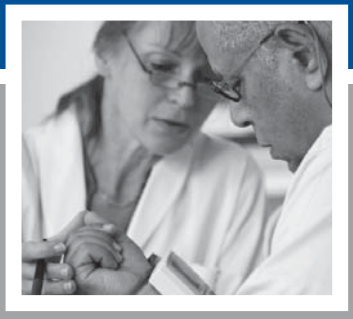
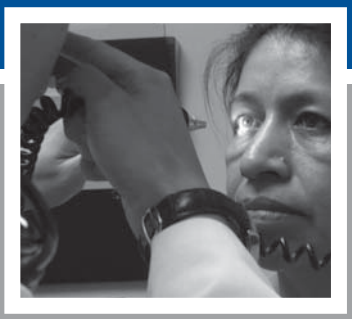
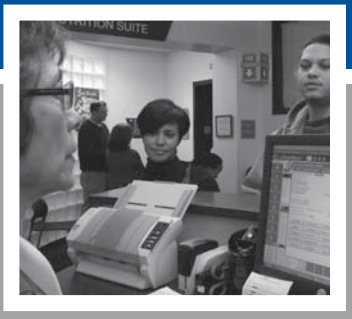
Care Coordination for Safety Net Providers







Tools and Lessons from a Front Line Health Home Experience

Produced by

PRIMARY CARE DEVELOPMENT CORPORATION

Community Healthcare Network

In Partnership with

HOUSING WORKS

HELP/PSI
Building Hope and Empowering Change

Supported by

ALTMAN FOUNDATION

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April 10, 2014

ACKNOWLEDGEMENTS

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P**CDC gratefully acknowledges the Altman Foundation for their support of this project.**

A SPECIAL DEDICATION IN MEMORY OF CATHERINE ABATE

This report is dedicated to Catherine Abate (1949-2014), who led the Community Healthcare Network since 1999. Catherine transformed CHN into a highly successful community health center network that provides access to quality, culturally competent and comprehensive community-based health care and social services for over 75,000 patients at 12 locations throughout New York City.

About PCDC

Founded in 1993, PCDC is a nonprofit organization dedicated to expanding and transforming primary care in underserved communities to improve health outcomes, lower health costs and reduce disparities.

Our Programs:

Capital Investment: We provide the capital and know-how to build, renovate and expand community based health facilities, so that providers can deliver the best care to their patients.

Performance Improvement: We provide consulting, training and coaching services to help practices deliver a patient-centered model of care that maximizes patient access, meaningful use of health IT, care coordination and patient experience.

Policy & Advocacy: We lead and support successful policy initiatives that increase access to quality primary care, improve the health of communities, and lower health system costs.

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INTRODUCTION

In a health care system often defined by its fragmentation, coordinating care among and between health care providers is widely seen as essential to ensuring patients get the right care, at the right time, in the right setting. This is the basis of achieving the "Triple Aim" – a better quality of care for patients, improved population health, and lower per-patient health costs.

It can be incredibly challenging to coordinate care in a health system designed with structural and historical barriers that discourage or prevent such coordination, including competition between providers and reimbursement that undervalues coordinating services.

Despite the challenges, care coordination can be adopted by health care organizations. It takes commitment at all levels of leadership and staff, development of new systems and protocols, a focus on the process of care delivery, and a greater reliance on team-based care.

> A key goal of this project is to assist other provider organizations in their efforts to coordinate care. The systems, workflows and tools developed are available to other Health Homes, multi-provider collaborations, or providers that simply want to provide more effective, coordinated patient care.

Faced with high health care costs but only mediocre health outcomes, New York State has made achieving the Triple Aim a top priority, and has launched several large-scale initiatives aimed at encouraging and incentivizing health care providers to collaborate and coordinate patient care more effectively. These include "Health Homes," which address the needs of patients with the most complex and expensive health and social needs. (See Health Home description below.)

ALTMAN CARE COORDINATION PROJECT

With funding from the Altman Foundation, the Primary Care Development Corporation (PCDC) sought to analyze and improve the delivery of care coordination services in Brooklyn as part of the New York State Health Homes initiative. To accomplish this, PCDC collaborated with Community Healthcare Network (CHN), a lead Health Home in Brooklyn, and Help PSI and Housing Works – two downstream Health Home providers in CHN's Health Home. All three organizations are Federally Qualified Health Centers (FQHC).

The project focused on addressing specific areas in which front line staff and their managers faced operational, workflow and training challenges related to care coordination.

Based on this work, PCDC and its project partners develop recommendations that can inform other efforts in which health care providers came together to better address the health care needs of their patients. Recommendations include:

- Involve Staff at All Levels for Successful Change
- Adapt and Use Care Coordination Systems, Workflows and Tools
- Engage Providers Early and Often
- Train All Staff on Care Management
- Conduct Onsite Training that Connects to Workflows and Tools
- Organize Caseloads by Risk and Complexity

HEALTH HOMES

Overall, New York estimates that over 1 million Medicaid beneficiaries are in its target population for Health Homes.[1] A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. This is done primarily through a "care manager" who oversees and coordinates access to the health and social services the participating patient needs to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. The health home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual "Health Home."[2] The Affordable Care Act (ACA) provides an option for states to implement Health Homes for chronically ill Medicaid beneficiaries and receive a 90% federal match rate for the first two years of the program.

In New York State, the Health Home provider is expected to be accountable for the patient's care and for reducing avoidable health care costs attributed to the patient. They may either provide services directly (i.e. post-discharge follow up, primary, specialty and behavioral health services) or through contractual arrangements with appropriate service providers[3], often called "downstream" providers.

The Health Home provider is expected to be accountable for the patient's care and for reducing avoidable health care costs attributed to the patient.

The Health Home model is based on the Patient Centered Medical Home (PCMH) model but promotes the use of non-physician staff to participate in care coordination and places less of a burden on the physician to be solely responsible for the coordination of patient care.[4] This model also expands upon the medical home to focus specifically on providing comprehensive care to patients with chronic conditions through the integration of primary, acute, mental and behavioral health, and long-term support services currently being obtained or needed by the patient.[5] Health Home services identified in the ACA include comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings; and use of health information technology to link services.

PROJECT PARTNERS

Community Healthcare Network (CHN): Founded in 1984, CHN is a network of FQHCs that serve some 75,000 patients a year in 12 locations, and serves as a Health Home lead in Brooklyn. PCDC worked with CHN to implement the internal and community care coordination model at its three Brooklyn program sites: CABS Health Center (Williamsburg), Dr. Betty Shabazz Health Center (East New York) and Caribbean House Health Center (Crown Heights). In sum, these sites serve 13,572 primary care patients, and have a caseload of 1,593 patients within the larger Health Home, which continues to grow. CHN staff then implemented the model at additional sites across New York City. Together, these sites serve primary care patients, and carry a caseload of New York Health Home patients.

Help/PSI: Founded in 1990, HELP/PSI provides a wide spectrum of services and programs to people living with HIV/AIDS and substance abuse issues, and to the broader underserved and at-risk population in Brooklyn, the Bronx and Queens. Programs include Adult Day Health Care, COBRA Case Management, Primary and Dental Care & Residential Health Care. Within Brooklyn, Queens, Manhattan and the Bronx, HELP/PSI provides primary care services to 1,750 patients and serves 552 people within the CHN Health Home, a figure that will continue to grow. On a citywide level, HELP/PSI serves 524 primary care patients and 2,821 individuals within New York's Health Homes.

Housing Works. Housing Works has provided a comprehensive array of services to more than 20,000 homeless and low-income New Yorkers living with HIV/AIDS since 1990. Supportive services include housing, healthcare, meals and nutritional counseling, mental health and substance use treatment, job training, and legal assistance. Within Brooklyn, Housing Works provides primary care services to 1,056 patients, serves 904 individuals within the Maimonides Health Home, and is part of the CHN Health Home. On a citywide basis, Housing Works serves 2,049 primary care patients and 1,969 individuals within New York's Health Homes.

[1] Patchias et at. (2013), p. 3
[2] Medicaid Health Homes (New York State). http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/ Accessed March 23, 2014
[3] NYS Health Home Provider Qualification Standards For Chronic Medical and Behavioral Health Patient Populations. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm Accessed March 23, 2014
[4] Patchias, Elizabeth, M.; Detty, A.; and Birnbaum M. (February 2013). Implementing Medicaid Health Homes in New York: Early Experience. Medicaid Institute at United Hospital Fund.
[5] Kaiser Commission on Medicaid and the Uninsured, August 2012, p. 1

PROJECT STRUCTURE: TEAM-BASED & COLLABORATIVE

To encourage clear lines of communication and a shared vision, the project was structured to promote the participation of multiple levels of staff, particularly front line staff who provide the majority of care coordination and care management services and their managers. At each organization, project work was divided among three overlapping teams with distinct functions: the Implementation Team, the Manager Team, and the Executive Team.

THE IMPLEMENTATION TEAM: ON THE GROUND CHALLENGES

The Implementation Team at each organization was made up of 6-8 front line staff including patient or care navigators and care managers, as well as 2-3 of their managers including site and regional or program directors. PCDC facilitated weekly working group meetings where participants discussed the on-the-ground challenges they were experiencing with meeting the Health Home standards and then developed and tested workflows and tools to help address these challenges. Teams at the downstream provider organizations would review the tools and workflows and make modifications as necessary in addition to developing additional tools.

Including both front line staff and their managers during these meetings was advantageous because it allowed managers to hear directly from the front line staff how they managed their day-to-day work, what challenges they faced, in what areas they did well, and where they needed additional support. It also provided an opportunity for managers to explain why work was structured in a certain way, to clarify expectations, and to provide some training and support to the front line staff. Working together, the front line staff and the managers were able to design solutions to common challenges that would support the goals of the program.

Working groups gave staff an opportunity to participate in the Health Home program design and management work.

Since new workflows and tools were developed with front line staff input, they were better received by Health Home staff overall. New processes and forms were not seen as another task leadership was asking them to incorporate into their everyday work. Instead, the model tools and workflows were seen as peer-developed and leadership-approved methods of streamlining their work. Finally, these working groups gave staff an opportunity to participate in the Health Home program design and management work that was happening at their organization. They helped clarify the roles and responsibilities of staff, and front line staff reported that through this project they appreciated getting the opportunity to provide their input to help improve operations.

HEALTH HOME MANAGERS TEAM: SUPPORTING THE FRONT-LINE

In addition to the working meetings, PCDC coaches met separately with the Health Home managers weekly at each

organization. These meetings provided an opportunity to get feedback and insight from the managers that they were not able to discuss during the working meetings due to lack of time or appropriateness with the front line staff present. The managers' meetings also provided an opportunity for managers to share and discuss the challenges they were having with transitioning the front line staff from the COBRA model to the Health Homes model. With the guidance of a PCDC coach, managers developed and implemented ways to support their staff through these changes, including providing additional training opportunities and restructuring staff meetings and/or supervision sessions to increase staff engagement.

SENIOR EXECUTIVES TEAM: ADDRESSING ORGANIZATIONAL AND POLICY ISSUES

Meetings with the Health Home managers and senior executives from each organization took place several times during the course of the project to inform executive staff about the project's progress, challenges, accomplishments, and any major changes that were needed to improve the delivery of Health Home services. Executive level staff approved or disapproved of these proposed changes and provided guidance to the PCDC coaches and Health Home managers about their vision for the Health Home program at their respective organizations. Examples of issues brought to the executive level staff for input included the need to streamline Health Home services across sites within the organization through implementation of standard policies and procedures; changing the patient assessment to include medical information beyond HIV/AIDS (all three were COBRA HIV/AIDS Targeted Case Management providers; and developing a process for scheduling case conferences with the organization's primary care providers.

KEY HEALTH HOME CHALLENGES

The tools and workflows resulting from this project are aimed at addressing specific areas in which front line staff and their managers faced operational, workflow and training challenges in meeting Health Home standards. These challenge areas were initially identified by CHN staff and leadership. Downstream providers identified similar issues that needed to be addressed to have a successful Health Home program.

TRANSITIONING FROM COBRA/TCM TO HEALTH HOMES

New York State converted its COBRA HIV/AIDS Targeted Case Management (TCM) and the Office of Mental Health's TCM programs to Health Homes as part of the Health Home initiative. Both of these TCM programs no longer exist and are now designated as Health Homes or participate in a State approved Health Home network. CHN, HELP PSI and Housing Works were all formerly COBRA providers.

The conversion of COBRA and TCM programs to the Health Home model has resulted in major changes for providers of these services. One of the most notable has been the significant expansion in program eligibility among Medicaid beneficiaries. Overall, New York estimates that over 1 million Medicaid beneficiaries are in its target population for Health Homes compared to 15,000-20,000 HIV positive patients enrolled in COBRA annually. The increase in patients as well as the expansion of eligible diagnoses to all major chronic conditions has resulted in several challenges at the provider organization level particularly with hiring qualified staff, managing a larger number of case management teams, and providing adequate training to staff to prepare them for their medical care management job functions.

The key challenges in meeting Health Home standards included:

- Transitioning from COBRA/TCM to Health Homes
- Patient Outreach & Engagement
- Patient Assessments
- Coordinating with Providers and ensuring their engagement
- Conducting Assessments
- Developing a "Living" Care Plan
- Increased Case Loads
- Staff Training
- Housing

In addition to the eligibility expansion, the Health Home program has a greater emphasis on outcomes compared to the COBRA program, mainly reducing avoidable hospitalizations and emergency department use. This change in focus has resulted in a shift in the day-to-day work of the care management staff to focus more energy on developing comprehensive care plans with goals that patients can realistically achieve, appropriately coordinating care and anticipating the needs of chronically ill patients, and communicating with the patients' medical providers.

At the organizational level, Health Home providers have had to develop new policies and procedures to support Health Home standards, re-define roles and responsibilities of their care management staff, train staff on these changes, implement new health information technology tools to support

care coordination, and attempt to break down silos between care management and medical staff to improve communication. Implementing and executing these changes operationally was a challenge for the Health Home provider organizations in this project. Thus, developing tools and workflows to help address these challenges and improve operations became the focus of the project.

PATIENT OUTREACH & ENGAGEMENT

Patients can enter the Health Homes program in one of two ways – either they are pre-identified for the program by the NYS Department of Health (referred to as a "top down" referral) or they can be referred to the program if they fit the NYS Health Home eligibility criteria (referred to as a "bottom-up" referral). For patients on the "top down" list, the organization has 90 days to enroll the patient before the per-member-per month rate for Health Home outreach activities is no longer provided. Health Home provider organizations generally provide outreach staff with specific policies and procedures for how to outreach to patients through phone calls, letters, and face-to-face visits.

Recruiting patients on the "top down" list presented a challenge for the patient navigators and outreach workers who were tasked with enrolling patients in the Health Home program. Despite often having inaccurate patient contact information, outreach staff needed to keep track of specific outreach activities provided for each patient and the outcome of these activities for both billing and managing their work. CHN developed an **Outreach Tracker** for this purpose. Outreach staff at the downstream providers used a similar tracker as well.

Patients on the top down list were often skeptical of the Health Home program and being able to explain and "sell" the program clearly was important to enrolling a patient successfully. The **Outreach Workflow** developed by the working teams was designed to improve outreach and enrollment practices. Talking points were created for outreach and enrollment staff about the Health Home program to explain clearly to potential enrollees that Health Homes is a medical case management program, that they would be coordinating care with the patient's providers, that the Health Home provider organization is here to support them, and that their engagement and participation is required.

COORDINATING WITH PROVIDERS

Overwhelmingly, front line staff and their managers expressed challenges with engaging their patients' medical providers with care planning and care coordination activities. This was perhaps the most significant challenge uncovered during this project. Although providers external to the Health Home were reportedly the most difficult to engage, Health Home staff also struggled with engaging medical providers within their own organization. Many providers were not aware of the Health Home program in general or their role in the program, and while those who were aware of the program saw its value as a resource for their patients, they faced challenges due to logistics. Providers rarely had protected or scheduled time to meet with care managers about Health Home patients and were not reimbursed for these efforts. Some providers also expressed confusion about the role of Health Home care managers.

To work around these challenges with physician engagement, some health centers designated a medical care manager or a nurse as the staff person that the care managers could case conference with regarding patients. Other health centers required care managers to have the patient present during a case conference, so that it could be included as part of the patient visit.

Overwhelmingly, front line staff and their managers expressed challenges with engaging their patients' medical providers.

In an effort to improve communication and prepare care managers for interacting with the patient's primary care providers for the assessment, **Provider Assessment Templates** were developed by the working groups to provide guidance on how to prepare for a case conference with a provider. The templates include steps on what pre-work needs to be done to get ready for a case conference as well as key questions to ask the provider to be included in the care plan. Templates were developed for meeting with providers in the following specialties: primary care, mental health, substance abuse, and housing. Educating the provider about social issues affecting the patient and steps the care manager has taken to address these issues, showed the value the care manager can provide in helping the patient reach his or her health goals.

To address external providers with limited knowledge of the Health Homes program, the teams worked on strategies

from the Health Home services side to improve the engagement of these providers. Each organization developed **Official Health Home Introductory Letters** and an external provider directory to help improve communication. The provider directory included the names and contact information of providers who commonly saw Medicaid patients, as well as tips from other care managers on how best to connect with these providers. The introductory letter from the Health Home provider organization introduced the program and identified which medical forms were being requested. The care managers found using this process and these tools made it easier for them to obtain medical information needed for the assessment in a timely manner. However, more work could be done at the executive level to strengthen relationships between organizations and to define roles and expectations clearly for serving Health Home patients. For example, Health Home care management staff spent much of their time trying to connect successfully with providers outside their own organizations in order to obtain pertinent patient information and coordinate services.

CONDUCTING PATIENT ASSESSMENTS: A DIFFICULT TASK

The level of experience and training among the Health Home care managers posed a challenge with completing patient assessments. At both CHN and Help PSI, assessments were due 30 days after the patient consented to the program. During this time, Health Home staff are expected to case conference with the patient's main providers and obtain copies of most recent labs and other medical information. In COBRA, staff had 60 days to complete an assessment and case conferencing with providers was not required.

The tight time frame, the lack of training and experience, and the number of providers from which to obtain patient information, combined with the transient nature of many Health Home patients, made completing a thorough assessment a difficult task. Health Home staff from the participating organizations developed several tools and resources to make this job easier.

Patient assessments required for participation in the NYS Health Home program must focus on the medical, mental health, substance abuse, housing, and social characteristics of the patient. On average, these assessments took about two hours to complete with the patient, either in one visit or several visits. Completing assessments are mandatory for reimbursement, and completing them efficiently means patients begin to receive services more quickly. Care managers often noted that getting through the assessment question by question with the patient was lengthy and impersonal and did not build the trusting relationship care managers were looking to develop with patients newly enrolled in the Health Home program. Supervisors often found submitted assessments to be incomplete and lacking all needed information to develop a comprehensive care plan. By developing tools and providing more training to the care managers on how to approach the assessment with the patient, the quality of the assessments improved.

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Patient Assessment Templates were developed for each section of the official assessment to guide care managers in a more efficient way and obtains better quality information from the patient. The templates include several key open-ended questions that promote an assessment that is more conversational rather than closed, "one word answer" questions. The templates are to be used as a guide, with care managers asking the patient follow-up questions as appropriate.

Responses from the post-project satisfaction survey indicated that over 80% of both front line staff and their managers found the templates to help greatly in improve completion of assessments in a timely manner and to gather better quality information from Health Home patients.

DEVELOPING A "LIVING" CARE PLAN

Developing appropriate goals, interventions, and tasks for the patient's care plan based on information obtained in the assessment was a common challenge for care managers. Care managers reported feeling solely responsible for the development of the care plans (as they had been during COBRA) even though a major goal of the Health Home program is for

comprehensive care plans to be developed through regular collaboration between providers and care management staff. Unfortunately, they were often left to create these goals because they could not engage a provider in the appropriate time frame. Care management staff also struggled with identifying the appropriate interventions, because they had not received training on how to do so and/or they did not yet have a deep understanding of the individual patient.

Addressing these challenges started with improving the care managers' approach to the assessment. By collecting complete information regarding patient's goals and the provider's goals during the assessment, care managers could more easily identify appropriate interventions and next steps. This was strongly encouraged through the sets of templates.

Leftover from COBRA, the care plan forms being used at the Health Home provider organizations required one "care plan" for each of the patient's issues and were more of a task list and less of a comprehensive summary of all the current issues that a patient faced with accompanying goals. These forms, while useful to the care managers as reminders of the tasks needed to be done for a patient, were not as useful to the patient or the providers. A new care plan was developed that allowed for inclusion of all of the patient's goals and interventions on one care plan. The new format encouraged the creation of a "living" care planning document that would be useful to all parties involved in the patient's care. CHN has since built this form into their care management software applications and is exploring ways to share the care plan with the providers and patients. Housing Works will be building the form into their system in early Summer 2014.

To help care managers work with patients to identify appropriate interventions for the care plan goals, use of the *Partners In Health PACT Brief Negotiated Interview (BNI)* tool was encouraged along with other motivational interviewing techniques. Previously, care plan development was less of a collaborative process, with care managers simply presenting a care plan to the patient that he or she would sign. Using the BNI and motivational interviewing techniques allowed the care managers to work with the patient to come up with a care plan that was manageable, and assess the willingness of patients to follow through on the care plans.

INCREASED CASELOADS IMPACT PATIENT MONITORING AND TEAM COMMUNICATION

The expansion of the caseloads from 30-40 patients in COBRA to upwards of 100 patients in Health Homes posed a challenge for the care manager-patient navigator teams, particularly with ensuring that each patient was receiving care properly and no patients were "falling through the cracks." Prior to this project, encounters were tracked by billing, but there was no way to check the appropriateness of the encounter based on the patient's needs. Care managers often took a reactive approach by addressing patient needs as they came up instead of proactively managing the care of the patient based on the care plan.

Prior to this project, encounters were tracked by billing, but there was no way to check the appropriateness of the encounter based on the patient's needs.

To help Health Home care management teams better track and plan what was needed for patients on their caseloads, the CHN team designed a method and **Patient Tracker Tool** to review patient rosters systematically at weekly or bi-weekly team meetings to plan which patients needed to receive care and how for the following week or two. By the end of the month, the expectation was that each patient would get at least one billable "touch" that moved them towards meeting their care plan goals. Tasks were recorded on the tracking tool and also tracked in Outlook calendars if they pertained to an upcoming provider appointment or documentation that needed to be completed, like an assessment or care plan. CHN has since made this an electronic tracker that is part of their care management software to increase efficiency and ease of use.

The Help PSI team also created a **Team Building Checklist** to guide care manager-patient navigator teams to have effective weekly team meetings and to allow their supervisors to better monitor the work being done by the teams. Housing Works maximized the functionality of their care management software to build a sophisticated tracker that not only tracks tasks, but overdue consent forms, assessments, and care plans.

STAFF TRAINING AND DEVELOPMENT

While some external training opportunities were available to care managers and patient navigators participating in the Health Home initiative, staff at all three organizations reported that they needed more training in the basics about common chronic and mental health conditions, medications, health coaching techniques, and keeping boundaries with clients. Staff burnout rates were fairly high with several care managers from the participating organizations leaving during the project period.

With the support of PCDC coaches, CHN, Help PSI and Housing Works developed staff trainings on conducting assessments and developing care plans. In their assessment trainings, CHN emphasized the importance of more fully understanding what the patient is saying during the assessment in order to develop a more complete care plan with the patient. Trainings also emphasized the differences between the assessment approaches of COBRA and Health Homes, provided new workflows and tools, and introduced social work theories and exercises to promote the use of critical thinking skills. Help PSI's nurse care manager for the Health Homes program also set up weekly 30-minute training sessions on clinical topics suggested by the care management staff.

Staff burnout rates were fairly high with several care managers from the participating organizations leaving during the project period.

HOUSING – A COMMON AND UNADDRESSED NEED

Health Home staff at all three organizations found that housing was a huge need among patients, and that assistance with obtaining housing was a service included in the program was a huge draw for patients. With limited housing options available in New York City, time on the project was not devoted to learn how to find housing resources. Instead the focus was on helping care managers explain to patients that Health Homes is a medical case management program and that while assistance with obtaining housing can be provided, it is not the main focus of the program. These interventions did little to reduce demand for housing. In the post-project survey, one Health Home manager suggested to designate housing specialists who partner with the Health Homes to help patients obtain housing, thus allowing Health Home staff to spend more time helping coordinate medical care for patients. Overall, it appears that offering services to assist with housing as it's currently structured seems to divert time and effort away from the intended focus of the Health Home program.

ANALYSIS AND RECOMMENDATIONS

The success of Health Homes will largely depend on the ability of Health Home provider organizations to be engaged and coordinated with one another, to actively engage medical and behavior health providers in the program, to implement effective work processes, staff training and management, and to re-evaluate caseload expectations and whether important interventions such as housing are being fully addressed.

INVOLVE STAFF AT ALL LEVELS FOR SUCCESSFUL CHANGE

At the start of the project, many of the front line staff suffered from "change fatigue" with the move from the COBRA to the Health Home model. They did not want to be required to fill out additional forms or adopt new approaches to their work. Many were unhappy with the change to Health Homes because they felt the larger caseloads and administrative work took them away from working with patients. The focus went from helping patients to getting the paperwork completed, which left a feeling of disengagement among many of the staff.

Working through these challenges took engagement of staff at all levels both for the project and beyond. While the team meetings allowed an opportunity for front line staff to get additional training and guidance from their managers, all three participating organizations saw the need to continue this type of engagement beyond the project in additional trainings sessions, supervision sessions, and staff meetings. Managers found that change was easier to manage when staff felt heard and supported. They also saw improvements in the quality of the work produced by front line staff when regular and consistent training was provided.

ADAPT AND USE CARE COORDINATION SYSTEMS, WORKFLOWS AND TOOLS

It is important to have a uniform set of standards and expectations in the Health Home. As part of the Altman Foundation project, PCDC, CHN, Help PSI and Housing Works collaborated to develop a series of systems, workflows and tools to assist in the care coordination function of being an effective Health Home. Workflows developed include:

- Patient Navigation
- First Appointment with Care Manager
- Patient Assessment In-Person Case Conferencing
- Care Plan Signing
- Use of Care Plan by Providers
- Ad Hoc Care Plan Updates
- Referral Tracking
- Transitions of Care
- Care Coordinator Patient Monitoring
- Health Home Care Team Meeting
- Senior management monitoring of patients

Tools and materials developed to support these workflows, included:

- Outreach Letter to Health Home Downstream Providers
- Talking Points for Outreach to Health Home Downstream Providers
- Guidelines for Identifying Parties in Care Team/Case Conferencing

- Health Home Patient Care Plan Template
- Instructions for Completing Health Home Patient Care Plan
- Patient Assessment Medical Template
- Patient Assessment Mental Health Template
- Patient Assessment Substance Abuse Template
- Patient Assessment Housing Template
- Guidelines for Using MS Outlook to Enhance Team Communication and Manage Schedules
- External Provider Directory

These are meant to serve as a basic template based on what was needed by these providers to implement an effective Health Home. They can be adapted to meet the specific needs of individual health homes, as well as other configurations of providers that come together to address the health needs of a specific population. **The systems, workflows and tools are in the appendix that follows, and can be downloaded at www.pcdc.org/altmanHealthHome.**

ENGAGE PROVIDERS EARLY AND OFTEN

Throughout the project, both the front line staff and their managers overwhelmingly expressed challenges with engaging their patients' medical providers with care planning and care coordination activities. While tools and workflows were developed as part of this project to increase provider engagement, this was still the most common challenge reported by both Health Home front line staff and their managers in the post-project survey. Ultimately no amount of effort will be enough to solve this problem if it is only originating from the care management services side of the Health Home. Medical providers need protected time to see Health Home patients and engage in leading and coordinating their care. They need training to understand the goals of the Health Home program and clarification about what their particular role is and how they can most effectively work with care management staff to produce the most favorable outcomes for patients.

Medical providers need protected time to see Health Home patients and engage in leading and coordinating their care.

TRAIN ALL STAFF ON CARE MANAGEMENT

All staff need training on what the Health Home program is and how to perform effective medical care management for patients. They also need strong supportive leadership that clearly sets the vision and expectations for how their Health Home is to provide services.

At sites where front line staff and managers were on the same page about the expectations of the Health Homes program and what medical care management was, staff were better able to think critically and act appropriately when completing Health Home related tasks. Managers also had an easier time managing these staff.

The Implementation Team meetings and Managers meetings provided a valuable opportunity for front line staff and their managers to come to a common understanding of what medical care management is and how to execute the new policies and procedures in a way that best supports that work. However, if managers were also able to attend the outside care coordination and medical case management trainings that their front line staff were attending, it may have been easier to get both front line staff and their managers to a shared understanding of what they were trying to accomplish.

CONDUCT ONSITE TRAINING THAT CONNECTS TO WORKFLOWS AND TOOLS

In addition to having a common understanding of medical care management, staff training and new Health Home workflows and tools should be connected, as the benefits to training are limited if staff do not have the appropriate tools and workflows to apply their new skills. This goes beyond implementing new policies and procedures but also having structures in place to conduct their care management work efficiently and effectively.

ORGANIZE CASELOADS BY RISK AND COMPLEXITY

While both Health Home front line staff and their managers indicated on the post-project survey that the patient tracking tools and workflows were helpful at better managing these larger caseloads, they still felt that the larger caseloads threatened the quality of the services being delivered. Staff should consider examining what types of patients make up larger caseloads and stratifying by risk. More advanced care managers or nurses can handle a smaller case load of very complex, high risk patients, freeing up other care managers to handle regular caseloads without becoming overwhelmed.

CONCLUSION

New York has laid out an ambitious agenda to improve care for New Yorkers – particularly those with the most complex health issues. One element is clear and constant – to succeed, care among and between providers must be coordinated.

The issues identified in this Health Home experience are broadly applicable. Some of these are beyond individual providers' control, such as State requirements or the adequate reimbursement for care coordination services. But providers can still make considerable progress in coordinating patient care by restructuring the way care is delivered; involving and training leadership and staff at all levels; and engaging with the patients' medical providers within and across provider organizations.

Most important, though, is commitment. The staff involved in this Health Home focused project are overwhelmingly committed to the goals of the program and support delivering services in a coordinated, comprehensive manner in order to improve the health of participating patients. Capitalizing on this energy and commitment greatly contributed to the success of this project and, we believe, can help to energize future advancements in other Health Homes, multi-provider collaborationsor providersthat simply want to provide more effective, coordinated care to their patients.