Domain 2: *System Transformation Projects*

Project ID*: 2.a.iii*

Project Title*: Health Home At-Risk Intervention Program: Proactive management of higher risk patients, not currently eligible for Health Homes, through access to high quality primary care and support services*

Objective:

Expand access to community primary care services and develop integrated care teams (physicians and other practitioners, behavioral health providers, pharmacists, nurse educators and care managers from Health Homes) to meet the individual needs of higher risk patients.

Description:

There is a population of Medicaid members who do not qualify for care management services from Health Homes under current NYS HH standards (i.e., patients with a single chronic condition but are at risk for developing another), but who are on a trajectory that will result in them becoming Health Home super-utilizers. This project represents the level of service delivery and integration for the complex super-utilizer population who fall in between the patient-centered medical home and the Health Home general population. Some risk stratification systems refer to these patients as “the movers.” Early intervention through this project shall result in stabilization reduction in health risk and avoidable service utilization.

Target Patient Population:

Complex patients with a high degree of healthcare utilization, not qualifying for Health Home status under NYS eligibility rules, but with care management needs exceeding those typically offered by the patient-centered medical home. This includes patients with a single chronic condition who are at risk for developing another due to medical and/or social factors.

Actively Engaged Patients for DSRIP Reporting Purposes:

The number of participating patients who completed a new or updated comprehensive care management plan.

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, behavioral health providers, substance abuse treatment providers, skilled nursing facilities / nursing homes, pharmacies, community based organizations, and others.

Project Milestones
Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.
Ensure all participating primary care providers in project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year 3.
Ensure that all participating providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging.
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.
Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.

Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).
Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.