



SIM Community Linkages Work Group #3

February 17, 2016

Agenda

- Examples of Current Data Sources in DC
- Current Health Information Exchanges in DC
- Envisioned HIE Landscape
- Opportunities:
 - CMS' Innovation Accelerator Program (IAP) for Housing Tenancy
 - CMS' Accountable Health Communities Model
- Next Steps

Examples of Current Data Sources

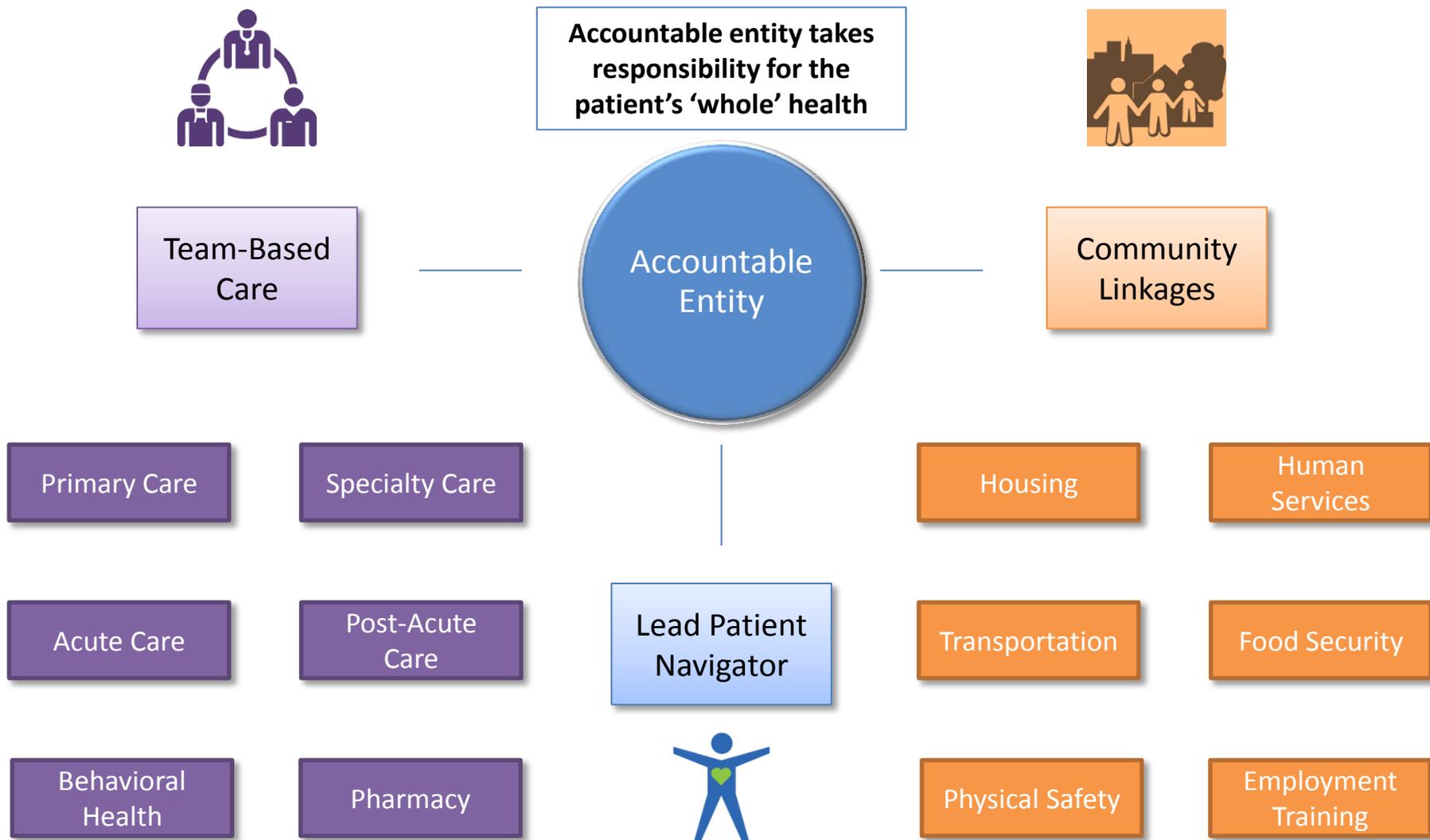
- **DHCF** : Medicaid Management Information System (MMIS): Stores Medicaid claims information for each individual's service that DC Medicaid paid for.
- **DHS**
 - Homeless Management Information System (HMIS): Repository for service data for the federal- and locally-funded homeless services programs individuals and families receive.
 - Automated Client Eligibility Determination System (ACEDS): Captures & tracks client demographics, financials, housing and medical data that's used Medicaid, TANF, Food Stamp, etc. eligibility & benefit determinations
 - Customer Assessment, Tracking and Case History (CATCH): Used to store & audit TANF case management data, including customer participation in work preparation, search, and placement activities; Also used to calculate vendor payments (incentives, stipends, bonuses, etc.) based on benchmarks achieved.
- **DBH**
 - Integrated Care Management System (iCAMS): Electronic health record for community mental health rehab providers; Also stores provider payment data
 - District Automated Treatment Accounting (DATA) System: Stores data for client enrollment & referrals; clinical interventions; and provider payments
- **DOH**: Systems used to capture vital statistics, infectious diseases; certain chronic diseases; etc.
- **Individual service provider's electronic or paper-based medical/ social service record**

Current HIEs in DC

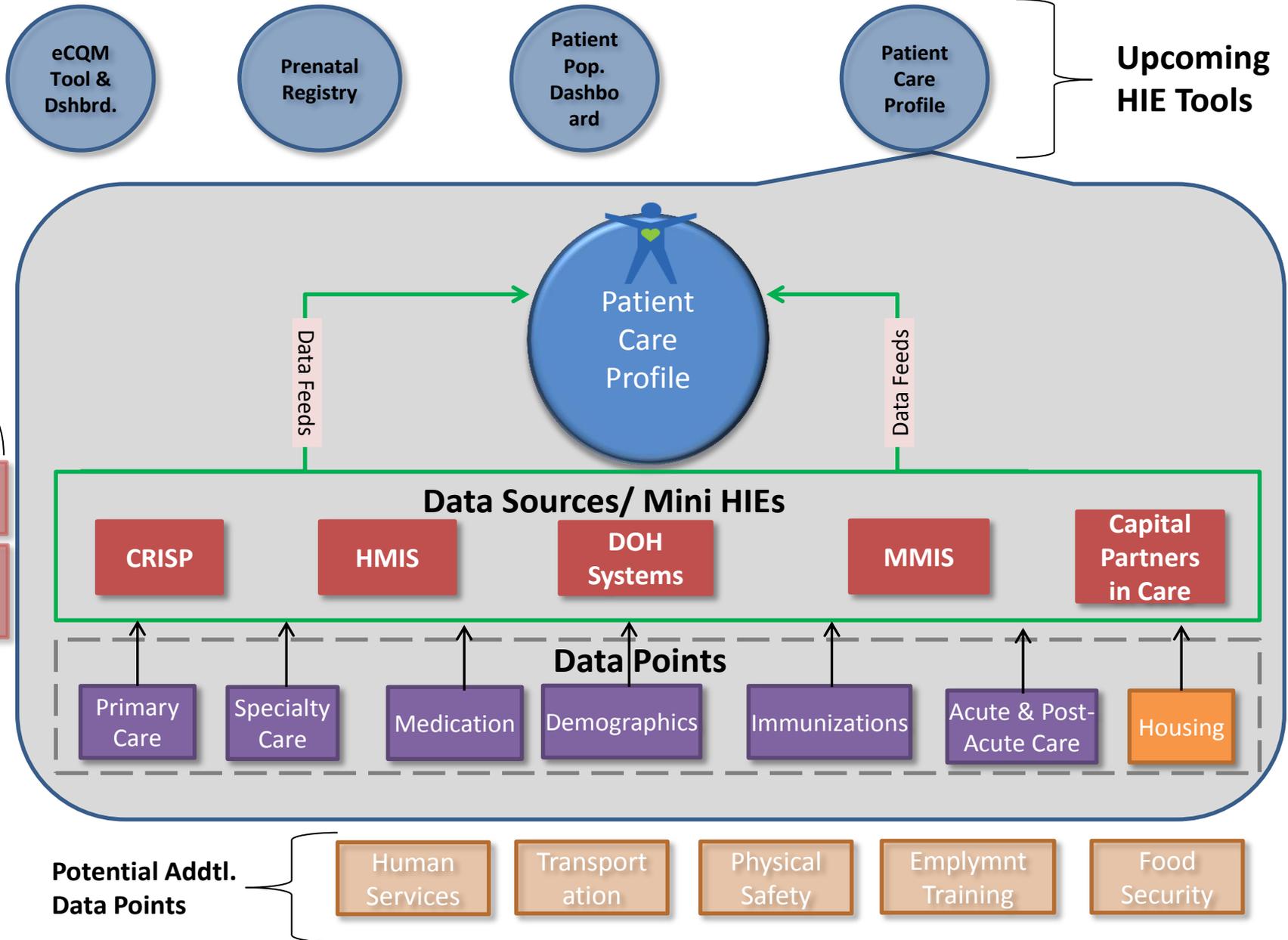
	iCAMS	DC Department of Health	CRISP	Capital Partners in Care	Children's National Medical Center (CNMC) IQ Network
<u>DATA</u>	Behavioral health data; Some Primary health data	Immunizations/ Vaccines ELR (reportable) Syndromic Surveillance Cancer Reporting Communicable Reportable Disease Clinical Information (hypertension related)	Admissions, Discharge and Transfer (ADT) feeds Labs Ordered Radiology reports D/C summary ENS	Clinical Encounter data (Progress Note, Diagnoses, Medications, Allergies, Immunizations, Labs, DI, etc.) Care Plans generated by CHWs	Pediatric data only
<u>PARTICIPANTS</u>	All mental health rehab providers	All hospitals and ambulatory care providers	All MD & DC-based hospitals*	Providence Hospital; Community Health Centers (e.g. FQHCs & others) ; Other ambulatory providers	CNMC; participating NOVA clinics

* UMC is completing its application to participate

Envisioned DC Healthcare Landscape



HIE Landscape



Draft Patient Care Profile

PATIENT CARE PROFILE VIEW - MOCK UP

PATIENT DEMOGRAPHICS			RISK STRATIFICATION			ATTRIBUTED PROVIDER(S)/PAYER(S)		
Name : John X. Smith	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]			HOSPITAL VISIT(S) [LAST 120 DAYS]			OTHER PROVIDER(S) [LAST 120 DAYS]		
Date	Facility	Visit Type	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	

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

Patient Total at All Hospitals				Conditions				Case Mix Data Through: August 2015						
Total Charges	\$423,868	Total Visits	38	Chronic Obstructive Pulmonar										
Total Hospitals	11	Zip on Last Visit	20001	Chronic: Asthma										
Primary Payer				Chronic: Chronic Kidney Dise.										
Medicaid fee for service				Chronic: Diabetes										
Secondary Payer				Chronic: Heart Failure										
Other				Chronic: Hyperlipidemia										
				Chronic: Hypertension										
				Mental Health: Depression										
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	048	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)"	78907	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 1989)"	40391	2761	4168	5363
9/25/2015	9/25/2015	Hospital 1	987654321	OBV		Yes				"DIAB NEURO MANIF TYPE II"	25060	5363	V5856	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	048	PERIPHERAL CRANIAL & AUTONOMIC NERVE DISORDERS	3	"DIAB NEURO MANIF TYPE II"	25060	40391	3441	2761

OPPORTUNITY:

**CMS' INNOVATION
ACCELERATOR PROGRAM (IAP)
FOR HOUSING TENANCY**

IAP for Housing Tenancy Program Overview

- Provides states with innovative strategies that are being used, or which could be used by states to support housing tenancy services for community-based LTSS Medicaid beneficiaries.
- Access to 3 Webinars:
 - **Webinar 1 (2/24/16):** Describes tenancy support services, current providers and funding sources, as well as Medicaid authorities that may cover tenancy support services. States will receive information that will enable them to conduct a crosswalk of housing-related services, current funding sources, and available Medicaid options.
 - **Webinar 2 (March TBD):** Features states with experience in providing Medicaid-funded tenancy support services and lessons learned from their experience.
 - **Webinar 3 (April TBD):** The final webinar focuses on implementation planning, and discussion of strategies to address challenges in implementing tenancy support services.

The timing of these webinars align well with DC's SIM efforts—particularly as we develop our second Health Home Medicaid benefit that will target chronically ill individuals with housing instability.

OPPORTUNITY:

**CMS' ACCOUNTABLE HEALTH
COMMUNITIES MODEL**

Accountable Health Community Dates

MILESTONE	DATE
Funding Opportunity Announcement Posting Date	January 5, 2016
Letter of Intent Due to CMS	February 8, 2016
<i>Applicant submit project descriptions to DHCF</i>	<i>February 22, 2016</i>
DHCF notify applicant of support	Early March 2016
Electronic Cooperation Agreement Application Due to CMS	March 31, 2016
CMS' Anticipated Notice of Award	December 2016
Anticipated Start Date	January 2017

Accountable Health Communities Overview

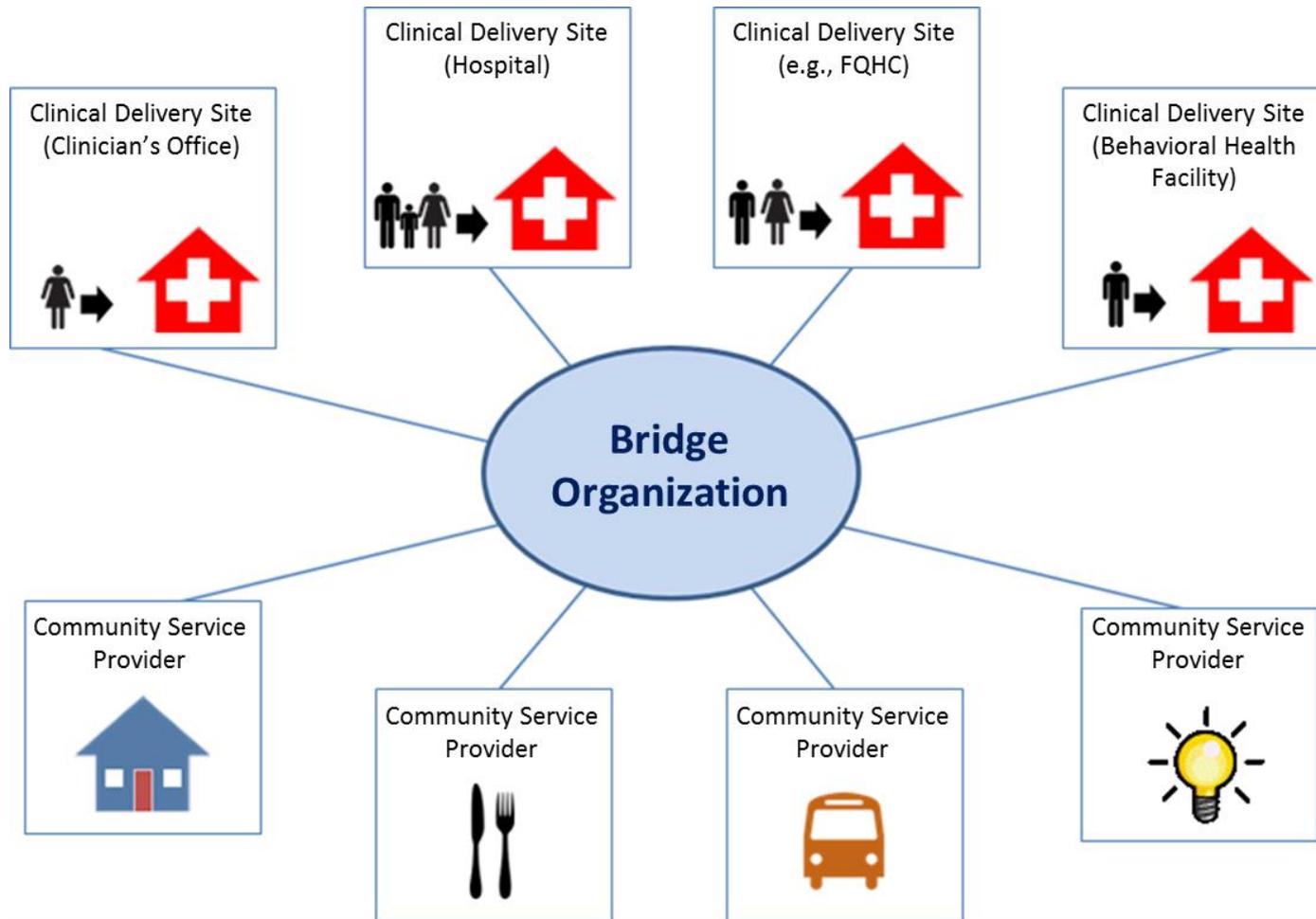
- CMS will award 44 cooperative agreements ranging from \$1 mil (per Track 1 site) to \$4.5 mil (per Track 3 site) for up to 5 years
- The AHC model will fund awardees, called bridge organizations, to serve as “hubs”
- These bridge organizations will be responsible for coordinating AHC efforts to:
 - Identify and partner with clinical delivery sites
 - Conduct systematic health-related social needs screenings and make referrals
 - Coordinate and connect community-dwelling beneficiaries who screen positive for certain unmet health-related social needs to community service providers that might be able to address those needs
 - Align model partners to optimize community capacity to address health-related social needs

Health-Related Social Needs

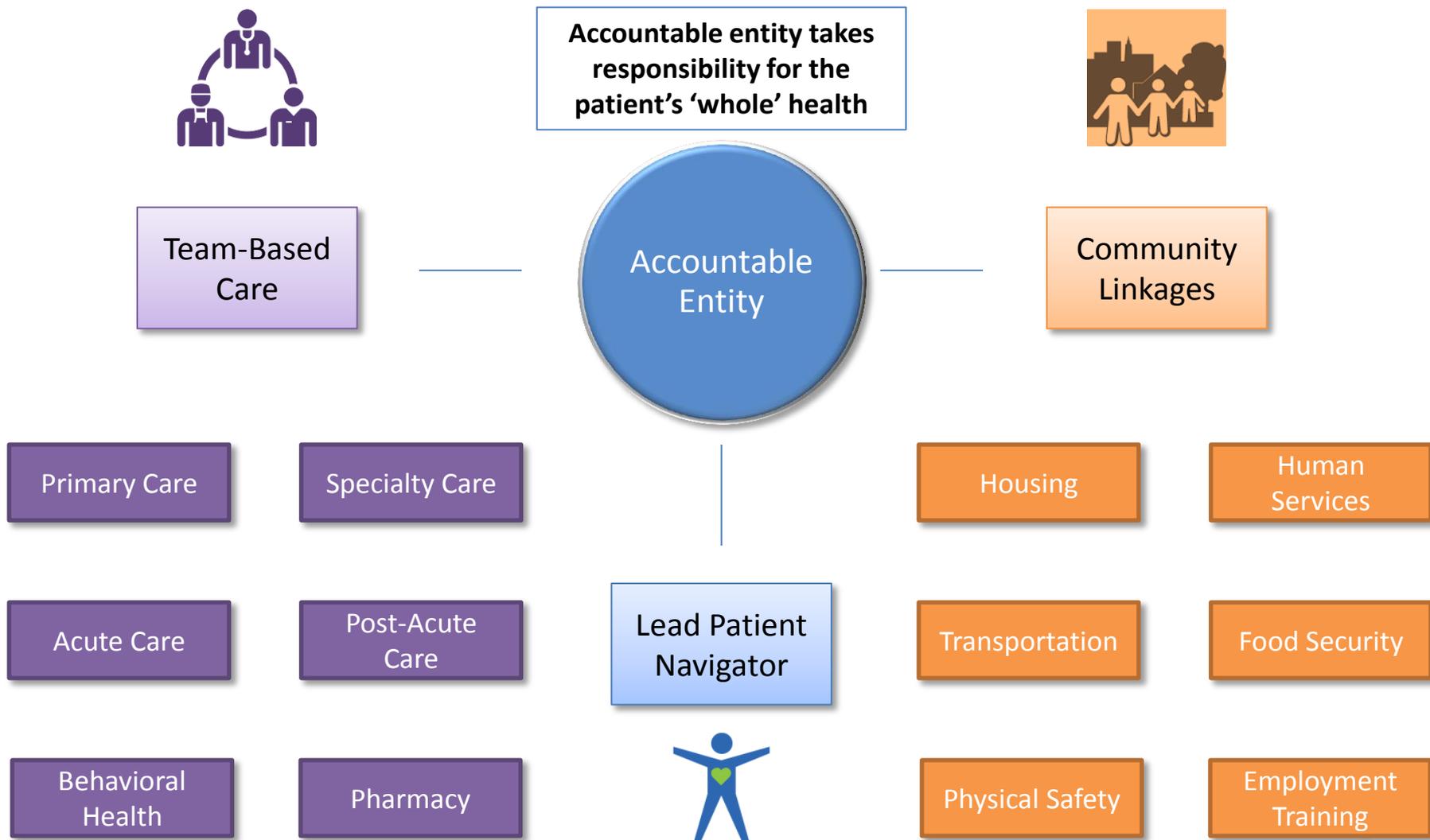
Core Needs	*Supplemental Needs
Housing Instability Utility Needs Food Insecurity Interpersonal Violence Transportation	Family & Social Supports Education Employment & Income Health Behaviors

* This list is not inclusive

Accountable Health Communities Model Structure



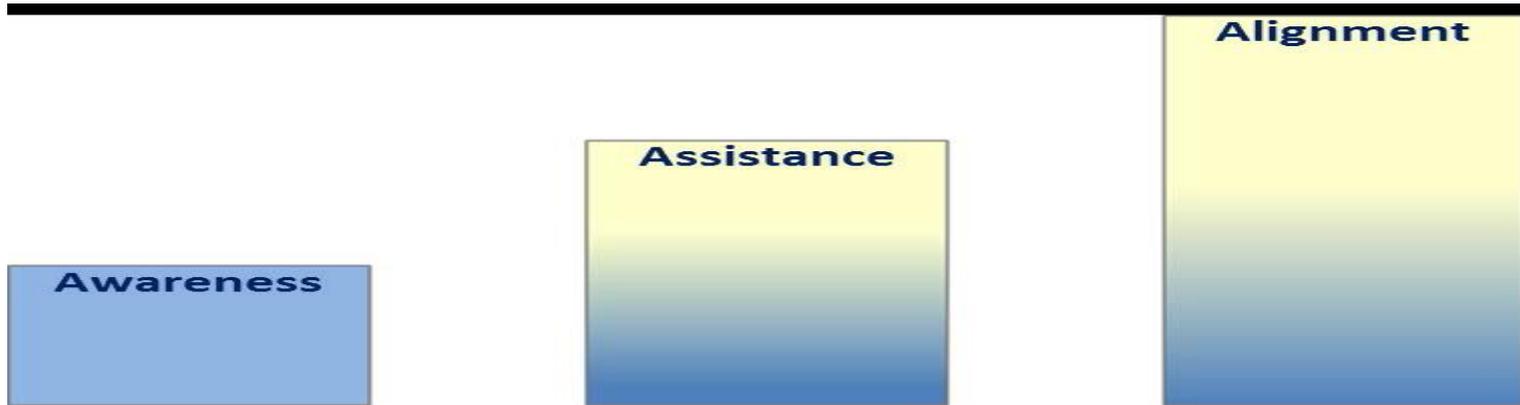
Envisioned DC Healthcare Landscape



Accountable Health Communities Overview

- Bridge organization
- At least one state Medicaid agency
- Community service providers that have the capacity to address the core health-related social needs
- Clinical delivery sites, including at least one of each of the following types:
 - Hospital
 - Provider of primary care services
 - Provider of behavioral health services

Accountable Health Communities Intervention Approaches

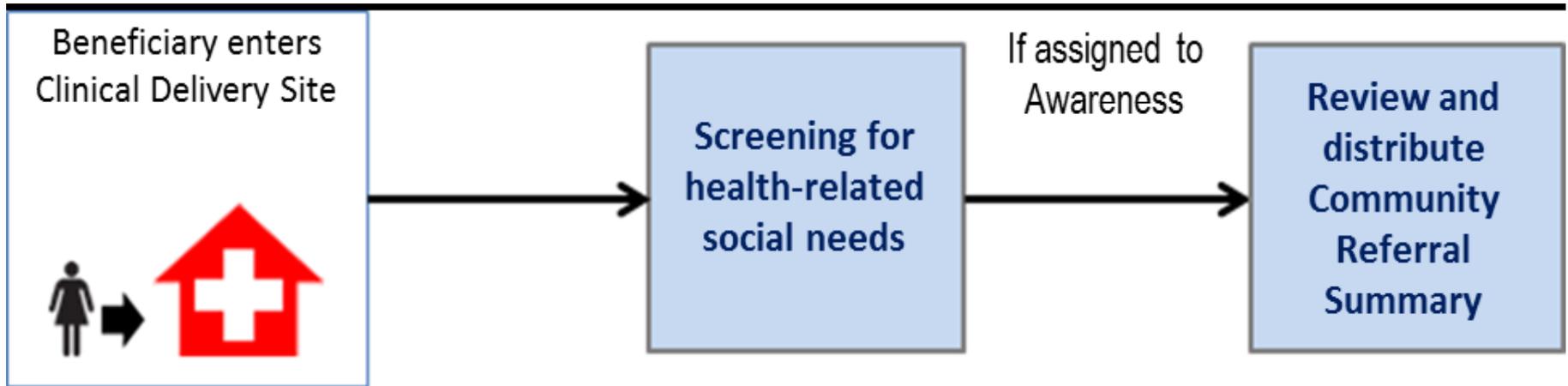


Track 1: Awareness –Increase beneficiary *awareness* of available community services through information dissemination and referral

•**Track 2: Assistance** –Provide community service navigation services to *assist* high-risk beneficiaries with accessing services

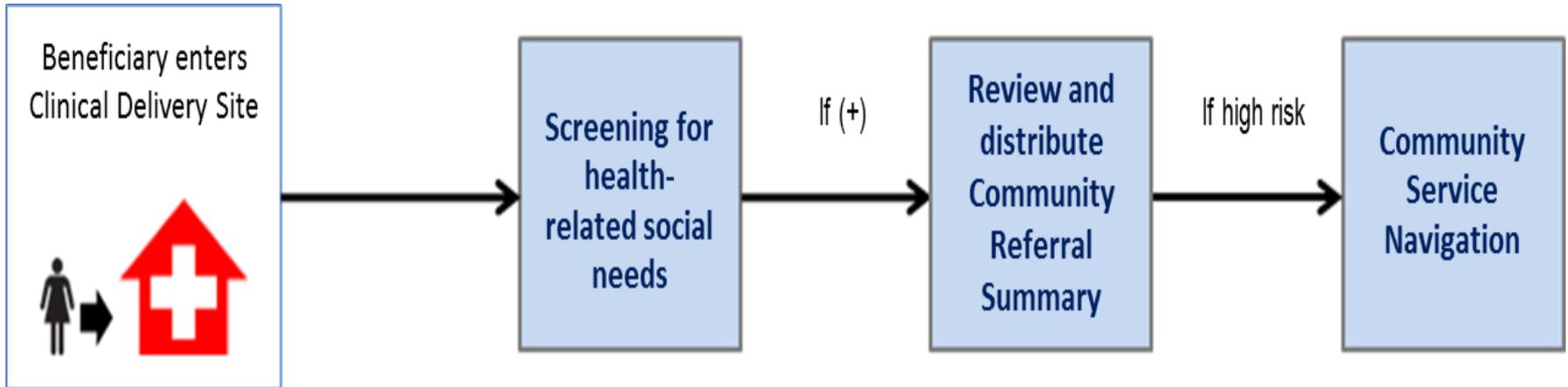
•**Track 3: Alignment** –Encourage partner *alignment* to ensure that community services are available and responsive to the needs of beneficiaries

Track 1 – Awareness Pathway



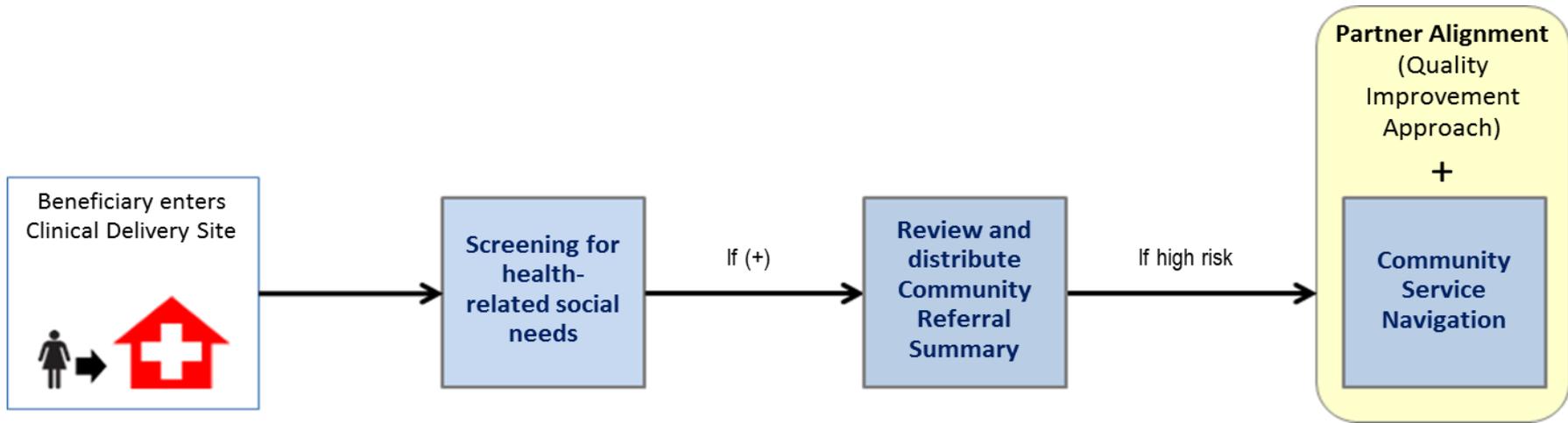
- **Target Population:** Community-dwelling Medicare and Medicaid beneficiaries with unmet health-related social need(s)
- **Question Being Asked:** Will increasing beneficiary awareness of available community services, through information dissemination and referral, impact total health care costs, inpatient and outpatient health care utilization and quality of care?
- **Partners:** State Medicaid Agencies; Clinical delivery sites; Community service providers

Track 2 – Assistance Pathway



- **Target Population:** Community-dwelling Medicare and Medicaid beneficiaries with unmet health-related social need(s)
- **Question Being Asked:** Will providing community service navigation to assist high-risk beneficiaries with accessing community services to address certain identified health-related social needs impact their total health care costs, inpatient and outpatient health care utilization and quality of care?
- **Partners:** State Medicaid Agencies; Clinical delivery sites; Community service providers

Track 3 – Alignment Pathway



- **Target Population:** Community-dwelling Medicare and Medicaid beneficiaries with unmet health-related social need(s)
- **Question Being Asked:** Will a combination of community service navigation (at the individual beneficiary level) and partner alignment at the community level impact total health care costs, inpatient and outpatient health care utilization and quality of care?
- **Partners:** State Medicaid Agencies; Clinical delivery sites; Community service providers; Local government; Local payers (e.g. Medicare Advantage (MA) plans; Medicaid MCOs)

Next Steps

- Refine Patient Care Mock Profile & apply for CMS funding to 'build' it
- Partner with entities applying for Accountable Health Community opportunity to complete application
- Next Meeting 3/16: Provider Capacity
 - Discuss current capabilities of providers to connect their clients with the multiple health and social services available to them
 - Explore what types of training would be most helpful in the next six – nine months