

MHSC – June 7, 2013

Health Home Update

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Now that there is HHCM

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 - Engagement and re-engagement
 - Case management charts
 - Treatment, rehabilitation and social service goals
 - Strengths based and client centered.

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A closer look at what this means

- ▶ No more regulations = monitoring outcomes
 - High clinical risk individuals (AOT, discharges from state hospitals, prisons and jails)
 - Appropriate intensity of care and in some cases mandated reporting
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A closer look at what this means

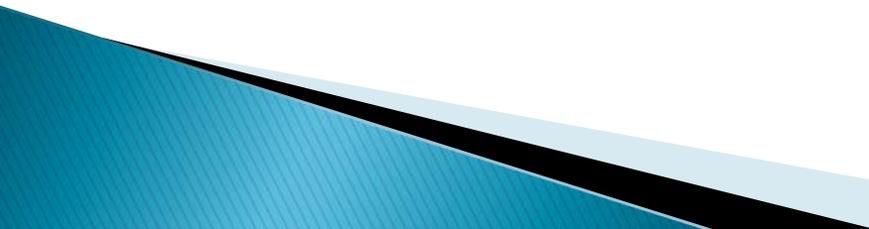
- ▶ Working closely with the HH network
 - Network partners represent behavioral health and physical health, social service providers (e.g. housing providers)
 - Rapid access to partner services
 - Eventually there will be HIT connectivity with the HHs and the RHIOs
 - **SINGLE PLANS OF CARE**

Integrated Single Plans of Care

▶ The cornerstone of HHCM

- Integrated = embedding behavioral health services, physical health services and social services
 - The care manager will be responsible to coordinate these services to achieve a recipients goal, e.g. a goal to re-claim custody of child.
 - Plan may include working with child protective services, AOD services, MH services, probation, schools, LDSS, housing provider...
 - Each service has their own plan with the recipient but the job of the HHCM is to coordinate these plans so that they are working in a cohesive way, communicating with each other, with the recipient and the family to achieve the goal.

HHs should manage clinical risk

- ▶ Assure that for high risk populations the appropriate level of intensity (frequency, duration, type of contact) is provided by staff who have qualifications and experience to meet the recipient's needs
 - ▶ Titrating contact intensity, higher or lower, based on assessed needs
 - ▶ Shortly, bring ACT services into HH network and utilize this service for high need individuals who are difficult to serve in a planned way
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A word about ACT

- ▶ At present, recipients of ACT services have not been assigned to HHs
 - ▶ HHs are required to provide CM to all of its members
 - ▶ ACT is a mobile treatment program that also provides CM services
 - ▶ DOH and OMH are collaborating on a plan that will allow the ACT team to be a HH network partner and also provide the majority of CM services for its recipients
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2010 Health Home Clinical Risk Groups: Behavioral Health Population

Diagnosis Grouping	Sum of MH/SA Spend	Sum of MH/SA Recips	Diagnosis Grouping	Sum of MH/SA Spend	Sum of MH/SA Recips
TOTAL	\$ 7,270,312,543	411,980	Two Other Moderate Chronic Diseases	\$133,721,190	16,691
Schizophrenia	\$ 1,064,324,943	71,796	Moderate Chronic Substance Abuse and Other Moderate Chronic Disease	\$130,702,804	10,031
Schizophrenia and Other Moderate Chronic Disease	\$ 987,483,578	51,021	One Other Moderate Chronic Disease and Other Chronic Disease	\$128,258,771	16,832
HIV Disease	\$896,305,908	22,252	Bi-Polar Disorder	\$104,845,381	7,233
Dementing Disease and Other Dominant Chronic Disease	\$ 323,686,677	11,961	One Other Dominant Chronic Disease and One or More Moderate Chronic Disease	\$97,316,553	6,436
Diabetes - Hypertension - Other Dominant Chronic Disease	\$ 237,735,446	11,303	Diabetes - Advanced Coronary Artery Disease - Other Dominant Chronic Disease	\$90,245,930	3,303
Diabetes and Other Dominant Chronic Disease	\$ 160,873,540	7,826	Schizophrenia and Other Chronic Disease	\$89,393,330	5,494
Psychiatric Disease (Except Schizophrenia) and Other Moderate Chronic Disease	\$ 156,625,537	15,842	Chronic Obstructive Pulmonary Disease and Other Dominant Chronic Disease	\$85,555,831	4,328
Schizophrenia and Other Dominant Chronic Disease	\$ 140,336,943	5,809	Diabetes and Hypertension	\$83,038,235	9,638
Diabetes and Other Moderate Chronic Disease	\$ 139,516,879	11,583	Diabetes and Asthma	\$79,170,754	5,484
Asthma and Other Moderate Chronic Disease	\$ 138,597,650	11,757	Diabetes and Advanced Coronary Artery Disease	\$57,899,075	3,577
Diabetes - 2 or More Other Dominant Chronic Diseases	\$ 137,828,720	4,185	Dialysis without Diabetes	\$55,750,739	904
Depressive and Other Psychoses	\$ 136,096,859	13,809			

Health Home Progress Report

- ❑ 48 Health Homes (HHs) in 57 counties have been designated under three implementation phases effective 1/1/12, 4/1/12 and 7/1/12
- ❑ Medicaid members eligible to be enrolled in Health Homes must have:
 - ❑ Two or more chronic conditions (e.g., SUD, Asthma, Diabetes, Heart Disease)
 - ❑ One chronic condition – HIV/AIDS
 - ❑ One serious mental illness
- ❑ Over 1 million of NY's 5+ million Medicaid members are HH eligible
 - ❑ HH enrollment targeted to 224,000 of the highest risk eligible members
 - ❑ Current Outreach/Enrollment = 34,022 or 15.2% of highest risk members
 - ❑ Over 200,000 claims totaling over \$100 million have been paid since 1/1/12
- ❑ Projected Health Home Enrollment:
 - ❑ 2013-14 = 151,000
 - ❑ 2014-15 = 225,000

New Health Home Volume!

We lowered risk score from 30 to 15.

Health Home	Risk > 15 and <=20		Risk > 20 and <=30		Grand Total
	FFS	MMC	FFS	MMC	
HH 1	312	14,044	298	9,493	24,147
HH2	116	5,865	108	4,052	10,141
HH 3	126	4,286	131	3,466	8,009
HH 4	121	4,246	130	3,121	7,618
HH 5	153	3,676	129	2,957	6,915
HH 6	102	3,162	135	2,579	5,978
HH 7	77	3,257	63	2,151	5,548
HH 8	72	2,591	114	2,124	4,901
HH 9	140	2,022	132	1,755	4,049
HH 10	73	1,792	59	1,467	3,391
HH 11	81	1,836	65	1,364	3,346
HH 12	49	1,780	54	1,249	3,132
HH 13 -32	952	10,283	864	8,192	20,291
	2,374	58,840	2,282	43,970	107,466

Designated HH Must Meet HIT Standards

- ▶ Designated HH providers must meet the following **initial** and **final HIT standards** within 18 months of program initiation
 - June 30, 2013 – Phase 1
 - September 30, 2013 – Phase 2
 - December 30, 2013 – Phase 3
- ▶ To achieve the HIT standards, designated HHs are required to utilize RHIOs or a qualified entity (QE) to access patient data and develop partnerships to maximize the use of HIT across providers (e.g., care managers, hospitals, primary care)

Initial HIT Standards for Designated HH

- ▶ **Initial Standards, HH must:**
 - a) Have structured **information systems**, policies and procedures and practices to create, document, execute, and update a **plan of care** for every member
 - b) Have a **systematic process to follow up** on tests, treatments, services and referrals which are incorporated into the patient's plan of care
 - c) Have a **health record system** that allows the patient's health information and plan of care to be **accessible to the interdisciplinary team** of providers and which allows for population management and identification of gaps in care including preventive services
 - d) **Make use of available HIT and access data** through the RHIO/QE to conduct processes, as feasible

Final HIT Standards for Designated HH

▶ **Final Standards, HH must:**

- e) Have structured **interoperable health information technology systems**, policies and procedures and practices to create, document, execute, and update a **plan of care** for every member
- f) Use an **electronic health record system** that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's **health information and plan of care to be accessible to the interdisciplinary team** of providers
 - Providers that currently do not have such a system are required to provide a plan for when and how they will implement it
- g) **Comply** with the current and future version of the **Statewide Policy Guidance**, which includes common information policies, standards and technical approaches governing health information exchange

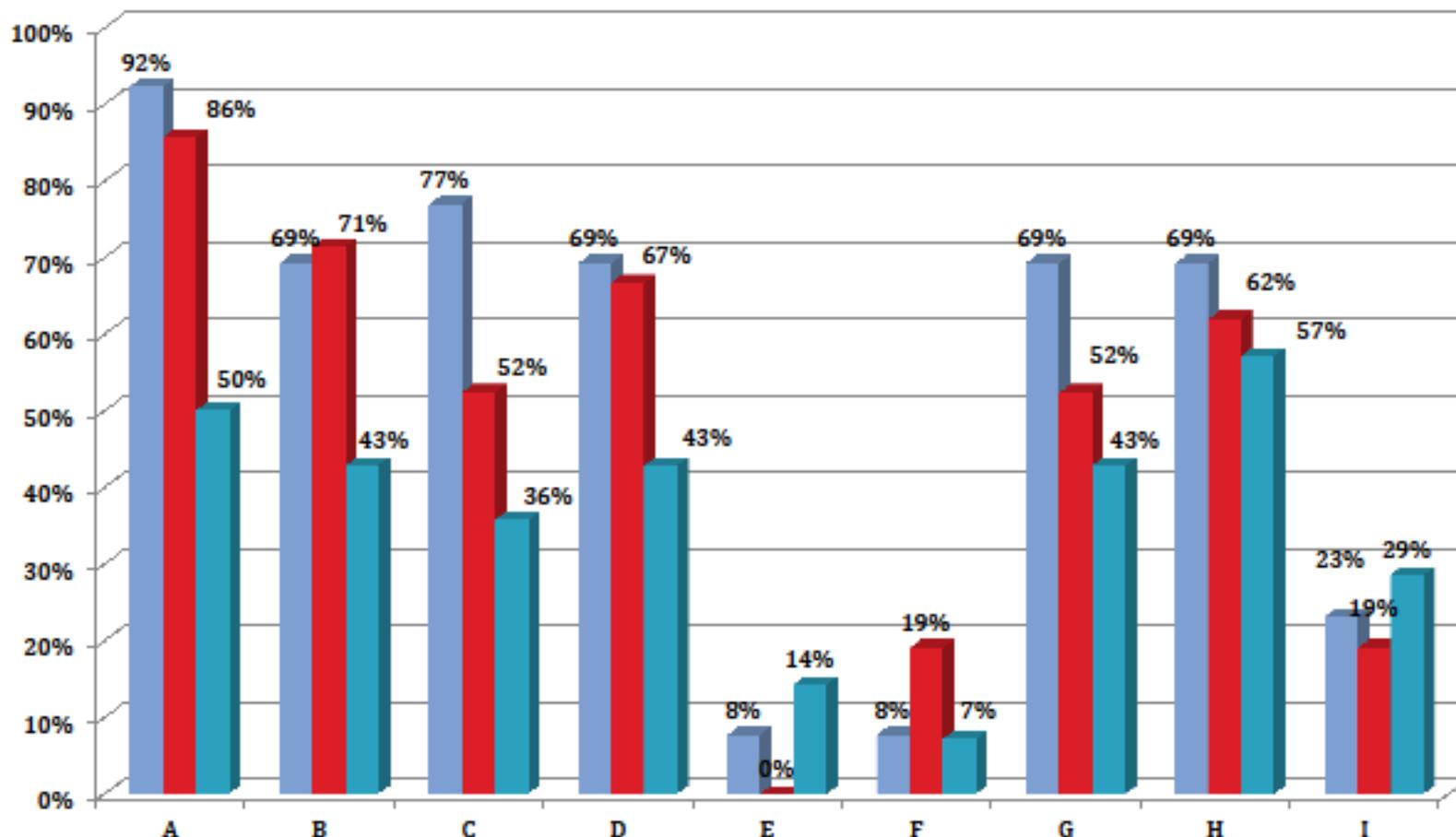
Final HIT Standards for Designated HH

▶ **Final Standards, HH must:**

- h) Commit to **joining regional health information networks** or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan.
 - **RHIOs/QE provide policy and technical services required for health information exchange through the SHIN-NY**
- i) Support the use of **evidence based** clinical decision making tools, consensus guidelines, and **best practices to achieve optimal outcomes and cost avoidance** (one example of such a tool is PSYCKES)

46% of All HIT Standards Have Been Met

■ Phase 1 (13 HHs) ■ Phase 2 (21 HHs) ■ Phase 3 (14 HHs)



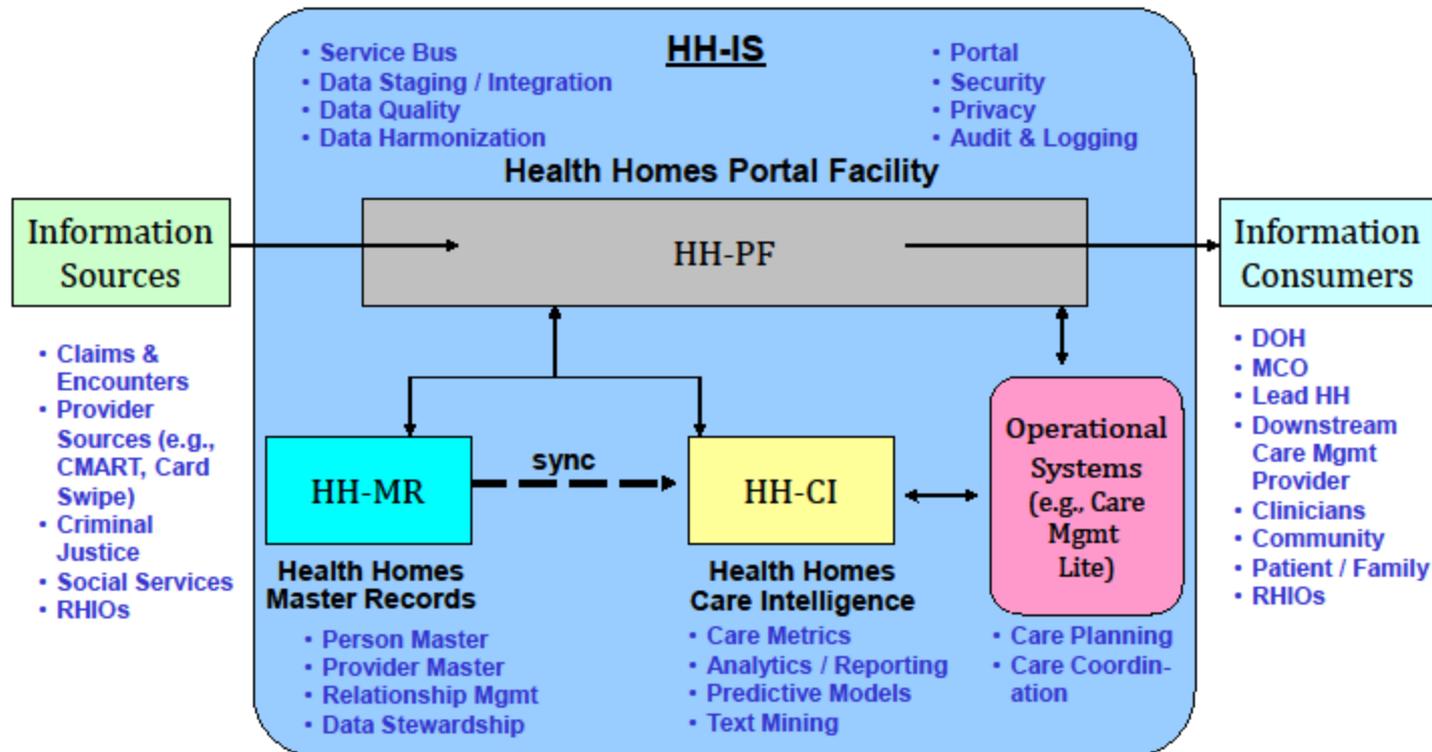
Percent of HH in Each Phase Which Are Compliant with Each HIT Standard

Health Home Implementation Grants

- Enacted 2013-14 Budget Includes up to \$15 million of HH Implementation Grants
 - Spending delayed until 2014-15 to address the loss in federal revenue from modifications to Medicaid financing system of OPWDD
 - HH Grants may be implemented in 2013-14 if Global Cap Spending savings can be identified
 - Statute requires distribution be based on formula, considerations include: access to similar funding opportunities, geographic and demographic factors including population served, prevalence of qualifying conditions, connectivity to providers
 - DOH is actively working to identify savings and is beginning to think about the formula for distribution.

Health Homes Information System (HH-IS)

Conceptual Solution Architecture Capabilities



Health Homes What Have We Learned

- ▶ Most parties have been completely vision aligned...need better service integration – plenty of conflicting views on how to get there.
- ▶ Building new programs on service dollars with no start up is difficult.
- ▶ Building on the fly is hard for everyone – especially for something so new.
- ▶ Amazing partnerships have formed. Success stories are heartening.
- ▶ Amazing difficulties have been overcome.
- ▶ Amazing challenges remain.
- ▶ Next step is for Health Home leads and partners to move from implementation to performance improvement.
- ▶ State and plans need to help.