



# Care Delivery Work Group

## Proposed Chronic Condition Health Home Detailed Policy Framework

April 25, 2016

# Health Home Overview

## MODEL:

- Providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports
- Must include FFS and MCO beneficiaries
- CMS provides 90/10 match for the first 8 quarters

## ELIGIBILITY:

- Have 2 or more chronic conditions
- Have 1 chronic condition and are at risk for a 2<sup>nd</sup>
- Have one SMI

## REQUIRED SERVICES\*:

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

# Goals for Health Home 2 (HH2)

- Improve the integration of physical and behavioral health care
- Reduce healthcare costs
  - Lower rates of avoidable Emergency Department use
  - Reduce preventable hospital admissions and re-admissions
- Improve the experience of care and quality of services delivered
- Improve health outcomes

# Proposed HH2 Overview

- **Target population:** ~25,000 beneficiaries (~2/3 FFS)
- **Eligibility:** 2 or more chronic conditions; or 1 chronic condition & historical chronic homelessness (i.e., matched to DC's Permanent Supportive Housing (PSH) program)
- **Enrollment\*:** Patients will be assigned to a HH2 provider through an opt-out, with utilization trigger process. Patient attribution to HH2 provider will be based on a prior provider/patient relationship (2 year look-back), geography, provider capacity
- **Target Start Date:** January 2017

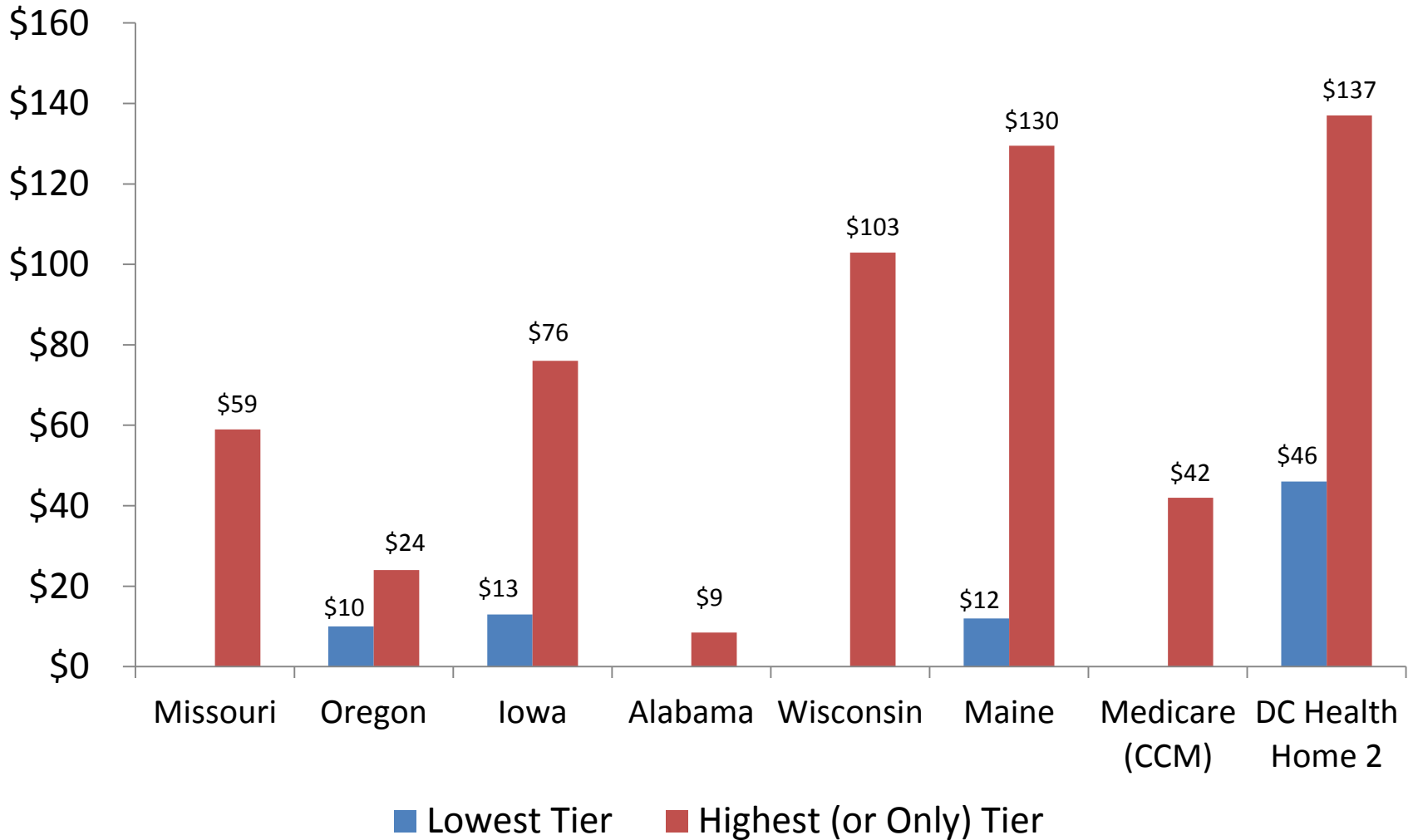
# Proposed HH2-Eligible Chronic Conditions

- **CMS Pre-Approved Health Home Chronic Conditions**
  - Mental Health Condition (Depression; Personality Disorders)
  - Substance Abuse Disorder
  - Asthma
  - Diabetes
  - Heart Disease (CHF; Conduction Disorders/Cardiac Dysrhythmias; Myocardial Infarction; Pulmonary Heart Disease)
  - BMI over 25 (DC using Morbid Obesity only)
- **DC-Specific Chronic Conditions**
  - Cerebrovascular Disease; Chronic Renal Failure (On Dialysis); COPD, Hepatitis; HIV; Hyperlipidemia; Hypertension; Malignancies; Paralysis; Peripheral Atherosclerosis; Sickle Cell Anemia
- **Analysis based on:**
  - Most common chronic conditions in DC;
  - Most common chronic conditions associated with high-cost beneficiaries; and
  - Chronic conditions amenable to care coordination

# Proposed Payment & Performance Metrics

- **Payment Approach:** PMPM; Triggered by the delivery of one of the six HH2 services. There will be an inactivity trigger if a HH2 service isn't delivered over a certain time frame
- **Payment Groups**
  - Group 1 = 2 or more chronic conditions
    - \$46 PMPM
    - ~17,000 beneficiaries
  - Group 2 = 2 or more chronic conditions + higher likelihood of future hospital utilization based on a risk assessment
    - \$137 PMPM
    - ~5,000 beneficiaries
  - Group 3 = 1 or more chronic condition + Historical chronic homelessness (i.e., matched to PSH program)
    - Payment rate TBD
    - ~3,000 beneficiaries
- **Pay-for-Performance:** At a later date, a P4P element will be added for HH2 providers who meet set metrics on readmission, preventable inpatient, avoidable ED utilization

# PMPM Rates from Chronic Condition Health Homes or Comparable Program



# Suggested HH2 Staff and Staffing Ratio

	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
<u>Estimated Average Daily Patient Hours</u>	<b>7.6 hours/day*</b>	<b>8.4 hours/day**</b>

\* 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



# Comparison of Health Home Staffing Ratios

	Missouri (Chronic Conditions)	Missouri (SMI)	Rhode Island (SMI)	DC (SMI)	DC (Chronic Conditions, Group 1)	DC (Chronic Conditions, Group 2)
HH Director	1 to 2,500	1 to 500	---	1 to 600	1 to 800	1 to 800
Nurse Care Manager	1 to 250	1 to 250	---	2 to 300	1 to 400	2 to 400
Primary Care Liaison	---	1 to 500	---	1 to 500	---	---
Behavioral Health Consultant	1 to 750	---	---	---	---	---
Bachelor Social Worker/Care Coordinator	1 to 750	1 to 500	---	---	---	2 to 400
Community Health Worker	---	---	---	---	1 to 400	7 to 800
Clinical Pharmacist	---	---	---	---	---	1 to 800
Team*	<b>1 to 150</b>	<b>1 to 125</b>	<b>11.25 to 200</b>	<b>1.3 to 150</b>	<b>1 to 200</b>	<b>1 to 50</b>

\* Team ratio doesn't include HH Director

# Proposed HH2 Payment Methodology

	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
<b>Subtotal</b>	<b>\$36.50</b>	<b>\$117.17</b>
Admin/Overhead (13%)	\$4.75	\$15.23
Health Information Technology	\$5	\$5
<b>Total</b>	<b>\$46.25</b>	<b>\$137.40</b>

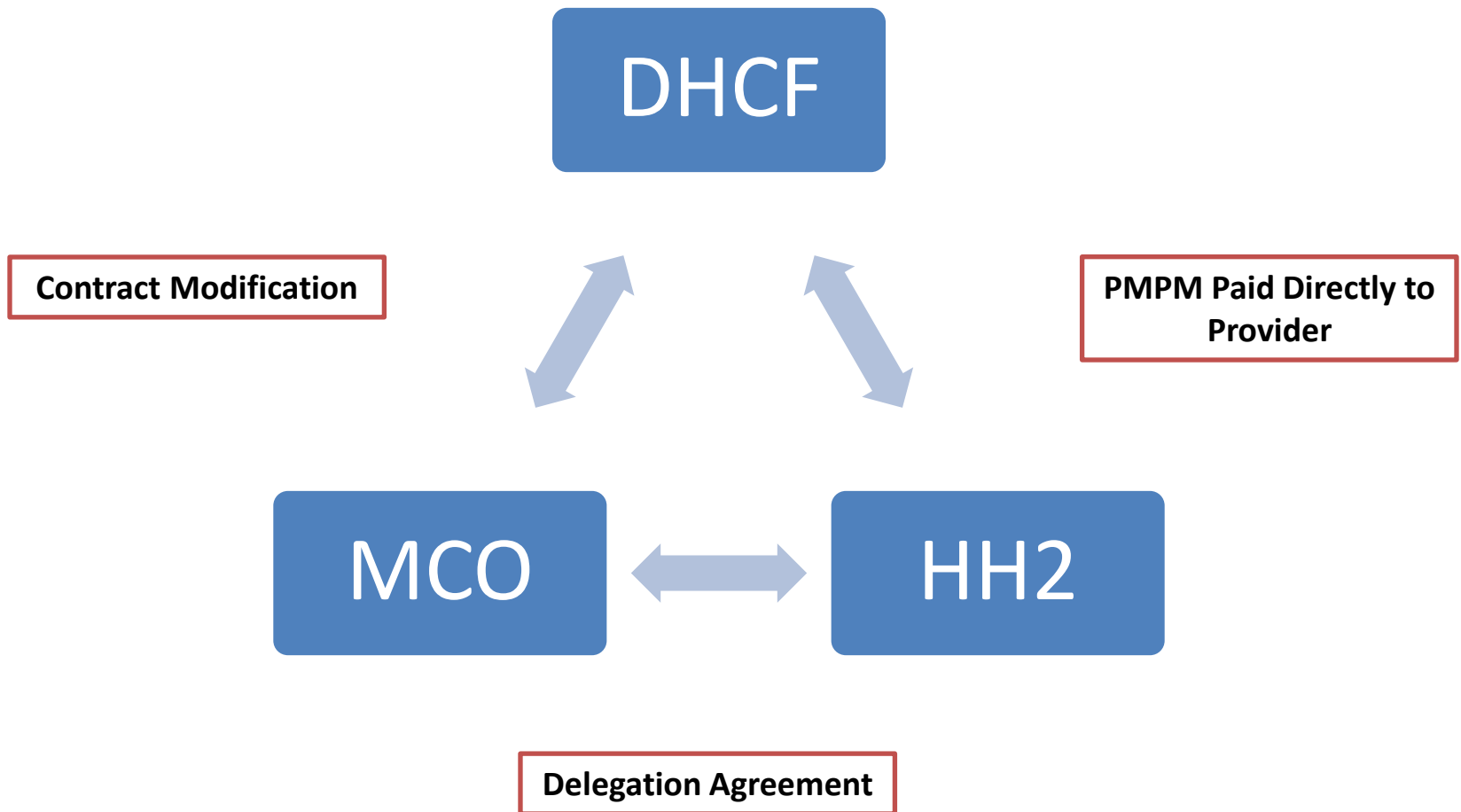
# Proposed HH2 Provider Standards

- 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.

# Proposed HH2 HIE/Data Infrastructure

- Utilize a certified EHR.
- Enroll in CRISP to receive hospital event alerts.
- Pending federal funding, HHs will also have access to
  - A Dynamic Patient Care Profile tool; an “on-demand” document made available to Meaningful Use Eligible Providers and Eligible Hospitals, in addition to members of the care team, that would display an aggregation of critical data (both clinical and administrative) for a selected patient.
  - An Electronic Clinical Quality Measurement Tool and Dashboard, an electronic clinical quality measurement tool to route inbound CCDs from eligible Medicaid hospitals and practices to support required quality calculations and reporting; develop a population-level dashboard accessible by EPs and EHs for patient panel management.
  - An Analytical Patient Population Dashboard, also being developed with support from IAPD funds to enable EPs and EHs to perform panel-level analysis on their associated patient populations.
- HHs are expected to share C-CDA or C-CDA equivalent structured data to one of the designated HIE entities in the District.

# Proposed HH2 + MCO Interaction



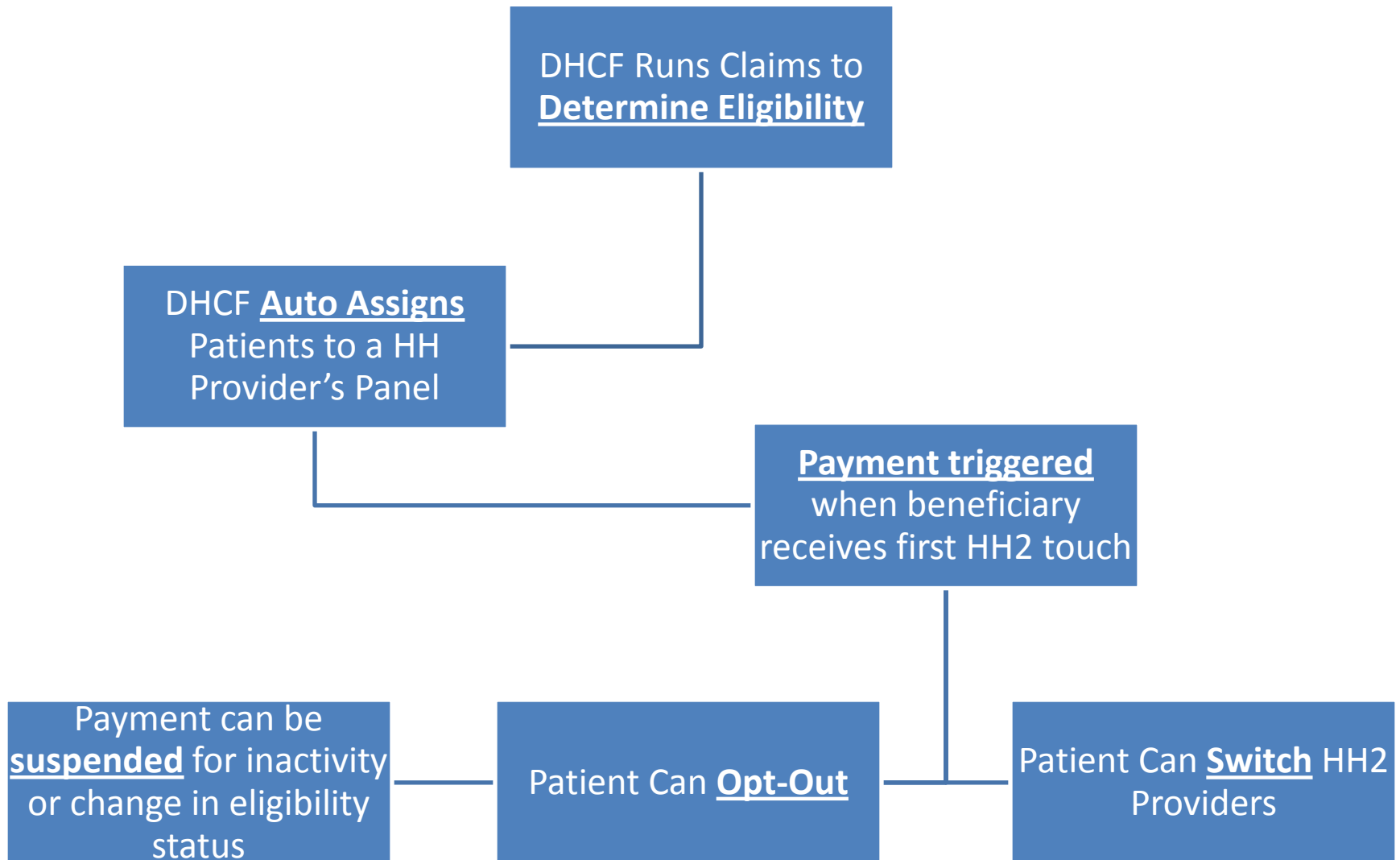
# Components of HH2/MCO Delegation Agreement

The HH and MCO will establish an Memorandum of Understanding that sets the communication frequency and protocol for:

- 1) Identifying individuals receiving services from both entities;
- 2) 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;
- 3) Outlining types of HH services delivered or that will be delivered to the shared individuals;
- 4) 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.
- 5) Establishing audit and program monitoring arrangements.
- 6) The MOU will specify the point of contact for each entity.

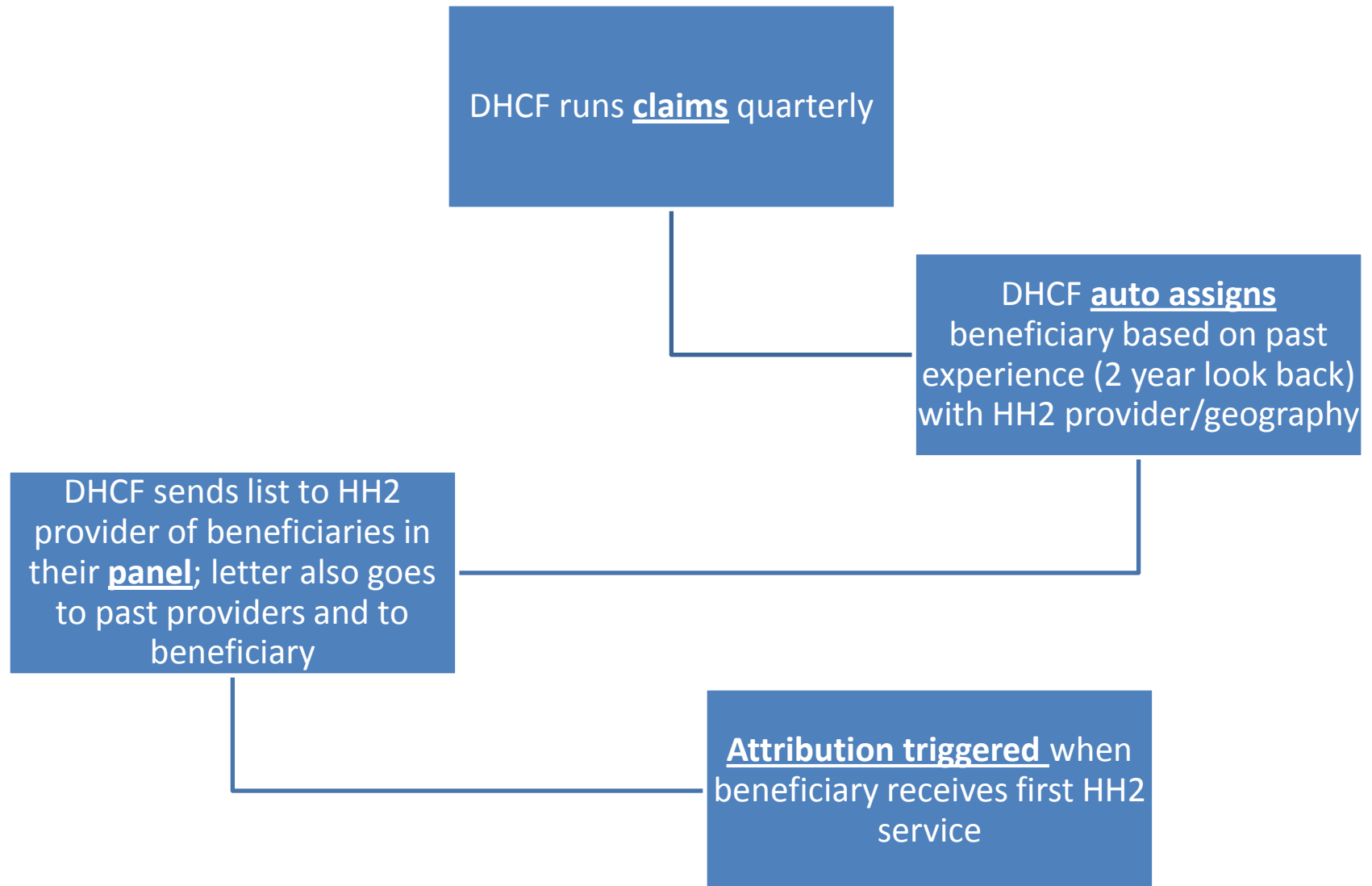
# APPENDIX A

# Proposed HH2 Attribution Process

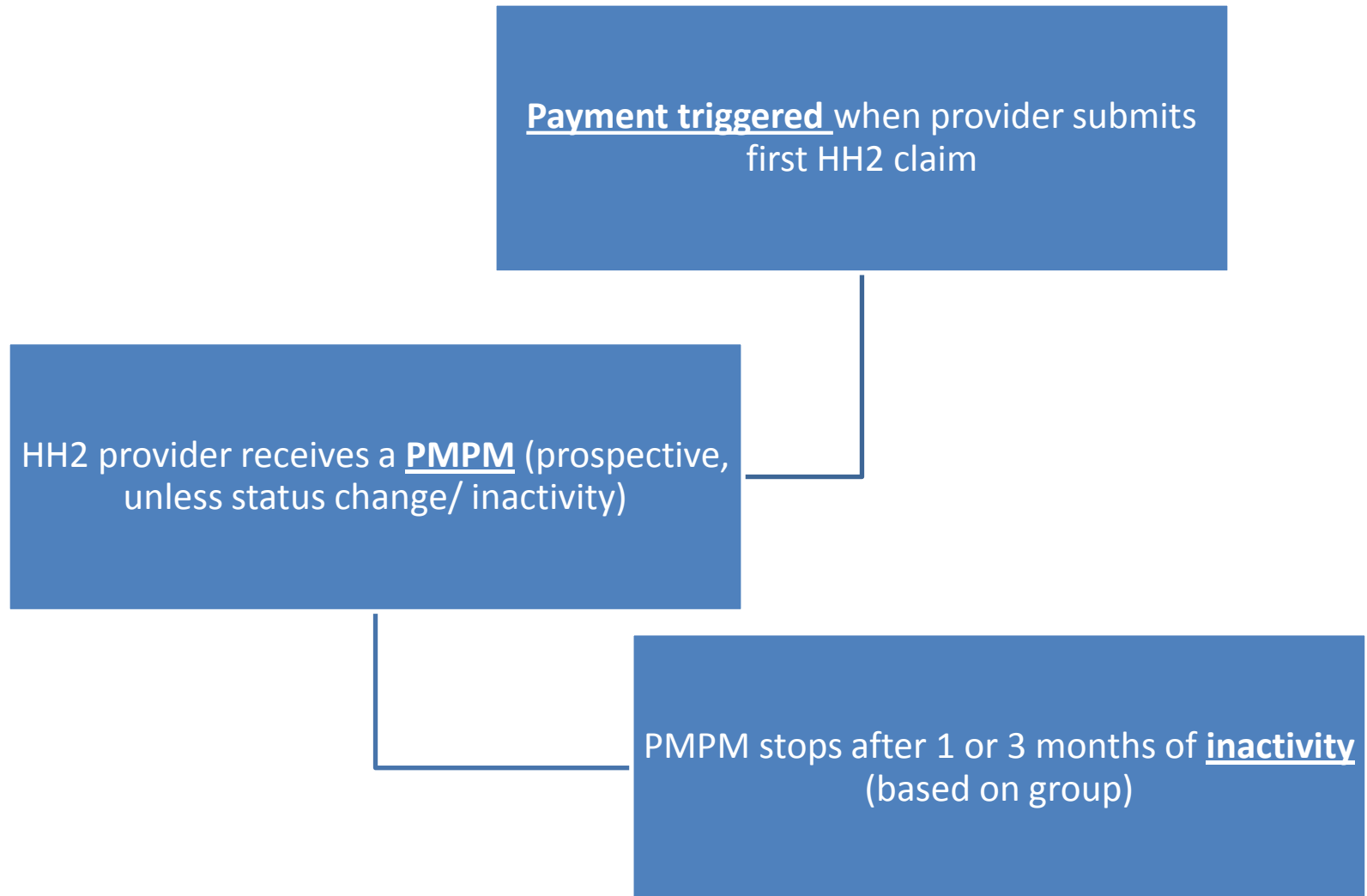




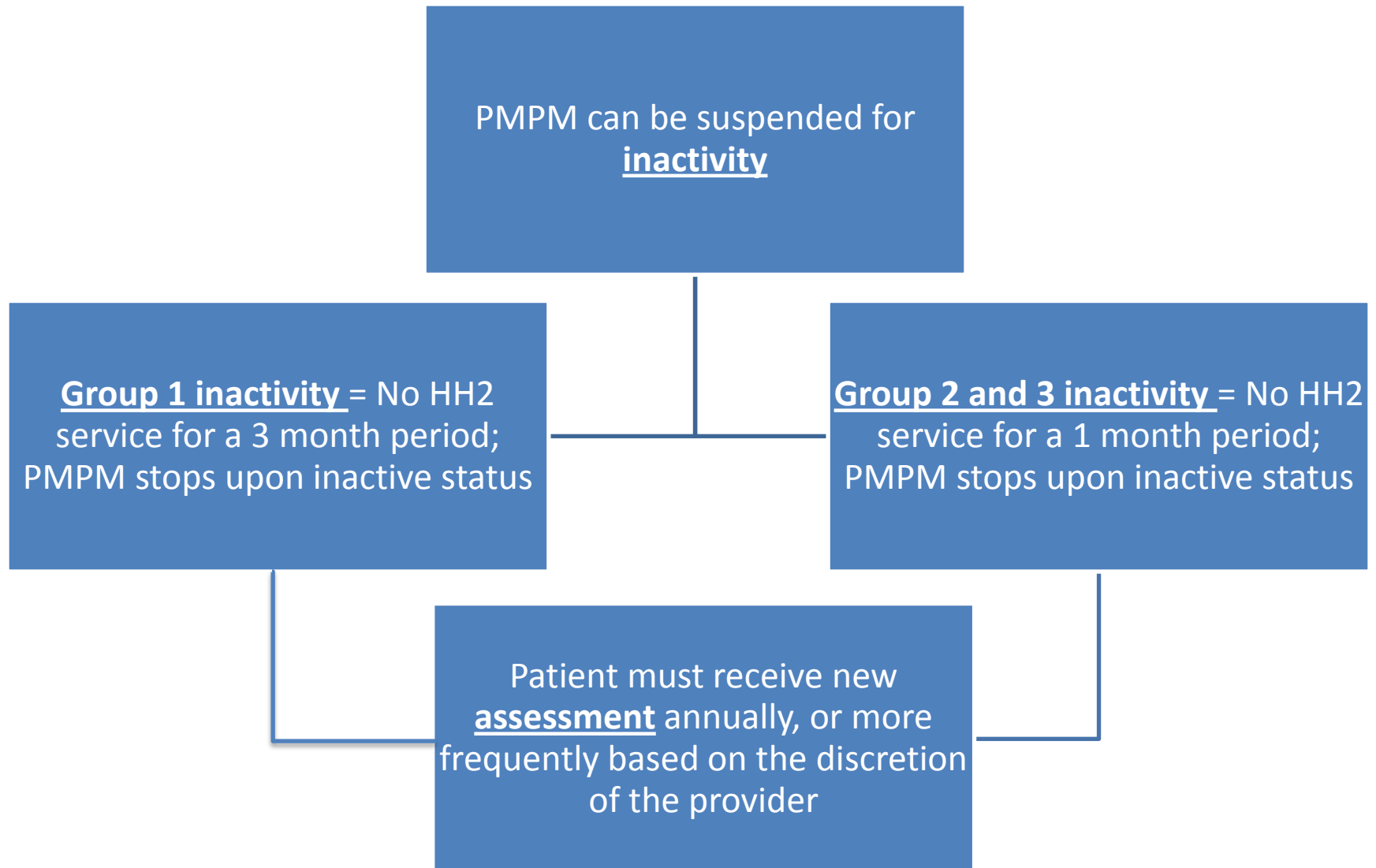
# HH2 Opt-Out w/ Utilization Trigger: Attribution



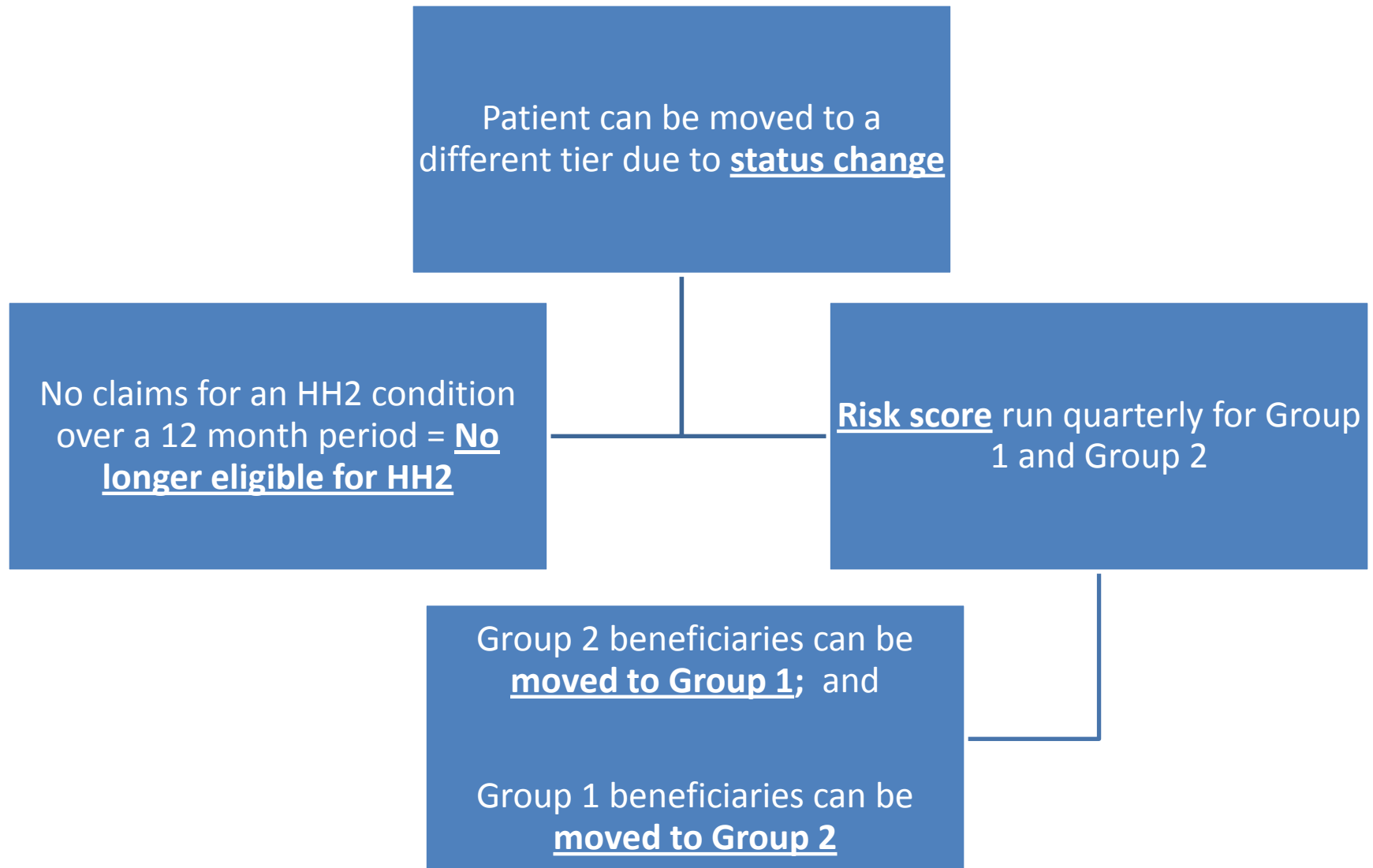
# HH2 Opt-Out w/ Utilization Trigger: Payment



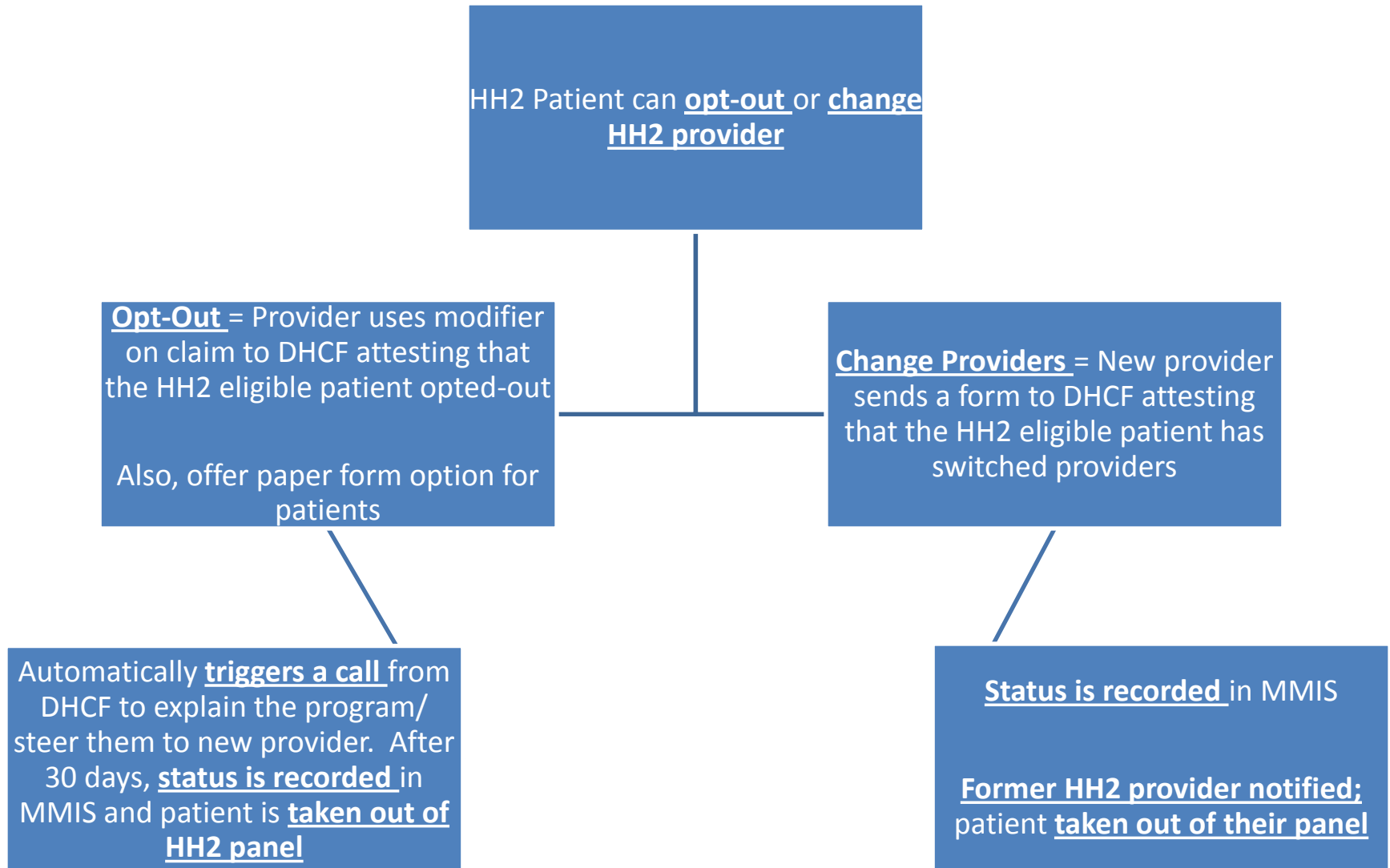
# HH2 Opt-Out w/ Utilization Trigger: Inactivity



# HH2 Opt-Out w/ Utilization Trigger: Status Change



# HH2 Opt-Out w/ Utilization Trigger: Change Provider



# APPENDIX B

# Proposed Comprehensive Care Management Definition

- **Comprehensive care management (CCM)** 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.

# Proposed Care Coordination Definition

- **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.



# Proposed Health Promotion Definition

- **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.

# Proposed Comprehensive Transitional Care Definition

- **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.

# Proposed Individual and Family Support Definition

- **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, developing family support materials and services, including creating family support groups.

# Proposed Referral to Community and Social Support Definition

- **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.