

## Lessons for Health Homes Identified Through the Chronic Illness Demonstration Project Learning Collaborative

In 2008, the New York State Department of Health (DOH), in consultation with the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services, developed the Chronic Illness Demonstration Project (CIDP) to improve health outcomes and reduce costs for chronically ill Medicaid beneficiaries in a fee-for-service setting. Six teams were chosen to participate in CIDP, including the Institute for Community Living, New York City Health & Hospitals Corporation, Optum Health, Federation Employment & Guidance Services, Hudson Health Plan, and the University of Buffalo, Family Medicine. Beneficiaries enrolled in CIDP typically had multiple chronic conditions and needs that cut across the spectrum of physical and behavioral health, housing and social supports and services.

While official outcomes are still being evaluated, the CIDP experience contributed to the development of New York's health home strategy, which is focusing specifically on adults with complex needs. Thus, lessons from CIDP may provide valuable guidance for health home implementation given the similarly complex characteristics of beneficiaries targeted for enrollment in both programs.

The following is a summary of key lessons from CIDP from the perspective of the six CIDP teams, as identified during the final meeting of the *CIDP Learning Collaborative* in June 2011. This summary highlights critical success factors for effective provision of health home services, as well as relevant considerations for overall policy and program design.

### Critical Success Factors

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CIDP aimed to establish innovative, interdisciplinary models of care to improve health care quality, ensure appropriate use of services, improve clinical outcomes and reduce the cost of care for Medicaid beneficiaries with complex conditions. Following are key program design elements that contributed to the success of the pilots:

- High-touch interdisciplinary team that is highly accessible;
- Dedicated housing coordinator;
- Dedicated staff with social service expertise;
- Inclusion of peers in the staffing model;
- Client-centered service delivery model;
- Partnerships with community-based organizations; and
- Ability to coordinate medical and behavioral health care, as well as social services.

### Opportunities for Improvement

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Not all teams were able to form partnerships with community-based organizations or address housing needs to the same extent; however, it was clear that these were critical issues for successfully working with this particular subset of the population. Some teams identified that the requirement for persons in transitional housing to become homeless prior to obtaining permanent housing should be eliminated. In

addition, it was stated that housing should be conveniently situated near other services. Other opportunities for improvement include:

- Integration of chemical dependency and mental health treatment;
- Integrated health information technology to allow for quicker assessment of trigger events;
- Transitional care from 28-day rehabilitation programs to long-term programs;
- Treatment resources for patients with personality disorders;
- Partnering with physicians, and potential use of incentives, to form an adequate network of specialists and multidisciplinary teams; and
- Alternatives to restrictions, as patients can easily work around them.

## **Recommendations for Future Program Enhancements**

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The teams came up with the following recommendations for DOH to help guide health home design strategies consider based on their experiences. To note, DOH used many of the recommendations below to directly inform health home program requirements and payment methodologies.

### **Reimbursement**

- DOH should consider using risk-adjustment to more adequately link reimbursement rates to required intensity of care management services; and,
- Teams should consider providing service dollars to meet enrollees' basic needs (i.e., air conditioning).

### **Coordination and Integration**

- All medical, behavioral health, socio-economic, and community-based services should be coordinated by the health home entity;
- The care plan should be shared electronically with the patient, all members of the care coordination team (including a peer specialist), and the health home;
- Develop partnerships with other organizations (Human Resource Administration, housing organizations, local Department of Social Services, Administration for Children's Services, discharge planners);
- Medical and behavioral health should be co-located and integrated; and
- Care teams should hold weekly team conferences.

### **Data and IT**

- DOH should consider fewer reporting elements and consistent definitions of data fields.
- Teams should implement integrated software and alert systems; and
- Teams should have access to claims history prior to enrollment.

### **Enrollment and Service Levels**

- Teams should prioritize outreach for frequent users of emergency department or inpatient services;
- Teams should implement warm transfers from eligibility to enrollment;
- Enrollment should be done by an enrollment team, as managing patients while simultaneously enrolling new patients was challenging;
- Duals should not be excluded;
- DOH and providers should consider tiered services by need; and

- Teams should focus on transitioning patients towards community health centers and “graduating” from intensive care management over time.

### Staffing Considerations/Education

- Case loads should be small, and should leverage use of health navigators;
- Teams should include housing and entitlement staff;
- Care managers should receive ongoing training in Motivational Interviewing; and
- Teams need to educate other staff (and partner organizations) about information sharing policies, and overall program goals.

### CIDP Case Studies

The table below summarizes two case studies from CIDP, providing examples of what health home providers may expect in terms of care management and coordination needs for this complex subset of beneficiaries. One case study highlights a CIDP success story, while the other presents a less successful CIDP experience. As described in the more successful case, an interdisciplinary care team was able to address housing needs, substance abuse issues and provide lasting health education. In the less successful case, lack of available housing meant the enrollee had to remain in an environment that was not conducive to recovery, which undermined progress that had otherwise been made through CIDP. In addition, a limited network of specialists contributed to long wait times and barriers to accessing needed care.

Characteristics	Success Story	Less Successful
<b>Demographics</b>	47-year old African American male, enrolled December 2009, known to partner agency.	40-year old African American single female, enrolled fall 2010.
<b>Chronic Conditions and Housing/Social/Family Situation</b>	<ul style="list-style-type: none"> <li>▪ Hypertension (HTN), coronary artery disease (CAD), history of depression; smoker; chemical dependency: crack cocaine and alcohol abuse (ETOH) for eight yrs;</li> <li>▪ Precariously housed and transitional housing at enrollment.</li> <li>▪ Tenuous natural support system at time of enrollment; reports stealing from mother and brother to ‘feed addiction.’</li> </ul>	<ul style="list-style-type: none"> <li>▪ Breast hypertrophy; back pain; H. Pylori and arthritis bilateral knees; depressive disorder; chemical dependency: uses crack cocaine (clean since 5/2010).</li> <li>▪ Living in a halfway house, attending a court-mandated chemical dependency day treatment program, a single point of access (SPOA) in place for housing.</li> <li>▪ Has some family support, lost custody of her five children.</li> </ul>

Characteristics	Success Story	Less Successful
<b>Goals</b>	<ul style="list-style-type: none"> <li>▪ More permanent housing.</li> <li>▪ Recovery.</li> <li>▪ Education.</li> <li>▪ Family reconciliation.</li> <li>▪ Interdisciplinary team later integrated goals around health-related matters, i.e. HTN, CAD, and smoking.</li> </ul>	<p>Motivated to stay clean and wished to “get my medical conditions under control, get my life together and get my children back in my custody.”</p>
<b>Intervention</b>	<ul style="list-style-type: none"> <li>▪ Understand patterns of care.</li> <li>▪ Coordination with PCP.</li> <li>▪ Family meetings.</li> <li>▪ Referral and move to more permanent housing.</li> <li>▪ Personalized Recovery Oriented Services (PROS).</li> <li>▪ Health education.</li> <li>▪ Job training program.</li> <li>▪ Regular case conferences with network.</li> </ul>	<p>Coordinated appointments with PCP, physical therapy and plastic surgery specialists.</p>
<b>Outcomes/ Barriers</b>	<ul style="list-style-type: none"> <li>▪ Three years prior to enrollment, inpatient costs alone were \$56,000.</li> <li>▪ Since enrollment, <i>no inpatient costs</i>.</li> <li>▪ Completed web design program.</li> <li>▪ Mentor to other residents.</li> <li>▪ Connected with family—ongoing.</li> <li>▪ Addressing continuing health needs, recently joined Smoking cessation program.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Long waiting times for specialists in clinics</li> <li>▪ Halfway house extended her stay for two more months (was on a waiting list for housing through Human Development Services of Westchester (HDSW); apartment did not become available and had to leave halfway house.</li> <li>▪ Lives with father of her children (who has been a trigger in the past) in an environment that does not support sober living.</li> <li>▪ May have relapsed in the last few weeks. Living situation has made it difficult to reach the member.</li> <li>▪ Poor transitional plan into permanent housing.</li> </ul>