Care Management in New York State Health Homes

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Contents

Acknowledgements

Executive Summary

Realizing the promise of care management requires a fundamental shift in the way health care is conceptualized, organized, and delivered—from a medical model of disease treatment toward person-centered care that incorporates social service provision, behavioral health care, self-management support, and family engagement alongside primary and specialty medical care. New York State's Medicaid health home initiative offers an unprecedented opportunity to expand and improve care management for beneficiaries with intensive, high-cost service needs. The health home model provides the basis for unified systems of care to coordinate and integrate physical and behavioral health care, chemical dependence treatment, and social services provided to health home members.

New York State defines care management as the comprehensive assessment of health home members' needs with an individual care plan carried out through specific interventions designed to provide coordinated, efficient, quality care to achieve the care plan goals and optimize health outcomes for people with complex health issues and needs. To inform practitioners and policymakers about progress toward the health home vision of comprehensive care management, the New York State Health Foundation (NYSHealth) commissioned a study on a limited number of health home networks from across the State. The key objective of this research was to identify the many aspects of the health home model that influence the design and delivery of care management within health home networks. Secondary objectives were to identify common challenges to implementing care management in health homes, highlight promising practices in care management, and identify issues that warrant more in-depth exploration to inform the field.

The study was conducted during fall 2013. Four health homes with diverse administrative structures, organizational histories, and geographic locations participated in semistructured interviews by telephone on a broad array of topics: Adirondack Health Home, Bronx Accountable Healthcare Network, Brooklyn Health Home, and FEGS Nassau Wellness Partners Health Home. For each health home, interviews were conducted with the health home administrative lead agency (health home administrative lead) and with two of its care management partner agencies (care management partners). Care management partners represent a wide array of organizational types and sectors, including health care institutions; patient-centered medical homes (PCMHs); behavioral health and social service agencies; and nonclinical agencies that have provided support to regional health care initiatives.

From the analysis of the qualitative findings, nine topics were identified as impacting the design and delivery of care management in health homes:

- Health Home Network Structure
- Care Management Approaches
- Staffing Models and Credentials
- Care Management Staff Training
- Health Home Member Risk Assessment and Care Planning
- Caseload Balance
- Assignment of Health Home Members to a Care Management Partner
- Health Information Technology and Data Sharing
- Care Manager Collaboration with Care Providers

Each topic was complex and impacted the health homes in different ways. However, all health homes interviewed were implementing promising practices to reconcile systemic challenges related to care management service delivery, providing examples of innovation and areas for future research. This survey was not intended as a means toward developing an inventory of current promising practices; furthermore, at this early stage, findings cannot inform recommendations for systemwide adoption. However, examples presented in this report provide encouraging directions for future exploration, including the development of quantitative research projects and evaluation strategies to assess health home member outcomes associated with these innovative practices.

The following areas for action were identified:

- **Increase standardization.**
  While administrative flexibility was essential to getting the State's health home program underway at the outset of the initiative, early evidence uncovered in this study indicates that greater standardization of administrative practices at individual health homes may now be needed. Increased standardization could help to further the goals of comprehensive care management by (1) preventing undue burdens on care management partners and network providers participating in multiple health homes and (2) reducing variation in fundamental services and quality assurance mechanisms in health homes across the State.

- **Define the right staffing mix.**
  Bringing together the rich experience of care management professionals from a variety of backgrounds is an important strength of the health home's comprehensive care management vision—a vision that will impact the way in which care management is conceptualized throughout the health system in the coming years, at PCMHs, accountable care organizations (ACOs), and beyond. As health home networks identify promising practices in staffing, the New York State Department of Health (NYSDOH) has a role to play in sharing those practices with all health homes and potentially adapting those practices into statewide guidelines for health homes to help operationalize the vision of comprehensive care management.

- **Increase training opportunities.**
  All agencies in health home networks need more training for their care management staff. In general, care managers in health care organizations require training to work more effectively within the social service and behavioral health realms—particularly in relation to housing needs and behavioral health care—while care managers in social service and behavioral health agencies need additional training in medical diagnoses and chronic conditions, as well as in facilitating medical care. Training in data use and reporting would benefit care managers in agencies of all types.

- **Revise reimbursement measures.**
  Incorporating social risk measures (such as homelessness, food insecurity, employment status, and recent prison release) into the development of acuity scores will lead to a more accurate

reflection of health home members' status. Such changes will also enhance the ability of care management partners to provide and be reimbursed for the type, intensity, and level of services they deem appropriate, delivered by the team members most fitting for the tasks.

- **Reassess health home member needs and update acuity scores.**
  Health home members have complex needs that require regular reassessment to ensure the delivery of the appropriate intensity and type of care management services. Developing a mechanism by which acuity scores may be formally adjusted more frequently to reflect changes in member status, and through which the continuum of need among health home members can be addressed, is essential.

- **Increase access to timely and appropriate data.**
  Health homes need timely access to health home member data from NYSDOH, Medicaid managed care organizations, and providers to accurately represent acuity, develop an appropriate care plan, and assess health home member improvement over time. At the same time, health home administrative leads need data to appropriately monitor care management partners and create incentives for them, as well as to provide them with meaningful feedback that care management partners can in turn use to manage health home members, supervise staff members, engage in improvement, and manage resources effectively.

- **Enhance technology, connectivity, and communication.**
  Facilitating real-time access to health home member data through shared care plans to which all care team members contribute is essential. Social service and behavioral health agencies, which have not benefited from the sustained technology development funding afforded to medical organizations, need support for technology adoption. Minimum standards for virtual data exchange should be tightened as capacity increases to ensure that care management partners have access to needed information for all health home members irrespective of the health home to which the member belongs.

- **Improve broader medical community participation in care management.**
  NYSDOH has a role to play in advancing treatment provider collaboration in the health home model. One of the key issues to be explored is what the current incentives are for treatment providers and what could possibly be put in place to help them engage more fully. Health homes and care management partners also have a role to play in formulating best practices for provider outreach and engagement.

Implementing health homes and establishing new care management models and infrastructure are ambitious undertakings. Capturing early lessons learned is critical for supporting model improvement at both the State and health home levels, as well as to inform plans for expanding the model to additional populations. As one of the first states to pilot health homes, New York's experience also holds valuable lessons for other states about to embark on health home implementation.

Introduction

About Care Management in New York State

Realizing the promise of care management requires a fundamental shift in the way health care is conceptualized, organized, and delivered—from a medical model of disease treatment toward person-centered care that incorporates social service provision, behavioral health care, self-management support, and family engagement alongside primary and specialty medical care. With large numbers of primary care practices across New York making the transition to the patient-centered medical home (PCMH) model, the successful adoption of the mechanisms, resources, and tools to facilitate care management has become increasingly common. Examples of this PCMH shift include hiring and training specialized care coordinators; adopting health information technology (HIT) to facilitate medical coordination; and building team approaches to care in which staff members work at the top of their license to deliver care and to engage with individuals and their families and caregivers to build support networks. However, the current PCMH care management model is not sufficiently robust to address the needs of highly complex populations.

New York State's Medicaid health home initiative offers an unprecedented opportunity to expand and improve care management for beneficiaries with intensive, high-cost service needs. The health home model provides the basis for unified systems of care to coordinate and integrate physical and behavioral health care, chemical dependence treatment, and social services provided to members. A revolutionary aspect of the model is the recognition that health care organizations must partner with social service and behavioral health agencies to realize the promise of the health home vision. As these partnerships take hold, an increased emphasis on cooperation and coordination among agencies is supplanting coordination of patient services across agencies; and new models of care management are emerging, with implications for service delivery and financing, as well as for the broad adoption of a more comprehensive and person-centered approach to care.

This paper analyzes findings from a study of New York health homes' early experience with care management, with the goal of informing practitioners and policymakers about progress toward the health home vision of comprehensive care management. Findings presented in this report characterize the experience of a small group of Phase 1 health homes in New York. While not an exhaustive illustration of care management in New York health homes, these data may provide a useful barometer of health home experience with comprehensive care management and indicate future directions for the field.

Report Objectives

Findings presented here are intended to inform more extensive, in-depth studies in each of the topics addressed. Specifically, the objectives of this paper are to:

- Present a broad overview of the many aspects of health homes that influence how care management is designed and delivered within those settings;

- Identify common challenges to care management in New York State health homes;

- Highlight promising practices in care management alongside variation in strategies and models across health homes; and

- Identify issues that warrant more in-depth exploration to inform the field.

In view of the limited number of survey participants and the early stage of health home development, findings presented here should not be used as the basis for generalized conclusions or broad recommendations for all health homes.

Background

The Evolution of Care Management for Complex Patients in New York State

New York State, alongside the Centers for Medicare & Medicaid Services and other federal agencies, has long recognized that for some individuals the traditional delivery of medical services, behavioral health services, and/or social services in isolation from one another is insufficient for achieving treatment goals on account of the complexity, severity, and/or sheer number of their health conditions and/or the instability of fundamental socioeconomic factors. At the same time, there has been increasing acknowledgement that the fragmented, siloed, bureaucratic network of health care and social services imposes significant barriers to accessing and getting the most out of available services for even the most resilient individuals.

In response, New York State has developed a number of categorical payment mechanisms to provide a plethora of supportive, integrative services—known variously as care management, case management, care coordination, and care navigation—that are more individualized and intensive for individuals while also introducing financial incentives to encourage innovation among providers and health care organizations. Prior to the recent introduction of PCMHs, which strive to provide integrated health care services responsive to individual needs, and ACOs, which seek to rationalize care delivery, New York State undertook the following programs (often referred to as legacy programs, serving legacy members):

- Targeted Case Management (TCM), a program administered through the Office of Mental Health (OMH) to address the needs of adults with serious mental illness and youth with severe emotional disorders;

- Managed Addiction Treatment Services (MATS), a program administered through the Office of Alcoholism and Substance Abuse Services (OASAS) that included case management and care coordination for individuals with intensive, high-cost service needs and chemical dependence disorders;

- Comprehensive Medicaid Case Management Program (COBRA care management or HIV/AIDS targeted case management), a family-centered intensive care management program for HIV-infected individuals and their families; and

- Chronic Illness Demonstration Project (CIDP), an initiative developed by NYSDOH, in consultation with OASAS, which provided funding to six teams across the State to test innovative solutions that address unmet needs among high-risk individuals.

As a result of its long history implementing care management programs, NYSDOH immediately recognized the opportunities to build upon existing programs under the Affordable Care Act (ACA) and applied for the necessary waivers to do so. In 2011, New York State was awarded a Centers for Medicare & Medicaid Innovation waiver under Section 2703 of the ACA to pilot health homes and work in a more focused, comprehensive way toward improving outcomes for the most vulnerable subset of the population. The health home model is a whole-person approach to integrating and coordinating all primary, acute,

and behavioral health care and long-term services and supports for high-risk Medicaid beneficiaries with complex chronic health and/or behavioral health needs, and whose care is often fragmented, uncoordinated, and duplicative. The model endeavors to improve care and health outcomes; lower Medicaid costs; and reduce preventable hospitalizations, emergency room visits, and unnecessary care for Medicaid members.

Defining Medicaid Health Homes in New York State

New York health homes are defined as partnerships between health care providers and community-based organizations. Health homes comprise partners at four levels: (1) governance partners (stakeholders); (2) a health home administrative lead, responsible—at a minimum—for maintaining data, securing payment, and ensuring quality; (3) network partners, designated as care managers (care management partners); and (4) a network of affiliated providers delivering a broad range of services to health home members. In many instances, health home leadership comprises multiple providers under a joint governance structure. This mandate for formalizing partnerships among agencies from multiple sectors is fundamental to New York State's vision for realizing comprehensive care management.

New York health home administrative leads and care management partners represent a wide array of organizational types and sectors, including health care institutions; PCMHs; behavioral health and social service agencies that have previously participated in the TCM program; nonclinical agencies that have provided support to regional health care initiatives; and, in more limited instances, local government entities.

Under the federal requirements, each health home must provide "comprehensive and timely high-quality services," defined as:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, including authorized representatives;
5. Referral to community and social support services, if relevant; and
6. Use of HIT to link services, as feasible and appropriate.

> ### Defining Comprehensive Care Management for New York Health Homes
>
> New York State's Health Home Care Management Assessment Reporting Tool (HH-CMART) guidelines define care management as "the comprehensive assessment of a member's needs with an individual care plan carried out through specific interventions designed to provide coordinated, efficient, quality care to achieve the care plan goals and optimize health outcomes for people with complex health issues and needs."

Background *(continued)*

While New York State provides specific direction about services that must be provided and the reimbursement mechanisms to support them, guidance regarding implementation is less prescriptive, leaving substantial room for interpretation. New York State purposefully built considerable flexibility into the program to promote testing and learning. As a result, health home leadership and care management partners must develop their own particular hybrid care management models—uniting medical coordination with behavioral health and social service provision—in a manner reflective of each agency's unique history and tailored to the complex needs of the health home population. Simultaneously, they face challenges inherent in the health care environment related to the following issues:

- **System fragmentation:** Historically, the health care, social service, and behavioral health spheres have operated independently from each other. Thus, building bridges and trust between these spheres, and changing protocols to prioritize teamwork among diverse professionals on a health home member's care team, will take time. This cross-sector fragmentation is compounded by fragmentation within the health care system itself, in which organizations still struggle to implement team-based care for patients with chronic conditions and coordinate care for patients across medical care, behavioral health, and social service organizations.

- **Workforce limitations:** As yet, a workforce has not been developed and trained to address the breadth of care coordination services to be provided in New York health homes. Even when responsibilities are shared across a multidisciplinary team, all staff members need to have a common conceptual framework and working knowledge that spans medical, behavioral health, and social services.

- **Gaps in available health and social benefits:** A lack of resources challenges the provision of health home services throughout the State. Examples include a lack of housing resources, primary care providers, and psychiatric services for the health home population.

- **Technology and connectivity limitations:** HIT holds great promise for care management; however, off-the-shelf HIT packages are not yet able to support comprehensive care management in the way envisioned by the health home model. Health home administrative leads and care management partners without robust in-house capacity and experience in developing, testing, and refining HIT to support team care are encountering challenges in operationalizing the processes needed to translate connectivity goals to reality. Furthermore, medical organizations have benefited from a much greater level of funding for technology development than other organizational types, leading to a disparity in technology adoption and facility across the medical, social service, and behavioral health fields.

Background *(continued)*

Methods

Recognizing the diversity of care management models being implemented by health homes across the State, a qualitative study of a limited number of New York health homes was chosen as the best way to examine the nuances of these models, and to support innovation by elucidating how promising care management practices impact service delivery at the health home administrative lead and among its care management partners. Findings reported here are intended to complement those of concurrent health home research initiatives being undertaken by NYSDOH and others, and are not intended to be used as the basis for generalized conclusions about care management in New York health homes. Instead, the aim is to present a broad survey of the issues impacting the delivery of care management services in health homes and inform more focused studies on the topics identified.

A literature review was conducted, exploring both the peer-reviewed and gray literature, to inform the development of the interview guide. Subsequently, seven key informants within the health care policy and practice spheres were identified. In interviews by telephone, key informants provided context for the current health home landscape and suggested criteria for the selection of health home networks to include in our survey.

Next, the sample was selected from among the 12 Phase I health homes in New York, which had received their health home designation in 2012; the sample was limited in this way to allow for the longest possible implementation experience. Selection criteria included the size of the network, its location (downstate or upstate), and health home administrative lead type (medical or social service). The objective was to develop a sufficiently diverse sample to gain insights into common themes across health homes, as well as differences that may stem from unique characteristics. As a result of funding and time constraints, the sample was limited to four New York health homes.

For each network, semistructured interviews were conducted with the health home administrative lead and two of its care management partners. First, one-hour telephone interviews with lead agency administrators were conducted. In most cases, these individuals were directors of the care management program for their health home network; in some cases, other executive and/or programmatic leaders joined the call. Each health home administrative lead was then asked to identify two care management partners that would be willing to participate in the survey and to provide introductions for the Joslyn Levy & Associates (JLA) team. A one-hour telephone interview was then conducted with the director of the care management program at each organization. In some cases, the program director was joined by one or more of the agency's executive leaders or program supervisors.

Interviewers used a structured interview guide to organize the discussion (see Appendix B). All interviews except one were recorded, and JLA team members also took notes during each call. Data were analyzed thematically to identify similarities and differences in approach. For each agency interviewed, innovative or unique practices were highlighted, as well as key challenges to care management implementation. Table 1 lists the health home administrative lead and the two care management partners interviewed for each health home in this survey.

Background *(continued)*

TABLE 1. Participants				
Health Home	Adirondack Health Home	Bronx Accountable Healthcare Network	Brooklyn Health Home	FEGS Nassau Wellness Partners Health Home
Health Home Administrative Lead	Adirondack Health Institute	Montefiore Medical Center	Maimonides Medical Center	FEGS Nassau County
Location	North Country	Bronx	Brooklyn	Long Island
Agency Type	Nonprofit Regional Coordinating Organization	Hospital	Hospital	Health and Human Services Agency
Care Management Partner Agency 1	Hudson Headwaters Health Network	Division of Substance Abuse, Albert Einstein College of Medicine	CAMBA	Central Nassau Guidance and Counseling Center
Care Management Partner Agency 2	Behavioral Health Services North	Puerto Rican Family Institute	NADAP	Options for Community Living

Findings

Findings are presented under nine topics that emerged as useful groupings for health homes' experiences and concerns related to care management. These topics were defined as issues that impacted the design and delivery of care management in each health home in different and substantial ways. To organize the presentation of the diverse experiences of health home administrative leads and care management partners, each section begins with key takeaways related to the topic of care management and includes examples of promising practices being implemented by New York health homes.

In view of the limited number of participants and the early stage of health home development, findings presented here should not be used as the basis for generalized conclusions or broad recommendations for all health homes. Findings are intended to inform more extensive, in-depth studies in each of the topics.

Health Home Network Structure

KEY TAKEAWAY

▶ To realize the vision of a democratic, collective program implementation, health home administrative leads need to invite frequent feedback from care management partners on program challenges, support collaborative problem solving, and raise needs and concerns with the State on partners' behalf. Health homes must give care management partners a meaningful voice in program design and evolution.

By definition, each health home comprises a new constellation of partners functioning under health home-specific governance structures and operational plans. Health home administrative leads and care management partners represent a diversity of agency types and have differences in organizational culture, clientele, and locality. These differences result in variations on how health home administrative leads and care management partners interact, the boundaries of their collaboration, and, ultimately, how each health home designs and implements care management. Decisions by the health home administrative lead, such as how to best leverage the strengths of care management partners and the degree of oversight and standardization to introduce into the network, impact the experience of the care management partners, their staff members, and their health home members.

Many care management partners work with multiple health homes—a feature of the health home administrative structure that provides flexibility and enables care management partners to continue to work with existing clients and transition them toward health home membership. This feature also

Findings *(continued)*

allows for an ample choice of providers for health home members, and ensures that health homes have sufficient capacity to manage fluid caseloads. However, care management partners working with multiple health homes must comply with various sets of administrative and reporting requirements, use multiple technology platforms, and fulfill a number of training requirements—all of which are health home-specific. In some instances, care management agencies partnering with multiple health homes assign staff members to teams specific to a particular health home (sometimes called pods) to limit administrative burden and confusion.

Furthermore, many health home administrative leads not only serve as conveners of health home networks, but also deliver care management services themselves alongside their care management partners. Thus, health home administrative leads' experience with care management may impact the development of their governance and administrative structures, particularly with regard to how open they may be to inviting input and incorporating strategies from their care management partners—an issue that arose across health homes.

One key challenge facing health homes is how to incorporate each care management partner's experience and best practices into health home-wide guidelines and protocols. Currently, networks vary tremendously in the frequency and formality with which health home administrative leads engage care management partners, which in some health homes can exceed more than 30 agencies. Great variation also exists in the degree to which health home leadership invites care management partner participation in efforts to develop health home-wide policies and procedures. Some health homes are tightly knit networks, built on established relationships that existed among sister agencies prior to the launch of the initiative. In these networks, health home administrative leads regularly review care management partners' data and provide oversight regarding outreach to potential health home members, enrollment of new members, and management of existing members. Other health homes are loose affiliations of regional entities that came together for the first time under the auspices of the health home. In these networks, the health home administrative lead may assume responsibility for administrative functions associated with the health home but impose fewer clinical standards. For example, clinical supervision may be left entirely to the individual agencies, with only minimal program oversight by the health home administrative lead.

Although advantages exist to both approaches, health homes with stronger central governance and administrative structures appear to offer care management partners more opportunities to interact and learn from each other, creating the conditions necessary for more rapid uptake of promising practices across the network. While establishing these structures does not necessarily create a tightly knit group of collaborating care management partners, the health home administrative lead can advance the entire network toward a shared concept of comprehensive care management by setting expectations for care management partners; recognizing and taking advantage of care management partner expertise in different content areas; conducting training; providing feedback; and serving as a channel through which tools and strategies may be assessed and adopted health home-wide.

Findings *(continued)*

Promising Practice

Fully Engaging Care Management Partners in Health Home Governance

One health home formed a new LLC with partners from six agencies. By having a coalition of diverse agencies share in its governance, the health home laid the foundation for collaboration going forward. In particular, the health home ensured that different perspectives on care management would be heard, and that tools and strategies used by a variety of organizations would be valued by the health home as a whole and shared throughout the network. Governance structures consist of topic-based committees—including a clinical committee, HIT committee, care management workflow committee, and housing committee—to which all care management partners can contribute. This has created a platform for collaboration where the concerns and ideas of care management partners can be expressed and acted upon. Perhaps reflecting this orientation, training for care management partners has been a key focus of this health home: a specialized health home-wide, 4-hour per week, 12-week cycle of training for care managers was introduced early in the health home's establishment. Care management partners note the differences in management between this health home and others that they serve and appreciate the training they receive.

Area for Action

Increase Standardization

While flexibility was essential to getting the health home program underway at the outset of the initiative, early evidence uncovered in this survey indicates that greater standardization in the administrative structure and practices of individual health homes may now be needed. Increased standardization could help to further the goals of comprehensive care management by (1) preventing undue burdens on care management partners and network providers participating in multiple health homes and (2) reducing variation in fundamental services and quality assurance mechanisms across New York health homes. This change would allow care management partners to focus on service models and delivery rather than the development of new administrative tools or on the fulfillment of multiple administrative requirements set by the various health homes to which they provide services.

Findings *(continued)*

Care Management Approaches

> **KEY TAKEAWAY**
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> ▶ Health homes are integrating individual agencies' unique expertise and experience to build new, flexible care management approaches incorporating social and behavioral health services alongside medical care coordination and to develop highly individualized, member-driven care plans.

Federal and State guidelines specify required health home functions, such as integrating diverse case management workforces; employing cross-discipline, cross-agency data sharing; and introducing care management oversight functions. However, health homes are afforded wide latitude in how to meet these requirements. Since there is no single correct way to design and implement care management, health home leadership and care management partners are testing new approaches that draw from the medical, behavioral health, and social service fields to achieve the best results.

Team composition was one aspect of care management that varied significantly among health homes both in terms of titles and skills. To an extent, the variation is semantic, resulting from the wide-ranging interpretation and application of titles. The terms care coordinator and care manager are key examples of this variation. However, differences also reflect the diversity of the health home stakeholders, administrative leads, and care management partners with respect to their agency history; existing administrative structure and team composition; and the concepts and practices characterizing each agency's approach to care management. To design a comprehensive care plan for individuals with complex behavioral health, social, and health care needs, the care management team may comprise any combination of the following: care manager, care navigator, primary care provider, psychiatrist and/or therapist (for members with serious mental illness), specialty care physicians, home care nurses, residence managers, social workers, chemical dependence treatment providers, and others. At least one health home includes representatives of emergency departments on the team. The care manager serves as coordinator of the care team, implementing individual care plans for health home members that include services spanning multiple fields and providers. Team composition is discussed further in the next section, Staffing Models and Credentials.

Another point of variation among the health homes interviewed was the difference in locus of care. Some care management partners—typically, health care delivery organizations—are providing office-based services in a manner similar to that which they have used to provide medical care coordination. Others—typically, social service and behavioral health agencies—are using the feet-on-the-street approach that has been fundamental to how these agencies conducted care management prior to the launch of the health home, when the TCM model guided service delivery to individuals with intensive behavioral health, HIV/AIDS-related, and social service needs.

Findings *(continued)*

While this dichotomous framing may be useful for understanding the source of some key differences in approach, it is also important to note that each care management partner is in the process of developing its own hybrid model of care management that spans the continuum in order to be responsive to the breadth of the health home mandate. Some health care organizations have adapted the TCM approach, acknowledging that TCM conversion agencies have vast experience in supporting individuals with complex needs; some social service agencies have introduced nurses or medically trained coordinators to supplement the work of their care managers. See the Promising Practice example described on the following page for more detail on how this hybrid model may look in action.

Another point of divergence pertains to the fundamental role of the care manager within the larger care team. Some health homes view the role of care managers as being limited to coordinating and implementing individual care plans that are designed and driven by a multidisciplinary care team; other health homes view the care managers as the driver of the care plan—the key staff member responsible for its design and implementation.

Some variation in the specification of standards also was noted. While the fundamental elements of care management are dictated by federal guidelines (as described in the Background section of this report), health homes establish expectations for how those care management components will be provided. For example, each health home may establish different timeframes and protocols for follow-up appointments subsequent to a medical or psychiatric hospital discharge. In some instances, health homes expect care managers to visit health home members while they are in the hospital and to be physically present at care team case conferences and discharge planning meetings whenever possible.

Findings *(continued)*

Promising Practice

Developing Nurse-Supported Care Management in a Behavioral Health Agency

One behavioral health agency recently added a nursing support component to its care management model. Previously, the agency's model relied on field-based bachelor's-prepared care managers to provide all care management services, supported by office-based staff members. This approach was built on the agency's experience in case management prior to the launch of the health home. However, over the first year of the health home initiative, the agency realized that health home members with multiple chronic conditions needed specialized medical support. A registered nurse now serves as a nurse coordinator, charged with interfacing with all health home members who have at least one chronic condition. According to the agency, the nurse is able to pick up nuances that nonmedical care management staff may miss, and provide education and support to health home members with chronic conditions that care managers are not equipped to do. The nurse ensures health home members have a regular source of health care, keep their medical appointments, and are able to self-manage their conditions, including conducting at-home A1c and glucose testing. Generally, the nurse provides services telephonically from the agency's office, but if needed, she accompanies care managers on home visits. Although outcomes data are not yet available to document the success of this approach, positive feedback from health home members and staff members suggests that this nurse-supported approach may represent a promising practice to developing a care management model that incorporates the best of both case management and medical coordination.

Staffing Models and Credentials

KEY TAKEAWAY

▶ Supporting staff members with diverse educational levels, work experience, and backgrounds to form effective teams in which true collaboration and joint problem solving take place is necessary to achieving the promise of comprehensive care management. Respecting and empowering care management staff, and providing career ladders for staff members within agencies, will support high-quality, continuous service provision.

NYSDOH has set the minimum educational requirement for care managers as a high school diploma plus two years of experience and defined a basic set of professional responsibilities for care managers working in health homes. This limited guidance has allowed for the flexibility necessary to integrate many different agencies and actors into the health home model. At this stage, titles, educational qualifications, and job responsibilities for care managers vary widely among agencies; even the terminology used by care management professionals differs from organization to organization, depending on its history, staffing, and philosophy of care. Agencies are experimenting with different care management delivery models and roles to determine the right mix of skills, training, experience, education, and background, including culture and language, that should be included on a care management team to most effectively serve health home members. As data become available over time, questions to be addressed include: can certain staffing models be linked to better outcomes for members? Should any model be recommended as a standard for the field, or should flexibility in staff member roles and requirements remain a feature of care management, to be determined at the discretion of implementing agencies?

Most of the agencies interviewed use a team-based approach, in which care management responsibilities are subdivided among different staff members to realize efficiencies and render their model most effective for both health home members and the staff. In agencies where care managers are bachelor's- or master's-prepared staff members in a human services field, peers or community health workers (CHWs) may be better suited to outreach and enrollment, freeing care managers to focus on problem solving with high-acuity members. In PCMHs that use registered nurses as care managers, care navigators with high school diplomas or associate's degrees may provide administrative support so that the care managers can focus on medication management and other issues that require their expertise.

Findings *(continued)*

> ### Supervision Structures
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> Capturing the diversity of approaches to staff supervision is difficult because of the extreme variety of educational qualifications, clinical backgrounds, and experience of each agency's staff members. Examples of supervision structures include:
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> - One licensed clinical social worker supervising 20 chemical dependence counselors who also serve as care managers;
>
> - One master's- or bachelor's-prepared care manager supervising a program supervisor who provides administrative supervision to all field-based care coordinators and care advocates. The care manager provides clinical supervision to one team of two care coordinators, as well as one team of two care coordinators and one care advocate; and
>
> - One program manager overseeing 4 to 5 care manager supervisors with either master's or bachelor's degrees, each of whom oversees 3 to 5 care managers and 20 peers.

In some cases, this model translates to a hierarchical team structure in which a nurse care manager supervises nonclinical care managers who in turn supervise peers or CHWs. In other agencies, the supervisory structure is less complex; staff members with higher educational qualifications and training serve primarily in supervisory roles, overseeing on-the-ground care managers. In a few of these agencies, individual care managers conduct all activities to prioritize continuity of contact and care with each health home member; however, as member enrollment increases and caseloads grow larger, this model may prove unsustainable.

Several common trends and issues emerged by agency type:

- **Social service/behavioral health agencies:** In the adapted TCM model, care management staff members do much of their work in the community: going to health home members to provide supportive services, helping them navigate complex systems, and accompanying them to appointments. In some instances, office-based staff members may provide administrative support to the care managers: making appointments for health home members and generating reports that care managers can use to track member needs and services delivered. Traditionally, TCM agencies have ascribed equal value to years of experience and educational attainment for their case managers. Thus, care managers may be certified case managers with a high school diploma and substantial field experience work or have college or master's degrees in social work or a related field. They are in turn supported by peers or CHWs, who come from the community being served and have unique skills in engaging health home members. However, several of the social service agencies interviewed indicated that a

minimum of a bachelor's degree may be more appropriate to address the demands of serving health home members with multiple chronic conditions and mental health issues, which requires highly developed problem-solving skills. In line with this finding, among agencies that require bachelor's-level training for their care managers, some noted that master's-level staff members are often more successful in managing members with complex mental health issues. All of the social service and behavioral health agencies interviewed were grappling with how to ensure that staff members have adequate medical expertise to provide comprehensive care management to health home members with multiple chronic conditions. A deeper exploration of this topic is needed to identify promising practices in this area.

- **Medical organizations:** Health care-based care managers generally have a professional degree, most often in nursing. These care managers, typically office-based staff members, conduct telephonic care coordination out of a central office or PCMH. Medical organizations note that their care managers have received limited training to facilitate access to entitlements, but that PCMH-based care managers are less familiar with and experienced in this field and, as office-based staff members, find their abilities constrained. Accordingly, some have engaged peers, CHWs, and/or care navigators to conduct field-based outreach; anecdotally, for most agencies, this strategy has been successful, but further investigation is needed to understand practices and outcomes. Some also employ junior care managers to conduct outreach by telephone to health home members who miss appointments or otherwise seem to slip off the PCMH's radar. Several care management partners, both medical and behavioral health/social services, noted that the colocation of their care managers with service providers was an advantage, allowing for warm hand offs between providers and care managers, as well as facilitating case conferencing between care managers and providers.

At this early stage, health homes are still experimenting with optimal team structures within their own agencies; but in the future, agencies in a health home may find ways to collaborate across the network to take advantage of areas in which each agency has particular strengths. More research in this area is needed to define staffing patterns that are most promising for the field.

Findings *(continued)*

Promising Practice
Developing Team-based Care Management from a Traditional TCM Model

At one social service agency, experimenting with a variety of staff members has led to a highly developed staffing and supervisory structure that relies on resource sharing among team members to deliver comprehensive care management. The care management team includes peers, outreach specialists, field-based care coordinators, office-based care managers (with higher educational qualifications and greater work experience than care coordinators), and program managers who provide supervision and oversight. The staffing model is adapted from the agency's original TCM model, and, over the years, different staff members have developed different areas of expertise, becoming the go-to people for the organization. The agency also prioritizes training by bringing training sessions to its staff members on-site, as well as sending staff members out for sessions. Recently, emphasis on workforce development has come into focus. The agency has developed a career path for peers, already promoting two of them to permanent positions as care coordinators or outreach specialists.

Area for Action
Define the Right Staffing Mix

Bringing together the rich experience of care management professionals from a variety of backgrounds is an important strength of the health home's comprehensive care management vision—a vision that will impact the way in which care management is conceptualized throughout the health system in the coming years, in PCMHs and ACOs, and beyond. As agencies identify promising practices in staffing, New York has a role to play in sharing those practices with all health homes and, potentially, adapting those practices into statewide guidelines for health homes to help operationalize the vision of comprehensive care management.

Findings *(continued)*

Care Management Staff Training

> **KEY TAKEAWAY**
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> ▶ Foundational and ongoing training coupled with clinical supervision are critical to ensuring that care managers are well prepared to provide the comprehensive care management services envisioned by the health home and that they are supported in their work.

Even when care management responsibilities are shared across a multidisciplinary team, all staff members need to have a common conceptual framework and working knowledge that spans medical, behavioral health, and social services.

No existing workforce has been trained to address the breadth of care management services to be provided in New York health homes. Care managers need adequate foundational training in conceptual aspects of all three of the health home's primary areas—medical, behavioral health, and social services—and in best practices for health home member engagement and services delivery. Care managers in health care organizations may be adept at medical care coordination but require training to work more effectively within the social service and behavioral health realms; housing and behavioral health care are both challenging areas for these staff members. Care managers in social service and behavioral health agencies need additional training in medical diagnoses and chronic conditions. Skills-based training to enhance HIT skills is also needed, as well as training in quality reporting and data use.

A comprehensive list of available trainings was not compiled as part of this broad survey of care management in the health home. However, interviews illustrated that training of health home staff members is provided at three levels—in the community, by the health home, and by care management partners. At the community level, examples of widely used trainings include the New York State Care Management Training Initiative, an NYSDOH Workforce Retraining Initiative program to ready TCM staff members for their new roles providing health home care management (offered by the New York Association of Psychiatric Rehabilitation Services, New York State Council for Community Behavioral Healthcare, Mental Health Association of Nassau County, and Clubhouse of Suffolk); care coordination training for front-line health care workers offered by 1199 Service Employees International Union (SEIU); and care management training offered through City University of New York (CUNY) and sponsored by OMH for which care managers can receive college credits.

At the health home level, training offered or arranged by health home administrative leads varies tremendously. Among those interviewed, some offer regular centralized training sessions for care managers working in care management partner agencies, while others also provide on-site training at each of their care management partner agencies to address specific training needs and concerns.

Findings *(continued)*

Case conferences, conducted both by telephone and in person for care managers across multiple care management partners within a single health home, provide opportunities for interaction among colleagues and for sharing of experiences. In addition to enhancing care management skills, health home-led training appears to enhance the cohesiveness of emerging health home networks by introducing common approaches to problem solving and building a strong sense of collaboration between the health home lead and its care management partners.

Similarly, training offered or arranged at the care management partner level takes multiple forms, including in-service sessions featuring specialized organizations (e.g., housing specialists or mental health providers) to enhance care managers' knowledge of available services and how to access them; off-site training at academic institutions or specialized agencies; and online trainings that enable care managers to address self-identified knowledge gaps through topical trainings. Formal case conferencing—internal to the care management partner agency, as well as with the health home lead—brings care managers together with medical and behavioral health specialists to discuss difficult cases and problem solve as a group.

As care managers move forward in their roles, clinical supervision serves as another vehicle for continuous training. Regular one-to-one interactions between care managers and their clinical supervisors provide opportunities for care managers to seek and receive guidance, and for supervisors to review care managers' work. Regularly scheduled staff meetings provide opportunities for group discussion and learning while also creating a forum for administrative updates regarding the health home. The degree to which data and reporting feed into these supervision structures varies among agencies and is often dependent upon each agency's level of HIT connectivity.

Yet, despite the availability of these many training resources at multiple levels, all of the health home administrative leads and care management partners interviewed indicated that more training is needed to ensure that care managers are adequately prepared to address the breadth of the issues that arise, particularly considering the diversity of care management backgrounds and qualifications. An in-depth exploration of training needs among all health homes would help to identify recommendations for training staff members in organizations of all types.

Findings *(continued)*

Promising Practice

Health Home-wide Case Conferencing

One health home relies on virtual case conferencing as a primary training tool for all care managers in its network. The weekly case conferencing call is convened by the health home administrative lead and attended by a senior medical provider and clinical supervisor. Each week, the health home administrative lead invites different care management partners to present cases, giving care managers across the network the opportunity to hear about different approaches being used by various care management partners. This opportunity also allows the health home administrative lead and care management partner organization supervisors and administrative managers to determine to what degree care managers are updating old approaches to provide the type of comprehensive care management that the health home envisions.

Area for Action

Increase Training Opportunities

All agencies need more training for their care management staff. In general, care managers in health organizations require training to work more effectively within the social service and behavioral health realms, particularly in relation to housing needs and behavioral health care. In contrast, care managers in social service and behavioral health agencies need additional training in medical diagnoses and chronic conditions, as well as in facilitating mental health care. Training in data use and reporting would benefit care managers in agencies of all types, and will become increasingly important as more data become available to assess health home member outcomes.

Health Home Member Risk Assessment and Care Planning

> **KEY TAKEAWAY**
>
> ▶ The care management partner-specific risk assessment criteria and tools used by agencies to determine member service needs can inform the development of a new, more comprehensive approach to calculating and updating NYSDOH acuity scores.

All health home members are assigned an acuity score calculated from medical data for the purpose of determining the appropriate per member per month rate. Acuity scores are recalculated quarterly based on updated encounter and claims data. Reliance on these medical data focuses reimbursement on a medical model of care management, rather than the person-centered, holistic vision of care that the health home promises. For example, homelessness is not currently captured in NYSDOH acuity scores; yet, it is a recognized risk factor impacting health home members' health and wellbeing. Incorporating social risk measures, such as recent prison release, food insecurity, and homelessness and risk of homelessness, is essential to developing acuity scores that accurately reflect members' status. Accurate acuity scores also allow for appropriate assignment of members to a health home and a specific care manager, as well as ensure adequate reimbursement for staffing a sufficient number of experienced care managers to provide the full range of care management services that health home members need.

For most health home administrative leads and care management partners, NYSDOH acuity scores provide only a starting point for risk assessment—a "thermometer," according to one behavioral health agency. Most care management partners are conducting supplemental risk assessments to determine health home member service needs and guide care planning. Some use agency-developed tools that have been tested and refined over years in practice, while others rely more heavily on care managers' qualitative assessment of health home member status based on their experience in the field. Several of the care management partners interviewed assign a site-specific acuity score to each new health home member. For example, one social service agency uses an agency-developed, comprehensive assessment tool to calculate an acuity score for each health home member, which is then entered into the record next to the NYSDOH score. This practice allows care managers and agencies to note the NYSDOH acuity score for administrative purposes, but use the agency's site-specific acuity score to plan and track service delivery, as well as monitor improvement.

In some instances, health home administrative leads have introduced supplemental assessment tools for networkwide adoption; however, in those instances they have not precluded care management

partners from continuing to use their own site-specific tools so that a complete assessment is conducted in a manner that suits their care managers' process and orientation.

Many of the agencies interviewed indicated that the current emphasis on medical acuity in determining payment does not adequately encourage or support service provisions aimed at maintaining new levels of stability, preventing future acute episodes, and advancing health through wellness activities—core premises of the health home model. In fact, this perceived limitation has contributed to a lack of clarity on how those health home members who have been stabilized should be handled. Current approaches range from graduating (i.e., transitioning) them out to a less-intensive care model, such as PCMH, to maintaining some of them indefinitely based on the belief that a subset of health home members are likely to need high-intensity services over the long term, albeit intermittently, to avoid cycling in and out of the health home for acute episodes.

Finally, care managers reassess health home member acuity regularly, according to their agency's guidelines, to update care plans and ensure that they are current with their members' needs. While this reassessment occurs frequently in practice, the current New York State guideline, which specifies quarterly updating, does not allow for updating on a sufficiently fluid basis; health home administrative leads and care management partners noted that a mechanism is needed for more frequent updating of acuity scores to reflect the typical fluctuation in health home member status and intensity of services required.

Promising Practice
Standardizing Tools to Facilitate Risk Assessment

One social service agency that serves as a care management partner to multiple health homes noted that, at the launch of the health home initiative, the agency did not have its own risk assessment tool that would be meaningful within the context of each health home to which it belongs. Therefore, the agency created a standardized care plan and worksheet that could both serve as a routine agency form and feed into the development of a health home member's care plan for any health home network with which the agency is affiliated. This action was significant because, regardless of the risk assessment results, the care planning process is the same; the agency noted that the tool has been very helpful, especially because some health homes do not have their own health home-wide standardized tools.

Findings *(continued)*

Areas for Action

Revise Reimbursement Measures

Incorporating social risk measures, such as homelessness, food insecurity, and recent prison release, as well as health promotion and disease prevention work, in the development of acuity scores would lead to a more accurate reflection of members' status. This change will enhance the ability of care management partners to provide and be reimbursed for the type, intensity, and level of services they deem appropriate as delivered by the team members most appropriate to the tasks. A workgroup of health home representatives is currently working with New York State to broaden the factors considered when calculating acuity scores.

Reassess Member Needs and Update Acuity Scores

Health home members have complex needs that require regular reassessment to ensure the delivery of the appropriate intensity and type of care management services. In parallel to redefining the calculation of acuity scores, developing a mechanism by which acuity scores may be adjusted more frequently to better support changes in member status, and through which the continuum of need among health home members can be addressed, is essential. With a more dynamic approach to member assessment and service delivery, reimbursement could reflect the health home goal of paying for prevention, maintaining members' stability, and even graduating members from the health home into PCMHs, as appropriate.

Findings *(continued)*

Caseload Balance

KEY TAKEAWAY

▶ Balancing caseloads to address needs of individual health home members while also accommodating the economic realities that dictate minimum caseloads is challenging. These considerations include broad variation in member need, as well as requirements to fulfill program-specific mandates that are more stringent than those of the health home, such as the labor-intensive requirements of court-mandated Assisted Outpatient Therapy (AOT) clients. Given the range of needs, a standard caseload size for health homes has not yet been determined.

As a result of harmonizing earlier systems of case management and care coordination into the comprehensive care management approach, great experimentation in caseload size is currently underway. As programs develop further and legacy clients are folded into health home membership, care management experience and health home member outcomes data may identify ideal caseload sizes that can become standards for the field.

Among health home administrative leads and care management partners, a typical caseload is 40 health home members to 1 care manager, with a range of about 30 to 50 members to 1 care manager. Agencies noted that determining and maintaining appropriate caseloads have been challenging on account of the limitations of acuity scoring noted above and because, in accordance with the mission of the health home, the intensity and frequency of services is highly individualized and variable over time.

Similarly, service intensity ranges widely across the health homes interviewed. Beyond the minimum requirements set forth by New York State of one monthly in-person or remote contact meeting with each health home member, no standard frequency of visits emerged from this survey, although each agency had a general scheme of intensity that it followed for new health home members with high needs, which may be dialed down over time as members become more stable. Even for very low-acuity health home members, nearly every agency noted that internal requirements for visit frequency go beyond the NYSDOH minimum requirement of one core service (either direct or indirect) per month with each member. Several agencies base their visit frequency on a minimum of one face-to-face contact every month with additional check-in calls, and a number of agencies had some variation on this minimal visit structure. One agency requires biweekly check-in calls for care managers with all clients and with all providers involved in their care; additionally, care managers are required to make a bimonthly home visit to each health home member in their caseloads, irrespective of acuity score or other risk assessment, to ensure members are stable in terms of housing, food security, medication management, and other issues. Another agency requires the delivery of a core service during the first

Findings *(continued)*

two weeks of every month, so that any required follow-up can be completed during the latter two weeks of the month.

For care management partners accustomed to providing telephonic medical coordination for patients with chronic illnesses, addressing more intensive service needs and increasing face-to-face time with health home members are requiring caseload reductions. Conversely, some social service agencies report that their caseloads have increased because health home reimbursement formulas do not always support the high service intensity previously provided to fewer clients in the TCM model. One care management partner noted that this shift to higher caseloads and less-intense services impacted not only their care managers, who are now managing more cases, but also their legacy health home members, who were accustomed to the previous TCM structure in which they had greater access to their case managers.

Determining appropriate caseloads in TCM conversion agencies has been further complicated by the fact that, alongside new health home members, they continue to serve clients who have not yet been enrolled as health home members, on account of administrative timelines that balance the integration of TCM legacy clients into the health home with outreach to new potential health home members as identified by NYSDOH lists. Effectively, this complication results in the agencies serving two populations with different administrative and clinical requirements. With the higher visit frequency of one face-to-face visit required for AOT clients, caseloads are lower (12 AOT clients to 1 care manager) and service provision is intensive. Most agencies retain designated care management staff for AOT clients and continue to provide court-mandated services in the same manner as they had prior to the launch of the health home. In some agencies, AOT clients are also health home members, soon to be designated as "health home plus" participants by the NYSDOH Medicaid Redesign Team, which introduces further complexity into this issue.

Findings *(continued)*

Assignment of Health Home Members to a Care Management Partner

KEY TAKEAWAY

▶ There is much to be learned about best practices in health home member assignment to care management partners. Some health homes take a generalist approach, assigning members to any of the care management partners within their network; others take a specialist approach, assigning members with particular issues to agencies that have expertise in those areas. Over time, data will demonstrate whether one method is more effective than the other.

Health homes are taking a variety of approaches to assigning new, nonlegacy members to care management partners. In some health homes, the care manager's role is solely to coordinate all members of the care team rather than provide any issue-specific care, rendering all of their member agencies equally qualified to provide the range of needed services. In these cases, the health home does not consider the agency's history or primary skill set (e.g., chemical dependence, HIV/AIDS) when making member assignments. Other health homes are more inclined to make assignments based on members' most critical needs (e.g., serious mental illness vs. HIV/AIDS) to take advantage of the specialized skills of each care management partner. Some care management partners also take this approach. For example, one medical organization described transferring members in cases where it perceives that a member's primary need could be better met by a social service agency on account of the agency's experience treating persons with similar problems.

In some instances, such as chemical dependence treatment, health home members are enrolled and treated by the care management partner with specialty care expertise; in these cases, the question of assignment does not arise. However, in many instances, and especially as health home membership expands, new health home members may have no affiliation with any of the care managers in a health home. Thus, the question of health home member assignment becomes extremely important to the successful enrollment and retention of the new members.

A related issue is the intent among health home administrative leads to encourage high-quality performance by rewarding those care management partners that are most effective with preferential assignment. However, to date, sufficient data have not been widely available to support this strategy.

Findings *(continued)*

Promising Practices

Building on Traditional Agency Areas of Expertise to Benefit New Members

One health home comprises an equal number of care management partners with experience in HIV/AIDS and in behavioral health. When lists of potential health home members are received from NYSDOH, the health home lead uses the information to identify the primary issue impacting each potential health home member. If HIV/AIDS is the primary issue, then the name of that potential health home member is assigned to one of the care management partners with specialized expertise in HIV/AIDS; whereas if a behavioral health issue is the most critical to address, the potential health home member is assigned to one of the care management partners with that expertise. However, if a potential health home member's principal issue is chronic disease-related, that member's name may be assigned to any of the care management partners. Alternatively, one of the care management partners in this health home explained that, since the launch of the initiative, all of the care management partners in the health home have had access to the same training and are expected to be equally fluent in medical care coordination; thus, in theory, none of the care management partners should be more adept than another at serving members with multiple chronic illnesses. However, the health home lead recognizes the traditional strengths of each care management partner and, when appropriate, assigns health home member names accordingly.

Reviewing Charts Quarterly to Assess Quality of Care

One health home administrative lead plans to conduct quarterly chart reviews to assess the quality of care being delivered by each of its care management partners. In addition to identifying areas for improvement in care management partners' work, goals of this quality review include determining an ideal caseload for care management partners in the health home network. Using the health home portal, the health home administrative lead will review information related to NYSDOH's specific requirements, including whether or not care management partners have correctly completed the comprehensive assessments; linked the documentation to the care plan; incorporated the issues documented into the care plan; addressed all of the issues raised; and identified appropriate interventions.

Findings *(continued)*

Health Information Technology and Data Sharing

KEY TAKEAWAY

▶ To communicate across parties and support data capture and exchange for a program of this magnitude, health home administrative leads and their care management partners need effective data systems and access to live data streams. A health home-wide technology platform supporting data exchange among care management partners, and agency-level access to and facility with using it, is essential to operationalizing the vision of comprehensive care management.

NYSDOH requires all health home administrative lead applicants to develop mechanisms for enabling the use of a shared care plan by care management partners and by all primary care and specialty care providers involved in health home members' care. In concept, the shared care plan allows agency-based care managers to enter health home member data via the network HIT platform, and in turn the care plan is accessible at any time to all care managers, as well as to primary care, specialty care, and behavioral health providers throughout the health home. In some instances, in which health home administrative leads and/or care management partners are members of regional health information organizations (RHIOs), the shared care plan may be populated by data from the RHIO, while in other cases the care plan also may be the source of information to populate the RHIO—with both methods leading to increased data availability at the regional level.

Yet even as this new vision drives the development of integrated HIT solutions, technological readiness is still being evaluated. An important consideration is the disparity in technology adoption and facility in agencies across the medical, social service, and behavioral health fields, which poses challenges at the network level through health home-wide shared technology platforms. At the health home administrative lead and partner agency levels, this disparity exists within electronic health records and administrative databases, as well as at the regional level where individual health data are stored in RHIOs and accessible only to member agencies. More detail on challenges specific to each level is presented below:

Health Home Network Level
A division was seen between health care system-led health homes and health homes led by social service and behavioral health agencies. Generally, health care system-led health homes have built on existing technology to introduce health home-wide platforms developed for the entry of care management services data. In these networks, health home administrative leads are able to pull data directly from the care plans to develop member-specific, agency-specific, and health home-wide

quality and administrative reports; some of these health homes allow for on-demand quality report generation and data review. However, these data may not be useful to care management partners that have not traditionally used these kinds of reports to review client progress. Nonmedical health home administrative leads, by contrast, are still identifying the technological solutions that will best fit their network's needs and working on building the platforms to allow for optimal care management service delivery. Among these health homes, shared technology platforms may allow for data entry into a care plan that care managers across the health home can access, but the depth of clinical data that care managers can enter may be constrained, or the platform may have limited reporting facilities.

Care Management Partner Level

A similar division between medical and nonmedical organizations is reflected at the care management partner level. Health care agencies tend to have advanced HIT access on-site with a single data entry process that feeds local administrative and clinical systems. By contrast, social service and behavioral health agencies are more likely to have dual systems, in which data for administrative purposes are entered into a site-specific package and clinical data are entered into the shared technology platform. In many cases, this dual system results in double data entry, increasing the administrative burden of partnering in a health home. For agencies that serve as care management partners to multiple health homes, that burden may increase substantially, particularly for health homes that require additional data entry for reporting purposes. As social service and behavioral health agencies strive to reduce the administrative responsibilities of field-based care managers facing growing caseloads, avoiding this administrative burden has been identified as a principal advantage of partnering with hospital-led health homes that feature advanced technology platforms.

Regional Level

RHIOs are at varying stages of development, impacting the ability of health homes in each region to access and use data from the RHIO to enhance care management service delivery. Some health homes already are downloading data from their RHIOs to enhance member care plans, while a few have begun to upload member care plan data to help populate the RHIO. However, to date, health care organizations have constituted the majority of participants in RHIOs—representing a major disadvantage for social service and behavioral health agencies, particularly smaller ones.

At all levels, concerns about privacy issues and information sharing pose challenges to the possibilities of data sharing via the care plan. Health home members have often refused to consent to data sharing; and when they do consent, medical providers may not recognize the health home consent form as a legal release on account of lack of familiarity with the health home model. Thus, provider misperceptions about the legality of data sharing hamper the effectiveness of the care plan, pointing to a need to better communicate with providers about the resolution of privacy and legal issues that permit information sharing across the health home network and with providers caring for health home members outside of the network.

An additional challenge to provider use of the care plan is the technology itself. As each health home develops its own technology platform, providers in institutions that are members of multiple health

homes need to learn how to use all of those technology packages to review and update their patients' care plans. Thus, while a powerful technology platform offers great promise for data sharing and reporting among care managers across a health home, the usefulness of the system beyond that purpose may be constrained by the specificity of the technology. An in-depth exploration of technology platform capabilities could inform recommendations about which platforms most effectively support health home care management service delivery.

Promising Practice
Building a Data Dashboard Tailored to Support Comprehensive Care Management

One hospital, which serves as a health home administrative lead, seized the opportunities offered by the health home vision to further build and enhance an already robust technology platform. The hospital had worked for a number of years with local community-based organizations, securing funding through HEAL grants and other sources of support, to develop a dashboard that could facilitate and support care management. Now, that dashboard has been further enhanced to facilitate care management in the health home. Key features include a function for clinical and administrative data entry, as well as access to data from the RHIO; a secure messaging function; a resource center that lists all primary care physicians and psychiatrists in the health home; and a patient portal. Clinicians can immediately view and update member status and communicate with each other in real-time, all via the dashboard—a level of connectivity that is unique among health homes. For instance, when a health home member is admitted to the hospital, an event notification is forwarded to care managers for follow-up, ensuring that health home-wide protocols for follow-up are observed. While that function is just beginning to become routine, it holds great promise for care management, particularly in terms of discharge planning and care transitions. One caveat to the success of the dashboard is that buy-in among medical providers has been slow. Although care managers must use the dashboard to receive reimbursement for services provided, no such incentive exists for providers. Moreover, providers may view the necessity of learning how to use the dashboard as a disincentive to uptake, particularly if they have panels of patients who belong to multiple health homes. Still, both the hospital and its care management partners cite the advantages of the dashboard in supporting care management in the health home and the notable success that has been achieved in integrating the shared care plan into daily practice for care managers.

Findings *(continued)*

Areas for Action

Increase Access to Timely and Appropriate Data

As New York State develops its health homes information system to respond to health homes' need for improved data access, a variety of issues merit consideration. In general, health homes need timely access to member data from NYSDOH, Medicaid managed care organizations, and providers to accurately represent acuity, develop an appropriate care plan, and assess member improvement over time. At the same time, health home administrative leads need data to appropriately monitor care management partners and create incentives for them, as well as to provide meaningful feedback to care management partners that they can in turn use to manage health home members, supervise staff members, engage in improvement, and manage resources effectively. Furthermore, as noted above, training in data use will be essential. Care management staff and supervisors across the health home need excellent skills in data management, data analysis, measurement, and data feedback delivery to make use of outcomes data to improve care.

Enhance Technology, Connectivity, and Communication

Further work needs to be done to facilitate real-time access to health home member data through shared care plans to which all care team members contribute. Social service and behavioral health agencies, which have not benefited from the sustained technology development funding afforded medical organizations, need support for technology adoption. Minimum standards for virtual data exchange should be tightened as capacity increases to ensure that care management partners have access to needed information for all health home members irrespective of the health home to which the member belongs.

Care Manager Collaboration with Care Providers

KEY TAKEAWAY

▶ Agencies are proactively facilitating engagement between care managers and treatment providers (including physicians, nurse practitioners, psychiatrists, psychologists, and others providing services to health home members) to facilitate care management, but the State also has a critical role to play in communicating the goals of the health home to providers and developing strategies to support their engagement, particularly in the case of medical providers.

Developing an integrated team of professionals across disciplines is critical to achieving the goals of the health home. Yet, many providers remain unaware of what the health home is or how it can support the treatment goals that they set for their patients; some also resist participation as a result of territoriality and misunderstanding. Additionally, no clear payment mechanism or financial incentive exists for medical providers to get involved with the health home. Some agencies have developed their own communication materials to introduce the health home to providers, and many have been proactive in seeking to connect with the medical community. However, NYSDOH also has a role to play in advancing provider engagement within the health home model. Strategies for connecting the medical and behavioral health spheres are needed.

While health care-based care managers may have trouble facilitating mental health care for their health home members, care managers based in social service and behavioral health agencies may have more success connecting with behavioral health specialists, on account of these agencies' history of coordinating services for TCM clients. Care managers are able to insert themselves into discharge planning and other meetings at psychiatric hospitals; with medical hospitals, by contrast, care managers struggle with a lack of familiarity of the health system—a difficulty that is exacerbated by medical providers' reciprocal lack of familiarity with social service and behavioral health agencies.

In general, medical organizations note challenges for their care managers in coordinating social services, especially housing, and behavioral health care; conversely, care managers in social service and behavioral health agencies faced difficulties in interfacing with medical providers. In the rural regions of New York, the lack of primary care providers who accept Medicaid poses a basic, structural challenge to facilitating medical care for health home members.

Findings *(continued)*

Promising Practice
Building Bridges Between Care Managers and Providers
Through Face-to-Face Contact

Agencies of all types are testing promising strategies to forge connections between care managers and primary care and specialty care providers to increase collaboration.

One health care organization, which serves as a health home administrative lead, explained that among its goals in becoming a health home stakeholder was to bring social services and behavioral health more into the fold of its on-site services to develop truly integrated care. To familiarize its care management partners with the hospital setting, the health home administrative lead credentials care managers from its care management partners to come on-site at the hospital to meet with potential enrollees within the medical setting. This approach allows care managers to interface directly with medical staff members and vice versa. Credentialing is offered for a limited time only so that the hospital can invite new groups of care managers on-site on a rolling basis.

A social service agency noted that if its care managers are unable to reach medical providers by phone to discuss health home member needs, care managers go directly to the providers on-site at the PCMHs or hospitals where they work. Not only does this in-person interaction facilitate team building, it also enables care managers to observe office operations and better understand how their role may fit into the organization's care model, allowing care managers to facilitate services for their health home members.

One health home has pursued contact with all of the psychiatric hospitals in its region to ensure that providers and administrators are aware of the health home and the services it provides, as well as to encourage hospitals to contact care management partners when a health home member is admitted.

Area for Action
Interface with the Broader Medical Community

NYSDOH has a role to play in advancing provider engagement within the health home model. One key issue New York State could explore further is what aspect of the health home would prove compelling enough to providers that they would engage with the model to achieve their own goals. At present, providers do not have incentives to get involved with health homes and may not understand how health homes can support their goals. New York State and its health homes also should take into consideration barriers to provider participation, such as the data entry burden that may be associated with provider involvement in one or multiple health homes. Requiring medical providers to enter data into multiple technology platforms may be an unrealistic expectation and a deterrent to participation.

Conclusions

All health homes surveyed concurred that the New York health home model represents a positive step toward realizing whole-person care; however, progressing toward this goal is not without difficulties. To fulfill the State mandate to forge new partnerships and develop new approaches to coordinating services across previously disconnected spheres of care delivery, agencies are working diligently and in partnership across disciplines to innovate, collaborate, test, and refine strategies to operationalize an integrated model of person-centered care.

Within this survey of a limited sample of health homes and agencies, vast diversity was seen in the ways in which care management programs have been structured and how they are being conducted. Analyzing the strengths and limitations of these hybrid models in the coming years will inform the development of comprehensive care management. At this early stage, identifying best practices in any single topic was not possible and was not an objective of this broad survey. The goal, instead, was to pinpoint the issues that impact care management service design and delivery across a sample of Phase 1 New York health homes. Promising practices were uncovered as part of this research; furthermore, current evidence suggests that there is no single right or best way to deliver care management. Over time, outcomes data may identify multiple effective strategies to structure and deliver services. The challenge will then be to analyze those data to determine which approaches generate the best results, and whether any particular factors must be held constant across agencies and models to achieve them.

This research was impacted by two important limitations:

Administrative Development Coincides with Model Design and Implementation
Health home leadership and care management partners are forming new networks at the same time that they are enrolling health home members and testing new models of care management. Health home networks have given substantial attention to nurturing new partnerships and implementing new administrative structures and systems to ensure that health homes are prepared to serve health home members over the long term. Furthermore, enrollment has been slower than expected, resulting in fewer members initially than had been projected. At this stage, many of the agencies interviewed are just reaching the point of being able to implement the robust care management models that were originally envisioned. Thus, while experience to date provides valuable lessons—and some agencies have even begun to revise their models based on early evidence—these findings are preliminary. As these models continue to evolve, there will be much to learn.

Lack of Outcomes Data Impedes Analysis of Agency Models and Perspectives
While New York State reports that early data suggest that the program overall is decreasing both inpatient and emergency room use, at this early stage, there is insufficient data on member outcomes to support identification of any single care management approach as superior to another. Over time, inpatient use rates, emergency department visit data, outpatient mental health visit data, follow-up after inpatient admissions, and outpatient quality measures may demonstrate the comparative effectiveness of different approaches to care management. In the interim, documenting promising practices is essential to supporting agencies' work in anticipation of these data, which will not only

support evaluation of care management approaches and allow for the identification of the most effective strategies, but also will help agencies motivate their care management staff and engage medical providers through the demonstration of improved health home member outcomes.

Areas for Future Research

While beyond the scope of this paper, this survey also uncovered areas that merit further attention. As NYSDOH and health home workgroups continue to address the issues noted in this report, more in-depth exploration of the following topics is indicated:

Health Information Technology (HIT)

HIT development for care management is occurring alongside numerous other initiatives to enhance connectivity between agencies, across the medical neighborhood, through RHIOs, and at the State level. As these processes occur simultaneously, a better understanding is needed of what technology is essential to support comprehensive care management, as is identifying the challenges facing various agency types as they implement HIT solutions. A focused report to describe the current state of HIT and suggest directions for enhancing connectivity related to care management in the future would move the field forward. Optimally, this study could lead to uniform recommendations regarding essential HIT functions to support care management both within health homes and more broadly across the spectrum of health care and social service fields.

Workforce

Developing the care management workforce is a critical need; and developing standardized staffing plans, career ladders, and training requirements for the field could facilitate this process. In January 2013, CUNY released a report exploring workforce development in New York health homes, using a case study approach to document the state of the field and raise topics for later consideration. Staffing plans and training needs were key areas of focus, and findings clearly illustrated the diverse approaches that health home administrative leads were taking to develop the workforce within their network to implement comprehensive care management and to manage the training needs they face. A broader inventory of approaches to workforce development is now needed. Such a survey would build upon the CUNY report findings, incorporate other work related to emerging health workforce issues, and consider the experience of organizations that have implemented training for care management staff to date, such as 1199 SEIU. The survey would include a larger sample of health homes—exploring workforce issues at the health home administrative lead level and the care management partner level—to inform the development of strategies for the initiative as a whole. Understanding different staffing plans would allow for the identification of staff member roles common to all agencies at the health home administrative lead and care management partner levels, as well as a better grasp of the minimum educational requirements and skills needed to fill those positions. That understanding in turn would allow for the development of standardized training modules for all health homes and career ladders for care management staff.

Conclusions *(continued)*

Severity Assessment and Payment

New York State is currently considering new payment mechanisms that would reflect the health home initiative's intent to provide comprehensive care management to health home members. Developing tools to assess severity in a more complex fashion is a necessary part of this process. At present, each agency assesses risk in different ways, using different timeframes to update risk assessments. Furthermore, many agencies have developed their own assessment tools to use in this process, and some are working with health home administrative leads and care management partners to incorporate strategies into health home-wide approaches to severity assessment. A survey of these strategies could elucidate best practices in risk assessment for this population and help to identify ways in which reimbursement can better reflect health home member needs.

Appendix A. Abbreviations and Definitions of Terms

ACO: Accountable care organization, referring to groups of doctors, hospitals, and other health care providers that join together voluntarily to deliver coordinated, high-quality care.

AOT: Assisted outpatient therapy, court-ordered outpatient treatment for people with mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision.

CHW: Community health worker, frontline public health workers who often come from the communities they serve, providing outreach, education, and support.

CIDP: Chronic Illness Demonstration Project, an approximately $30 million initiative developed and implemented between 2008–2011 to improve health outcomes and contain the cost of caring for a subset of vulnerable fee-for-service Medicaid beneficiaries.

Care manager: Used as an all-encompassing title for the clinical staff member principally charged with delivering care management services; note that specific staff titles vary for this position and include, but are not limited to, care coordinator, care navigator, and program manager.

Care management partner: Care management partner organization, a term used for agencies of all types that deliver care management services within one health home or to multiple health homes.

COBRA care management: Comprehensive Medicaid Case Management Program (also referred to as HIV/AIDS targeted case management), a family-centered intensive care management program for HIV-infected individuals and their families; one of the legacy programs integrated into the health home initiative.

Health home: Referring either to the overarching model or to the individual networks receiving designation through the New York State health home initiative.

Health home administrative lead: Lead administrative agency within the health home network, which applied for and received the health home designation from New York State or, in the case of a multistakeholder partnership, the agency holding the management contract to support the health home administrative infrastructure on behalf of the partners.

Health home member: An individual enrolled in and receiving services through health homes.

HH-CMART: New York State Health Home Care Management Assessment Reporting Tool, a tool for the collection of standardized care management data for members assigned to health homes, intended for NYSDOH to evaluate the volume and type of interventions and the impact care management services have on outcomes for people receiving these services.

HIT: Health information technology.

MATS: Managed Addiction Treatment Services, a model formerly implemented by New York State's Office of Alcoholism and Substance Abuse Services to provide care coordination and case management for high-cost, high-needs adults; one of the legacy programs integrated into the health home initiative.

New York State: Sometimes used to refer to New York State's governmental agencies.

NYSDOH: New York State Department of Health.

Peer workers/peers: Support staff members who are community residents that share similar life experiences with the participants in the programs they design and deliver.

PCMH: Patient-centered medical home, indicating both the program to designate these entities (e.g., the PCMH initiative) and individual health centers that have received designation through that initiative.

RHIO: Regional health information organization.

TCM: Targeted Case Management, a model formerly used by New York State's Office of Mental Health to guide service provision to individuals with intensive behavioral health, HIV/AIDS-related, and social service needs; one of the legacy programs integrated into the health home initiative.

Appendix B. Interview Guides

① Health Home Administrative Lead Agency Interview Guide

Introduction

Thank you very much for your willingness to participate in this one-hour telephone interview. We have three team members on the call: myself, Joslyn Levy, who will be conducting the interview; Rachel Sacks, who will be listening, taking notes, keeping time, and possibly asking additional questions; and Sara Softness, our assistant, who will be taking notes. Please be aware that we are recording this interview so that we may refer back to your comments at a later time.

Our goal for this hour is twofold. First, we hope to gain an understanding of (NAME OF THE HEALTH HOME)'s organizational structure. Second, we want to learn about how (NAME OF THE HEALTH HOME)'s model has enhanced continuity of care for health home enrollees, and what challenges have surfaced during the initial stage of program implementation. Ultimately, this information will be analyzed as part of our effort to understand opportunities and challenges facing care managers within health homes at this early stage in the development of this new model, and to derive initial lessons learned to inform policy development and local practice around care management for people with complex health and social needs.

Topics we will address include:

- Organizational roles in delivering care management services across your health home;
- The breadth and depth of care management services delivered;
- Your health home care management staffing model; and
- Communication with and about health home members among the various levels of health home sponsors, partners, and providers.

We are purposely limiting our scope to these few areas rather than attempting to survey all aspects of health home implementation. A few major topics that we will not explore in depth are the development and use of technology in your health home network, financing issues encountered by your health home, and training the health home workforce. The reason for this limitation is that these issues are very complex ones; we are recommending to NYSHealth that it pursues separate papers on these topics. That said, we expect these topics to arise in relation to the other operational areas we'll discuss with you. Please share your thoughts about them as appropriate.

As a final note, we will be keeping a close watch on time because we know that each of the questions we ask could lead to its own hour-long conversation. When necessary, Rachel or I may ask you to wrap up a particular question before we fully explore it, simply to ensure that we are able to at least touch on all of the questions on our list. Please don't mistake any such intervention as disinterest in what you have to share with us.

Appendix B. Interview Guides *(continued)*

1. Your organization's relationship to its care management and network partners
   a. How did you determine which care management partner agencies to bring into the health home?
   b. Please briefly describe your relationship with your care management partners.
      i. Is there one or several care management partner agencies you work with more closely than others? If yes, which ones and why?

2. Your care management model as designed (ideal)
   a. How would you describe the care management model you've introduced? For example:
      i. Nurse led
      ii. Nurse supported
      iii. Nonprofessional (e.g., TCM case managers)
      iv. CHWs/peers (led or supported)
      v. Wellness coaches
      vi. Other
   b. Who is on your (multidisciplinary) care management team?
   c. What are the qualifications of your care managers and other care management team staff?
   d. What are the key services that a care manager (or care management team) provides or should provide?
      i. Client manager vs. client advocate
      ii. Caregiver/family engagement (member of team)
      iii. Other
   e. Locus of management services: care management agency/home/remote?
   f. Member/enrollee assignment to care management partner.
      i. How do you determine caseload?
      ii. Do you use any kind of stratification scheme to determine which care management partner you will assign the member to?
         • Medical risk
         • Social risk
         • Behavioral risk
         • Activation risk
         • Caseload-size guidelines by risk category
   g. Service intensity: Is there a mechanism for responding to variation in member need (e.g., what happens when they get better)?
      i. Variable level of service
      ii. Graduated-out services and integration into less-intensive setting (to what extent does organization mirror an integrated care delivery system?)
   h. Do you expect care managers to consistently pair care managers with certain primary care providers, psychiatrists, or other providers in the network? Is this a goal for you? If not, why not?

3. Care management: staffing, hiring, and training
   a. When you introduced the model,
      i. Did you have the right job descriptions? What was (still is) missing?

       ii.   Have you found that the care managers and other care management team members are appropriately credentialed to serve the needs of the patients who are assigned to them?
- In terms of legal scope of practice
- In terms of skills and training

  b.   What training have you provided to care managers and other members of the care management team?

4. Care management services (actual)

  a.   Is the model you designed the same one that you ultimately implemented?
       i.   If yes, what surprised you during implementation? What's missing from the model?
       ii.   If no, what changed?

  b.   Following enrollment, what happens? Can you describe the flow of patients through your organization?

  c.   Do your care management partners use any kind of stratification scheme to determine level of services or assignment of staff members?
       i.   Medical risk
       ii.   Social risk
       iii. Behavioral risk
       iv. Activation risk
       v.   Caseload-size guidelines by risk category

  d.   Do care management partners vary their approach to care management by primary/predominant risk?

  e.   Do care management partners offer a range of service intensity?
       i.   Variable
       ii.   Graduated out

5. Quality assurance

  a.   What supervision structures do you have in place?
       i.   Describe supervisors' qualifications and backgrounds.
       ii.   What types of meetings and other formal structures are in place (e.g., case conferencing, individual care manager review, etc.)?
       iii. What kind of reports does your agency require from care management/partner agencies/network providers?

  b.   What aspects of performance are you monitoring?
       i.   Service delivery
       ii.   Documentation
       iii. Cost
       iv. Impact/outcomes
       v.   Client retention

  c.   What practice standards have you put in place for monitoring and evaluation of service provision?

  d.   What key measures/indicators are you looking at to assess adherence to these standards (e.g., days to follow-up postdischarge)?

6. Communication regarding care management (not payment, not IT, etc.)
   a.   Within your (lead) agency .
   b.   Lead agency with care management partners.
   c.   Lead agency with network providers.
   d.   What are the key communication mechanisms related to care management other than the shared care plan/data platform?
   e.   What are your expectations for care manager interaction with:
        i.   Other members of the care management team?
        ii.   Members of the care team?

7. Care management development opportunities and problem solving with health home colleagues (external to agency)
   a.   Describe the interface between your agency and the care management partners.
   b.   How frequent are interagency health home meetings? Administrative vs. case conferences?
        i.   Who attends (Network providers: primary care providers, specialty care providers, etc.)?
        ii.   How are meetings structured?
              •   Case conferences
              •   Challenges you have encountered in communication (apart from the care plan)
        iii. Perceived value
   c.   Network capacity building (facilitating interactions, partnerships, etc.).
        i.   Convening
        ii.   Identifying service gaps and engaging new partners
        iii. Enhancing strength of interpartner links
        iv.   Other
   d. Provider capacity building.
        i.   Training
        ii.   Provision of care management tools (the following are categories identified in a Robert Wood Johnson Foundation paper)
              •   Assessment tools
              •   Care planning
                  o   Algorithms
              •   Teaching and coaching (patients and families)
                  o   Accessible educational materials and scripting
                  o   Tools, prescription taking, self-management goal setting, etc.
                  o   Red flags
              •   Tracking
              •   Plan updating

8. Suggestions to improve care management/health home structure and/or capacity

② Care Management Partner Interview Guide

Introduction

Thank you very much for your willingness to participate in this one-hour telephone interview. We have three team members on the call: myself, Joslyn Levy, who will be conducting the interview; Rachel Sacks, who will be listening, taking notes, keeping time, and possibly asking additional questions; and Sara Softness, our assistant, who will be taking notes. Please be aware that we are recording this interview so that we may refer back to your comments at a later time.

Our goal for this hour is twofold. First, we hope to gain an understanding of how your organization fits into the health home model at (NAME OF THE HEALTH HOME). Second, we want to learn about how (NAME OF THE HEALTH HOME)'s model has enhanced continuity of care for health home enrollees at your organization, and what challenges have surfaced during the initial stage of program implementation. Ultimately, this information will be analyzed as part of our efforts to understand opportunities and challenges facing care managers within health homes at this early stage in the development of this new model, and to derive initial lessons learned to inform policy development and local practice around care management for people with complex health and social needs.

Topics we will address include:

- Organizational roles in delivering care management services across your health home;
- The breadth and depth of care management services delivered by your organization;
- Your agency's care management staffing model; and
- Communication with and about health home members.

We are purposely limiting our scope to these few areas rather than attempting to survey all aspects of health home implementation. A few major topics that we will not explore in depth are the development and use of technology in your health home network, financing issues encountered by your health home, and training the health home workforce. The reason for this limitation is that these issues are very complex ones; we are recommending to NYSHealth that it pursues separate papers on these topics. That said, we expect these topics to arise in relation to the other operational areas we'll discuss with you. Please share your thoughts about them as appropriate.

As a final note, we will be keeping a close watch on time because we know that each of the questions we ask could lead to its own hour-long conversation. When necessary, Rachel or I may ask you to wrap up a particular question before we fully explore it, simply to ensure that we are able to at least touch on all of the questions on our list. Please don't mistake any such intervention as disinterest in what you have to share with us.

1. Your organization's relationship to the lead health home agency
   a. What is your administrative relationship to the lead agency?
   b. How did you come to form this relationship with the lead agency (e.g., do you have a history of working with that agency)?

2. Staffing, hiring, and training your care management workforce
   a. Who is on your (multidisciplinary) care management care team?
   b. What are the qualifications of your care managers?
      i. Do you find that your care managers are appropriately credentialed to serve the needs of the patients who are assigned to them?
         • In terms of legal scope of practice
         • In terms of skills and training
      ii. When there are care management demands you can't address, what do you do?
      iii. Have you encountered situations where you feel you can provide care management but don't have the referral options the patient needs?
   c. How would you describe the care management model you've introduced? For example:
      i. Nurse led
      ii. Nurse supported
      iii. Nonprofessional (e.g., TCM case managers)
      iv. CHWs/peers (led or supported)
      v. Wellness coaches
      vi. Other

3. Care management services
   a. Following enrollment, what happens? Can you describe the flow of patients through your organization?
   b. What are the key services that a care manager provides?
   c. How do you determine caseload?
   d. Do you use any kind of stratification scheme to determine level of services or assignment of staff members?
   e. Are you able to consistently pair care managers with certain primary care providers, psychiatrists, or other providers in the network? Is this a goal for you? If not, why not?

4. Communication
   a. Care manager with patients.
      i. How frequent/intense is contact with health home members?
         • One-to-one meetings (e.g., face-to-face, phone, other)
         • Accompany to appointments/calls
      ii. How frequently does the care manager check the care plan for each patient?
   b. Care manager with agency colleagues and care team.
      i. Shared care plan
         • How do care managers update the shared care plan?
         • How do they share it with others on the care team?

- • How do they ensure that other agencies in the health home have access to the updated care plan when they need it?
  - ii. How do care managers interact with others on the care management team?
    - • How frequent are team meetings?
    - • What happens at them?
    - • How are immediate questions handled (e.g., if a care manager needs an urgent consult from a specialist)?
      - o If on-site, face-to-face consults
      - o Phone, e-mail, other
  - iii. How do care managers interact with member of the care team?
    - • How frequent are team meetings?
    - • What happens at them?
    - • How are immediate questions handled (e.g., if a care manager needs an urgent consult from a specialist)?
      - o If on-site, face-to-face consults
      - o Phone, e-mail, other

5. Supervision/training
   a. What supervision structures do you have in place for care managers?
      i. Describe supervisors' qualifications and backgrounds.
      ii. What types of meetings and other formal structures are in place?
      iii. What kind of supervision or QA is provided at the health home level?
      iv. What do you need to report up? Does the lead agency provide standards and guidance?
   b. What training have you or the health home provided to care managers?
   c. Additional training questions if indicated:
      i. Have you hired new staff members?
      ii. If no, are you planning to do so, or are you relying entirely on your current staff members?
      iii. If yes:
         • Who, and how many positions?
         • Where did you recruit them?
         • What qualifications and skills did you look for?
         • What additional training did you provide? Was this done alongside current staff members or as a special session for new staff members?

6. Care management development opportunities and problem solving with health home colleagues (external to agency)
   a. How frequent are interagency health home meetings? Administrative vs. case conferences?
   b. Who attends (Network providers: primary care providers, specialty care providers, etc.)?
   c. How are meetings structured?
      i. Case conferences
      ii. Challenges you have encountered in communication (apart from the care plan)
   d. Perceived value

7. Suggestions to improve care management/health home structure and/or capacity

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