Better Health for Northeast New York

BHNNY Cares

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BHNNY Cares

- Program overview
- Components of BHNNY Cares Program
- Why partner with a MCO?
- Additional partner engagement
- Critical success factors

BHNNY Cares

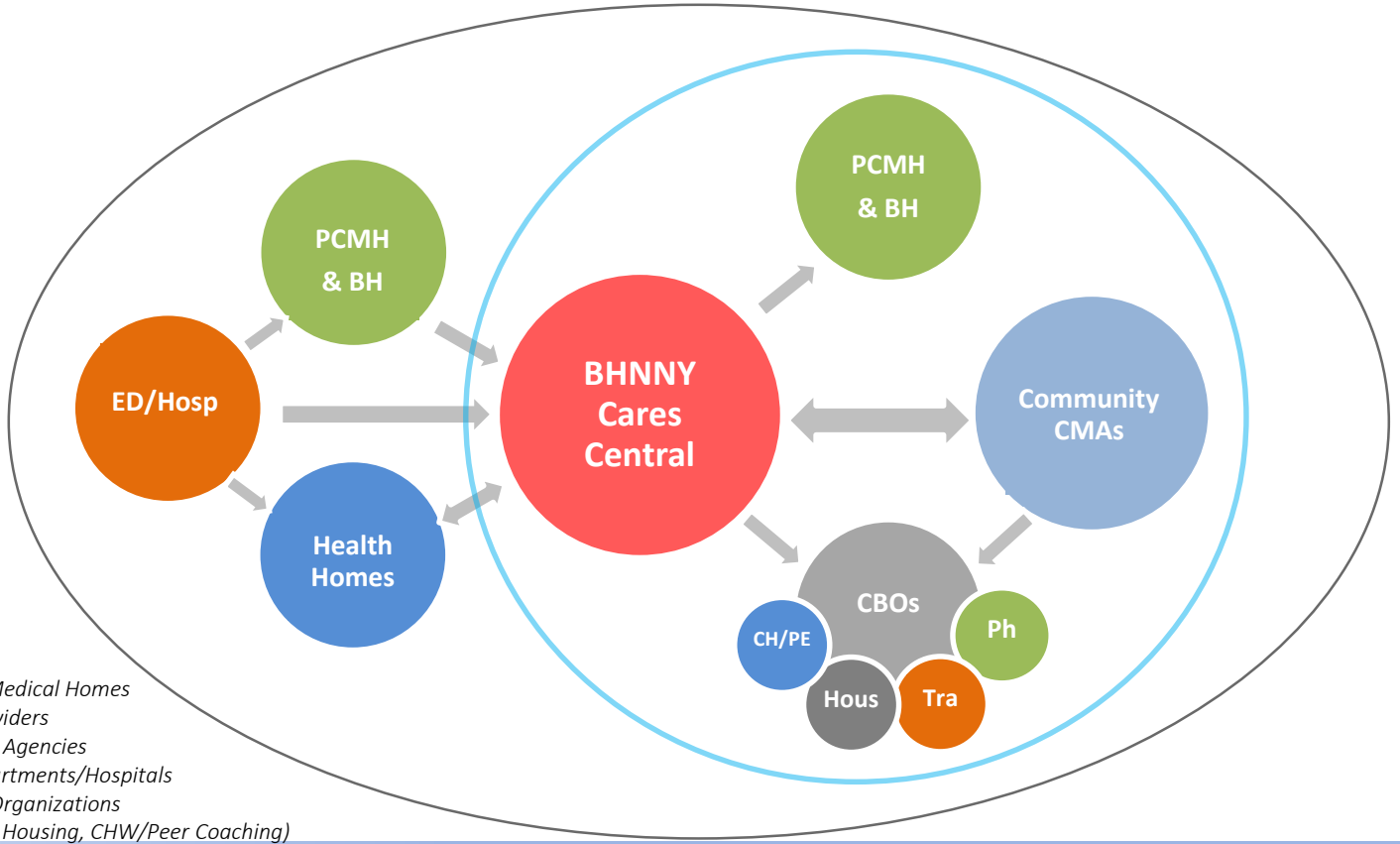
A care management program sponsored by

Better Health
for Northeast New York

BHNNY Cares – Objectives

- Identify, engage, address identified needs
  - Clinical, medication adherence, self-management support
- Facilitate access
  - Primary care, BH services, Health Homes,
- Enhance communication and data sharing
  - Care plans, access to Hixny (RHIO)
- Collaborate to address relevant Social Determinants of Health (SDH)
  - Housing, Transportation, Health Literacy/Health Coaching
  - Community-based support for members with Asthma & Hypertension

BHNNY Cares – Component of a developing IDS



Keys:
PCMH – Patient Centered Medical Homes
BH – Behavioral Health Providers
CMAs – Care Management Agencies
ED/Hosp – Emergency Departments/Hospitals
CBOs – Community-Based Organizations
(Pharmacy, Transportation, Housing, CHW/Peer Coaching)

BHNNY Cares Central – Why Partner with a MCO?

- CDPHP - Prominent physician-led regional MCO with an effective community-based care management program
- BHNNY's need to align with HHARI project objectives & meet milestone timelines
- BHNNY's desire to develop a potentially sustainable program to minimize negative impact on patients and providers
- CDPHP's extensive primary care and behavioral health provider networks

BHNNY Cares – Additional Partner Engagement

- Community Care Management Agencies
  - Alliance for Positive Health
  - Catholic Charities Care Coordination Program
  - Mental Health Association of Columbia and Greene
  - Rehabilitation Support Services
- Non-clinical care coordination needs
- Linkages to community-based providers to address SDHs

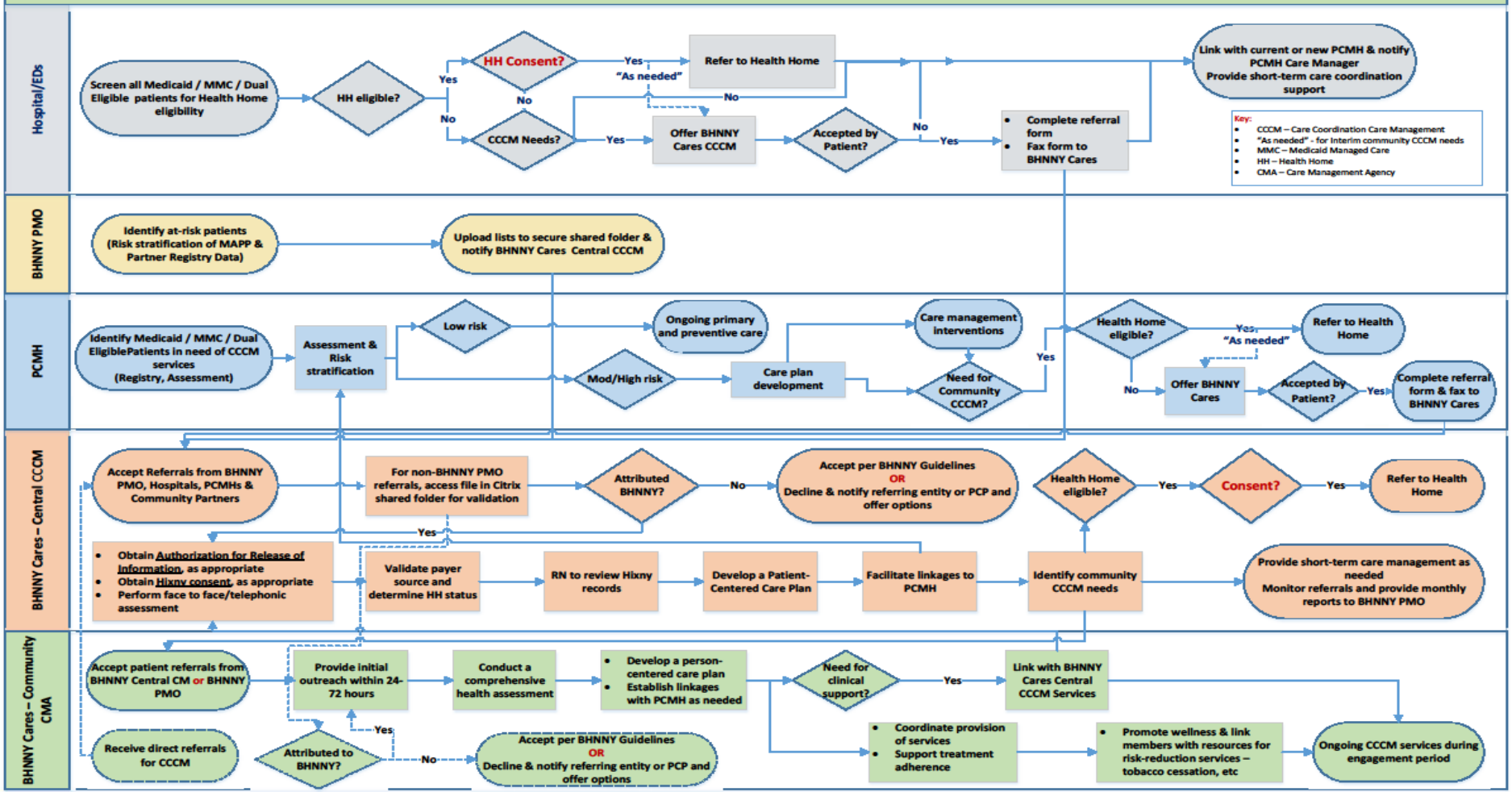
BHNNY Cares – Additional CBO Engagement

- Working on establishing agreements with CBOs to address SDH
  - **Transportation** – *Circulation Platform* – Collaboration with other PPSs
  - **Housing** – Collaboration with Alliance for Better Health & AHI PPS
  - **Health literacy & Health coaching** – Collaboration with ABH PPS & AHI PPS
  - **CVD self-management support** –Albany County DOH CHW program
  - **Asthma medication adherence** – exploring options

BHNNY Cares – Target Population

- Priority Groups for Initial CM Interventions
  - Patients identified by partnering providers
  - Patients with frequent ED visits/Hospitalizations
  - Patients identified by data analytics – patients without PCP assignment, high risk, high users, P4P gap list, etc.
  - Additional groups – Hospital CM feedback

BHNNY Cares – Referral Process & Service Delivery Workflow – DRAFT – 20170727



BHNNY Cares - Referrals are easy!

- Identified patients can be referred with a simple fax or a call

- **Fax (518) 810-0021**

or

- **Call (518) 810-0002**

BHNNY Cares – Critical Success Factors

- Shared vision
- Active leadership support
- Active practitioner / organizational participation
- Effective member / consumer engagement
- Availability and utilization of health information systems – *risk stratification, real-time exchange of care plans, data analytics*
- Ability to demonstrate value – reduce cost and improve care

Centralized Care Management in Partnership with CDPHP

Charlene Schlude BSN, MPA, CCM

Director Centralized Care Management

Innovative Partnership: MCO and PPS collaborate on a unique centralized care management model

How did we come together?

- Strong hospital partnership between CDPHP and PPS affiliated hospitals
- CDPHP's mission aligns well with BHNNY Cares population health strategy
- Solid relationships with community partners
- Alignment in our roles for supporting primary care practices
- Demonstrated success of CDPHP's Medicaid case management program

Centralized Care Management Model

- Dedicated Multidisciplinary Care Team
  - ✓Care Coordinators
  - ✓RN Case Manager
  - ✓SW case managers (behavioral health background)
  - ✓Pharmacist
- Comprehensive Assessment
- Patient Activation Measure (PAM)
- Person Centered Care Plan
- A hybrid model : triage and refer /triage and management for defined subsets of the population
- Monthly reporting in support of DSRIP requirements

Key Program Deliverables

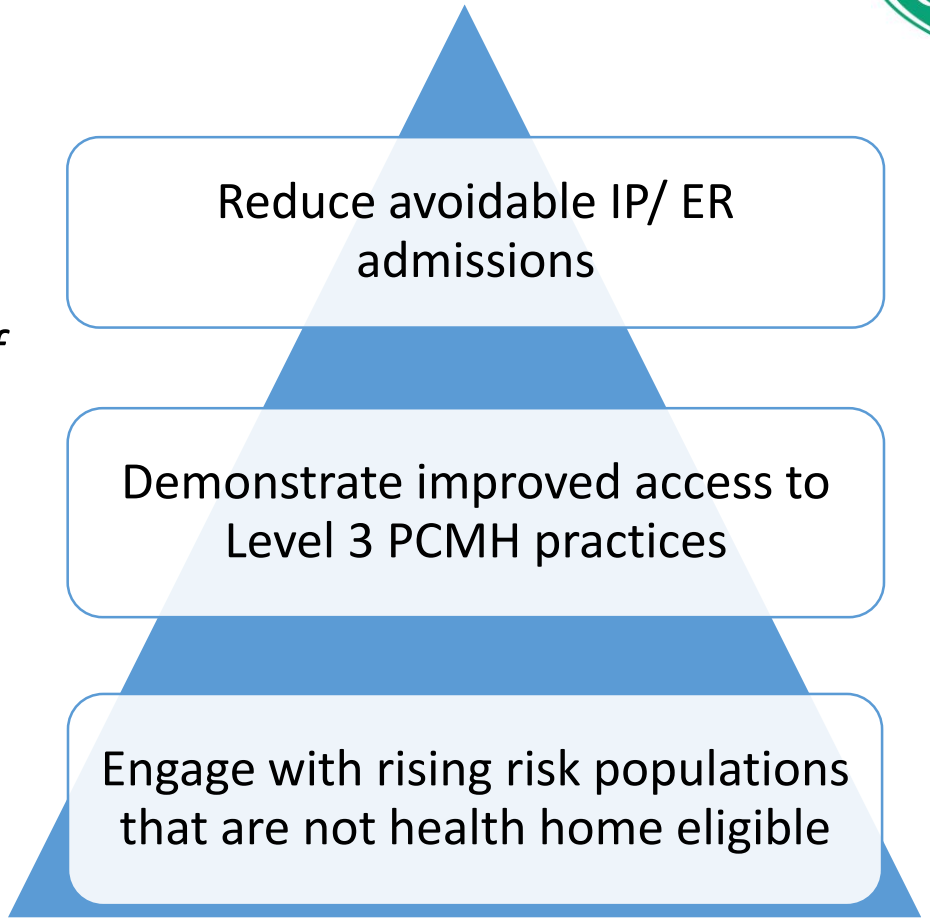
- Perform care transitions after an ER encounter
- Address all social determinants of health
- Facilitate engagement with NCQA Level 3 PCMH practices
- Maintain relationships with community-based resources and refer as appropriate
- Maintain relationships with payers and evaluate benefits and services offered
- Use health information technology to link services
- Maintain accurate data and provide timely, meaningful data to PPS
- Perform regular monitoring of all referrals to assess for care plan modifications
- Facilitate health home referrals as appropriate

Challenges along the way…

- Limited options for case management system on go live date
- Restricted access to alternate PPS data
- Difficulty identifying health home eligibility

Expected Outcomes…

- *Strong focus on DSRIP milestones*
- *Follow guiding principles of the Triple Aim*



Program status…

7/14/17 through 8/30/2017

- 25 enrolled
- 95% engagement rate
- Referral source : primary care practices