
Rhode Island Health Home Initiative

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Why These Populations?

- Children and Youth with Special Health Care Needs (CYSHCN) have complex medical, behavioral health and psychosocial needs
- At greater risk of developing secondary conditions than the general Medicaid population
- Have higher utilization of Emergency Department and Inpatient Care
- 12,000+ CYSHCN in RI Medicaid

Why These Populations (cont'd)

- Some Infrastructure already in place
 - CEDARR Family Centers (CFCs) (CYSHCNs)
- Opportunity for further innovation
- Promote natural transitions between child and adult systems of care

CEDARR Family Centers for Children and Youth with Special Health Care Needs

- Comprehensive, Evaluation, Diagnosis, Assessment, Referral and Re-evaluation
 - Started in 2000
 - Teams led by Licensed Clinicians (LICSW, RN, Psychologist)
 - Family Centered Practice Approach
 - Statewide Coverage
 - 95% of work done in child's home or in a community setting

Other Opportunities

- Harness unique capabilities of CFCs “boots on the ground”
- Enhance connections between Health Homes and PCPs and specialists
- Take advantage of data collected by Medicaid Managed Care Organizations (MCOs) and Medicare claims to inform delivery of care

History of CEDARR

- Launched as part of a broader initiative to address the needs of CYSHCN and their families
- Broad based stakeholder involvement in entire development and implementation process (advocates, family members, providers, state agencies)

Goals of the CEDARR Initiative

- Decrease fragmentation within and between the systems serving children with special health care needs and their families through care management including the coordination and integration of services
- Assure that services are provided through a strength-based and person-oriented system of care
- Support families to their fullest potential and provide direct services, where necessary
- Assure a flexible and responsive delivery system with adequate staffing, equipment and educational resources

CEDARR Today

- Approximately 2,700 children and youth enrolled at any point in time
- Birth to 21 years of age
- 30% Developmental Disabilities, 50% Behavioral Health, 20% Physical Health condition

CEDARR Responsibilities

- Assessment of Need
- Identification of, and referral to resources
- Integration of services provided through different systems (LEA, Medicaid fee-for-service, Medicaid Managed Care, Child Welfare)
- Oversight of Medicaid Fee-for-Service specialized Home- and Community-based services
- Reassessment and adjustment of Treatment Plans on an annual basis

Why CEDARR as a Health Home

- Required Home Health Services are the core foundation of CEDARR
 - Comprehensive Care Management
 - Care Coordination and Health Promotion
 - Transitional Services
 - Individual and Family support
 - Referral to Community and Social Support Services
- 95% of current population meets Health Homes diagnostic criteria

Enhancements to CEDARR practice as a result of Health Homes

- Enhanced screening for secondary conditions (yearly BMI and Depression screening)
- Additional reimbursement to PCPs to engage in Care Planning and dashboard report developed to share CEDARR information with PCPs
- Enhanced Information sharing between CEDARR and Medicaid MCOs

How will we measure success?

- **Traditional Methods**
 - Decrease in Emergency Room utilization for ambulatory care sensitive conditions
 - Reduction in Readmissions
 - Provision of services within required time frames
 - Medical follow-up after Emergency Room visit
 - Health Home Services provided within required timeframes
 - Collaboration between Primary Care Provider and/or MCO in development of Care Plan

How will we measure success? Cont'd

- **Outcomes Based measurements**
 - Child/Youth/Family Satisfaction with service delivery, content of services, appropriateness of interventions
 - Child and Family Outcomes
 - Knowledge of Condition and available services and resources
 - Child's participation in age appropriate, peer group activities
 - Ability of family to engage in "normal family activities"

Core Quality Measures

Adult BMI Assessment	Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year
Ambulatory Care Sensitive Condition Admission	Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years. http://www.guideline.gov/content.aspx?id=15067
Care Transition – Transition Record Transmitted to Health care Professional	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=15178
Follow-Up After Hospitalization for Mental Illness	Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=14965
Plan- All Cause Readmission	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
Screening for Clinical Depression and Follow-up Plan	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received: (1) Initiation of AOD treatment and (2) Engagement of AOD treatment.

Coordination with Managed Care Organizations

- 2 participating Medicaid Managed Care Organizations (MCOs)
- Both paid capitation, inclusive of an administrative rate that includes care management
- CMS concern/requirement that no duplication of functions occur between Health Home and MCO
- Created contract amendment – protocols for collaboration/coordination

Coordination with MCOs, cont.

- Development and Implementation of a common communication protocol
- Joint Planning and Implementation Meetings convened by the State
- Enhanced Data Sharing between MCOs and Health Homes
 - Health Utilization Profile (MCO to Health Homes)
 - Monthly Enrollment Report (Health Homes to MCO)

Challenges and Suggestions

- Collecting core measures
- Ensuring non-duplication
- Beware of “the cliff”
- Begin stakeholder work early and often
- Include MCOs in process, if you are a managed care state
- Prepare for “the cliff”

Thank you

Questions

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