Transformation of Healthcare in New York State: Integrated Community Based Care for Children’s and Adolescents

Presentation: A Provider Perspective on implementing Children’s Medicaid Redesign Initiatives in New York State

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Presenter Disclosures

The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

No relationships to disclose
Introduction

- The Visiting Nurse Service of New York (VNSNY) was established in 1893 by Lillian D. Wald, the founder of public health nursing in the United States. VNSNY staff provide and coordinate the care of patients residing throughout New York City and in Westchester, Nassau and Suffolk counties.

- Established in 1986, VNSNY’s division of Community Mental Health Services (CMHS) was the first of its kind to exist within a home health care agency. CMH started the first NYC community based Mobile Crisis program and has grown over the years to encompass a wide range of behavioral health programs and services.

- Today, CMHS consists of 25 programs with a staff of over 300 and an annual budget of $31 million. Our programs provide care to approximately 12,000 individuals throughout New York City.

- CMHS delivers care to a spectrum of underserved individuals including those with acute and chronic mental illness, the geriatric population, children with emotional and psychiatric problems, the homeless and individuals with substance use disorders.

- CMHS has a long history and well established reputation for delivering high quality community based integrated care throughout NYC, providing psychiatric outreach, crisis intervention, care management and treatment services.

- City and state agencies such as NYC DOHMH and NYS DOH, as well as hospitals, CBO’s and managed care plans, recognize CMHS’s expertise in running successful and innovative programs, and have approached us to start up &/or expand programs when opportunities arise.
Introduction – VNSNY Children’s services

Children Programs at CMHS provide mental health treatment, wellness and prevention services for children, adolescents and their families. CMHS children’s program staff are trained in Cognitive Behavioral Intervention for Trauma in Schools (CBITS), giving them a directly trauma-informed perspective on their work. In 2017, we served a combined total of about 2000 children and families.

**Children’s Mobile Response team (CMCT)** – Bronx, Brooklyn, Queens: Targets children and adolescents up to age 17. This program provides short term crisis response and management services to help link children and their families to community services, as an alternative to emergency room use and hospitalization. The model uses a “rapid response” service and responds to referrals within two hours of a call to the Crisis Single Point of Access (Crisis SPOA).

**Home Based Crisis Intervention (HBCI)** – Bronx and Brooklyn operating since 1995, targets seriously emotionally and behaviorally disturbed children and adolescents with an Axis I diagnosis. This program provides short-term family-centered services to families with children who are at imminent risk of hospitalization because of a serious psychiatric crisis. In-home therapeutic services are provided three times weekly for four to six weeks.

**Bronx Fatherhood Program** – Bronx: Targets fathers ages 13-35. This program promotes responsible parenting through discussion approaches, experiential learning and father-child relationship enhancement activities, peer mentoring, counseling, mediation (when desired by both parents), and support groups.
Introduction – VNSNY Children’s services

**FRIENDS Crisis Stabilization Program** – Bronx operating since 2004, focuses on youth up to age 21 and targets seriously emotionally and behaviorally disturbed children, adolescents and their families. This project provides a comprehensive assessment and intensive in-home crisis intervention. The assessment and treatment visits are twice a week for six to 12 weeks. Supportive services, linkages and therapeutic recreation continue for three to six months thereafter.

**Article 31 FRIENDS Clinic** – Bronx, in operation since 2008, accepts clients 5 - 17 years of age and targets seriously emotionally and behaviorally disturbed children, adolescents and their families. The clinic provides outpatient mental health services including assessment, treatment planning, individual, and family / group psychotherapy, crisis intervention, and medication management. Generally clients are seen once per week with an average length of stay of six to eight months.

**Promise Zone** - operates out of five targeted public schools in the Bronx, and has engaged with an average of 112 children and adolescents per year over the past six years. Promise Zone combines a unique collaborative framework that teams a local school with an external mental health partner to create a learning environment that engages students so they are on task and ready to succeed. Promise Zone schools are mostly middle schools with at least 1,000 students, a high percentage of which reside in shelters, in disenfranchised neighborhoods.

**100 Schools Project in Brooklyn & Queens** - a school based behavioral health DSRIP initiative funded by 4 hospital based Performing Provider Systems (PPS) and administered by JBFCS - operating in 38 schools now, expanding to 40 by end of current school year

**STEPS Program** – The Self-Esteem Team-Building Empowerment (STEPS) provides emotional and behavioral support in a group setting for children and youth, ages 5 to 21. This program meets four times a week Monday through Thursday, 3PM – 5:30PM.
Children Statistics For VNSNY Programs

Gender
- Male: 60%
- Female: 40%

Ethnicity
- White: 72%
- Black: 25%
- Latino: 2%
- Other: 1%

Wages & Benefits
- Working: 31%
- Cash Assistance: 23%
- SSI/SSD: 12%
- One Income: 24%
- Unemployed: 10%
Children Statistics For VNSNY Programs

**Custody**
- Single Mother: 14%
- Single Father: 9%
- Two Parent: 6%
- Other Relative: 15%
- Guardian: 15%
- Other: 59%

**Psychiatric Diagnoses**
- ADHD: 15%
- Mood/Bi-Polar: 8%
- Adjustment: 1%
- Conduct/ODD: 47%
- Disruptive/Impulse: 7%
- Anxiety/PTSD: 7%
Healthcare Reform: The Affordable Care Act and New York State

- **Affordable Care Act - Passed in March of 2010**
  - ✓ Decrease Cost of Healthcare
  - ✓ Increase Access to Healthcare
  - ✓ Increase Quality of Healthcare Service

- “**Health Home**” is a State Plan benefit authorized under Section 2703 of the Affordable Care Act (ACA) to coordinate care for people with Medicaid who have chronic conditions. Implemented in 2012, there are currently **176,284** members enrolled in 35 Health Homes across the state.

- New York’s **Delivery System Reform Incentive Payment** (DSRIP) program implemented in 2014 is an initiative and opportunity to reinvest $6.42 billion dollars of projected Medicaid savings to support and transform the state’s health care delivery system.
What is the “Health Home”?

A Health Home is a care management service model for Medicaid patients who have complex chronic diseases and mental health disorders.

Health Home Care Coordination Goals:

- Enhanced care coordination and integration of primary, acute, behavioral health (mental health and substance abuse) services
  - Utilization of best practices
  - Improve Preventative Care

- Linkages to community services and supports, housing, social services, and family services for persons with chronic conditions

- Reduce high cost avoidable hospital inpatient stays and emergency room visits

Key Elements of Health Home Care Coordination

- A clearly identified Care Team
  - Coordinated care between a care manager and all providers treating a patient
  - Identify and address barriers to care
  - Implement single, integrated care plan

- A single Care Plan
  - Comprehensive, single document
  - Trans-disciplinary
  - Part of routine care for all providers
NYS Children Eligible for Health Home Care Coordination Services

- **Medicaid** covers 43% of all New York Children (2.3 Million)
- 37% of State-wide Medicaid beneficiaries are Children
- 20% of the **Children beneficiaries** have been identified as potential eligible Health Home members

<table>
<thead>
<tr>
<th>Existing and Modified Eligibility Options</th>
<th>Number of Children</th>
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</thead>
<tbody>
<tr>
<td><strong>Children that Meet Existing HH Eligibility Criteria</strong></td>
<td></td>
</tr>
<tr>
<td>Foster Care (With SMI*, HIV or 2 or more Chronic Conditions)</td>
<td>6,152</td>
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<tr>
<td>Medically Fragile Children (With SMI*, HIV or 2 or more Chronic Conditions)</td>
<td>3,558</td>
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<tr>
<td>Foster Care and Medically Fragile Children (With SMI*, HIV or 2 or more Chronic Conditions)</td>
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<tr>
<td>All Other Children (With SMI*, HIV or 2 or more Chronic Conditions)</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>89,886</strong></td>
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<table>
<thead>
<tr>
<th>Potential Eligibility Modifications</th>
<th>Number of Children</th>
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<tbody>
<tr>
<td>Foster Care not Eligible under Existing Criteria</td>
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<tr>
<td>Medically Fragile Children not Eligible under Existing Criteria</td>
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<tr>
<td>Expanded MH Definition SED-Like</td>
<td>63,344</td>
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<tr>
<td>Foster Care and Medically Fragile Children not Eligible under Existing Criteria</td>
<td>131</td>
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<tr>
<td>Foster Care and SED - Like not Eligible under Existing Criteria</td>
<td>3,459</td>
</tr>
<tr>
<td>SED Like and Medically Fragile Children not Eligible under Existing Criteria</td>
<td>173</td>
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<tr>
<td>Foster Care, SED- and Medically Fragile Children not Eligible under Existing Criteria</td>
<td>4</td>
</tr>
<tr>
<td>ADHD</td>
<td>42,243</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>144,817</strong></td>
</tr>
</tbody>
</table>

Total Children that Meet Current and Potential Eligibility Modifications: 234,703

*SMI: Schizophrenia, Bi-Polar Disorder, Depressive Psychosis
**Expanded MH Definition – Single condition of eating disorder; conduct, impulse control, other disruptive behaviors, major personality disorders, chronic mental health diagnoses, depression, chronic stress and anxiety, post traumatic stress disorder

Eligibility Criteria for Health Home Care Management

- Children from birth through age 21, enrolled in Medicaid
- Two or more chronic conditions* (e.g. substance use disorder, diabetes, hypertension, asthma), OR
- Severe Emotional Disturbance (SED) OR Complex Trauma (Children) OR
- HIV/Aids
VNSNY is a partner in two key NYC Health Homes: CCMP (Bronx and Manhattan) and the Brooklyn Health Home (Brooklyn).

VNSNY serves the most vulnerable New Yorkers with severe behavioral health needs. Since its inception in January 2012, the HH has provided care coordination services to 2,790 adult members.

**NYS Adult Health Home Achievements:**

- There has been a 5% drop in emergency room utilization and a 1% percent increase in primary care utilization (Oct 2015 –March 2016 data).
- There was a 17% drop in preventable readmissions between 2014 and 2015.
Children’s Health Home Implementation Challenges

- Delivery of services to meet the needs of children and family
  - Meet the needs of complex populations
  - Partner with school districts and the education system

- Consent process
  - Voluntary and role of parent and/or guardian in this process

- Referral and Assessment process

- Tailoring Network Requirements for Children

- Staffing challenges
DSRIP (Delivery System Reform Incentive Payment)
New York State DSRIP Overview

- **New York’s Delivery System Reform Incentive Payment (DSRIP) program** is an opportunity to **transform the state’s delivery system** by developing integrated delivery systems, removing silos, enhancing primary care and community-based services.

- DSRIP will allow the state to reinvest over **$6.42 billion** in federal savings generated by Medicaid Redesign Team (MRT) reforms in **infrastructure and programs for population health management** and focus on system reform, specifically a goal to achieve a **25% reduction in avoidable hospital use over five years**.

- **25 Performing Provider Systems** (PPS) were awarded DSRIP contracts for 5 years. Performing Provider Systems (PPS) are entities responsible for creating and implementing a DSRIP project.

Source: [http://www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm](http://www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm)
NYS DSRIP: 45 Projects Organized into 4 Domains

Domain 1: Overall Progress
- Measured by achieving process & other metrics

Domain 2: System Transformation
- Select between 2-5 projects
- Create Integrated Delivery System
- Implement Care Coordination & Transitional Care Programs
- Connecting Settings

Domain 3: Clinical Improvement Projects
- Select between 2-4 projects, 1 must be behavioral health
- Behavioral Health
- Cardiovascular Health
- Diabetes Care
- Asthma
- HIV/AIDS
- Prenatal Care
- Palliative Care
- Renal Care

Domain 4: Population Wide Projects
- Select 1 or 2, consistent with Domain 3
- Promote Mental Health & Prevent Substance Abuse
- Prevent Chronic Disease
- Prevent HIV & STDs
- Promote Healthy Women, Infants & Children

VNSNY Participation in Children Focused DSRIP Initiatives

- **Health Home At-risk Intervention Project** - part of Domain 2 System Transformation and Domain 3 Clinical Improvement Initiatives
  - Partnership with **Community Care of Brooklyn (CCB) PPS**. 4th largest PPS in our service area with a total valuation of $489 million
  - For those with single chronic conditions who do not qualify for a Health Home.
  - To expand access to community primary care services and develop integrated care teams to meet the individual needs of higher risk patients who appear on a trajectory of decreasing health and increasing need that will likely make them HH eligible in the near future.

- **100 Schools DSRIP Initiative** - part of Domain 2 System Transformation and Domain 4 Population Wide Projects
  - Partnership with 4 PPS’s: **One City PPS, Bronx Partners for Health Communities (BPHC) PPS, Community Care of Brooklyn (CCB) and NYU Langone Health** who invested **11.5 million** to the Jewish Board to coordinate the 100 Schools Project as a way of addressing mental health problems before they turn into full-blown crises that require more expensive emergency care.
Pediatric providers will identify patients who are “at risk” and refer to care management. Embedded Health Coaches:

- Establish goals and creates care plan, with the patient
- Coordinate care, manage referrals, and monitor & outreach between visits
- Create and monitor patient registries
- Educate member and family on basic management of the disease
- Work with patient / family to mitigate impacts of social factors on health and functional status
- Track and follow up on test results to ensure patient and care giver take appropriate next steps as needed
- Serve as primary care practice’s first point of contact during ED or inpatient discharge care transition
- Refer to the Health Home, as needed
## Home at Risk Intervention Program—Pediatric Partnerships

279 kids referred to the Health Home and 193 children served through this project (May 2017-Dec 2017 Data)

<table>
<thead>
<tr>
<th>Practice</th>
<th>Schedule</th>
<th>Time Period</th>
<th>Population Served</th>
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<tbody>
<tr>
<td>De Vito Pediatrics</td>
<td>2 days</td>
<td>Jan ‘18 - Current</td>
<td>Hispanic</td>
</tr>
<tr>
<td>Belilovsky Pediatrics</td>
<td>2 days</td>
<td>Feb ‘18 - Current</td>
<td>Russian/Hispanic / Bangladeshi</td>
</tr>
<tr>
<td>Eastern Pediatrics</td>
<td>4 days</td>
<td>June ‘17 – Current</td>
<td>African American</td>
</tr>
<tr>
<td>Comprehensive Pediatrics</td>
<td>2 days</td>
<td>June ‘17 – Jan ‘18</td>
<td>Hispanic</td>
</tr>
<tr>
<td>Kinder Care Pediatrics</td>
<td>2 days</td>
<td>May ‘17- Sept ‘17</td>
<td>Hasidic Jewish</td>
</tr>
</tbody>
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Health Home at Risk Program Data

- **193** children served (2017 data).
- Average length of intervention = **4 months**
- Interventions include:
  - Parent Education
  - Referrals to Air NYC (Asthma Self Management Program), Health Home (higher level of care coordination need), Nutritionists and developing exercise goals with member and parent
Sample Care Plans

### Care Plan Goals related to Asthma

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<tr>
<th>ISSUE SUMMARY</th>
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<tr>
<td><strong>Collaborators</strong></td>
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**LONG-TERM & SHORT-TERM GOALS**

<table>
<thead>
<tr>
<th>Type</th>
<th>Start Date</th>
<th>Anticipated End Date</th>
<th>Last Modified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Term</td>
<td>5/26/2017</td>
<td>10/26/2017</td>
<td></td>
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<tr>
<td>Objective Goal</td>
<td></td>
<td></td>
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Goals to be made 07/28/17 Date 09/31/17 - Pt to incorporate 9 essential nutrients in diet. Reduce snacks and replace with vegetables, eg carrots, celery and other vegetables that pt likes. These to be done lunch and evening meals seven days/week. Saturdays, Pt needs to research nutrition plan options.

### Care Plan Goals related to Obesity

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<th>Last Modified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Term</td>
<td>6/27/2017</td>
<td>9/29/2017</td>
<td></td>
</tr>
<tr>
<td>Objective Goal</td>
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1. Adjust diet to include eating more vegetables. 
2. Increase activity to eg. Dancing for 10-15 minutes 3 days/week, Tuesday & Thursday evenings.

Comments: Mother's feeling of stress could become a barrier to performing the activity goals. To overcome stress mother will think of her daughter's A1C reading of 5.8 and the importance for change in her daughter's health. A1C Referral.
100 Schools DSRIP Project: What we do & how it’s measured

- Train school staff on Mental Health and Substance abuse topics
- Promote parent engagement
- Train school staff on “healthify” a platform for community resources
- Classroom observations (Coaching)
- Case consultations
- Crisis Team Participant
- Develop school plans to support school needs
- Qualtrics (records school visits, Interactions with staff, Trainings, observations and coaching)
- Journal Entry (all coaches submit Journals through Jewish Board system every Friday)
- Trainings Satisfaction
The 100 Schools Project works to make sure New York City’s teachers, guidance counselors, and administrators are better prepared to identify students who are grappling with issues like depression or addiction, so they can get the help they need—and teachers can focus on their classrooms.

This five-year initiative in 100 middle and high schools in Brooklyn, the Bronx, Manhattan and Queens was launched in the Fall of 2016.

Our Goals
- We aim to address mental health problems in students before they turn into full-blown crises.
- Increase academic successes, reduce dropout levels, reduce truancy, and reduce teacher turnover
- Increase mental health literacy in both staff and students, to develop the necessary skills to reduce risky behaviors, and to better utilize behavioral health services in the community
- Trainings for teachers and students on understanding mental health and substance use and prevention strategies
- Provide professional development, support, and self-care for teachers
- Coach and support school staff on effective crisis responses and de-escalation techniques
- Assist school staff in early identification of behavioral health issues and help school staff with referrals and community linkages
- Develop a sustainable plan to ensure continuation of project gains by integrating into school systems
Future of Children’s Health Care in New York State

- Effective Models of Care Delivery and Value Based Payment
- Social determinants of health and how they impact care delivery
- Changing the culture of the provider system
- Optimize the use of Health Information sharing technology
DSRIP Needs Assessment Data – Bronx

DSRIP Needs Assessment Data – Bronx

Source: Community Needs Assessment Bronx: [http://www.onecityhealth.org/community-needs-assessments/]
DSRIP Needs Assessment Data – Bronx

DSRIP Needs Assessment Data – Bronx

DSRIP Needs Assessment Data – Brooklyn

Source: Community Needs Assessment Brooklyn [http://www.onecityhealth.org/community_needs_assessments/](http://www.onecityhealth.org/community_needs_assessments/)
DSRIP Needs Assessment Data – Brooklyn
DSRIP Needs Assessment Data – Brooklyn

Source: Community Needs Assessment Brooklyn [http://www.onecityhealth.org/community_needs_assessments/]
New York State Health Home Model

Managed Care Organizations (MCOs)

New York State Designated Lead Health Homes
Administrative Services, Network Management, HIT Support/Data Exchange

Health Home Care Management Network Partners
(includes former TCM Providers)
- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services
- Use of Health Information Technology to Link Services
  (Electronic Care Management Records)

Access to Required Primary and Specialty Services
(Coordinated with MCO)
- Physical Health, Behavioral Health, Substance Use Disorder Services, HIV/AIDS,
  Housing, Social Services and Supports

Six Core Functions of NYS Health Home Model

- **Comprehensive Care Management**
- **Care Coordination and Health Promotion**
- **Health Information Technology**
- **Patient and Family Support**
- **Referral to Community and Social Supports Services**
- **Comprehensive Transitional Care**

*HH Care Manager & HH Client*

Health Home care management is “whole-person” and “person-centered” and integrates a care philosophy that includes both physical/behavioral care and family and social supports – includes the foundation for and elements of Wraparound Models.
New York State Health Home Model for Children

Managed Care Organizations (MCOs)

Health Home
Administrative Services, Network Management, HIT Support/Data Exchange

HH Care Coordination
- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services
- Use of HIT to Link Services

Care Managers Serving Adults
(Will support transitional care)

Pediatric Health Care Providers

OMH TCM (SCM & ICM)

Waivers (OMH SED, CAH & B2H)

DOH AI/COBRA

OASAS/ MATS

OCFS Foster Care Agencies and Foster Care System**

Care Managers Serving Children

Access to Needed Primary, Community and Specialty Services (Coordinated with MCO)
Pediatric & Developmental Health, Behavioral Health, Substance Use Disorder Services, HIV/AIDS, Housing, Education/CSE, Juvenile Justice, Early and Periodic Screening Diagnosis and Treatment (EPSDT) Services, Early Intervention (EI), and HCBS/Waiver Services (1915c/j)

Note: While leveraging existing Health Homes to serve children is the preferred option, the State may consider authorizing Health Home Models that exclusively serve children.