	Respondents' report EBT and SSI have the largest impact on improving their quality of life.	Housing and EBT have the greatest impact on quality of life.	EBT is the most wide-spread and beneficial service.
Improvements	The disabled have a harder time navigating the benefits landscape and recipients are not educated on how to manage their benefits so they do not run out.	Recipients are not educated on how to manage their benefits so they do not run out. Several respondents also would like job search and placement services.	Respondents also noted the lack of job placement and training services.	Respondents noted that when there are administrative mishaps or safety concerns, they are not addressed in a timely manner.
Are there any social services that you need that you were unable to get?				
Yes	40%	36%	29%	50%
No	60%	64%	71%	50%
What social services do you need that you are not getting?				
Free text response	1. Housing 2. EBT 3. Utilities 4. Transportation and Disability	1. Housing 2. EBT 3. Child Care 4. Transportation	Tie: Housing, EBT, Utilities	1. Housing 2. EBT 3. Utilities

	5. Child Care			

Table 5. Overall Satisfaction with the DC Healthcare System

Responses	All Respondents (n=106)	Health Center (n=66)	Pathways to Housing (n=7)	Emergency Department (n=31)
How good or bad would you rate your experience in the DC healthcare system?				
1	3%	4%	14%	0%
2	3%	4%	14%	0%
3	24%	24%	14%	36%
4	36%	16%	29%	32%
5	35%	51%	29%	32%

Table 6. Additional Analysis

	All Respondents (n=106)	*Health Center (n=66)*	*Pathways to Housing (n=7)*	*Emergency Department (n=31)*
Percent of Respondents with a Primary Care Doctor that also have a Chronic Condition				
N/A	51%	46%	57%	58%
Percent of Respondents with a Primary Care Doctor that go the ED before the Doctor's Office				
N/A	51%	48%	57%	65%
Percent of Respondents that have been the ED in the last year and who have a chronic condition				
N/A	50%	43%	57%	59%

Appendix 5 – Health Home 2 Program Description

Under our approach, the Health Home is the central point for coordinating patient-centered and population-focused care for eligible individuals. Health Home 2 (HH2) providers can be embedded in community-based settings to effectively manage the full breadth of individual needs. This includes providing HH2 enrollees with enhanced care management and care coordination services that address gaps in traditional acute care. Informed by comprehensive needs assessments, care plans will guide care delivery tailored toward each individual and increase use of preventative care services to address potential health issues before they arise.

The HH2 team receives a list of attributed Medicaid beneficiaries and makes plans for team members to inform and enroll individuals during a planned or newly scheduled visit. After consent and enrollment, the HH2 gathers and enters into certified EHRs health information from individuals' service providers, health risk screens, and a comprehensive health assessment. The Nurse Care Manager (NCM) and individual review assessment results, health goals and health care priorities.

The beneficiary and multi-disciplinary HH2 team agree upon a comprehensive HH2 care plan that addresses wellness and self-management goals for physical and behavioral health conditions and the HH2 team delivers services, which are documented in certified EHRs. The HH2 team works with an individual's PCP via protocols for disease management and steps are taken to link an individual with a PCP, if necessary.

- **Daily,** the HH2 care team reviews hospital ADT feeds to determine if any individuals used the ER or were admitted to the hospital.
- **Weekly,** the HH2 care team uses huddles to monitor individuals' progress and plan accordingly for interventions/interactions.
- **Monthly,** the HH2 care team reviews updated registries and care plan statuses for all individuals on the HH2 care team's panel and targets planned services accordingly, identifying emerging issues warranting changes and follow-up.

Issues flagged include medication management, care compliance, outlier lab values, and progress controlling BMI levels, tobacco use, and metabolic screening values. HH2 care plans are updated at least every 180 days or when there is a change in patient needs to enable up-to-date care management, delivery, and coordination for enrollees.

HH2 enrollees are given improved access to primary care services that are complemented by an integrated network of supports and services aimed at addressing the health of the 'whole person.' An enrollee can receive physical, behavioral, mental, and social services during a single visit to an attributed HH2 provider. A strong system of supports and integrated care,

underpinned by an enriched HIT and HIE framework, will give enrollees improved care management tools, especially important in appropriately monitoring and managing chronic conditions that typically contribute to high spending and poor outcomes. HH2 will subsequently help to lower rates of inappropriate emergency department use, reduce costs associated with care for chronic conditions, and improve quality outcomes through enhanced care monitoring, management, delivery, and integration. This model can then be used as a platform on which to build a larger integrated care delivery system reaching a broader portion of the District's population.

Individuals eligible for HH2 will be placed into one of three groups based on acuity:

Table 1. HH2 Acuity Groups

Group 1: Low Acuity	Group 2: Medium Acuity	Group 3: High Acuity
Two or more chronic conditions, with lower likelihood of future hospital utilization based on a risk assessment score or lower historical service utilization.	Two or more chronic conditions, with higher likelihood of future hospital utilization based on a risk assessment score or higher historical service utilization.	At least one chronic condition and a history of chronic homelessness.

HH2 Provider Care Team Structure

An interdisciplinary team of healthcare professionals will be embedded in the primary care setting to effectively manage the full breadth of individual needs. The team must be adequately staffed by healthcare professionals that, at a minimum, are capable of providing specific functions to meet HH2 standards. The ratio for each required HH2 staff member to HH2 enrollee is listed in the DC Municipal Regulations (DCMR), and serves as the foundation for the HH2 care team. Health Homes are encouraged to add additional roles to HH2 teams that reflect the needs of their empaneled members (e.g., a dietician).

HH2 Provider Eligibility Standards and Structure

Designated HH2 providers will need to meet the standards of a Health Home, as determined by the District. The designated provider leads a team of health care professionals and support staff that may include a Nurse Care Manager, Bachelor Social Worker, Community Health Worker, Clinical Pharmacist, Health Home Director (often the primary care physician), support staff, and other services as appropriate and available. The District has outlined provider standards guiding the composition of a Health Home for HH2, shown in Table 2.

Table 2. Proposed HH2 Provider Standards

- A team of health care professionals embedded in the primary care and/or community based setting to effectively manage the full breadth of beneficiary needs and capable of delivering the 6 HH services.
- Achieve NCQA Level 2 recognition (or submission of application and achievement within 12 months of program start date).
- Establish communication protocols with external partners, including legally compliant data sharing agreements, to assure effective coordination and monitoring of enrollees' health care services.
- Offer 24/7 access to clinical advice (including appropriate services for beneficiaries with limited English proficiency).
- Enroll in CRISP to receive hospital and ER alerts for enrolled individuals.
- Use a certified EHR to create and execute a person-centered care plan for each enrolled individual based on HH assessments, hospital data and information gathered from other external health care providers.
- Develop a plan to become more effective/improve past performance.

Workforce and Capacity Building Considerations

We are making significant investments in its workforce and technical assistance offerings to aid providers in implementing and sustaining care delivery redesign.

The care delivery model will rely heavily on non-clinical providers to coordinate and monitor individual healthcare. We will help build such workforce capacities by working with its partners to train more non-clinical providers and enhance the presence of non-clinical providers in the workforce.

Clinical providers will be offered training and technical assistance on how to work with non-clinical providers in team-based settings and how to facilitate connections between clinical and health-related social services. Clinical providers will also be trained to provide core HH2 services in line with 'whole person' needs, such as using HIT and HIE, documenting care processes in and properly leveraging care plans, and building infrastructure to deliver more value-based care. These competencies will be underpinned by incentives to provide team-based care to treat the 'whole person' though HH2's care delivery and payment structure.

Both clinical and non-clinical providers will need to build skills and competencies specific to providing 'whole person' value-based care. This will also require providers to be redeployed in non-traditional roles and to assume an expanded set of responsibilities that foster provider accountability for the patient panel.

We can preliminarily infer *projected staff* needed for care teams in each Group by dividing the total number of expected enrollees by the staffing ratio for a HH2. This methodology assumes enrollment of 17,000 persons in Group 1 and 5,000 persons in Group 2. Group 3 staffing ratios are not yet available, but will developed assuming enrollment of 3,000 persons.

Figure 1. Suggested HH2 Staff and Staffing Ratio (Acuity Groups 1 and 2)

	Group 1	Group 2
Nurse Care Manager	1 FTE per every 400 enrolled beneficiaries	2 FTE per every 400 enrolled beneficiaries
Bachelor Social Worker		2 FTE per every 400 enrolled beneficiaries
Community Health Worker	1 FTE per every 400 enrolled beneficiaries	3.5 FTE per every 400 enrolled beneficiaries
Clinical Pharmacist		0.5 FTE per every 400 enrolled beneficiaries
Health Home Director (Required)	0.5 FTE per every 400 enrolled beneficiaries	0.5 FTE per every 400 enrolled beneficiaries
Estimated Average Daily Patient Hours	**7.6 hours/day***	**8.4 hours/day****

* Assumes 2 touches per month, 25 minutes per touch, 2 FTEs per 400 enrolled beneficiaries over 22 business days per month
**Assumes 6 touches per month, 40 minutes per touch, 8.5 FTEs per 400 enrolled beneficiaries over 22 business days per month

The ratios above are used to calculate number of FTE staff for each Acuity group in Y1 of the HH2 benefit. These ratios and subsequent staffing projections will change based on the number of enrollees, churning between acuity groups, and inception of Group 3 staffing ratios.

- **Group 1 Total Projected Care team Staff:**
  - Nurse Care Manager: 43 staffers
  - Community Health Worker: 43 staffers
  - Health Home Director: 27 staffers
- **Group 2 Total Projected Care Team Staff:**
  - Nurse Care Manager: 25 staffers
  - Bachelor Social Worker: 25 staffers

- Community Health Worker: 44 staffers
- Clinical Pharmacist: 7 staffers
- Health Home Director: 7 staffers

HH2 PMPM Rate Description

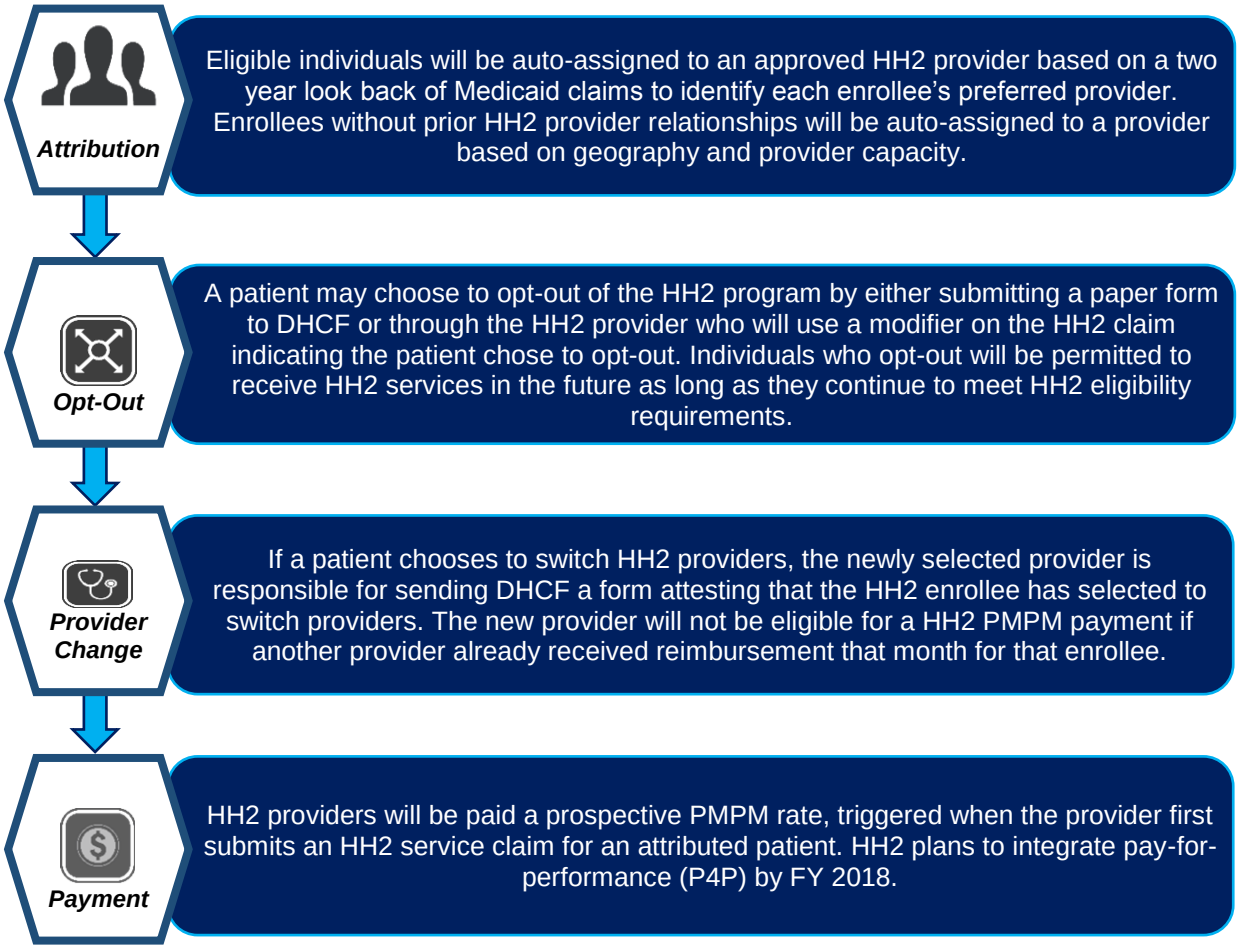
The PMPM rate paid to a HH2 care team is developed by examining customary rates and

	Group 1	Group 2
Nurse Care Manager ($82,912)	$17.27	$34.55
Bachelor Social Worker ($65,837)		$27.43
Community Health Worker ($40,224)	$8.38	$29.33
Clinical Pharmacist ($144,036)		$15.01
Health Home Director ($104,125)	$10.85	$10.85
Subtotal	**$36.50**	**$117.17**
Admin/Overhead (13%)	$4.75	$15.23
Health Information Technology	$5	$5
Total	$46.25	$137.40

incomes for each provider type within the care team. Each provider rate is then broken down into an hourly rate. The hourly rates are multiplied according to each provider type's the FTE and then added to compile a final PMPM rate for each acuity group. See the below figure for rate breakdowns.

HH2 Participant Enrollment Process

Approved HH2 providers will start receiving attributed HH2 enrollees as part of their patient panels. We have designed the enrollment method for eligible Medicaid HH2 enrollees as an '**Opt-Out with Utilization Trigger'** process.



Coordination with MCOs

As MCOs already provide care coordination and case management services to their enrollees, HH2s work with MCOs to clearly define roles and responsibilities so that services which HH2s perform are not duplicated by the MCO. At a set frequency stated in the DCMR and Medicaid MCO contracts, DHCF will forward a report to each MCO that lists:

- Enrollees eligible for HH2, and of this list, individuals currently empaneled with a HH2
- Enrolled HH2s as DHCF will encourage MCOs to refer eligible enrollees to HH2s

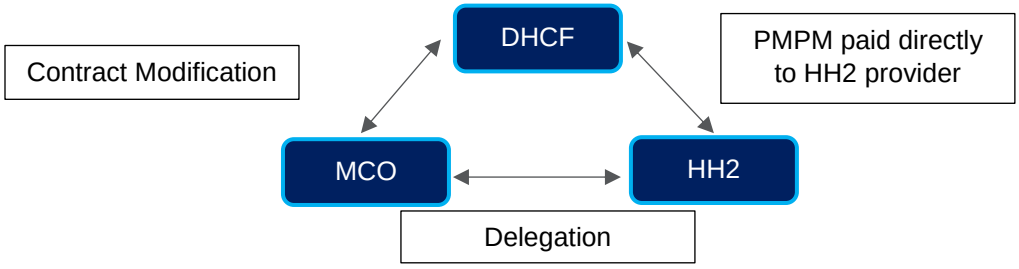
Each MCO and relevant HH2 will develop a memorandum of understanding (MOU) between each other that details how both entities will partner to deliver services to individuals enrolled in

the MCO's case management program and HH2. The Memorandum of Understanding (MOU) sets the communication frequency and protocol for:

- Identifying individuals receiving services from both entities
- Developing a joint care plan for each shared individual, and clear division of labor for executing the care plan, that is reflected in each entity's respective care plan for each shared person
- Outlines types of HH services delivered or that will be delivered to the shared individuals
- Flagging each other on new information necessary for coordinating services, such as failure to pick up medication, recent housing status, new community-based supports, and others. This MOU will specify the point of contact for each entity.

Specific guidance on the collaboration requirements between HH2s and MCOs is in the DCMR and MCO contractual language. Figure 3 below depicts the interactions between DHCF, HH2s, and MCOs.

Figure 3. Proposed HH2 and MCO Interaction



Modifications to the current Medicaid MCO contracts will be executed to ensure MCOs and the downstream HH2s included within their MCO provider networks truly collaborate in primary, acute, and behavioral health, and long-term services and supports. MCOs will be expected to leverage relationships between the HH2 and their MCO-enrolled individuals in meeting their contractual population-based service coordination mandates. We will establish payment policies and procedures to avoid duplication and may periodically examine Medicaid MMIS files to check that individuals enrolled in the HH2 program are not receiving similar services through other Medicaid-funded programs

Integrated Services Provided to Enrollees

CMS requires Health Homes to provide at least six specific services. Below is a description of how each of these services will be provided in the context of our HH2 program.

- **Comprehensive care management (CCM).** These services address stages of health and disease to maximize current functionality and prevent individuals from developing additional chronic conditions and complications, which includes a comprehensive needs assessment to determine the risks and whole-person service needs of individuals for HH team assignment, and lead the HH team through the collection of behavioral, primary,

acute and long-term care information from health and social service providers to create a person-centered HH care plan for every enrolled individual.

- HHs will use a strengths-based approach in developing the HH care plan that identifies the positive attributes of the individual, which includes assessing his/her strengths and preferences health and social services, and end of life planning; each HH team will update the care plan for each empaneled individual
- The HH team will monitor individual's health status and progress toward goals in the care plan documenting changes and adjusting the plan as needed.
- The HH care plan is created and updated in the HH's certified EHR, along with documented activities completed to create and maintain the HH care plan.

- **Care coordination** is the implementation of the HH care plan through appropriate linkages, referrals, coordination and follow-up to needed services and support. Care coordination may involve appointment scheduling and providing telephonic reminders of appointments; telephonic outreach and follow-up to individuals who do not require face-to-face contact; ensuring that all regular screenings are conducted through coordination with the primary care or other appropriate providers; assisting with medication reconciliation; assisting with arrangements such as transportation, directions and completion of durable medical equipment requests; obtaining missing records and consultation reports; participating in hospital and emergency department transition care; and documentation in the certified EHR.

- **Health promotion** services involve the provision of health education to the individual (and family member/significant other when appropriate) specific to his/her chronic illness or needs as identified in his/her HH care plan.
  - Assistance with medication reconciliation and provides assistance for the individual to develop a self-management plan, self-monitoring and management skills and promotion of a healthy lifestyle and wellness (e.g., substance abuse prevention, smoking prevention and cessation, nutrition counseling, increasing physical activity, etc.).
  - Health promotion also involves connecting the individual with peer/recovery supports including self-help/self-management and advocacy groups, providing support for improving an individual's social network, and education about accessing care in appropriate settings.
  - HH team members will document the results of health promotion activities in the individual's care plan, and ensure health promotion activities align with the individual's stated health and social goals.
  - Each HH will use data to identify and prioritize particular areas of need with regard to health promotion; research best-practice interventions; implement the activities in group and individual settings; evaluate the effectiveness of the interventions, and modify them accordingly.

- **Comprehensive transitional care** includes the HHs efforts to reduce hospital emergency department and inpatient admissions, readmissions and length of stay through planned and coordinated transitions between health care providers and settings. HHs will:
  - Increase individual's and family members' ability to manage care and live safely in the community, shifting the use of reactive or emergency care and treatment to proactive health promotion and self-management.
  - Automatically receive notifications of emergency room visits, admissions, discharges and transfers (ADT) from hospitals as part of HHs' enrollment in CRISP, and will outreach to the hospitals individuals related to these notifications to ensure appropriate follow-up care
  - Conduct in-person outreach when the individual is still in the hospital or call the individual within 48 hours of discharge.
  - Schedule visits for individuals with a primary care provider and/or specialist within one week of discharge.
  - Have a clear protocol for responding to ADT alerts from hospitals or any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care.
  - As part of consumer contacts during transitions, the HH will: a) review the discharge summary and instructions; b) perform medication reconciliation; c) ensure that follow-up appointments and tests are scheduled and coordinated; d) assess the patient's risk status for readmission to the hospital or other failure to obtain appropriate, community-based care; and e) arrange for follow-up care management, if indicated on the discharge plan.
- **Referral to community and social support services** provide individuals with referrals to a wide array of support services that will help them overcome access or service barriers, increase self-management skills, and achieve overall health.
  - Facilitating access to support and assistance for individuals to address medical, behavioral, educational, social and community issues that may impact overall health.
  - The types of community and social support services to which individuals will be referred may include, but are not limited to: a) wellness programs, including smoking cessation, fitness, weight loss programs; b) specialized support groups (e.g., cancer, diabetes support groups, etc.); c) substance treatment, support groups, recovery coaches, and 12-step programs; d) housing resources; e) social integration; f) financial assistance such as TANF or Social Security; g) Supplemental Nutrition Assistance Program; h) employment and educational program or training; i) legal assistance resources; and j) faith-based organizations.

- HHs will assist in coordinating the services listed above and following up with individuals after services have been received.
- The HH will develop and monitor cooperative agreements with community and social support agencies in order to establish collaboration, follow-up, and reporting standards and provide training and technical assistance as needed regarding the special needs of the population.

- **Individual and family support services** include all the ways a HH supports the individual and their support team (including family and authorized representatives) in meeting their range of psychosocial needs and accessing resources (e.g., medical transportation; language interpretation; appropriate literacy materials; and other benefits to which they may be eligible or need).
  - Provide for continuity in relationships between the individual/family with their physician and other health service providers and can include communicating on the individual and family's behalf.
  - Educate the individual in self-management of their chronic condition; provide opportunities for the family to participate in assessment and care treatment plan development; and ensure that HH services are delivered in a manner that is culturally and linguistically appropriate.
  - Includes referrals to support services that are available in the individual's community and assist with the establishment of and connection to 'natural supports.'
  - Promote personal independence; assist and support the consumer in stressor situations; empower the consumer to improve their own environment; include the individual's family in the quality improvement process including surveys to capture their experience with HH services; and allow individuals/families access to electronic health record information or other clinical information.
  - Where appropriate, the HH will see the whole family as the client,

Appendix 6 – CMS Health Home Program Requirements

The Affordable Care Act of 2010, Section 2703, 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 states health home providers to operate under a 'whole-person' philosophy. Health Home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

Eligibility. Health Homes are for Medicaid recipients who have:

- Two or more chronic conditions
- One chronic condition and are at risk for a second
- One serious and persistent mental health condition

Core Services. Health Homes must provide six core services:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient and family support
- Referral to community and social support service

Providers. Health Home providers can be:

- *A 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 other.
- *A 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.
- *A health team* - Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractics, licensed complementary and alternative practitioners.

Reporting. Health Home service providers must report quality measures to the state. States are also required to report utilization, expenditure and quality data for an interim survey and an independent evaluation.

Financing. States have the flexibility in designing their payment methodologies and may propose alternatives.

States receive a 90% enhanced Federal Medical Assistance Percentage (FMAP) for the specific health home services in Section 2703. The enhanced match does not apply to the underlying Medicaid services also provided to people enrolled in a health home.

The 90% enhanced FMAP is good for the first eight quarters the program is effective. A state can get more than one period of enhanced FMAP, but can only claim the enhanced FMAP for a total of eight quarters for one enrollee.

The Health Home Information Resource Center located on Medicaid.gov provides useful information to States considering the health home Medicaid State Plan option HHIRC. Technical assistance is available to support state Medicaid agencies in developing and implementing health home programs under Section 2703 of the Affordable Care Act. [88]

Appendix 7 – Barriers to and Model Practices for Implementing Integrated Care Delivery System

While there are numerous degrees and types of integrated care models, common significant barriers exist to implementing most models. Financial challenges due to disparate reimbursement practices for physical, mental, and behavioral health hinder integration. Without proper service codes and reimbursement mechanisms to incentivize coordination, providers will have little impetus to integrate their practices.[89] Additionally, start-up costs to build an integrated practice can be overly-burdensome with no guarantee of success or savings.

Compounding financial difficulties is the need to implement a culture shift in the way care is delivered. As the care delivery system changes, providers must alter their methods of care delivery to treat the 'whole person' and coordinate care, a change which may foster physician discontent. This culture change involves providers:

- Assuming increased coordination responsibilities
- Making linkages and work with a multi-disciplinary care team
- Implementing shared decision-making protocols and reorganizing governance structures
- Assuming risk and accountability for patient outcomes
- Building internal infrastructure to enable use of HIT
- Instilling a multi-condition, population focus on health maintenance[90]

Various model practices and strategies have been developed to help provider practices address barriers and ease the burden of integrated care implementation:[91]

- **Foster a shared vision, joint-accountability, and joint-decision making at executive level.** There needs to be a consistent vision for integration throughout the model, spanning from executives down to care team members. Understanding that all stakeholders are held accountable for patient care is essential to obtaining buy-in of providers and as care teams are interdisciplinary, a culture of joint-decision making where members can voice opinions about care delivery is required. Appropriate governance agreements must guide organizational integration.[92]
- **Utilize technical assistance to train staff and optimize leveraging of existing resources.** A variety of tools are available to provider organizations wishing to integrate care, ranging from staff training, to building IT capacity, to devising care protocols and governance strategies.
- **Progress through levels of coordination to gradually build up integrated care capacity.** There are many steps to achieving integrated care, and change will not happen immediately. Instead, organizations should set incremental targets and goals for

achieving quality and implementation milestones, signaling readiness to proceed to a greater degree of integration.[93]

- **Leverage information systems and HIE to share data, improve referral processes, and track performance.** As a patient panel is attributed to a team of providers, it is essential that all providers have up-to-date information about each patient to enable accurate risk profiling, planning for care needs and making referrals, measure reporting and implementing decision supports in accordance with treatment protocols. A strong information system exchange will facilitate real time performance management at the provider level that can drive reimbursement decisions, while also allowing population health management to occur at a patient panel level.[94]
- **Stratify patients based on risk and need to delivery appropriate care.** Individuals on a panel should be stratified by level of risk, with resource allocation matching risk levels to prioritize which patients need the most attention. Predictive modeling and screening practices by risk tier will help integrated practices better manage their population's health and develop accurate care plans.[95]
- **Standardize care delivery protocols for interdisciplinary care teams.** Care teams should develop evidence-based protocols for delivering care, detailing roles and responsibilities of each care team member to ensure smooth transitions between provider types. Shared protocols can include clinical care pathways, referral processes, use of decision-making tools, and data collection and reporting among others.[96]
- **Clinical leaders should champion culture shifts.** Providers will drive change towards an integrated system of care delivery and must be the leaders of such shifts. To achieve integration, provider leaders must articulate a relatable vision for why integration is necessary and how it will be successful in improving care while reducing costs. Provider champions will be the first movers in building trust and partnerships with other actors in the health system and within their practice.[97]
- **Co-location of services and organic team structure.** Physical location of services is a barrier to many chronically ill that can be addressed by moving from collaborative models to integrated models with co-located services, especially those for mental and behavioral health. Co-location enhances individuals' access to services, reduces stigma and discrimination associated with mental health treatment, and fosters collaboration and appreciation among providers in a care team by enabling face-to-face consultation and sharing of information.[98]

Patient and caregiver engagement. Vital to any integration effort is engaging patients and their caregivers in their own health. The care team should work with patients and families to develop care plans, fostering buy-in to the care delivery process. Educational programs, tools, and information provided to patients and their caregivers through portals and dashboards, or other means, will help improve patient adherence to care plans and tracking of compliance with care.[99]

Appendix 8 – MACRA, MIPS, and APM Description

Table 1. MIPS and APM Description

Merit-Based Incentive Payment System (MIPS)		Alternative Payment Models (APMs)	
Description: An enhanced FFS system that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program in which Eligible Professionals (EPs) will be measured on: quality, resource use, clinical practice improvement, and meaningful use of certified EHR technology	**Examples:** ▪ Supplemental Payments (Health Homes) ▪ P4P ▪ Penalties (Readmission, Hospital Acquired Conditions)	**Description:** Provides bonus payments for participating in new ways to deliver care by incentivizing quality and value. APMs require a share of provider revenue to assume risk for providing care, tying payments to the quality of care provided as measured through patient outcomes.	**Examples:** ▪ ACOs ▪ Accountable Communities of Health ▪ Bundled Payments ▪ PACE (Program of All-inclusive Care for the Elderly)

Appendix 9 – Dynamic Care Profile Mock-Up

Patient Care Profile View Mock Up

PATIENT CARE PROFILE VIEW - MOCK UP

PATIENT DEMOGRAPHICS	RISK STRATIFICATION			ATTRIBUTED PROVIDER(S)/PAYER(S)		
Name : John X. Snith	Risk Type	Score	Band	Organization	POC	Phone
DOB : 04/09/1954	Redmission	51	Medium	Bread for the City	Dr. X	2025556688
Address: 3700 Massachusetts Ave NW, Washington DC, 20016	Re-ED visit	70	High	MFA	Dr. O	2025679876
Phone #1: 202-444-7777				Trusted Health Plan		2026453546
Phone#2: 202-555-3232						

CARE MANAGEMENT PROGRAM(S)

Care Plan available	Organization	Care Manager	Phone Number	Email	Type	Short / Long term	Start Date	End Date
Yes, click HERE to view	Trusted Health Plan	Ms. Mary Von	443-410-4100	mvon@hcc.org	Diabetes control	Long term	2/1/2014	2/1/2016
Yes, click HERE to view	Providence Hospital	Sally Brown	443-555-8787	sallyomailey@cfmp.org	COPD	Short	3/1/2014	6/1/2014

CHRONIC CONDITIONS		MEDICATIONS		IMMUNIZATIONS		HOUSING STATUS	
Type	Date	Type	Date	Type	Date	Status	Date
COPD	3/21/2008	Metformin	2/15/2014	MMR	6/6/2015	Permanent Supportive Housing	10/10/2010
Diabetes	8/22/1982	Levalbuterol	6/11/2009	Influenza	11/11/2014		
		Insulin	11/23/1985				

ENCOUNTER NOTIFICATION(S)

ER VISIT(S) [LAST 120 DAYS]			OTHER PROVIDER(S) [LAST 120 DAYS]		
Date	Facility	Visit Type	Date	Facility	Visit Type
6/15/2014	MFA	ER	6/15/2014	MFA	
7/2/2015	Bread for the City	ER	7/2/2015	Bread for the City	

HOSPITAL VISIT(S) [LAST 120 DAYS]		
Date	Facility	Visit Type
6/15/2014	Providence Hospital	Inpatient
7/2/2015	Howard University Hospital	OBV

MEDICAID CLAIMS DATA FROM LAST 12 MONTHS
(MM-DD-YYYY - MM-DD-YYYY)

Admit Date	Discharge Date	Hospital Name	MRN	Visit Type	IP Re admit	PqI	DRG	DRG Description	SOI	Dx1Description	Dx1	Dx2	Dx3	Dx4
9/25/2015	9/25/2015	Hospital 1	123456789	IP	Yes	Yes	045	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS	3	"DIAB NEURO MANIF TYPE II"	25060	40391	3441	5856
9/25/2015	9/25/2015	Hospital 2	987654321	OBV		Yes				"DIAB NEURO MANIF TYPE II"	25060	5363	5856	V4511
9/25/2015	9/25/2015	Hospital 1	123123123	ED						"ABDOM PAIN GENERALIZED (Begin: 1994)"	78607	7295	25000	V5867
9/25/2015	9/25/2015	Hospital 3	123456789	IP	Yes		460	RENAL FAILURE	3	"HYP RENAL NOS W REN FAIL (Begin: 1985)"	40391	2761	4168	5363
9/25/2015	9/25/2015	Hospital 1	987654321	OBV		Yes				"DIAB NEURO MANIF TYPE II"	25060	5363	V58..	40391
9/25/2015	9/25/2015	Hospital 3	987654321	OBV						"GASTROPARESIS (Begin: 1994)"	5363	3441	40391	5856
9/25/2015	9/25/2015	Hospital 1	654321	IP	Yes	Yes	045	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS	3	"DIAB NEURO MANIF TYPE II"	25060	40391	3441	2761

Appendix 10 – Sample DC SIM Newsletter

DISTRICT OF COLUMBIA INNOVATION UPDATE

Weekly Newsletter | April 29, 2016

Better Health Together

This electronic newsletter will be produced weekly to provide high-level updates on the work of the DC Department Health Care Finance- Health Care Reform and Innovation Administration under the State Innovation Model (SIM) grant as DC develops the State Health Innovation Plan (SHIP). We look forward to your input on our activities and milestones as we work to improve healthcare for DC residents.

SIM Work Group Calendar

All Work Group Meetings will be held at 441 4th Street NW-Room 1028

Care Delivery Work Group

Recent News

SIM Workgroup Update:

The **Care Delivery Work Group met on April 25th**. During the meeting, DHCF presented the proposed policy framework for the Health Home 2 Program that will shape the State Plan Amendment (SPA). The program will target approximately 25,000 beneficiaries with two or more chronic conditions, or one chronic condition and a history of chronic homelessness. In addition to the chronic conditions preapproved by the Centers for

April 25, 2016
3:00pm-4:30pm

Payment Models Work Group
April 27, 2016
3:00pm-4:30pm

Advisory Committee Meeting
May 11, 2016
2:00pm-4:00pm

Payment Models Work Group
May 12, 2016
3:00pm-4:30pm

Quality Metrics Work Group
May 16, 2016
3:00pm-4:30pm

Community Linkages Work Group
May 18, 2016
2:00pm-3:30pm

Medicare and Medicaid Services (CMS), the District will also include COPD, HIV, and sickle cell anemia among other conditions. For full details, view this slide deck from the meeting**. Please share your thoughts and comments by emailing** joe.weissfeld@dc.gov **before COB Monday, May 2nd**.

The **Payment Models Work Group met on April 27th**. Participants discussed the experience of hospitals implementing the Medicare and commercial value-based payment reforms. For hospitals, the Medicare pay-for-performance initiatives focus on hospital acquired conditions, readmissions, and a composite value-based purchasing program. During the meeting, participants emphasized the importance of creating a system that comprehensively serves the patient's needs through clear roles and responsibilities of providers. Meeting materials and summaries can be found here.

Announcements

CMS Solicits Comments on Regional Budget Payment Concept

The **Centers for Medicare and Medicaid Services** is interested in seeking input on a concept that promotes accountability for the health of the population in a geographically defined community. Under the Maryland All-Payer Model, CMS and the State of Maryland are testing a new hospital global budget payment program in which all payers in aggregate pay hospitals a fixed annual amount for inpatient and outpatient services, adjusted for quality and irrespective of hospital utilization. CMS is seeking input on the feasibility of similar approaches for other geographical areas, which could include areas smaller than a state. **Comments on the Request for Information should be submitted electronically to regionalbudgetconcept@cms.hhs.gov by Friday, May 13, 2016**.

CMS Releases Final Managed Care Rule for Medicaid and CHIP

The **Centers for Medicaid and Medicare Services** (CMS) released a long-awaited final rule that updates the regulations for managed care organizations in the Medicaid and Children's Health Insurance Programs (CHIP). According to the National Academy for State Health Care Policy (NASHP), these new requirements represent the first major updates to Medicaid and CHIP managed care since 2002. NASHP developed a list that contains some of the rules most significant changes, and will develop other materials that highlight the provisions that most affect states. Read more here.

The Robert Wood Johnson Foundation Announces Funding for Technology for Healthy Communities

The **Robert Wood Johnson Foundation** announced a funding opportunity for individuals with a tech solution for improving health. Health 2.0 seeks to match digital innovators with four participating U.S. communities to tackle local health issues. Ideal candidates are health technology companies with market-ready products that offer solutions to the communities' health needs.

Companies will work with the communities to test and implement their technologies. Up to $300,000 is available to support the pilots. **The application deadline is May 17, 2016**. Apply here.

The Robert Wood Johnson Foundation Calls for Research Proposals

The **Robert Wood Johnson Foundation** is launching a call for proposals to support research studying how states are implementing the Affordable Care Act's (ACA) health reforms to inform current implementation efforts and future policy. The ACA introduced a series of reforms to the U.S. health care system, including expanding eligibility for Medicaid, the creation of insurance marketplaces, and the advancement of new payment and delivery models. However, because of the way the law is written, as well as subsequent Supreme Court cases and decisions, states have the ability to implement the ACA reforms in unique ways, often differing in their approach from their neighboring states. Up to $1.3 million in funding will be awarded, with individual grants ranging from $50,000 to $150,000. **The submission deadline is June 1, 2016**. Find more information here.

Events

The **Centers for Medicare & Medicaid Services (CMS)** invites the public to three opportunities on the recently released Notice of Proposed Rulemaking (NPRM), which implements key provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) through the unified framework of the Quality Payment Program.

- **Overview of the Quality Payment Program Proposed Rule :** Tuesday, May 3, 2016, 12:00pm - 1:00pm EDT To participate, visit the registration webpage
- **The Merit-Based Incentive Payment System (MIPS) in the Quality Payment Program:** Wednesday, May 4, 2016, 12:00pm - 1:00pm EDT To participate, visit the registration webpage
- **MACRA Listening Session: Quality Payment Program Proposed Rule**: Tuesday, May 10, 2016, 2:00pm - 3:00pm EDT Visit MLN Connects Event Registration. Space may be limited, register early.

The **ICH Singles Coordinated Assessment and Housing Placement (CAHP) Leadership and Community Teams are hosting the CAHP Community Roundtable on Friday, May 6th, from 10:00am – 12:00pm at N Street Village**. During the roundtable, participants will hear an overview of the CAHP System; learn the latest news about outreach and assessment coverage, housing placement progress and goals, and the updated policies and procedures manual; learn how to formally participate in CAHP through an MOU; and provide feedback on what's working and what needs to be improved in the CAHP system. The team encourages provider agency stakeholders to have two representatives attend: the Executive Director (or the person with decision-making authority about whether the agency participates in CAHP) and the program manager in charge of implementing agency's participation in CAHP. **To attend, please RSVP at:** https://CAHPcommunityroundtable.eventbrite.com.

The **Health Management Associates are hosting a webinar on May 12th at 2:00pm** to discuss how the D.C. launched major delivery system change through the Medicaid Health Home Program for individuals with serious mental illness. During this webinar, leaders from the DC Departments of Behavioral Health and Health Care Finance will describe how they set a course toward integrated care with the structure of the DC health homes, and provide important lessons learned for other states. The webinar will also address how providers can play an important role during the policy planning process to ensure the effectiveness and feasibility of state initiatives and requirements. Register here.

The **Institute for Healthcare Improvement** is hosting an intensive three-day seminar, **Transforming the Primary Care Practice, from June 13th to June 15th in San Diego**. The seminar will provide leading edge insight on how to: implement key changes that lead to effective, high-quality, person-centered care; apply tested tools for forecasting appointment demand and tracking appointment supply as you work to improve access to care; identify opportunities for improving care delivery through partnerships with patients and families within your practice; use a set of key metrics to guide your empanelment, access, and continuity journey; and develop pragmatic ideas for change to achieve your goals and objectives. To register, click here.

Resources

CHCS Brief on Integrating Behavioral Health into Medicaid Managed Care

The **Center for Health Care Strategies, Inc.** released a brief titled 'Integrating Behavioral Health into Medicaid Managed Care: Lessons from State Innovators.' The brief provides insights from Medicaid officials and health plan representatives in five states -- Arizona, Florida, Kansas, New York, and Texas -- that are integrating behavioral health services within a managed care arrangement. It explores three emerging options for integration, including comprehensive managed care carve-in, specialty plans for individuals with serious mental illness, and hybrid models, and outlines practical strategies for facilitating effective integrated care models. Read the brief here.

Mathematica Study on Primary Care Reforms

Mathematica Policy Research released a study evaluating the second year of the Comprehensive Primary Care (CPC) initiative, which launched in 2012 and is one of the largest efforts by the Centers for Medicare & Medicaid Services (CMS) to improve primary care. In their study of CPC's first two years, Mathematica researchers found the strongest improvements in care management for high-risk patients and in access to care. However, the estimated reductions in Medicare expenditures resulting from the CPC initiative were not enough to offset the fees that Medicare provided to participating practices. For more information, click here.

Quality Talk on Prescription Drugs

Quality Talks posted a video titled 'Better Med for the Money.' In the video, Mary Roth McClurg discusses prescription drugs. Dr. McClurg says much of the $271 billion we spent on prescription drugs last year was wasted, and argues that for every dollar spent on drugs, another dollar is spent addressing a medication misadventure. Dr. McClurg describes what she calls a $200 billion opportunity to improve. Watch the full video here.

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Appendix 11 – HIE Policy Board Guiding Principles

The HIE Policy Board is composed of 22 member, seven of which are filled by government representatives appointed by the Mayor. The remaining slots are filled by members representing various hospitals, clinicians, payers, and beneficiaries in the District.

The HIE Policy Board's initial focus was to advise DHCF regarding grant funding to implement a District-wide HIE. Funds were used to support hospitals wishing to enroll in Chesapeake Regional Information System for our Patients (CRISP) HIE and to bolster existing system connectivity. The HIE Policy Board advises on the operation, maintenance and sustainability of HIE in the District. HIE Policy Board activities were divided amongst three subcommittees: governance, technology, and finance. The governance subcommittee provided the HIE Policy Board with a set of guiding principles to inform the District's HIE Road Map, which are presented below:

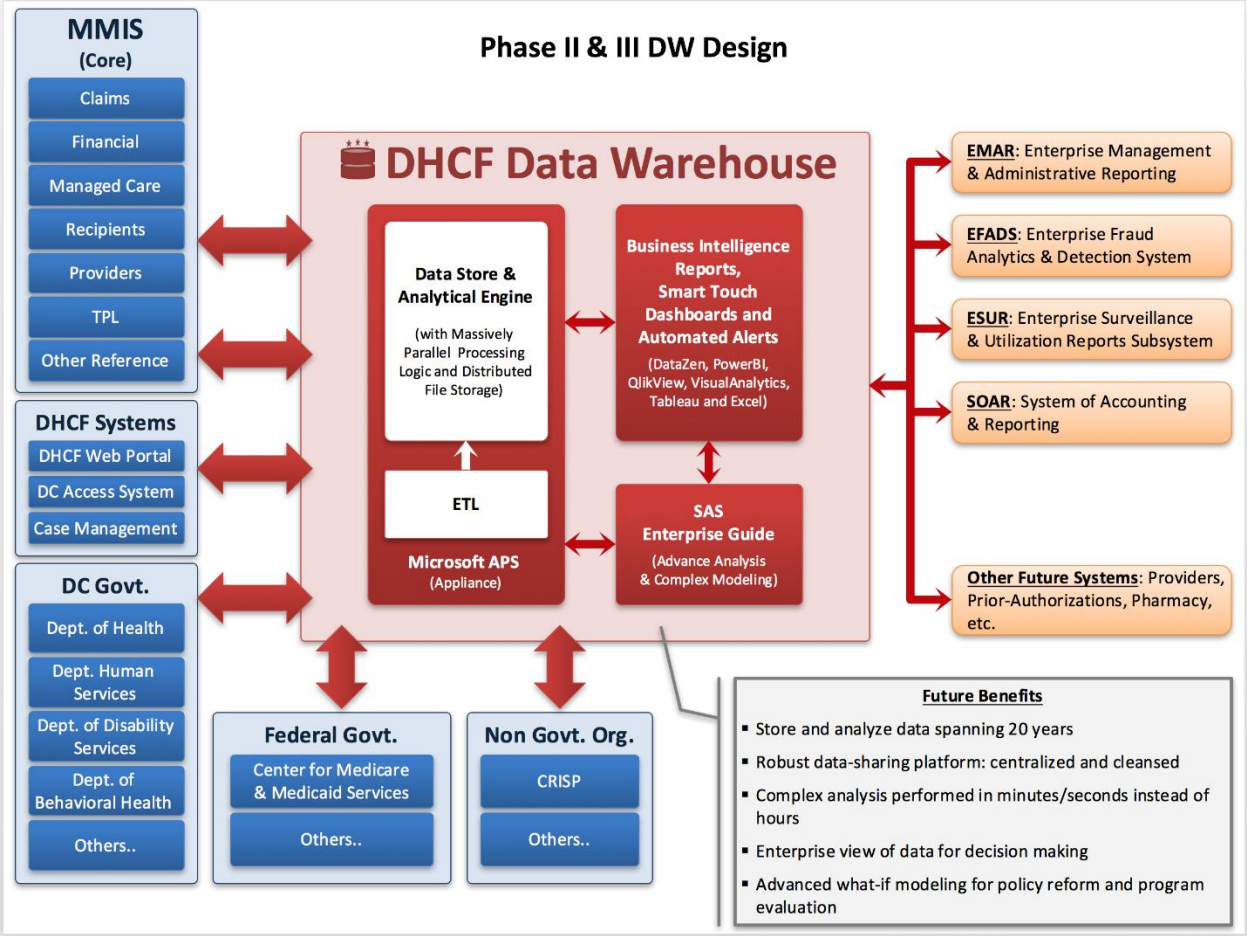
- **Governance of HIT in the District must be inclusive of multiple stakeholders.** HIE touches and affects many individuals and organizations within the District. They must each have input on the development of HIE policy moving forward to improve transparency in the development process and encourage innovative use of data.
- **Goals for HIE should be aligned with District goals for the health of patients.** The advantages to a functional and sustainable HIE are significant for patients. At the same time, HIE is most effective when it is aligned with other strategies such as payment policy and public health investment. Aligning HIE functionality with payment incentives for providers should produce the most widespread HIE adoption. This also requires significant patient education and engagement in monitoring their own health with the help of various HIT tools. Increasing patient access to health information enables them to more effectively manage their own health while also instilling a sense of shared-accountability.
- **Operations of HIE in the District must be flexible to both address and adapt to changes in the marketplace.** The state of technology is constantly changing and improving, and the HIE operations must be able to respond to advances in technology, changes in health policy (such as reporting on national quality programs), changes in legal issues (such as those regarding privacy and security of personal health information) and potential new mandates regarding issues such as care coordination or disease surveillance.
- **Any efforts to expand HIE must coordinate with existing HIE programs within the District.** There are a number of HIEs (with various functionality and funding sources) currently operating within the District, each with its own network of patients, providers

and stakeholders. It is important that efforts to expand HIE build on this work and are coordinated in order to avoid redundancy. This strategy will take a multi-payer and multi-site approach in order to expand access to health information and fill gaps in connectivity. This will allow for information to follow the patient across sites of care and will enable payers to monitor population health and to improve their operations accordingly.

- **Innovation must be accelerated.** Any governance approach to HIE should serve as catalyst for innovations in the way information is exchanged, collected, and used.
- **The privacy and security of personal health information must be preserved.** The exchange of personal health data is significant and the appropriate protections, both from a legal and technical standpoint, must be implemented.

The HIE Policy Board will continue to monitor and oversee the District's HIT strategy throughout the SIM grant and will meet at least quarterly to discuss ongoing and future HIE initiatives, including progress of IAPD submissions and the HIE designation process. The HIE Policy Board is discussing a general governance model that would be based upon a public utility model that would use the influence of key stakeholders to drive how we are going to manage HIT in the District. The consensus was to use the funds and infrastructure that are currently in place and not to try to create alternate paths for governance. Some key functions were also discussed in the subcommittee regarding the governance structure, including privacy laws, security, standards, and monitoring and evaluating the performance of the HIE.

Appendix 12 – Data Warehouse Phases II and III



Appendix 13 – Actively Accepting Medicaid Providers

Figure 1. Actively Practicing Primary Care Physicians Accepting Medicaid Compared to Medicaid Beneficiaries, 2014

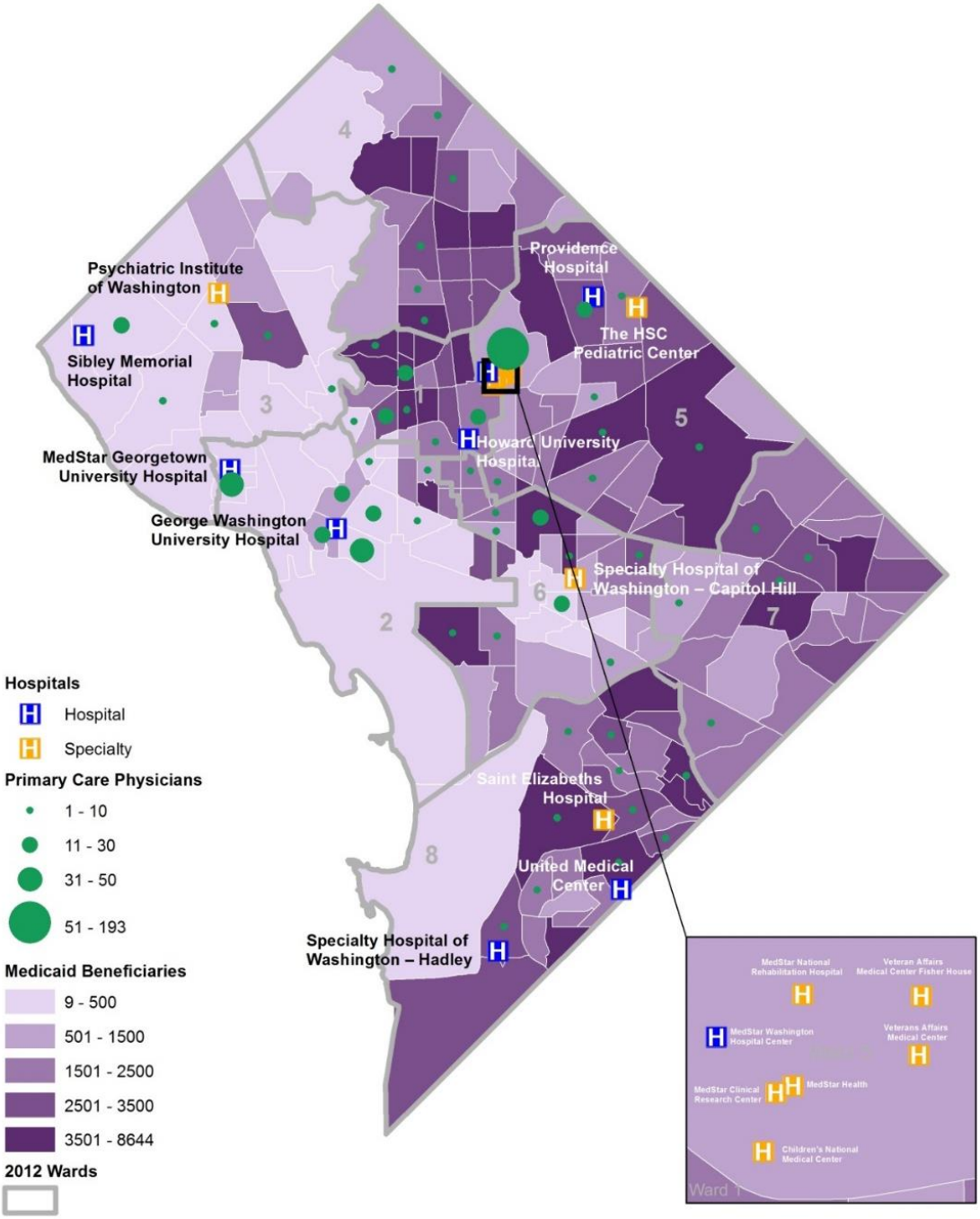
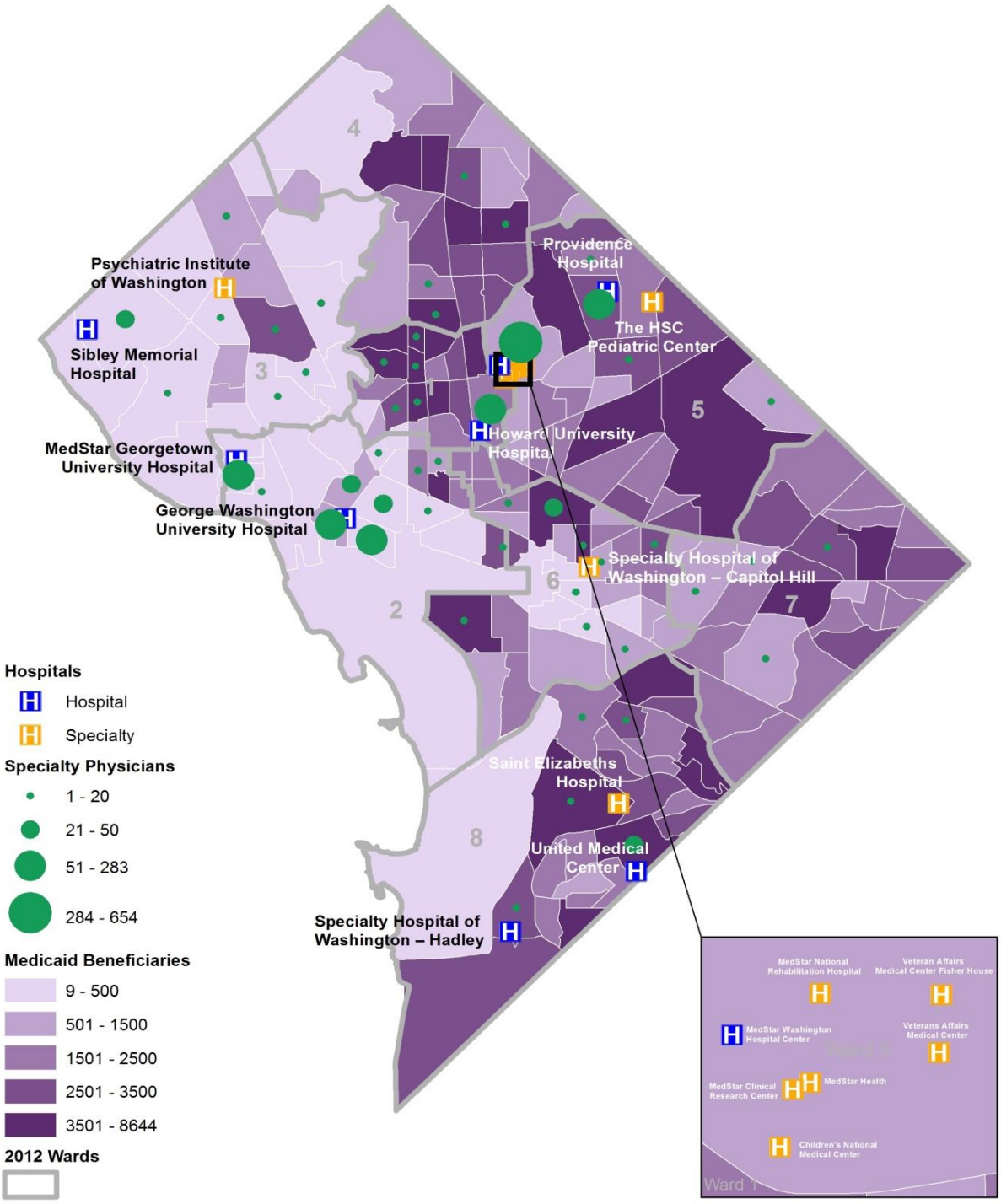


Figure 2. Actively Practicing Specialty Care Physicians Accepting Medicaid Compared to Medicaid Beneficiaries, 2014



Appendix 14 – Model Practices for Care Delivery Redesign

The District used the experiences and lessons learned from various past and ongoing initiatives to help structure its strategy for care delivery redesign. The below initiatives are examples of past and current efforts to redesign care delivery towards a more coordinated and integrated system of care.

Table 1. Current and Past District Care Delivery Initiatives

Initiative and Operating Institution	Initiative Description
My DC Health Home – DHCF	A new benefit for Medicaid individuals with mental healthcare needs that will help coordinate a person's full array of health and social service needs. My DC Health Homes are community-based mental health providers that have hired nurses, primary care doctors and others with social and health-related backgrounds, to create care teams that work with individuals and their caregivers to address social and mental health needs while reducing costs and improving quality of care.
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) Demonstration – Unity Healthcare	Tested the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for Medicare patients. Participating FQHCs were expected to achieve Level 3 patient-centered medical home recognition, help patients manage chronic conditions, as well as actively coordinate care for patients. FQHCs were paid a monthly care management fee for each eligible Medicare individuals receiving primary care services and agreed to adopt NCQA care coordination practices.[c]
Patient Centered Medical Home – CareFirst BlueCross BlueShield	Provides shared savings incentive payments to primary care providers and supporting care coordination teams to encourage development of care plans and achievement of quality milestones for patient outcomes. The program helped lower hospital admissions and improve outcomes for enrolled members, while increasing provider revenue.[ci]
Medicaid Managed Care Case Management Programs - DHCF	The District's Medicaid office (DHCF) contracts with Medicaid managed care organizations (MCOs) to deliver services to their enrolled patients, which comprise two thirds of all Medicaid enrollees in the District. MCOs are contractually obligated to provider case management activities to its enrollees, helping to coordinate and manage their care in an attempt to prevent future readmissions or costly provider visits.
Coordinating All Resources Effectively (CARE) – Children's National Health System, HSCSN	A collaboration between CNHS and HSCSN to pursue about 600 high-need children for interventions to improve outcomes and reduce costs through realigning provider incentives and payments. The focus will be on reducing emergency department visits via improved care coordination and promoting prevention through medical home services.[cii]
Racial and Ethnic Approaches to Community Health (REACH) – Centers for	REACH is a national program aimed at reducing racial and ethnic disparities in health. The CDC supports awardee partners that establish community-based programs and culturally-tailored interventions serving African Americans, American Indians, Hispanics/Latinos, Asian Americans,

Initiative and Operating Institution	Initiative Description
Disease Control and Prevention (CDC)	Alaska Natives, and Pacific Islanders. Current REACH programs underway in the District include:[ciii] • George Washington University: The project will select, implement, evaluate, and disseminate best practices to address the key risk factors of poor nutrition, resulting in positive changes in obesity, diabetes, and heart disease. This effort will focus on populations in Langley Park and Prince George's County, MD. • Leadership Council for Healthy Communities (LCHC): LCHC collaborates with local community organizations to increase access to services that help prevent and manage chronic diseases; establish a health information exchange system that permits efficient delivery of health services; and promote community preventive health resources in underserved, low-income communities in the District.
Transitions Clinic Network - Foundation for California Community Colleges	City College of San Francisco (CCSF), University of California at San Francisco, and Yale University are collaborating to address the health care needs of high risk/high cost Medicaid and Medicaid-eligible individuals with chronic conditions released from prison. Targeting eleven community health centers in seven states including the District of Columbia and Puerto Rico, the program will work with the Department of Corrections to identify patients with chronic medical conditions prior to release and will use community health workers to help these individuals navigate the healthcare system, find primary care and other medical and social services, and coach them in chronic disease management.
Using Telemedicine in Peritoneal Dialysis to Improve Patient Adherence and Outcomes while Reducing Overall Costs - George Washington University	George Washington University received an award to improve care for 300 patients on peritoneal dialysis in the District of Columbia and eventually in Virginia and Maryland. The intervention will use telemedicine to offer real-time, continuous, and interactive health monitoring to improve patient safety and treatment. The model will train a dialysis nurse workforce in prevention, care coordination, team-based care, telemedicine, and the use of remote patient data to guide treatment for co-morbid, complex patients.
On the Road - Joslin Diabetes Center, Inc	This program will send trained community health workers into community settings to help approximately 5100 unique participants (most of whom are Medicare/Medicaid beneficiaries and /or low income/uninsured) understand their risks and improve health habits for the prevention and management of diabetes. The program will target at risk and underserved populations in New Mexico, Pennsylvania, and the District of Columbia helping to prevent the development and progression of diabetes and reducing overall costs, avoidable hospitalizations, and the development of chronic co-morbidities.
Independence at Home Demonstration - MedStar Washington Hospital Center	Under the Independence at Home Demonstration, the CMS Innovation Center worked with medical practices to test the effectiveness of delivering comprehensive primary care services at home and if doing so improves care for Medicare beneficiaries with multiple chronic conditions. Additionally, the Demonstration will reward health care providers that provide high quality care while reducing costs.
Bundled Payments for Care Improvement (BPCI) Initiative: Model	Four broadly defined models of care each link payments for multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. Model 2

Initiative and Operating Institution	Initiative Description
2 - George Washington University Hospital	involves a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Under this payment model, Medicare continues to make fee-for-service (FFS) payments to providers and suppliers furnishing services to beneficiaries in Model 2 episodes. The total expenditures for a beneficiary's episode is later reconciled against a bundled payment amount (the target price) determined by CMS. A payment or recoupment amount is then made by Medicare reflecting the aggregate performance compared to the target price.
Prevention at Home (HIV/AIDS + IT) – George Washington University	Study of a new model to prevent new cases of HIV and improve outcomes for those with HIV/AIDS while lowering healthcare costs. This relies on mobile technologies, home testing and integrated care for HIV/AIDS patients.[civ]
Capitol Clinical Information Network – Mary's Center/ Providence	Past project to implement and test the use of an integrated clinical network to improve care for high-utilizing chronically ill Medicaid recipients. The project used care teams and telemedicine to communicate with patients, develop care plans for them, and personally manage their care as they were gradually transitioned into patient-centered medical homes. This became the Capital Partners in Care – Community Health Information Exchange.[cv]

To inform its approach to care delivery redesign, the District considered the following model practices as sub-components of restructuring care delivery as compiled from analysis of these efforts, relevant literature, other states' experiences, and conversations with stakeholders during SIM Workgroup meetings:[cvi]

- **Forge partnerships with other public and private entities.** Involve major players in the District to help develop a shared vision, gaining institutional buy-in. These include leaders from government, industry, education, consumer advocacy, community and social programs, payers, providers, and professional societies. The District accomplished this through its comprehensive stakeholder engagement platform previously described in Enabler A.
- **Leverage data to understand the target population characteristics, potential financial impact of reforms, and gaps in the care delivery system.** The District uses data to identify populations that are high-cost and high-need, engaging in data mining and predictive modeling to guide its program design and identify potential areas for reform opportunities.
- **Build on work from existing programs and use tools provided by professional associations.** The District researched existing demonstrations and programs to identify and build on successful strategies of care coordination, integration, and delivery reform already developed. The District also used tools such as NCQA guidelines to help determine programmatic structure and craft milestones for implementation.
- **Create a realistic and actionable implementation plan.** The District's plan will be driven by data, evidence-based guidelines, stakeholder input, and milestone targets for

implementation. The plan must be flexible to allow practices with varying capabilities to move through implementation in a timeframe that fits their capacities and goals.

- **Training, transparent information sharing and technical assistance are key.** Given the multitude of barriers to implementation, the District must provide and encourage its partners and professional associations to offer training to provider organizations undertaking care delivery reform. Encouraging information sharing and training among participating entities will help improve provider capabilities and will forge a sense of shared vision. Technical assistance and training should cover at least clinical service requirements, implications for practice redesign, cultural competency for target populations, financial considerations for care delivery reimbursement, workforce and infrastructure expectations, leveraging HIT and HIE, and policy regulations associated with reform.
- **Explore legislative avenues to prompt change.** The District has considered various avenues to formalize its care delivery concept and start the process of redesign. With help from stakeholders, the District has decided to pursue a Health Homes State Plan Amendment that will provide funding for and initiate the care delivery redesign process.

Integrated care models incorporate services and supports vital to addressing 'whole person' health. These services help to coordinate care and link individuals with resources needed to bridge common gaps in care experienced due to social and health disparities.

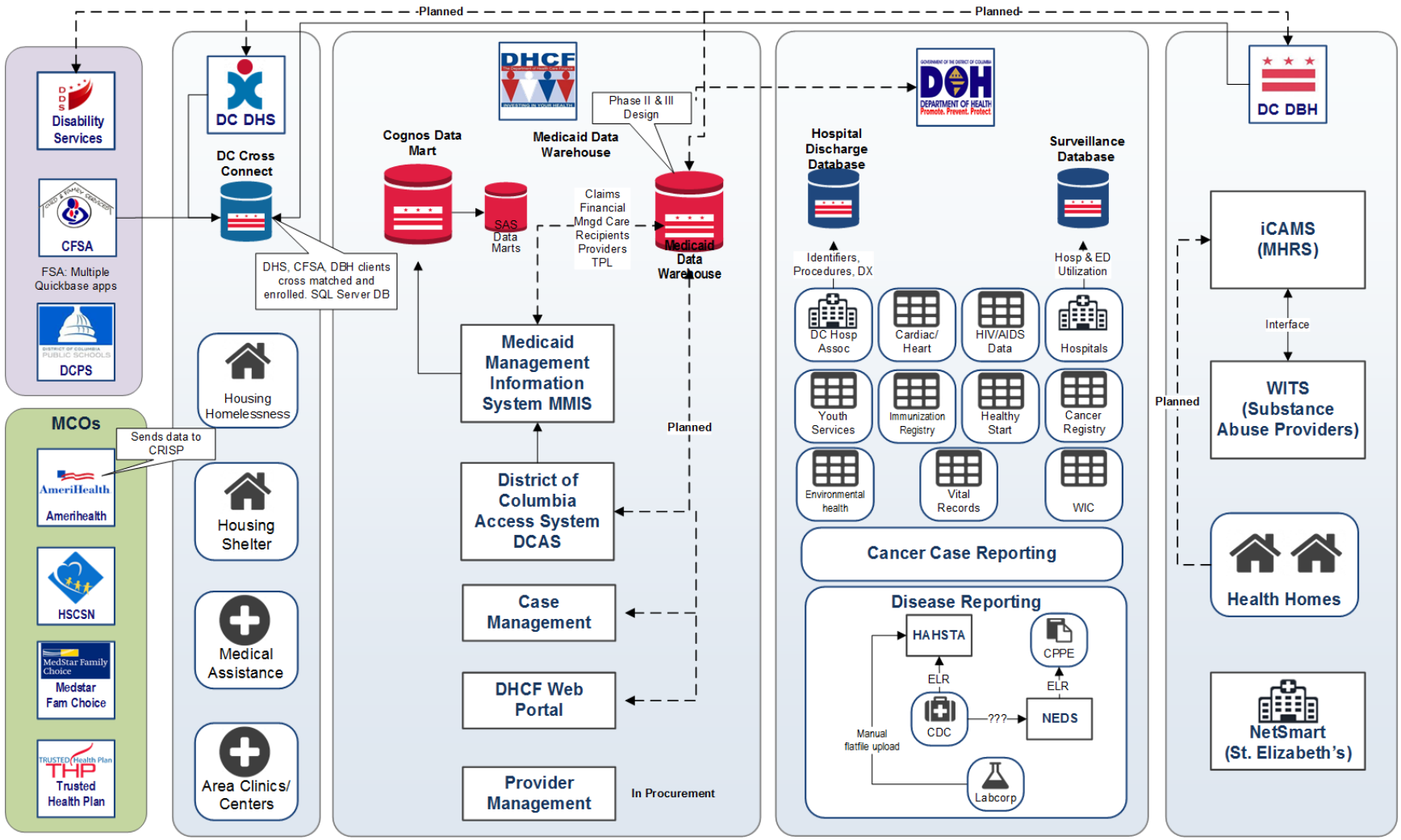
Below is a description of key integrated care model efficiencies:

- Integrated care models link individuals with transportation and scheduling assistance services to help them overcome access barriers caused by disparities.
- Increased primary care availability facilitates coordinated care for multiple physical and behavioral conditions, replacing multiple disconnected providers to treat each condition.
- Care coordination helps streamline individuals' preferences into care plans for all involved providers on a respective care team to see, thereby reducing duplication of services and increasing adherence to individualized care protocols.
- Integration of care provides incentives for improved prevention of, early identification of, and interventions targeting chronic disease and other illnesses.
- Integrated care establishes clear methods for follow-up and case management to promote population health management and improve individuals' health outcomes.
- Integrated care models align financial incentives across providers of physical, behavioral, and mental health to deliver the most efficient care possible, thereby reducing spending.

The Care Delivery Workgroup views such efficiencies as primary tools for addressing the numerous gaps in access to and coordination of services and supports, detailed below:

- Information is not transmitted between providers and sites of care, and subsequently individuals may not receive services in the manner or timeframe needed, as documented in their care plan, or services may be duplicated.
- Care plans are not updated with recent information on care visits, medications, and treatments.
- Providers have overlapping responsibilities causing confusion as to who is accountable for certain functions.
- There are no financial incentives for providers to engage in care coordination activities in the traditional FFS system, as health outcomes are not tied to physician payments and service codes for coordination activities are limited.

Appendix 15 – DHCF and DBH Data Stores



Appendix 16 – District's Population Health Trends

Below are descriptions of the major themes and their importance in context of the District's population.

- **Asthma:** In 2009, there were 479,300 hospitalizations due to asthma, 1.9 million emergency department visits and 8.9 million doctor visits. The cost burden for asthma is high and inequities persist among older and younger individuals as well as those living in substandard housing environments. African Americans are 2 to 3 times more likely than any other race/ethnicity to die from Asthma[1].
- **Cancer:** Cancer is partly preventative and risk can be reduced by avoiding tobacco, eating a balanced diet; maintaining a healthy weight; exercising regularly; getting timely cancer screenings, health assessments and treatment; and, avoiding environmental risks such as the sun or chemicals. There is evidence of inequities at each stage of the patient pathway, from information provision through palliative care.

  Despite a significant reduction in cancer incidence in the District of Columbia, cancer still remains the second leading cause of death. In particular, lung and breast cancers affect District residents as a higher rate than those in the rest of the U.S. Additionally, all cancers affect Black residents disproportionately, and, of those who have cancer, more Black residents die as a result
- **Cardiovascular Disease:** In the District, 32.3% of all deaths are a result of heart disease or stroke, and disparities are stark, especially among African-American/Black residents who experience 3 times the rate of heart disease deaths compared to Whites.1 Not only is the death burden high, but costs associated with increased hospitalizations and disability and decreases in quality of life.
- **Diabetes:** Diabetes disproportionately affects different racial and ethnic groups, notably African-Americans and Hispanic/Latino populations.
- **Behavioral Health:** Those living with mental illness face more barriers to healthy living, while physical illnesses such as chronic disease can negatively affect a person's mental health and likelihood for treatment adherence and/or recovery. In addition, stigma surrounding mental illnesses and treatment is a barrier to diagnosing and receiving appropriate care.
- **Oral Health:** The District of Columbia has little population-level data surrounding childhood caries, sealants, and access to oral health care, but surveillance systems are under development. Almost 30% of District adults failed to access dental care within the past year, with lower access for African-American residents.

- **Prevention**: An assessment conducted by the DC Department of Health Diabetes Prevention and Control Program in 2005 showed that the District had less than 50% of the capacity needs to provide public health services. In some instances, the system's ability to conduct essential services such as mobilizing partnerships, developing policies and plans and enforcing laws and regulations met less than 35% of the needed system capacity.

- **Maternal and Infant Health:** The cognitive and physical development of a child is influenced by health status and the health behaviors of the mother before, during and after pregnancy. Studies have linked unhealthy pregnancies to more respiratory and psychological disorders in children.

  The District has made great strides in the previous decade, reducing the infant mortality rate to 6.8 infant deaths per 1,000 live births in 2013. However, the national IMR at this time was lower (6.0). Low birth weight, pre-pregnancy weight status, and prenatal care each contribute to the high IMR in the District.[1]

- **Sexual Health:** Advances in HIV prevention and treatment have helped reduce the burden of the infection and have allowed persons living with HIV (PLWH), with proper treatment, to control the infection similar to a chronic disease. However, the District is still experiencing a continued generalized epidemic (2.5% of the population are PLWH). African Americans living in the District are disproportionally impacted by HIV with 75% of District residents living with HIV identifying as African American/Black. Over 90% of all females in the District living with HIV are African American, experiencing a rate over 24 times the rate of White women in the District.

Table 1. Illustration of the Common Themes Addressed across Various Initiatives

Domain Areas	DC Healthy People 2020	Medicaid	Medicare	FQHC	DC Healthy Community Collaborative	Other Community Needs Assessment	CMMI	CDC Racial and Ethnic Approaches (REACH)
Asthma		✓✓✓		✓✓✓	✓✓		✓✓✓	
Behavioral Health	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓		✓✓✓	
Cancer	✓✓	✓✓✓	✓✓✓	✓✓✓		✓✓✓		
Cardiovascular Disease	✓✓✓	✓✓✓	✓✓✓	✓✓✓		✓✓✓	✓✓✓	✓✓✓
Care Coordination	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓
Child Health	✓✓✓	✓✓✓		✓✓✓	✓✓✓		✓✓✓	
Diabetes	✓✓✓	✓✓✓	✓✓✓	✓✓✓		✓✓✓	✓✓✓	✓✓✓
Maternal and Infant Health	✓✓✓	✓✓✓		✓✓✓	✓✓✓		✓✓✓	
Oral Health	✓✓✓	✓✓✓		✓✓✓				
Prevention	✓✓✓	✓✓✓		✓✓✓				
Sexual Health	✓✓✓	✓✓✓		✓✓✓	✓✓✓		✓✓✓	

Appendix 17 – Measure Set Identified by Stakeholders

Table 1: Core Measure Set Identified by DC SIM Stakeholders

Measure Name	Domain	Steward	Process/Outcome
Medication Management for People with Asthma	Asthma	NCQA	Process
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Behavioral Health	NCQA	Process
Anti-depressant Medication Management	Behavioral Health		Process
Screening for Clinical Depression and Follow-Up Plan	Behavioral Health	CMS	Process
Follow-Up After Hospitalization for Mental Illness	Behavioral Health	NCQA	Process
Cervical Cancer Screening	Cancer	NCQA	Process
Colorectal Cancer Screening	Cancer	NCQA	Process
Breast Cancer Screening	Cancer	NCQA	Process
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Cardiovascular	NCQA	Process
Controlling High Blood Pressure	Cardiovascular	NCQA	Outcome
Persistence of Beta-Blocker Treatment After a Heart Attack	Cardiovascular	NCQA	Intermediate clinical outcome
Plan All-Cause Readmission	Care Coordination	NCQA	Process
Low-Acuity Non-Emergent Emergency Visits	Care Coordination	N/A	Process
Care Transition Record Transmitted to Health Care Professional	Care Coordination	AMA-PCPI	Process

Measure Name	Domain	Steward	Process/Outcome
Appropriate Testing for Children with Pharyngitis	Child Health	NCQA	Process
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Child Health	NCQA	Process
Comprehensive Diabetes Care: Eye Exam	Diabetes	NCQA	Process
Diabetes: Foot Exam	Diabetes	NCQA	Process
Comprehensive Diabetes Care: Hemoglobin A1c Testing	Diabetes	NCQA	Outcome
Comprehensive Diabetes Care: Hemoglobin A1c (BbA1c) Poor Control (>9.0%)	Diabetes	NCQA	Outcome
Comprehensive Diabetes Care: Medical Attention for Nephropathy	Diabetes	NCQA	Process
Elective Delivery Prior to 39 Completed Weeks Gestation (PC-01)	Maternal and Infant	The Joint Commission	Process
Live Births Weighing Less Than 2,500 Grams	Maternal and Infant	CDC	Outcome
Frequency of Ongoing Prenatal Care	Maternal and Infant	NCQA	Process
Prenatal & Postpartum Care	Maternal and Infant	NCQA	Process
Annual Dental Visits	Oral Health	NCQA	Process
Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers	Oral Health	University of Minnesota	Process
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index	Prevention	NCQA	Process

Measure Name	Domain	Steward	Process/Outcome
Assessment for Children/ Adolescents			
Tobacco Use: Screening and Cessation Intervention	Prevention	AMA-PCPI	Process
Childhood Immunization Status	Prevention	NCQA	Process
Adult Body Mass Index (BMI) Assessment	Prevention	NCQA	Process
Prevention Quality Indicators #92	Prevention	AHRQ	Process
Chlamydia Screening	Sexual Health	NCQA	Process
HIV Viral Load Suppression	Sexual Health	NCQA	Outcome
HIV Medical Visit Frequency	Sexual Health	NCQA	Process

Appendix 18 – Health Home Core Measure Set

Table 1. List of Measures in Health Home Core Measure Set

Measure	Description	Data Source	Type of Measure
Adult Body Mass Index (BMI) Assessment	Percentage of Health Home enrollees ages 18 to 74 who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year	Administrative or Hybrid	Nutrition
Plan All-Cause Readmission Rate	For Health Home enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days of discharge and the predicted probability of an acute readmission	Administrative	Utilization
Follow-Up After Hospitalization for Mental Illness	Percentage of discharges for Health Home enrollees age 6 and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge	Administrative	Care Coordination
Controlling High Blood Pressure	Percentage of Health Home enrollees ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled	Hybrid	
Screening for Clinical Depression and Follow-Up Plan	Percentage of Health Home enrollees age 12 and older screened for clinical depression using a standardized tool, and if positive, a follow-up plan is	Hybrid	Care Coordination

Measure	Description	Data Source	Type of Measure
	documented on the date of the positive screen		
Care Transition – Timely Transmission of Transition Record	Percentage of Health Home enrollees discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility, Health Home provider or primary physician, or other health care professional designated for follow-up care within 24 hours of discharge	Hybrid	Care Coordination
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of Health Home enrollees age 13 and older with a new episode of alcohol or other drug (AOD) dependence who: (a) Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis (b) Initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Administrative or hybrid	Behavioral Health
Chronic Condition Hospital Admission Composite— Prevention Quality Indicator	The total number of hospital admissions for chronic conditions per 100,000 Health Home enrollees age 18 and older	Administrative	Utilization
Emergency Department Visits	Rate of ED visits per 1,000 enrollees	Administrative	Utilization
Inpatient Utilization	Rate of acute inpatient visits per 1,000 enrollees	Administrative	Utilization
Low acuity non-emergent Emergency Department visits	The number of non-emergency visit which enrollee presented with a low-acuity medical condition based on a 500 ICD-9 code per 1,000 enrollees	Administrative	Utilization

Measure	Description	Data Source	Type of Measure
Potential Preventable Hospital Admissions	The number of hospitalizations among eligible adults for specific ambulatory care conditions that may have been prevented through appropriate care. The conditions are based on National Quality Forum endorsed Prevention Quality Indicator (PQI) developed by Agency for Healthcare Research and Quality (AHRQ).	Administrative	Utilization

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